Northern Ireland Ambulance Service
Health and Social Care Trust

A Meeting of Trust Board to be held at 1.00pm on

Thursday, 7 April 2016 in Roe Park Resort Hotel, 40 Drumrane Road, Limavady, Co Londonderry, BT49 9LB

		Paper Enclosed	Timing Guide
Welcome, Introduction and Format of Meeting			
1.0	**Apologies**		13:00
2.0	**Procedure:** Declaration of potential Conflict of Interest: Quorum:		
	Suspension of Standing Orders		
	Transforming Your Care Presentation: • An update on NIAS Transformation and Modernisation Programme • Question and Answer Session		
	FINISH		
	Re-instate Standing Orders		
3.0	**Minutes of the previous meeting of the Trust Board held 4 February 2016** (for approval and signature)	TB/1 07/04/2016	14:00
4.0	**Matters Arising:** **Action Log from 4 February 2016:**	TB/2 07/04/2016	14:05
5.0	**Chairman's Business**		
	5.1 Chairman's Update		14:10
	5.2 Visit to Limavady Ambulance Station		14.15
6.0	**Chief Executive's Business**		
	6.1 Chief Executive's Update		14.20

7.0	**Performance Report as at 29 February 2016**				
	7.1	Highlight Reports by each Director: Operations, Finance, Human Resources, Medical	TB3	07/04/2016	14:30
	7.2	Chief Executive Report – Trust Delivery Plan Report on Commissioning Priorities 2015-16	TB4	07/04/2016	15.20
8.0	***Items for Approval***				
	8.1	Performance Management Framework	TB5	07/04/2016	15:30
	8.2	ICT Security Policy	TB6	07/04/2016	15:40
	8.3	Information Governance Strategy 2015-2018	TB7	07/04/2016	15:50
	8.4	Records Management Strategy	TB8	07/04/2016	16:00
	8.5	Information Risk Policy	TB9	07/04/2016	16:10
9.0	***Items for Information***				
	9.1	Assurance Committee Report (Dr Livingstone)			16:20
	9.2	Board Governance Self-Assessment Tool 2015-16			16:30
10.0	***Items for Noting***				
	10.1	Assurance Committee Minutes dated 18 January 2016	TB10	07/04/2016	16:40
	10.2	Audit Committee Minutes dated 18 January 2016	TB11	07/04/2016	
11.0	***Application of Trust Seal***				16:45
12.0	***Forum for Questions***				16:50
13.0	***Any Other Business***				16:55
14.0	***Summary & Forward Agenda***				17:00
			Total Approx Time:		**4hrs**

Next meeting of Trust Board will be held on Thursday, 2 June 2016, Belfast Division, NIAS HQ, Site 30 Knockbracken Healthcare Park, Saintfield Road, Belfast, BT8 8SG

Standing Orders

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

Admission of Public and the Press

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

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

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

3.18 ***Observers at Board meetings***

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

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

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

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

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

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

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

Trust Board Meeting to be held on Thursday, 7 April 2016 at 1.00 pm in The Roe Park Resort Hotel, 40 Drumrane Road, Limavady, Co Londonderry, BT49 9LB

TB/1 07/04/16

Northern Ireland Ambulance Service
Health and Social Care Trust

Minutes of a Trust Board Meeting held
Thursday, 4 February 2016 at 2.00pm, in the Kilmorey Arms Hotel,
41-43 Greencastle Street, Kilkeel, Co Down, BT34 4BH

Present:

Mr P Archer	Chairman
Mr L McIvor	Chief Executive
Mrs S McCue	Director of Finance & ICT
Dr D McManus	Medical Director
Mr B McNeill	Director of Operations
Mrs L Gardner	Assistant Director of HR&CS
Mr N McKinley	Non-Executive Director
Mr A Cardwell	Non-Executive Director
Dr J Livingstone	Non-Executive Director
Mr T Haslett	Non-Executive Director
Mr W Abraham	Non-Executive Director

In Attendance

Miss K Baxter	Executive Administrator (T)
Ms J Fleming	Senior Secretary

Welcome and Format of the Meeting

The Chairman opened the meeting by welcoming members of the Trust Board.

1.0 Apologies

Ms R O'Hara, Director of Human Resources & Corporate Services

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

No potential Conflicts of Interest/pecuniary Interests were declared and the Board was confirmed as quorate.

3.0 Minutes of the Previous Meeting of the Trust Board held on 3 December 2015.

Members accepted the minutes as a true reflection of discussions held on the proposal of Dr Livingstone, seconded by Mr Cardwell.

Action: Approved

4.0 Matters Arising;

Action Log from Meeting held 3 December 2015 :

Visit to Newcastle Ambulance Station

The Chairman advised that due to recent personal commitments he has not yet written to the Chief Executive of the Belfast Trust to arrange for NIAS Board to visit the Royal Victoria Hospital A&E Department. Item to remain on Action Log.

Performance Report

The Assistant Director of HR&CS confirmed that the staff communique on the Job Evaluation process has now been issued. Remove from log

The Chief Executive confirmed that the Complaints Report & Patient Experience Stories report have now been reinstated into the HR&CS Trust Board Performance Report. Remove from Log.

In relation to the Regional Community Resuscitation Strategy, the Chief Executive advised he has written to Dean Sullivan of Health and Social Care Board and awaits his response with regard to the clarity of the funding.

Other Matters Arising

None

5.0 Chairman's Business

5.1 Chairman's Update

The Chairman gave a brief outline of his diary commitments since the last Board meeting.

5.2 Visit to Kilkeel Ambulance Station

The Chairman expressed his appreciation for the earlier visit to Kilkeel Ambulance Station asking that his thanks be passed on to all involved. He recognised Kilkeel Station as a model station and the Board echoed these sentiments.

Action: The Chairman to contact the Chairman of the Belfast Trust to arrange a site visit for Board members to the Royal Victoria Hospital A&E.

6.0 Chief Executive's Business

6.1 Chief Executive's Update

The Chief Executive gave a brief outline of some of his activities since the last Board Meeting. Dealing with winter pressures took up a lot of his time,

however he highlighted the following activity:

- Working with Director of Operations to improve performance.
- Engagement with Health & Social Care Board (HSCB) re HSC financial balance.
- Engagement with Strategic Leadership Group.
- Engagement with the Air Ambulance (HEMS). At this point the Chief Executive invited Medical Director to update the Board who advised that the public consultation closed on 22 January 2016. The outcome is awaited.

The Chairman and Board members congratulated the Chief Executive on his appointment as Chief Executive of BSO.

7.0 Performance Report as at 31 December 2015

7.1 Operations

The Director of Operations updated members advising the verbal Report is comprised of three components: -

(1) Review of performance
(2) Overview of Christmas and New Year period
(3) Plans to improve performance at year end.

Review of Performance

- Overall activity in December 2015 had increased by 2% equivalent to an additional 24 calls each day when compared to December 2014. Compared to November 2015 activity increased by 5.5%, the equivalent to 61 additional calls per day.
- Emergency activity rose by 7.6% in comparison to November 2015 equating to 40 additional emergency calls per day from previous month.
- NIAS has not met the Cat A target. Cumulatively Cat A demand has dropped by 4.3% compared to April – December last year. The cumulative number of Cat A Calls responded to within 8 minutes has also significantly dropped, 14.2% compared to the same timeframe.
- The average Cat A response regionally in December 2015 was 11.41 minutes with Belfast achieving 9.01 minutes and 16.16 minutes in the Northern LCG.
- NIAS did not meet the conveying target in any of the LCG areas.
- RRVs contributed 24% toward Cat A response times within 8 minutes
- In December 2015 50.8% of all ambulance turnaround times were “in standard” (30 minutes or less) compared to 54% in December 2014
- Emergency Department ambulance turnaround times has increased by 21% compared to December 2014 showing an additional 1047 hours lost during December 2015 compared to December 2014. Loss of ambulance production hours equates to 8 ambulances lost per day of December 2015 compared to 6.6 ambulances lost in December 2014.

- The circumstances and process used to implement diverts were explained in detail.

Overview of Christmas and New Year Period

The Director of Operations expressed his appreciation to all staff who had worked over the Christmas and the new year period particularly in light of the increased number of Cat A Calls received. He recognised recent problems exacerbated by diverts, and acknowledged that while Transforming Your Care (TYC) projects will bring benefits, this will take time. He further recognised the pressure on staff, particularly regarding ambulance turnaround times and late finishes.

Plans to improve performance by Year End

The Director of Operations outlined recent engagement with Commissioners and in particular the recent work of the Operations Team in the development of the March 60 Plan which aims to achieve no less than 60% performance regionally during March 2016.

The following questions/points were noted:

- Can the March 60 Plan be sustained?
  - With reduced demography funding this would not be possible but added it would provide guidance to assist in future funding applications.
- The Board asked for clarity regarding the HALO posts
  - The Director of Operations confirmed that the HALO posts advertised were to replace the previously held posts on a recurrent basis and were not new positions.

Discussion ensued regarding diverts and ambulance turnaround times particularly the length of turnarounds. The Director of Operations commended the work of the Workforce Stabilisation Programme over the past 18 months in the recruitment of paramedics, Emergency Medical Technicians and Ambulance Care Attendants.

In relation to Control, the Director of Operations agreed to provide information in relation to identifying and triaging calls.

The Director of Operations gave a brief update on Fleet and Estates. The following points/comments were made:

- The Fleet Report is very positive with most of the fleet being less than 5 years old.
- New Ballymena Ambulance Station progressing well – due to complete late February 2016. Building will soon be ready to occupy.
- Enniskillen archaeology report showed no significant finds and report submitted to planning with approval awaited.
- Roll out of new uniform planned for Summer 2016.

- The Board asked the reasons for the lack of progress of the Fleet Maintenance Contract?

➢ The Director of Operations indicated that NIAS continue to engage with BSO. The Assistant Director of Fleet has further detail of the current position.

Action:

The Chief Executive agreed with Mr McKinley's observation that written performance reports for the Board needed to be forward facing as well as providing an account of performance to date.

Update on the Fleet Management Contract to be provided at next Board meeting.

7.1 <u>Finance and ICT</u>

The Director of Finance & ICT updated members on the report. The following issues/comments were raised.

- Break-even anticipated at year end subject to key risks and assumptions. As at Month 9 there is a small surplus of £8k.
- Savings Proposals - £1.2m on track to deliver in year.
- Cumulative Capital Spend noted as £7.256m in year.
- Prompt Payment of Invoices –the target has been met and exceeded for the first time this year sitting at 97.4%
- BSO – no particular issues to highlight
- Information Technology Systems – loss of telephony was reported together with Mobile Data fault. Disruption was minimal.
- Information Governance - ongoing work regarding policies and procedures.
- Freedom of Information Requests (FOIs) - 75.2% requests have been processed within 20 working days.
- Data Protection Requests **-** 61% of subject access requests have been processed within 40 days.
- Patient Report Forms (PRFs) –It was noted that approximately 15,000 Patient Report Forms were manually processed each month.

The Board enquired when work on Policies and Procedures will be completed? The Director of Finance responded that this has been discussed at the Information Governance Steering Group. There has been significant pressure on her team but she will endeavour to have some completed by end March 2016.

7.1 <u>Human Resources and Corporate Services</u>

The Assistant Director of HR&CS gave a detailed update to members. She reported:

- The Trust has an overall vacancy level of 105.35 WTE posts.
- In June 2014 the Trust commenced a workforce stabilisation programme which included recruitment to frontline vacancies. Since this date 176 appointments have been made resulting in a reduction in vacancy levels albeit the Funded Establishment has also increased by 50 WTE since then.
- Staff Communique issued to staff in December 2015 regarding Job Evaluation. Unison have stated that the Trust breached Agenda for Change protocols by issuing the communique but the Trust are clear they have stayed within process at all times.
- Absence Levels at December 2015 were noted as 11.97%. NIAS sickness levels are high in comparison to NHS Ambulance Trusts. HSC Comparative figures are no longer available for comparison by Occupational Grouping as these figures are no longer collated centrally for the HSC by the DHSSPS.
- Industrial Relation issues still remain challenging. The Board were advised that Trade Unions withdrew from the Job Evaluation process in July 2015 and continue to disengage on this. Local issues arising from the Industrial Action day on 13 March 2015 continue to be managed internally.
- BSTP Update - HRPTS was implemented February 2014 and work is ongoing regionally to provide full deployment.
- Benefits Realisation – regional meetings continue.
- Shared Services - NIAS continues to engage with BSO Shared Services in planning the phased transition of the recruitment function to shared services. This will not impact directly on staff within HR Department. It was noted that Payroll in NIAS moved to BSO Shared Services in February 2015. Regular meetings continue with BSO.
- Complaints and Compliments Reports were noted. The full Complaints Report has been reinstated as requested by the Board.

The following issues questions arose:

- In relation to Comp 983 which was not upheld, why was a letter of explanation and apology issued to the Complainant?
  - An apology is issued as part of a standard response. The letter apologises that the patient experience was not good rather than the reason behind the complaint.
- Why over the festive period are sickness levels so high?
  - Sickness is mainly in the operational area and is due to variety of reasons such as muscular skeletal injuries which may be more prevalent at that time of year.
- The Board enquired why staff in NIAS Payroll still remain at HQ and why they have not moved over to Shared Services so that savings can be realised.
  - NIAS were late in transferring across compared to the other HSC Trusts. There are still some issues and now is not the right time to move until the problems have been ironed out. NIAS are working closely with BSO and discussions are ongoing at Audit Committee.

7.4 Medical

The Medical Director gave a brief outline of his Report. He reported:

- Business Continuity Report - Training in Business Continuity was delivered by Department of Finance & Personnel (DFP) to NIAS Directorate Business Continuity functional leads on 2 February 2016. Further work on this is being undertaken to develop a questionnaire to inform the development review and exercising of business continuity plans during 2016/17.
- Major Incident Report - A major incident was highlighted which received significant media attention at the time in which a car had driven into a crowd resulting in six people being taken to hospital with serious injuries. Trust Board were advised that the incident had been managed very well.
- Risk Management Report - Trust Board were advised that a new interim Risk Manager had been appointed from mid-January 2016.
- Community Resuscitation Strategy – Trust Board were informed that a decision from HSCB in response to an investment proposal submitted in November 2014 was still awaited. This was for funding in accordance with the Strategy for a team of Community Resuscitation Development Officers (CRDOs) to support its implementation. While work is still ongoing to support a number of issues, full implementation is significantly constrained by the lack of funding and a number of initiatives have now ceased as a result.
- Electronic Patient Report Form (ePRF) - there has been no further progress. A Business Case was submitted and the Trust is still awaiting Commissioner support for revenue funding. The situation is now further complicated by the regional proposal for an Electronic Health Care Record (EHCR) and whether it will meet the needs of the Trust. The Trust is still awaiting an outcome from HSCB in relation to support for revenue funding and the role of the Trust in the EHCR. The Chief Executive has written to HSCB to request a decision and further information regarding this.
- Alternative Care Pathways – A number of further Appropriate Care Pathways (ACPs) have been introduced with a number of previously introduced pathways now in place on a regional basis. Work is continuing on the development of further pathways and a clinical support desk in Emergency Ambulance Control.
- Patient Experience – It was noted that the reports provided related to calls and patient stories some time ago. It was explained that this was due to NIAS relying on the other HSC Trusts to provide us with patient responses in relation to the Ambulance Service and that often significant delays were experienced in receiving this information. Engagement is currently ongoing to ensure more timely receipt of the information from the other Trusts. While most of the patient stories are positive, there were a number that reflected that patients felt vulnerable and anxious if left alone in the passenger compartment of PCS vehicles. It was agreed that a member of the ambulance crew

should remain with patients at all times.

- Clinical Audit – An audit of Out of Hospital Cardiac Arrest data in relation to Return of Spontaneous Circulation (ROSC) on arrival at hospital was presented. A significant improvement in this outcome from cardiac arrest was noted and was similar to other ambulance services.

7.5 Chief Executive Report
Trust Delivery Plan Report on Commissioning Priorities 2015-16

The Chief Executive identified the key risks the Trust faces:-

1) Capacity and Demand;
2) Link of timely response to clinical calls (Cat A)
3) Financial Balance.

The Chief Executive also provided a brief update on the Trust Delivery Plan on Commissioning Priorities 2015/16 since last Trust Board. He advised the Board that the HSCB had selected NIAS to host a visit of representatives from Finland in relation to Alternative Care Pathways. This meeting is scheduled to take place on 10 February. He advised that information on priorities for 2016/17 is awaited and the Trust will strive to continue to meet CAT A target.

8.0 Items for Approval

8.1 Gifts and Hospitality Policy

The Director of Finance presented this updated policy for approval confirming that it had been to Audit Committee on 12 October 2015.

8.2 Terms of Reference – Audit Committee

The Director of Finance presented the Terms of Reference which had been tabled at Audit Committee on 12 October 2015. The following items have been amended:-

'1.4 The Committee will regularly review and reflect on best practice and adopt new learning as part of a commitment to continuous improvement.'
'2.6 One member of the Audit Committee should have a financial background'.

8.3 Terms of Reference – Remuneration Committee

The Chairman advised that changes were cosmetic and not significant.

8.4 Smoke Free Policy

The Director of Operations advised that all Trusts have been obligated by the DHSSPS to be Smoke Free by 9 March 2016. He indicated that this policy replaces the previous Smoke Free workplace policy of 2007. The

Board remarked that this policy will be difficult to implement.

Action All above approved on the proposal of Mr Abraham seconded by Mr McKinley with the exception of item 8.2 which was seconded by the Chief Executive.

9.0 Items for Information

9.1 Long Service Medal Ceremony

The Chair reminded the Board of the Long Service Medal Ceremony planned to take place on 23 March 2016 in Balmoral Hotel, Belfast. The Lord Lieutenant will not be attending this year as no staff are eligible for the Long Service (Emergency Duties) medal. He remarked a good representation by the Board would be welcome.

9.2 Northern Ireland Ambulance Service HSC Trust Management Statement

The Director of Finance advised that Trust Board have been requested by the DHSSPS to review this document. The Board remarked it is an interesting document setting out NIAS' obligations and objectives. It was noted that gender is an issue on page 17 in relation to Board vacancies (2nd bullet point). The Chairman stated that the Minister makes the final appointments however the point was well made.

10.0 Items for Noting

10.1 Minutes of Audit Committee Meeting held 12 October 2015

Noted

11.0 Application of Trust Seal

The Trust Seal was used once on 16 December 2015 for the Lease for Ballymacarrett/Bridge End.

12.0 Forum for Questions

No questions were submitted through the recognised process. Further discussion of general matters with those present took place after the meeting.

Action: Chairman to consider the procedure for questions.

13.0 Any other Business

None

Date, Time and Venue of Next Meeting

The next meeting of Trust Board will be held on Thursday, 7 April 2016 at 2.00pm in Western Division (venue to be confirmed).

The Chairman thanked those present for attending and called proceedings to a close.

Signed: _____
Chairman

Date: _____

TB/2 07/04/16

Northern Ireland Ambulance Service
Health and Social Care Trust

Trust Board Public Meeting - Action Log

At each Board Meeting, action points are recorded throughout the meeting to note items which need further development, additional work or raise other issues which need to be considered or discussed. This document has been created to keep a record of these action points. **This list will be issued after each meeting as a reminder to the relevant Directors.**

Date of Meeting	No	Minute Reference	Agenda Item (topic)	Allocated To	Action
4 February 2016	1	5.2	Chairman's Business	Chairman	Chairman to contact Chair of Belfast Trust to arrange site visit for members to the RVH.
	2	7.1	Operations Performance Report	Director of Finance & ICT	Update on Fleet Management Contract to be provided for next Trust Board.
	3	12.0	Forum for Questions	Chairman	Chairman to review procedure for submission of questions by the public

TB/3 07/04/16

PERFORMANCE REPORT AS

AT 29 FEBRUARY 2016

NORTHERN IRELAND AMBULANCE SERVICE

TRUST BOARD REPORT
OPERATIONS DIRECTORATE

Director of Operations
07/04/2016

The Operations Directorate report is comprised of three sections:

Section 1 is an analysis of performance against demand and the various contributing factors.

Section 2 is a brief synopsis of key Control & Communications elements of the service and their relevance to our performance.

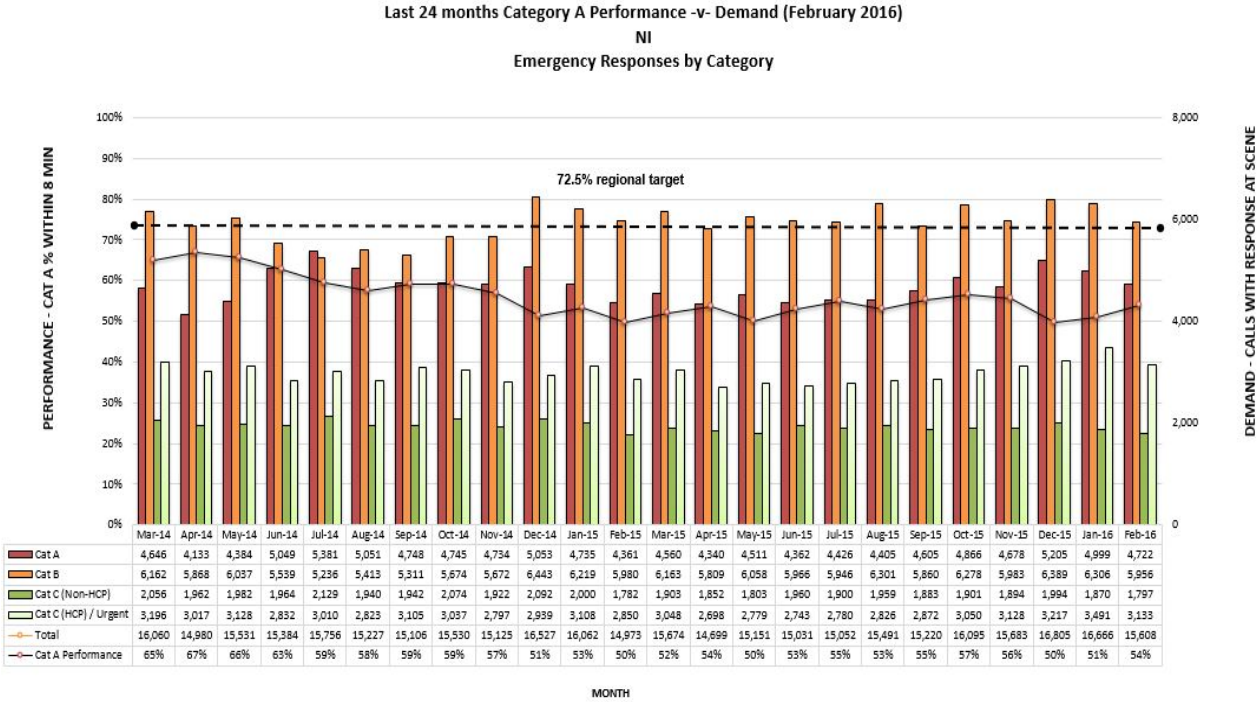
Section 3 is the Fleet and Estates report.

The report highlights pressures and resulting performance and includes information on proposals to address the current position which are found on Page 6.

SECTION 1 – Performance

1. CATEGORY A PERFORMANCE

(i). Trends over the last 24 months



	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Cat A	4,646	4,133	4,384	5,049	5,381	5,051	4,748	4,745	4,734	5,053	4,735	4,361	4,560	4,340	4,511	4,362	4,426	4,405	4,605	4,866	4,678	5,205	4,999	4,722
Cat B	6,162	5,868	6,037	5,539	5,236	5,413	5,311	5,674	5,672	6,443	6,219	5,980	6,163	5,809	6,058	5,966	5,946	6,301	5,860	6,278	5,983	6,389	6,306	5,956
Cat C (Non-HCP)	2,056	1,962	1,982	1,964	2,129	1,940	1,942	2,074	1,922	2,092	2,000	1,782	1,903	1,852	1,803	1,960	1,900	1,959	1,883	1,901	1,894	1,994	1,870	1,797
Cat C (HCP) / Urgent	3,196	3,017	3,128	2,832	3,010	2,823	3,105	3,037	2,797	2,939	3,108	2,850	3,048	2,698	2,779	2,743	2,780	2,826	2,872	3,050	3,128	3,217	3,491	3,133
Total	16,060	14,980	15,531	15,384	15,756	15,227	15,106	15,530	15,125	16,527	16,062	14,973	15,674	14,699	15,151	15,031	15,052	15,491	15,220	16,095	15,683	16,805	16,666	15,608
Cat A Performance	65%	67%	66%	63%	59%	58%	59%	59%	57%	51%	53%	50%	52%	54%	50%	53%	55%	53%	55%	57%	56%	50%	51%	54%

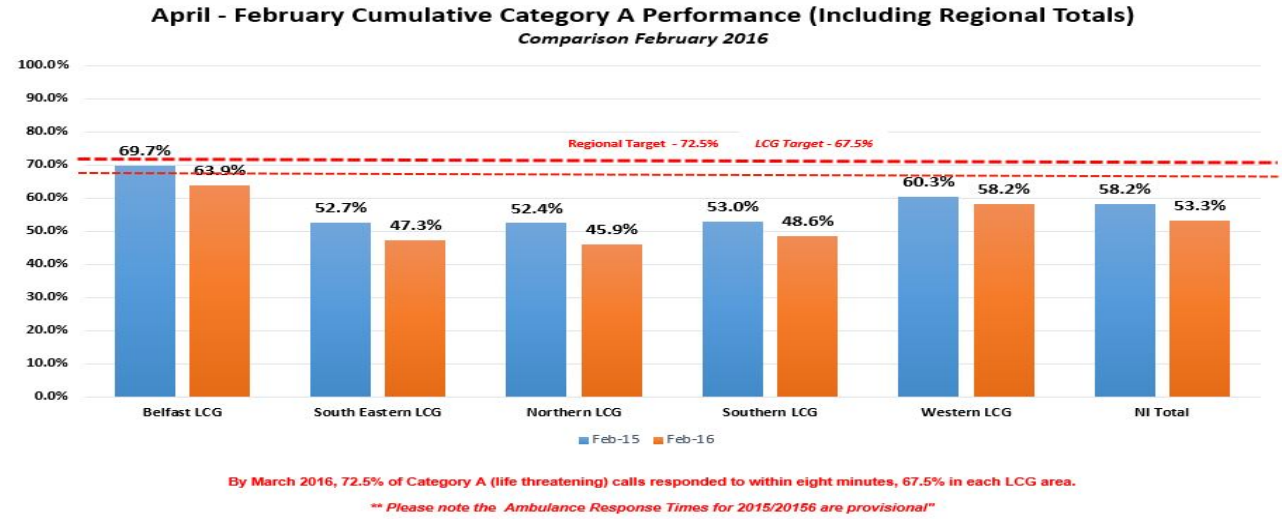
- The chart above shows the regional trends in Emergency and Urgent Activity over the last two years. Seasonal trends are noticeable around December and January each year especially in the Cat B levels. As can be clearly seen the increased demand on the totality of the emergency responses tends to result in a reduction in performance against the Ministerial Cat A target.

- There was an increase of 2% in the overall activity across NIAS in February 2016 compared to the same month last year. This equates to 23 more calls every day of the month.

- Emergency activity increased by 3.1% (equating to nearly 17 more emergency calls each day of the month), a 5.3% increase in Urgent activity and a 0.2% increase in non-urgent activity.

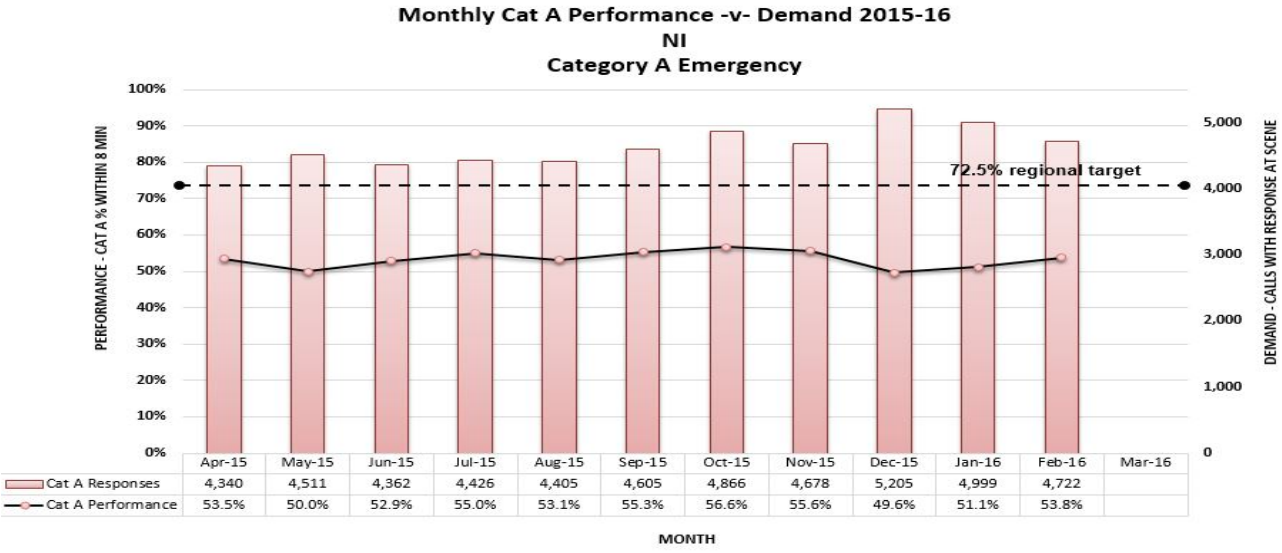
(ii). Cumulative Cat A performance

- As can be seen from the chart below, since April 2015 to date NIAS has not met the Cat A target either regionally or at LCG level. Trends are similar to the same time last year and are similar across every Area (please see chart above for seasonal trends).



- Cumulatively Cat A demand has dropped by 2.4% with the number of Cat A calls responded to within 8 mins dropping considerably (10.7%), which has resulted in 4.9% reduction in Cat A responses in 8 minutes compared to the same time frame last year.

(iv). Monthly Cat A performance



- There has been a 3.9% increase in Cat A performance for the month of February 2016 compared to February 2015.

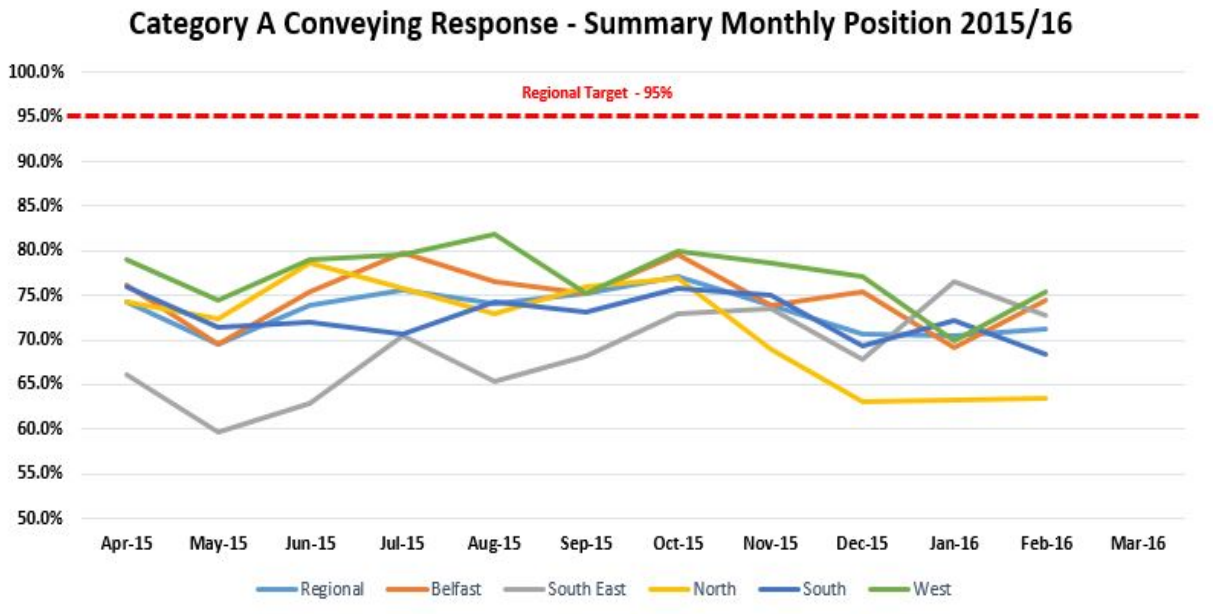
- There has been an 8.3% increase in demand for Cat A responses in February 2016 compared to February 2015. This equates to nearly 13 more calls each day of the month. This trend is most noticeable in Belfast and Western LCG areas where demand increased by 13.6% (over 5 Cat A calls each day) and 21.6% (just under 5 calls each day) respectively.

- Furthermore there was also a welcomed 16.9% increase in the proportion of Cat A call response to within the 8 minute target during February 2016 compared to the same time last year. This equates to 12 more Cat A calls in standard every day. Once again this trend is most noticeable in the Belfast and Wester LCG areas with nearly 5 more cat A calls in standard in Belfast and just under 4 more calls in standard in Western LCG area

- In February 2016 the average Cat A was responded to in 10 minutes and 17 seconds across the region with Belfast LCG area achieving an average of 8 mins and 15 secs compared to 12 mins and 18 secs in Northern LCG.
  Generally Cat A response times are further improved during day time hours (08.00 to 20.00hrs) where the regional average is 9 mins and 12 secs with Belfast achieving 7 mins and 42 secs and Northern LCG achieving 10 mins and 4 secs.

(iii). <u>Monthly Regional and LCG Category A conveying response</u>

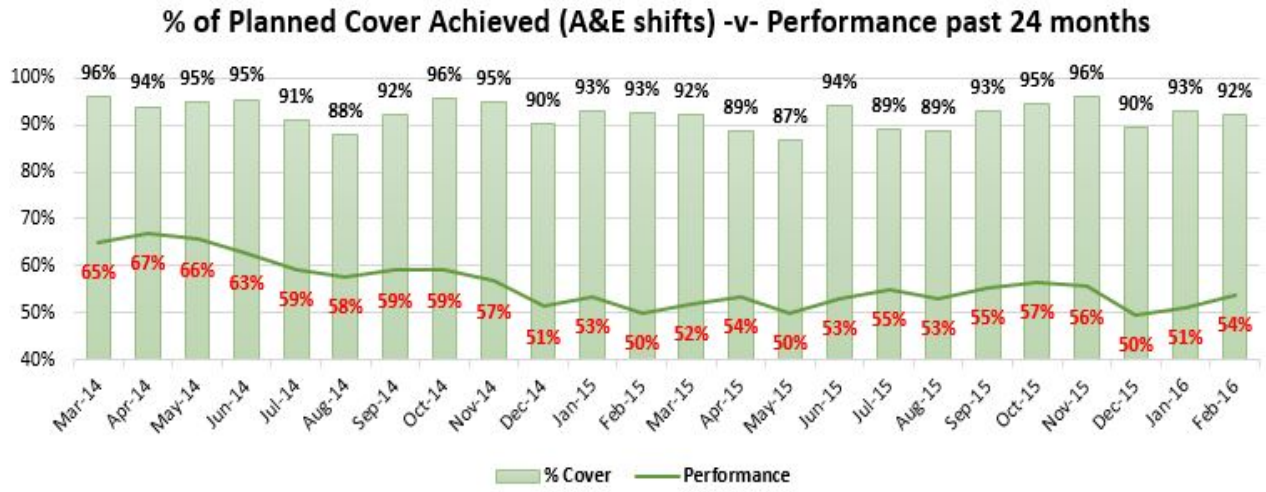
NIAS 2014/15 Target – "NIAS should ensure an average of 95% of Category A (life-threatening) calls have a conveying resource at scene within 21 minutes"



- From the chart above NIAS conveying standard is not being achieved in any of the LCG areas. However there has been an improvement in the rate of conveying within 21 mins for Cat A calls in both Belfast and Western LCG areas.

- The low performance in conveying for Cat A calls is affected by the availability of ambulances. This availability is reduced due to a number of factors e.g. the increase in emergency activity generally; lengthy ambulance turnaround at hospitals, longer ambulance journeys due to the configurations of acute services regionally and spending more time at scene as part of the introduction of alternative Care Pathways which enable more patients remain at home without having to attend the Emergency Departments.

2. PLANNED v ACTUAL COVER



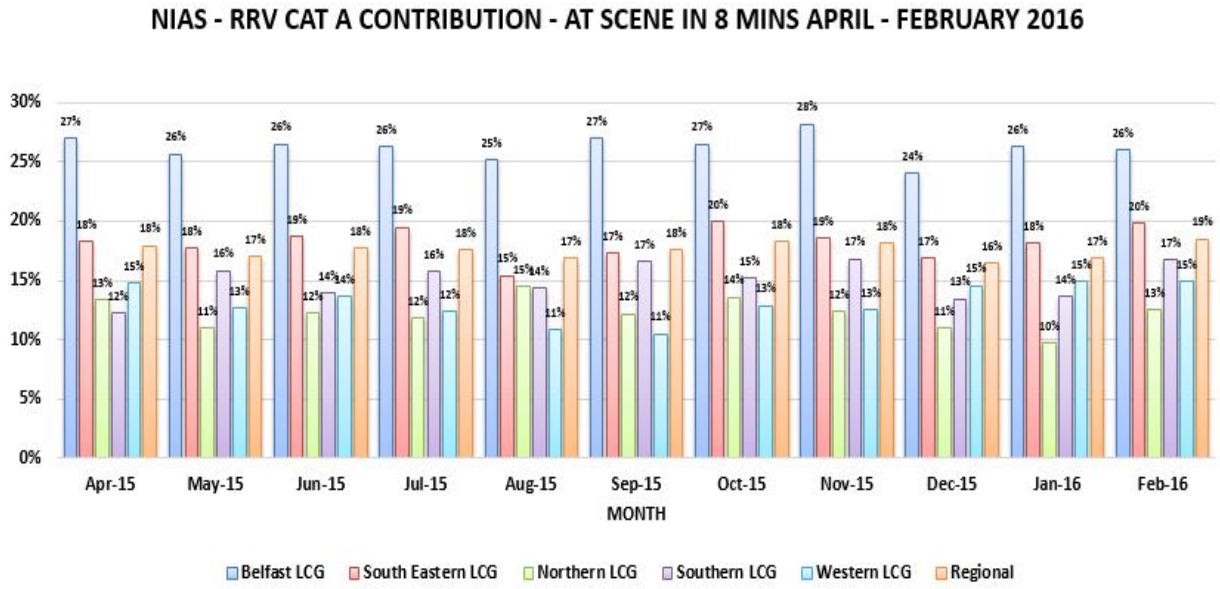
- The chart above shows compliance in planned production hours compared to the actual production hours produced. The above figures include core hours and any additional extra hours required (to support non-recurrently funded services and additional ad hoc pressures at local level such as bank holidays, public events, etc.)

- As can be seen from the chart, the trend in cover approximates the trend in Cat A performance. The reduced levels of cover are exacerbated by higher levels of sickness during the winter months.

3. NON CONVEYING RESOURCE CONTRIBUTION TO CATEGORY A PERFORMANCE

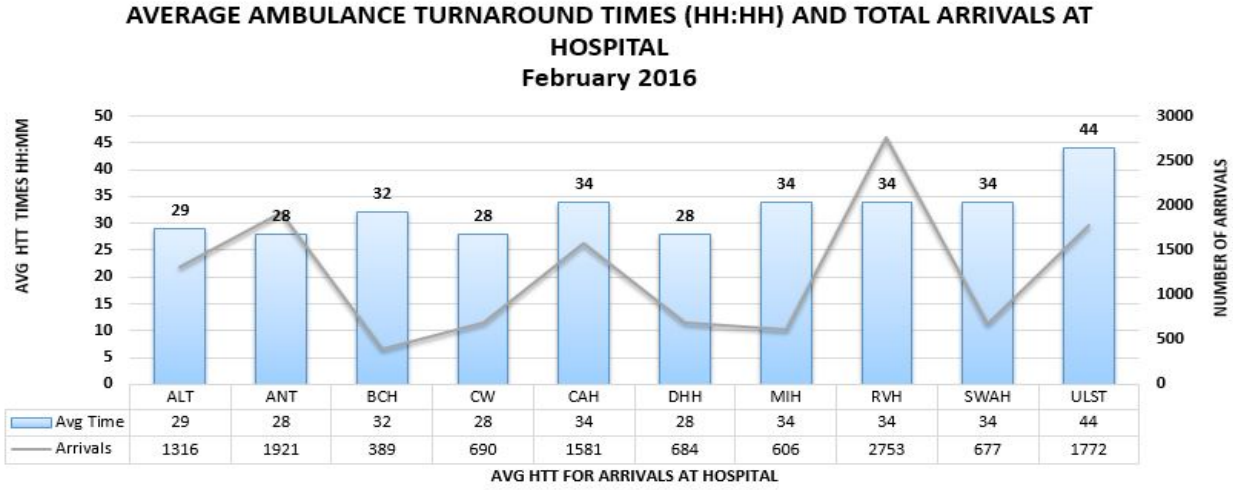
(i). Rapid response vehicle contribution to Category A performance

- The chart below shows the effectiveness of RRVs in urban environments such as the Belfast LCG area. More rural LCG areas, such as Northern and Southern LCG, benefit from this type of ambulance responses in their larger town areas.



- In addition the chart shows that the ratio of contribution across the divisions is generally stable across the different months of the year expect for Western LCG area, mostly due to the geography and the location of the larger/highly densely populated areas. .

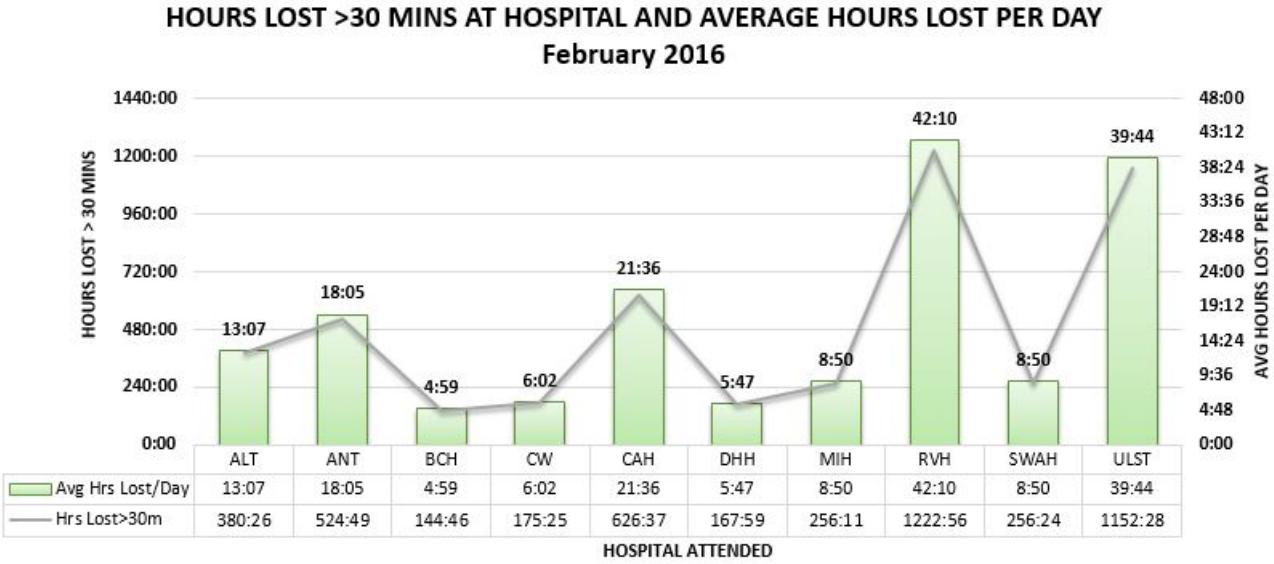
4. AMBULANCE TURNAROUND TIMES



	ALT	ANT	BCH	CW	CAH	DHH	MIH	RVH	SWAH	ULST
Avg Time	29	28	32	28	34	28	34	34	34	44
Arrivals	1316	1921	389	690	1581	684	606	2753	677	1772

- The above table shows the average ambulance turnaround time at the respective hospitals. The agreed national standard and the NIAS Indicator of performance consider ambulance turnaround times of 30 minutes or less as in standard.

- The number of ambulance arrivals at the hospitals clearly affects the overall length of ambulance turnaround time especially at very busy Emergency Departments such as the RVH and UHD. In February 2016 there was a small increase of 1.7% (i.e. 219) in the number of ambulance arrivals at EDs compared to the same month last year.



- 48.8% of all ambulance turnaround times in February 2016 were in standard (i.e. completed within 30 mins) compared to 48.3% in February 2015.

- There was welcomed reduction in the proportion of lengthy ambulance turnaround times (greater than 1 hour) across the main EDs regionally in February 201 (6.1% or 804) when compared to the same time last year (7.6% or 987).

- However there was an increase in the number of very lengthy ambulance turnaround times (i.e. over 2 hours or more) with 53 in February 2016 compared to 40 in February 2015.

- The total loss of production hours due to out of standard ambulance turnaround times has fallen slightly by 1.7% compared to same time last year, with a reduction 71 hrs regionally compared to same time last year.

- This loss of NIAS ambulance production hours equates to 7.3 ambulances lost each day of February 2016 compared to 7.7 ambulances lost in February 2015. Of the 7.3 ambulances 1.8 were lost at the RVH ED, 1.7 at the Ulster ED, 0.9 at Craigavon ED and 0.6 at Antrim ED.

5. DIVERTS

- There were 53 diverts lasting a total of 327 hrs in February 2016 compared to 50 diverts lasting a total of 346 hrs in February 2015.

- Of the 53, 4 were imposed by NIAS 43 requested by the Patient Flow Managers and 6 from an HSC Director. Of the 53 diverts 3 were full 999 diverts and 45 were within the same trust.

- 38% of all the time spend on divert occurs in the Southern Trust hospitals (Craigavon and Daisyhill).

6. ACTIONS FOR IMPROVEMENT

- The Operations Directorate continues to progress with the action outlined in the Performance Improvement Plan for 2015/6 with the vast majority either completed.

- Following discussions with the Commissioner, the Operations Directorate has been focusing on addressing the downward Cat A trend in March 2016. A specific plan set to achieve 60% Cat responses in 8 minutes regionally has been developed and implemented with initial outputs looking positive.

- Of particular note are the piloting of a Logistics' Officer role in South Eastern and Southern LCG areas to undertake a more proactive co-ordination function at local level especially at shift change over times; the introduction of specific guidance in Control to support a number of novel approaches (including splitting the East Desk, introducing ring-fenced ICV support for RRV responses, etc) and the additional production hours in emergency cover (both A&E and RRV).

- The stabilization of the workforce through the recruitment programme is continuing as planned and with the support of the HR Directorate a number of training courses have been brought forward and plans are being developed to continue in 2016/17. .

- The use of Voluntary and Private Ambulance Service providers especially over the Christmas and New Year holidays has proven very welcomed. NIAS continues to monitor usage and quality of services delivered in line with the approved contract.

SECTION 2 – Control & Communications

Ambulance operational performance against Cat. A and other targets relies on availability of resources and efficiency of systems.

Command & Control systems play a significant part in creating and maintaining the effiiciency of the operating and deployment processes. To ensure that this occurs as effectively and consistently as possible the Control function requires skilled professionals and excellent technology.

Staffing

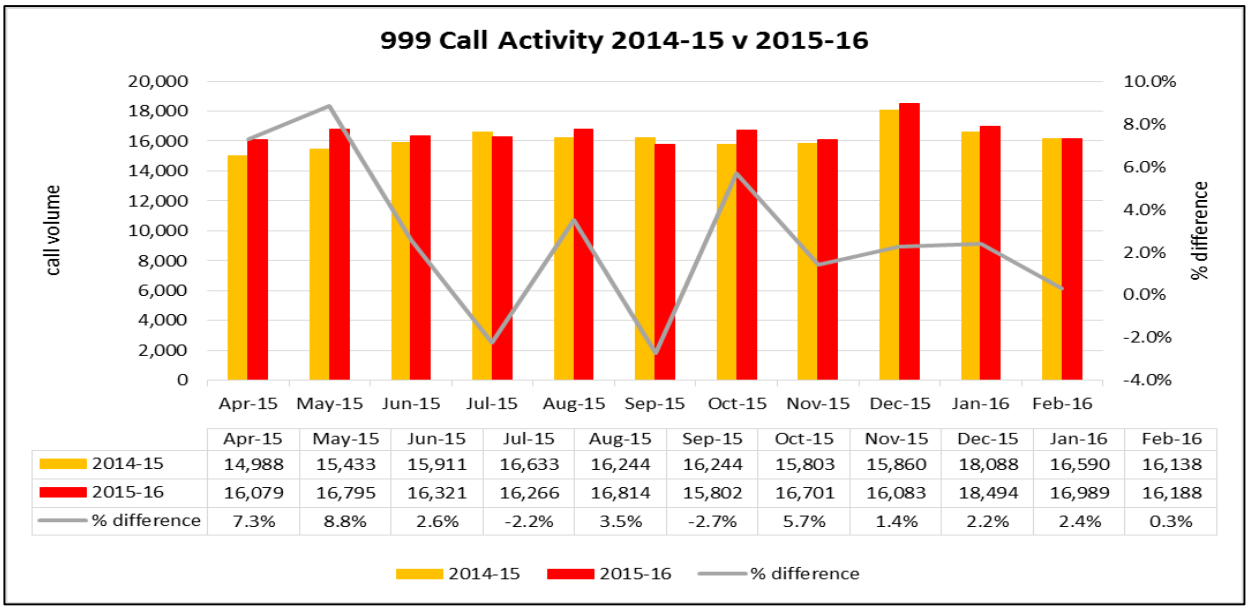
NIAS two control facilites – Emergency Ambulance Control (EAC) and Non-Emergency Ambulance Control (NEAC) have a workforce of 118 (88 EAC + 30 NEAC) whole time equivalents (WTE).

In EAC where emergency and GP calls are managed the key roles are call take and ambulance deployment. We have a WTE workforce of 46 Emergency call takers or Emergency Medical Dispatchers (EMDs) who are trained in application of the Medical Priority Dispatch System (MPDS). There are also GP call takers also trained in MPDS for HCP calls only and Routine call takers.

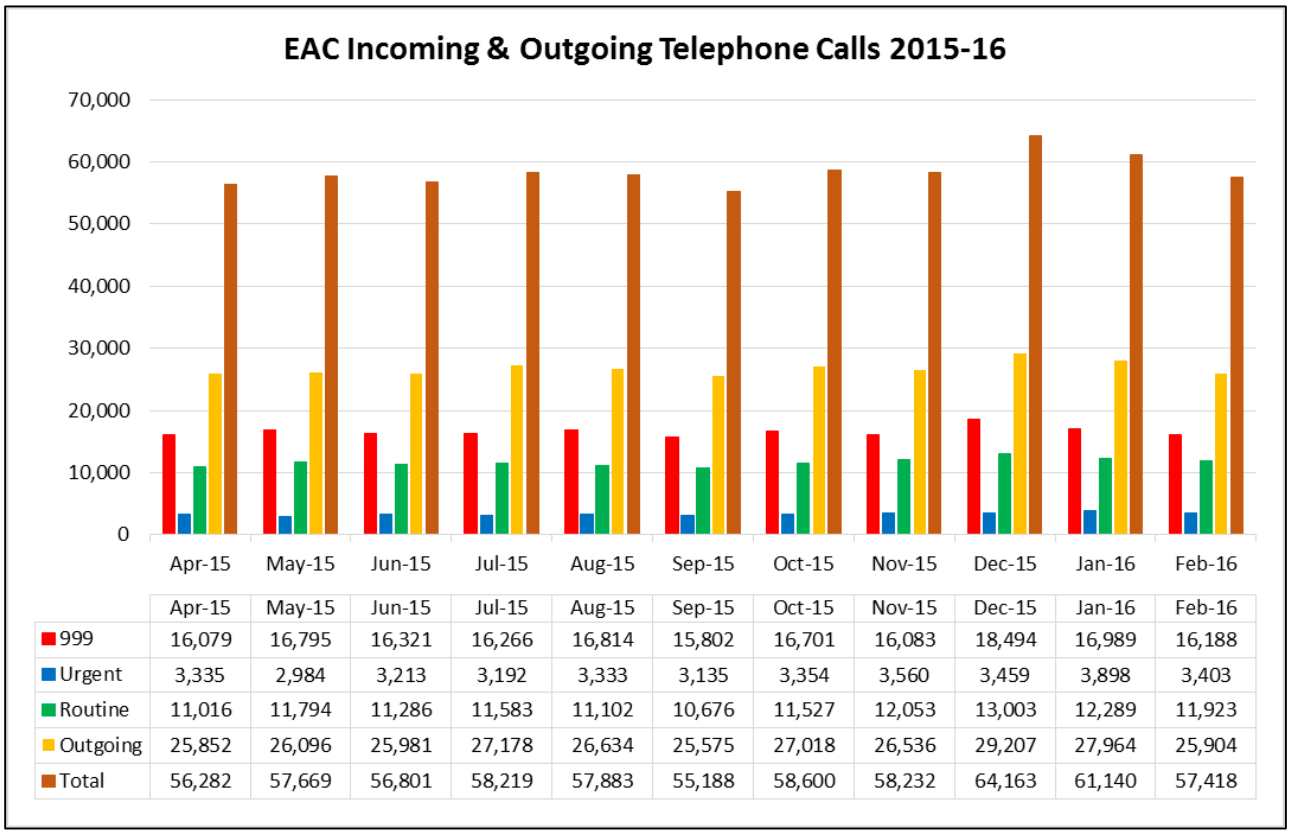
Call Demand

Telephone calls are received via Automatic Call Distribution (ACD) on three types of line; 999, Urgent and Routine. This allows for fair and timely distribution of incoming calls and gives the Management team access to reports on efficiency, productivity and performance on timeframes ranging from daily, monthly to quarterly.

The year 2015-16 to date shows an increase in the number of 999 calls received in most months as compared with 2014-15.



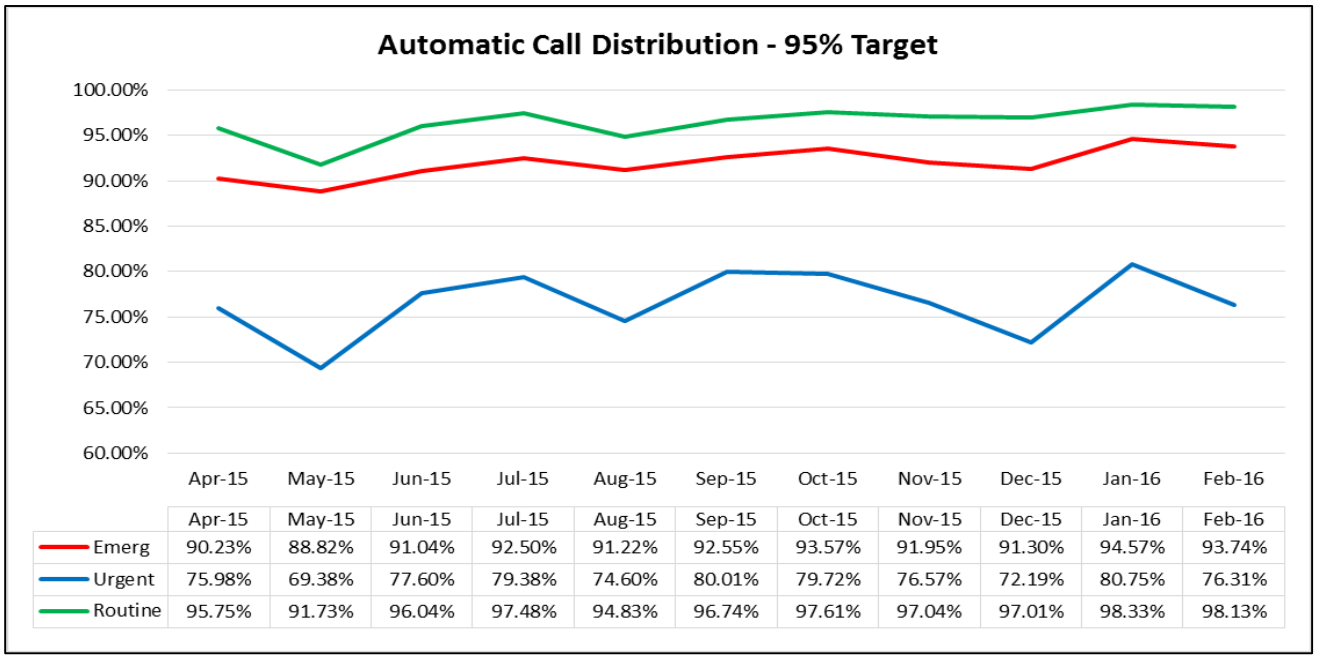
The table below shows the overall number of calls by type received by the ACD system and the total number of outgoing calls.



	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
999	16,079	16,795	16,321	16,266	16,814	15,802	16,701	16,083	18,494	16,989	16,188
Urgent	3,335	2,984	3,213	3,192	3,333	3,135	3,354	3,560	3,459	3,898	3,403
Routine	11,016	11,794	11,286	11,583	11,102	10,676	11,527	12,053	13,003	12,289	11,923
Outgoing	25,852	26,096	25,981	27,178	26,634	25,575	27,018	26,536	29,207	27,964	25,904
Total	56,282	57,669	56,801	58,219	57,883	55,188	58,600	58,232	64,163	61,140	57,418

999 Call Answer Times

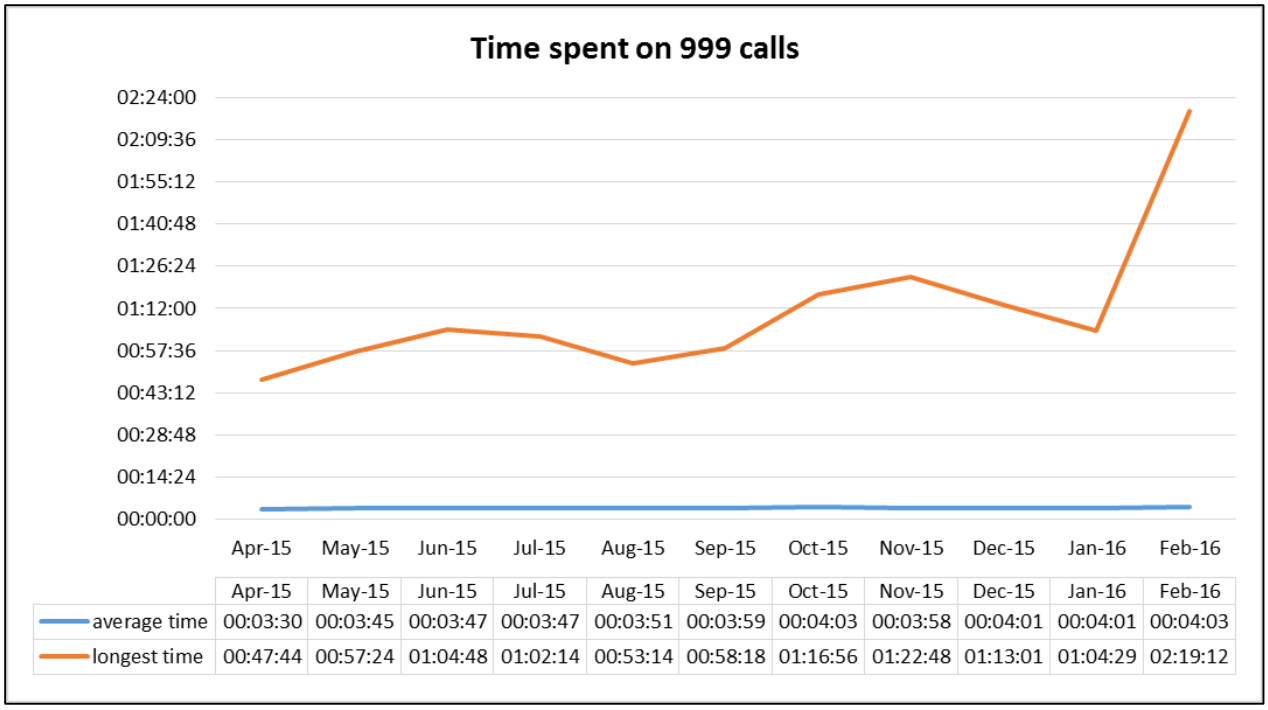
We aim to answer our telephone calls as quickly as possible and the system delay between the call arriving our telephone switch and distributed to an available call-taker with the appropriate skill set is 2 seconds. Call delays occur when there is no call-taker free when the call arrives. The target for 999 call answering is 95% within 2 seconds.



	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Emerg	90.23%	88.82%	91.04%	92.50%	91.22%	92.55%	93.57%	91.95%	91.30%	94.57%	93.74%
Urgent	75.98%	69.38%	77.60%	79.38%	74.60%	80.01%	79.72%	76.57%	72.19%	80.75%	76.31%
Routine	95.75%	91.73%	96.04%	97.48%	94.83%	96.74%	97.61%	97.04%	97.01%	98.33%	98.13%

Time spent on 999 calls

EMDs are required to remain on the line for certain health critical situations. They may remain on the line until one of our operational resources is in attendance at the scene. Longest times are a combination of demand and resource availability. High volumes of incidents and reduced levels of cover can also impact on availability of call takers.



	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
average time	00:03:30	00:03:45	00:03:47	00:03:47	00:03:51	00:03:59	00:04:03	00:03:58	00:04:01	00:04:01	00:04:03
longest time	00:47:44	00:57:24	01:04:48	01:02:14	00:53:14	00:58:18	01:16:56	01:22:48	01:13:01	01:04:29	02:19:12

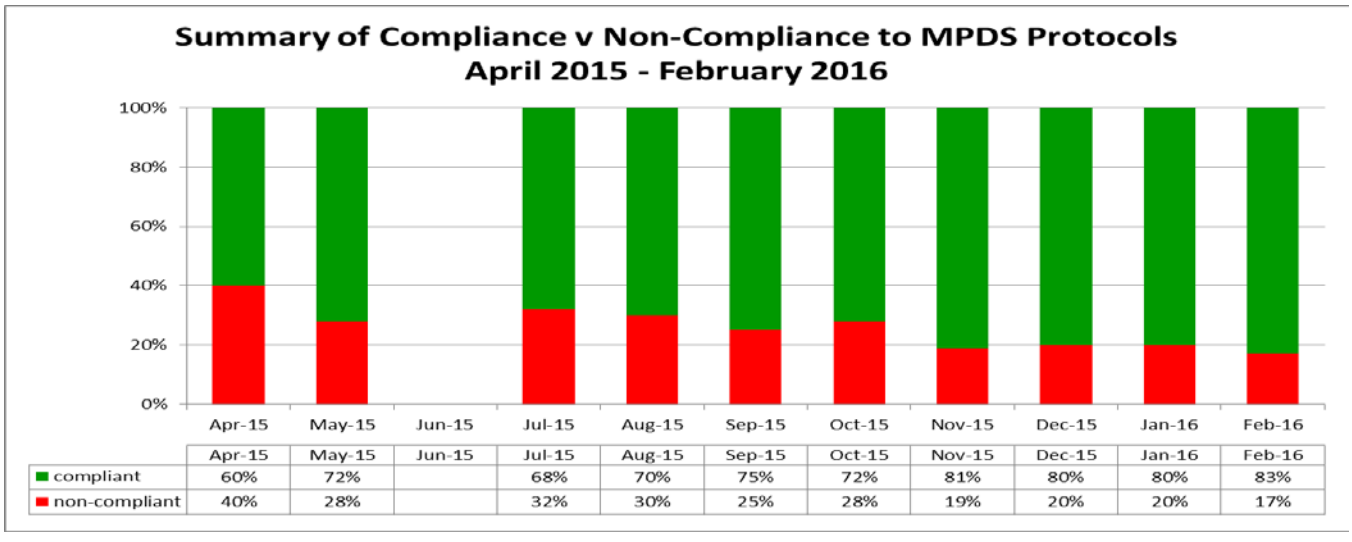
Quality Assurance /Quality Improvement in using Medical Priority dispatch System:

Objective: To ensure best practice is employed and allow for benchmarking against other Medical Priority Dispatch System (MPDS) users both in the UK, the Republic of Ireland and worldwide NIAS .

NIAS is committed to reviewing a percentage of 999 calls as per International Academy Emergency Dispatch (IAED) guidelines in line with annual call volume. The audit of 999 phone calls and continuous feedback to EMDs measured against agreed Academy standards helps to ensure the most appropriate response is sent. For 2015-16 this equates to approximately 2.71% of 999 calls or approximately 60 calls per week (not including Special Case Review, complaints etc.). Calls are measured across seven areas including customer service and final coding to ensure the highest standards of patient care are provided. Each call is reviewed in line with Academy standards and any deviation advised / discussed with the EMD.

Progress: There has been consistent QA in progress since September 2014 with full audit volume met since April 2015. The overall trend has seen a reduction in deviations across all areas. This minimises risk and waste in terms of response and increases the quality of standardised patient care. NIAS now exceeds IAED standards in six of the seven areas of protocol compliance.

The following chart highlights the improvement in overall MPDS Protocol compliance in any of the four levels of compliance against those classed as “Non-Compliant”. Those in the “Non-Compliant” level having fallen from 40% in April 2015 to 17 in February 2016. The required standard in “Non-Compliant” for ACE is no more than 7%.

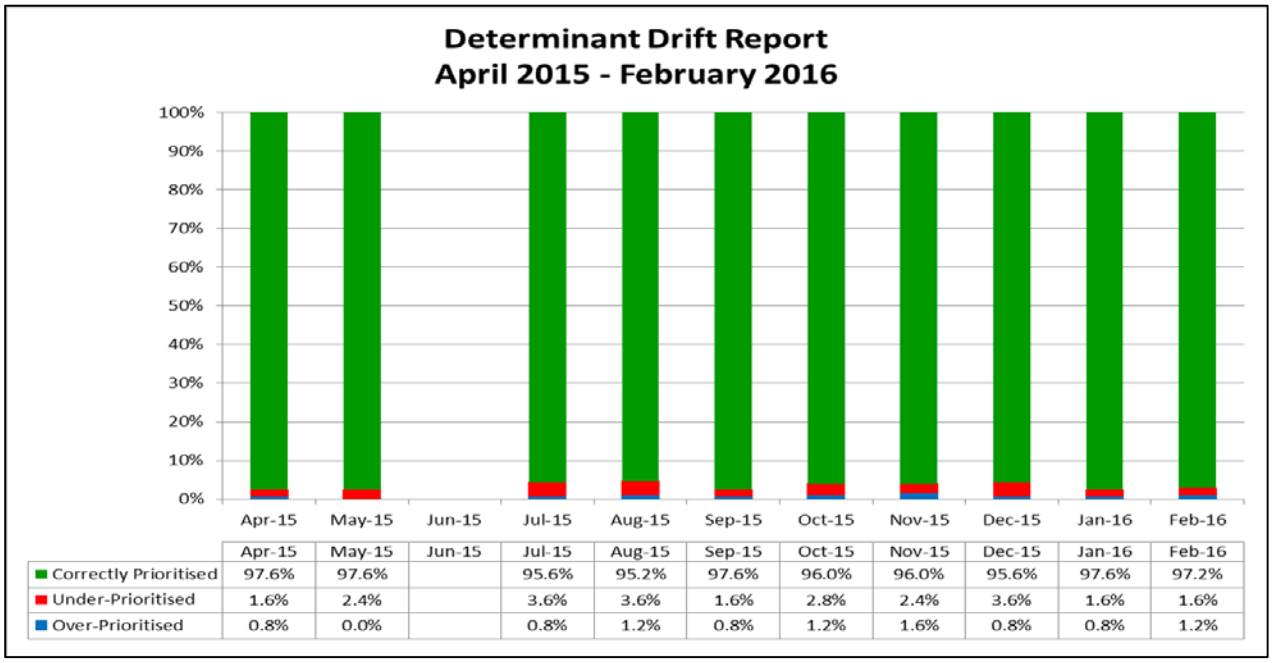


	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
compliant	60%	72%		68%	70%	75%	72%	81%	80%	80%	83%
non-compliant	40%	28%		32%	30%	25%	28%	19%	20%	20%	17%

(no figures available for June 2015)

The monthly Determinant Drift report indicates whether the audited calls have been over or under prioritised in terms of one of the six levels within MPDS. These levels do not exactly correlate to category of response (i.e. Cat A, B or C) and a variation in

MPDS determinant level will not always result in a variation in response category. The required standard for ACE is no more than 5% of calls audited being either “under” or “over” prioritised. NIAS has consistently been well within this target.



	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Correctly Prioritised	97.6%	97.6%		95.6%	95.2%	97.6%	96.0%	96.0%	95.6%	97.6%	97.2%
Under-Prioritised	1.6%	2.4%		3.6%	3.6%	1.6%	2.8%	2.4%	3.6%	1.6%	1.6%
Over-Prioritised	0.8%	0.0%		0.8%	1.2%	0.8%	1.2%	1.6%	0.8%	0.8%	1.2%

(no figures available for June 2015)

EMD Award Scheme:

As of end February 2016 the following awards have been attained;

999 High Compliance:	Bronze	8
Exemplary Customer Service:	Bronze	45
	Silver	22

Baby Born: 2

Cardiac Life Saver 1 (with a further 2 being assessed)

SECTION 3 - FLEET AND ESTATES

SECURING THE INFRASTRUCTURE

Objectives

- NIAS is committed to investing in the fleet and estate necessary to deliver safe, high quality ambulance services
- To achieve a fleet profile of vehicles that is less than 5 years old.

Controls Assurance Progress report

Controls Assurance standards are continually reviewed in NIAS and in Operations the following are maintained:

(i) Buildings and Land
(ii) Environmental Management
(iii) Fire Safety
(iv) Fleet and Transport
(v) Security
(vi) Waste Management

CONTROLS ASSURANCE PROGRESS:

	RAG	Rating (75% in all criteria)	Comment
Buildings & Land	80.0%	Substantive	Agreed with Audit
Environmental Mgt	79.5%	Substantive	Self Assessed
Fire Safety	89.7%	Substantive	Self Assessed
Fleet & Transport	83.8%	Substantive	Self Assessed
Security	83.3%	Substantive	Self Assessed.
Waste Management	84.0%	Substantive	Self Assessed
Performance Commentary: All achieved greater than 75% in all criteria. Buildings and land achieved substantive after further evidence provided to audit.			

FLEET PROFILE 2015/16:

% Fleet Profile (less than 5 years old)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Emergency Ambulances	78.4	78.4	78.4	87.1	89.7	95.7	96.6	96.6	96.6	96.6	96.6	
Non-Emergency Ambulances	94.3	94.3	87.7	86.8	83.0	83.0	83.0	83.0	83.0	84.9	85.8	
Rapid Response Vehicles	73.8	73.8	73.8	76.2	83.3	85.7	85.7	88.1	88.1	85.7	85.7	
Support Vehicles	36.7	36.7	36.7	40.0	40.8	40.8	44.9	44.9	42.9	44.9	44.9	

PERFORMANCE COMMENTARY :
Additional Vehicles retained not in Establishment: 8, over 5 years old.
2014/15 : Commissioning is ongoing.
A&E: Complete
PCS: Ongoing
RRV, Complete
Specialist Vehicle: control. Complete

Fleet improvement Proposals for 2015/2016:

Introduction of new carry chair with clip-on tracks to aid descent of stairs has been rolled out to North, West and South-East Divisions.

New Fleet Recovery Contract is in standstill, to go live 1 April 2016.

2015/16 : A&E, PCS and car conversions awarded.

ESTATE CAPITAL PROGRAMME

Ballymena:

Site visited in February by Health Minister, Simon Hamilton and Finance Minister, Mervyn Storey. They stayed for a short tour of the Station and Divisional Headquarters as it neared completion and were impressed at the facilities it provided for NIAS in Ballymena.

The handover from the contractors has been delayed as some building systems remain to be commissioned. This is disappointing but does not create significant operational issues. Nonetheless NIAs have expressed their dissatisfaction at the delay to our training and commissioning plans. Delivery of NIAS furniture and equipment has commenced w/c 14 March 2016.

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Enniskillen:

LPS valuation has been completed and land transfer should complete prior to 31 March 2016.

OTHER

Uniform – Orders for Uniform have been placed with delivery expected by June 2016. Returns and exchanges will take place over the summer.

Estates - NIAS participating in Regional Minor Works Consultancy Framework. NIAS Building Survey tender has been awarded and surveys are ongoing for 16 buildings. The remainder of the estate will be surveyed under the MWCF contract when awarded in 2016.
Minor Schemes spend estimated at £200k +.

Fire – Station audit visits complete, no significant issues. EAC issues outstanding.

Energy - NIAS participating in Regional Energy (Electricity and Gas) contracts awarded and due to commence 1 April 2016.
Environmental – A 6 year trend for fuel usage(Litres) and cost(£) shows how fuel consumption has remained relatively consistent over the period and the cost gap when fuel was more than a Pound per litre increased and then reduced to current level.

NIAS strikes Gold at the 17th Annual Arena Network Environmental Benchmarking Survey

NIAS took part in the 17th Annual Arena Network Environmental Benchmarking Survey. Organisations from 14 industry sectors had been invited to take part including the top 200 companies and leading public sector organisations such as health trusts, local authorities, education and library boards and universities. NIAS was represented at the launch of the results at the Harbour Commissioner's Office, Belfast. This Survey is a key driver for corporate environmental management and improvement and is seen as a positive influencer to help organisations achieve a more sustainable way of doing business.

The Survey aims to ensure environmental issues are on the Board agenda of these key organisations in Northern Ireland and measures the extent to which they are managing environmental issues. This enterprise is intended to persuade organisations of all sizes of the importance of environmental management. The ARENA Survey is Northern Ireland's only benchmark for environmental management, performance and reporting. This year 83 organisations from 14 different sectors took part.

David Gavaghan the Chair of Arena Network presented the Gold Award to George Anderson who accepted it on behalf of NIAS. Ian Nuttall is the Programme Manager for the Survey (Photo from Arena)

The ARENA Network Survey benchmarks organisations against both their sector peers and the leading Northern Ireland organisations, on the basis of their environmental management and performance in key areas. A voluntary exercise, the Survey helps organisations analyse gaps, measure progress, drive improvement and raise awareness of the environment as a strategic, competitive issue at board level. The awards range from Platinum through Gold, Silver and Bronze to Green. The Platinum award is for organisations that obtain 90% or over.

NIAS was awarded Gold which ranges from 80% to 89%. NIAS have participated in the Survey on several occasions and we have found that it supports our Controls Assurance Standard assessments and in the business of several groups and committees. The data contained in the Survey is kindly supplied from various sources in NIAS and this has contributed to this Gold award. We will continue our involvement in the future and the challenge will be to improve our environmental performance and thereby contribute to a better environment.

NORTHERN IRELAND AMBULANCE SERVICE

TRUST BOARD REPORT

FINANCE DIRECTORATE

Director of Finance and ICT

07/04/2016

FINANCIAL PERFORMANCE

Financial Breakeven

The Trust is currently forecasting a breakeven position at year end, within tolerance, subject to key risks and assumptions in particular in respect of the required level of savings and the level of investment to support delivery and developments. These have largely been agreed. In addition, 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.

The position at the end of February 2016 (Month 11) is a surplus of £77k.

Financial Breakeven Assessment (£k)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Staff Costs		8,090	12,193	16,318	20,554	24,718	28,880	33,058	37,217	41,340	45,456	
Other Expenditure		1,651	2,593	3,467	4,347	5,282	6,200	7,091	8,094	9,026	10,022	
Expenditure Total		9,741	14,786	19,785	24,901	30,000	35,080	40,149	45,311	50,366	55,478	
Income		73	110	182	224	262	299	338	367	420	457	
Net Expenditure		9,668	14,676	19,603	24,677	29,738	34,781	39,811	44,944	49,946	55,021	
Net Resource Outturn		9,668	14,676	19,603	24,677	29,738	34,781	39,811	44,944	49,946	55,021	
Revenue Resource Limit (RRL)		9,668	14,685	19,620	24,677	29,737	34,784	39,817	44,952	49,986	55,098	
Surplus/(Deficit) against RRL		0	9	17	0	(1)	3	6	8	40	77	

NIAS Financial Position to February 2016 (Month 11)

(£ 000s)	FYB	YTD Budget	YTD Actual	*Variance*
Chief Executive's Office				
Payroll	163	150	148	*1*
Non-Payroll	45	41	40	*2*
Chief Executive's Office Total	**208**	**191**	**188**	***3***
Director of Finance				
Payroll	1,343	1,233	1,194	*39*
Non-Payroll	777	724	720	*3*
Director of Finance Total	**2,120**	**1,957**	**1,915**	***42***
Director of HR				
Payroll	3,782	3,492	3,404	*88*
Non-Payroll	917	863	853	*10*
Director of HR Total	**4,699**	**4,355**	**4,257**	***98***
Dir of Ops (incl Divisions & RCC)				
Payroll	44,062	40,379	39,989	*390*
Non-Payroll	8,435	7,794	8,250	*(457)*
Dir of Ops (incl Divisions & RCC) Total	**52,496**	**48,173**	**48,240**	***(67)***
Medical Director				
Payroll	800	724	721	*3*
Non-Payroll	188	157	159	*(1)*
Medical Director Total	**987**	**881**	**880**	***1***
NIAS Total Payroll	**50,149**	**45,977**	**45,456**	***521***
NIAS Total Non-Payroll	**10,362**	**9,578**	**10,022**	***(444)***
NIAS Total	**60,511**	**55,556**	**55,478**	***77***

Figures last updated: 21/03/2016 12:53

The position at the end of February 2016 (Month 11) is a surplus of £77k.

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

The Trust is also implementing an ambitious programme of action to provide additional cover linked to Demography funding from HSCB and also performance improvement plans and initiatives linked to Winter Pressures funding. There are a range of other issues affecting financial performance, for example late finishes can create additional financial pressures. Conversely, a continued and sustained reduction in the cost of fuel has resulted in expenditure below even the cost reductions included as part of the 2015/16 savings plans.

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.

NIAS Savings Prosal Summary - The Trust is working to deliver a savings requirement of £1.2m in 2015/16 which is on track for delivery. The Trust assumes that no further efficiency savings are required in year.

Ref #	Scheme	Detail Per TDP	Current Year Effect (£k)	OVERALL STATUS	Screening	Engagement	Monitoring of Impact	Monitoring of Finance	Update February 2016
1	Non-Emergency Patient Transportation	NIAS spends c. £10Million p.a. on the direct cost of non-emergency services. This proposed saving of £200,000 represents 2%. NIAS does not propose to reduce the number of patients transported by PCS rather to increase the number of patients transported per journey, w here appropriate, thereby increasing the efficiency and productivity of the PCS service.	200	Started - on track	Complete	Started - on track	Started - on track	Started - on track	On Track Recurrently
3	Administration/Management Costs	Reduction in expenditure derived from further scrutiny and streamlining/re-provisioning of support services.	100	At risk of delay	At risk of delay	At risk of delay	At risk of delay	Started - on track	AT RISK - VES engagement w ill commence 8 October 2015. Savings requirement allocated to Directorates to achieve non recurrently against management and administaration (non front line) budget lines. Monthly monitoring returns provided to DHSSPS.
4	Non Pay Expenditure	Reduction in expenditure derived from further scrutiny and streamlining/re-provisioning of non-pay expenditure.	100	Started - on track	Complete	Not Required	Not Required	Started - on track	On Track Recurrently
5	Reduction in expenditure associated w ith training and development	NIAS spends in the order of £2 Million p.a. on training. This proposed saving of £300,000 represents 15%. A review of training focused on mandatory training requirements has identified opportunities for more cost-effective provision w ithout impacting on delivery of mandatory clinical training.	300	Started - on track	Complete	Started - on track	Started - on track	Started - on track	On Track Recurrently
6	Fuel Savings	Specific saving associated w ith reduced price of fuel.	100	Started - on track	Complete	Not Required	Not Required	Started - on track	On Track Recurrently
7	Constraining expenditure on minor schemes for estates	Continued restraint to be exercised on estate repair, maintenance and refurbishment.	200	Started - on track	Complete	Started - on track	Started - on track	Started - on track	On Track Non Recurrently
8	Constraining expenditure on replacement/introduction of non-critical medical equipment	Continued restraint to be exercised on replacement/introduction of non-critical medical equipment.	200	Started - on track	Complete	Started - on track	Started - on track	Started - on track	On Track Non Recurrently

Capital Spend

The Trust has received a Capital Resource Limit (CRL) of £7.526m (previously £7.608m). This has been allocated against Fleet Replacement, Estate, IT and General Capital. This revised allocation takes into account revised expenditure forecasts and estimated slippage for both Ballymena and Enniskillen Ambulance Stations and also General Capital. The Trust has also received notification of support for an additional specialist paediatric vehicle. A further formal CRL Change Request will be submitted to reflect this investment and any further required changes.

Cumulative capital spend at the end of February 2016 (Month 11) is shown in the table overleaf. This indicates a significant amount of expenditure profiled in the final month of the financial year. The Trust is working with suppliers in an effort to deliver expenditure by 31 March 2016, though this is subject to a number of risks, particularly in respect of supplier constraints.

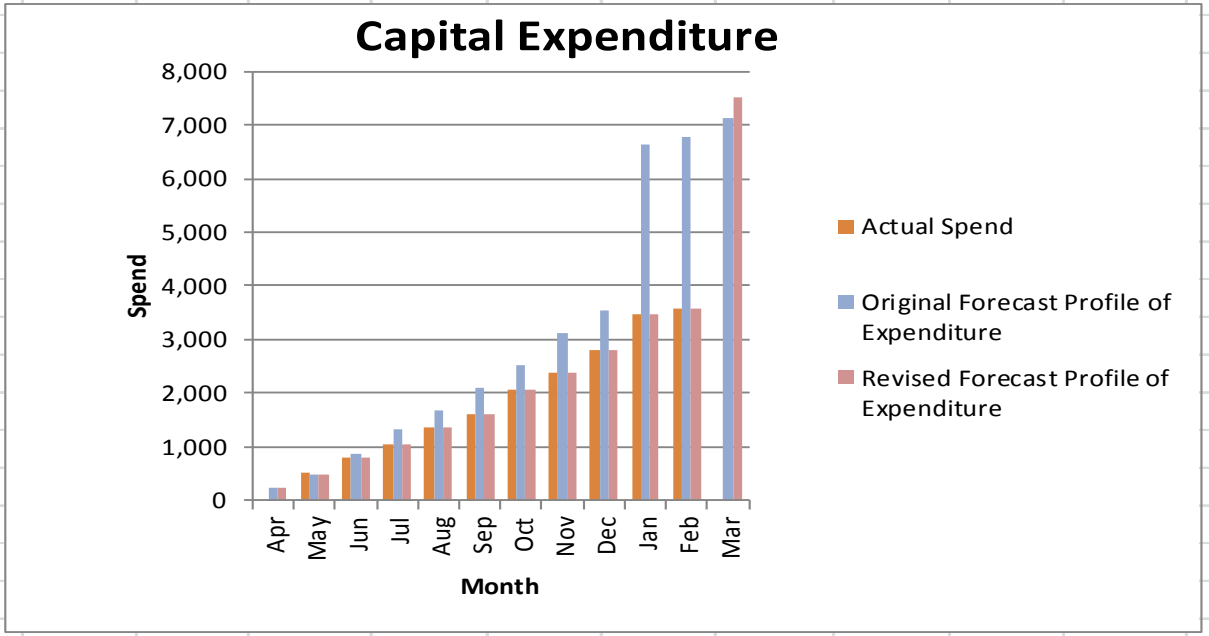
Asset Disposals

The profile of planned asset disposals is linked to the forecast capital spend profile.

Asset Disposals (£k)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Proposed Disposals		10	22	27	39	39	40	117	120	152	197	
Actual Disposals		10	22	27	39	39	40	117	120	152	197	

Cumulative Capital Spend

Cumulative Capital Spend (£k)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Fleet		0	114	114	114	114	114	114	114	114	114	
Estate		490	670	924	1,244	1,479	1,934	2,269	2,686	3,231	3,338	
Medical Equipment		0	0	0	0	0	0	0	0	0	0	
IT Equipment		0	0	0	0	0	0	0	0	96	96	
General Capital		12	0	0	16	16	16	16	16	21	43	
Actual Spend		502	784	1,038	1,374	1,609	2,064	2,399	2,816	3,462	3,591	0
Original Forecast Profile of Expenditure	242	490	869	1,323	1,674	2,085	2,526	3,137	3,538	6,624	6,779	7,116
Revised Forecast Profile of Expenditure	242	490	784	1,038	1,374	1,609	2,064	2,399	2,816	3,462	3,591	7,526



Prompt Payment of Invoices

The target of 95% of invoices paid within 30 days was missed in 2014/15 largely due to the days of processing lost during preparation for and implementation of the new Finance, Procurement and Logistic (FPL) system. All payment processing functions transferred to Accounts Payable Shared Service Centre in mid December 2014.

Performance by number of invoices paid for each of these measures is shown below. Performance figures have been updated at February 2016 (Month 11). In month performance from October 2015 to date has met and exceeded the targets set.

A range of plans are in place to improve and maintain performance in this area, however the cumulative target of 95% of invoices within 30 calendar days in 2015/16 can no longer be met. As aged invoices are cleared and paid, performance between months can vary significantly. The Trust has established a target of 50% (2014/15 40%) of invoices paid within 10 days and will be working towards the regional target of 60%. This 60% target has been achieved cumulatively from January 2016.

Number	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative
Total bills paid	1,433	1,164	1,900	839	1,560	1,806	1,329	1,266	1,424	1,536	1,350		15,607
Total bills paid within 30 calendar days of receipt of undisputed invoice	1,161	867	1,484	779	1,227	1,519	1,273	1,208	1,387	1,458	1,298		13,661
% bills paid on time	81.0%	74.5%	78.1%	92.8%	78.7%	84.1%	95.8%	95.4%	97.4%	94.9%	96.1%		87.5%
Total bills paid within 10 working days (14 calendar days)	733	646	974	506	884	1,043	995	878	1,066	1,059	983		9,767
% bills paid on time	51.2%	55.5%	51.3%	60.3%	56.7%	57.8%	74.9%	69.4%	74.9%	68.9%	72.8%		62.6%

Business Services Organisation (BSO) Key Performance Indicators (KPI's)

The Business Services Organisation provides a range of services to The Trust, including Procurement and Logistics Services (PaLS), Legal Services, Technology Services and Internal Audit. New reporting arrangements for the Service Level Agreements have identified Key Performance Indicators (KPIs) in respect of Purchasing and Supply. Figures for February 2016 were not available in time for this report. Performance against these KPI's to the end of January 2016 is as follows:

Key Performance Indicator	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Average Processing Time Per Requisition Days (Target 5 Days)	4.81	4.24	3.17	3.66	3.17	4.02	3.42	3.55	4.34	4.28		
Percentage of Products Supplied on First Request % (Target 95%)	99.60%	99.04%	99.35%	98.96%	99.66%	98.52%	99.17%	99.17%	98.86%	98.60%		
Number of Lines Issued (Stock and Non Stock Line)	1,224	1,014	972	1,068	864	887	1,366	1,096	1,094	1,094		
Value of Spend £k (Stock and Non Stock)	135	158	135	571	1,414	315	266	2,246	327	439		

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.

11 February 2016 – Priority1 Telephony fault - Audio not being presented on all calls.

At approximately 12pm a number of 999 phone calls presented to Ambulance Control were not presenting audio to the call taker due to a technical fault. The fault was identified as a failed hardware component at Cregagh Telephone Exchange. All incoming calls to NIAS were re-routed through Carryduff Telephone Exchange while the faulty hardware was replaced with minimal disruption to service.

Information Technology Systems - Developments

Any system developments are reported in this section.

Work is ongoing on a project to upgrade the Network infrastructure between NIAS HQ and the remote Ambulance stations and outposts across Northern Ireland. This project is nearing completion with 45 sites migrated to the new network and 2 sites still outstanding.

The overall aim of the project is to provide a robust NIAS network provision fit for purpose to meet the current and future requirement that can sustain the demands placed upon it by both the needs of managers at remote sites and operational users.

A project to replace the HQ central computer system for corporate systems was completed in March 2016. This project replaced end of life hardware and upgraded data storage disks with capacity to allow for data growth for the next 5 years.

A project to replace the NIAS Telephony platform at HQ, Altnagelvin and the short term contingency site is under way which will provide NIAS with a telephony architecture capable of using the latest VOIP technology.

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	5	5	100%	9	9	100%
Urgent	54	53	98%	51	49	96%
High	7	7	100%	6	6	100%
Medium	467	454	97%	439	428	97%
Low	839	839	100%	794	794	100%
Total	1372			1299		

ICT Planned Maintenance January 2016 – system upgrades Critical Systems

There was no planned maintenance to Critical Systems during this period.

ICT Planned Maintenance January 2016 – 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	196	4 Hours	0.15	No	
File Server	196	4 Hours	0	No	
Virtual Server	198	2 Hours	0	No	
BlackBerry	196	4 Hours	0	No	
Promis	196	4 Hours	0.10	No	

ICT Planned Maintenance February 2016 – system upgrades Critical Systems

There was no planned maintenance to Critical Systems during this period.

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ICT Planned Maintenance February 2016 – 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	196	4 Hours	0	No	
File Server	196	4 Hours	0.05	No	
Virtual Server	198	2 Hours	0	No	
BlackBerry	196	4 Hours	0	No	
Promis	196	4 Hours	0.10	No	

Information Governance – Developments: 01/01/2016 to 29/02/2016

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

- ***Ongoing work on policy and procedures to support Information Governance across the Trust to support the Information Management Control Assurance Standard including Information Governance Strategy, Records Management Strategy, Information Risk Policy, Staff Guidance – Anonymisation etc. The Information Management Control Assurance audit will take place in March 2016 and extensive work has been undertaken in the past months to complete associated assessment and supporting documentation by the Corporate Manager.***

- ***Work is underway to destroy records currently off-site in line with Retention and Disposal Schedule. A change in protocol for staff is also being developed to support destruction of records and off-site management of records.***

- ***Analysis of historical clinical datasets held in Command and Control systems for support for service development of frequent callers, other pathways under the remit of Transforming your Care. Review of weekly reports and monthly report currently being undertaken with work already way. Supporting TYC colleagues with MDT developments, clinical quality indicators, review of monthly reports, Quality Improvement Templates – Clinical Audit etc***

- ***Ad hoc datasets to internal/external stakeholders included (examples only, not an exhaustive list) – Casement Park (demand profile); performance/turnaround times; zoning postcodes; diverts; PCS dataset to support Equality; Newry and Mourne Super Council Performance; Prison Attendances and Chief Complaints; RVH Arrivals ie patient handovers, clearances; attendances to Welcome Centre (Homeless Persons), NISTAR activity; Asthma and Burns datasets; Station Profiles; HELMS Mapping with Trauma Datasets***

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 Operations 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

Freedom of Information, Data Protection (Subject Access) and Departmental requests

REPORT FOR FREEDOM FOR INFORMATION PROCESSING FOR THE PERIOD OF 01/04/2015 to 29/02/2016

The 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)

Freedom of information	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Total (Apr 2015-Feb16)**	**Total (2014-15)**
Number of Requests Received	4	11	11	8	6	15	19	9	6	13	14		116	147
Number of Questions Received	20	32	64	48	31	43	52	14	33	39	33		409	467
Completed Requests processed within 20 days or less	4	8	8	7	4	11	15	5	5	11	8		86	118
Completed Requests exceeding 20 days	0	3	2	1	0	4	1	4	1	0	0		16	28
REQUESTS Still Being Processed	0	0	0	0	0	0	0	0	0	0	1		1	
REQUESTS Still being processed (outside 20)	0	0	1	0	1	0	2	0	0	2	2		8	
Stood Down	0	0	0	0	0	0	1	0	0	0	2		3	
Number of Records Fully Disclosed	20	25	53	43	27	43	27	14	33	26	15		326	
Vexatious Requests	0	0	0	0	0	0	0	0	0	0	0		0	
Number of Records for which records not held	0	0	0	4	0	0	0	0	0	2	0		6	
Requests where exemptions wholly/partially applied	0	7	3	1	0	0	1	0	0	0	0		12	
Questions stood down	0	0	0	0	0	0	9	0	0	0	9		18	

QUESTIONS Still Being Processed	0	0	0	0	0	0	0	0	0	0	6		6		
QUESTIONS Still Being Processed (outside 20)	0	0	8	0	4	0	15	0	0	11	3		41		
Referrals for Independent Review	1	1	0	0	0	0	0	0	0	0	0		2		
Appeals to the Information Commissioner	0	0	0	0	2	0	0	0	0	0	0		2		

Requestor Type

Member of Public	3	2	4	5	2	3	7	2	5	4	7		44		
Local Government	0	1	1	0	0	1	0	0	0	0	0		3		
Staff Member	1	5	2	1	1	8	4	1	0	4	4		31		
Media	0	1	0	2	1	1	2	5	0	4	3		19		
Student	0	0	0	0	0	0	4	1	1	1	0		7		
Commercial Company	0	0	2	0	1	0	0	0	0	0	0		3		
Solicitor	0	0	0	0	0	0	0	0	0	0	0		0		
WhatDoTheyKnow.com	0	2	2	0	1	1	1	0	0	0	0		7		
NHS	0	0	0	0	0	0	0	0	0	0	0		0		
Trade Union	0	0	0	0	0	0	1	0	0	0	0		1		

- **From 01/04/2015 to 29/02/2016- 74.14% of requests have been processed within 20 working days**
- **For the same period of monitoring, the number of questions received was down 58 compared to 2014/15, with requests in total being down by 31.**
- **Note that one request in October 2015 is awaiting clarification from the requestor and therefore currently on hold**

DATA PROTECTION ACT 1998 – SECTION 7: SUBJECT ACCESS MONITORING

REPORT FOR DPA PROCESSING (SUBJECT ACCESS) FOR THE PERIOD OF 01/04/2015 to 29/02/2016

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.

Data Protection Act 1998 – Section 7, Subject Access	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr 15 – Feb 16
Number of Requests Received	2	4	2	1	3	1	1	2	2	2	2		22
Completed Requests processed within 40 days or less	2	2	1	0	1	1	1	1	2	1	1		13
Completed Requests exceeding 40 days	0	1	0	1	-	0	0	1	0	1	1		5
Identity Not Confirmed and therefore could not be further processed	0	1	1	0	2	0	0	0	0	0	0		4
Patient	0	1	1	0	2	0	0	1	1	1	0		7
NIAS Staff Member	2	2	1	1	1	0	1	1	1	1	1		12
External Agency	0	1	0	0	0	1	0	0	0	0	1		3
Relative of Patient	0	0	0	0	0	0	0	0	0	0	0		0

- **From 01/04/2015 to 29/02/2016: 72% of Subject Access Requests processed within 40 calendar days**
  (this is based on this requests that were fully processed ie identity and fee received)

POLICE SERVICE OF NORTHERN IRELAND REQUESTS – Police Acts, Common Law for the Period of 01/04/2015 to 29/02/2016

Purpose:

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

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 15 – Feb 16**	**Apr 14- Feb 15**
Number of Requests Received (based on receipt of correspondence date)	25	19	28	20	44	27	31	35	35	38	35		337	347

SOLICITOR ENQUIRIES for the Period of 01/04/2015 to 29/02/2016

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 15 – Feb 16**	**Apr 14 – Feb 15**
Number of Requests Received (based on receipt of correspondence date)	42	37	31	48	44	65	66	63	29	37	48		510	536

DEPARTMENT OF HEALTH AND SOCIAL SERVICES – REQUEST FOR INFORMATION for Period of 01/04/2015 to 29/02/2016

DHSSPS/AQ's/CORs/TOF's/INV's	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	**April 15 – Feb 16**
Assembly Questions (Oral)	0	0	0	0	0	0	0	0	0	0	0		0
Assembly Questions (Written)	3	9	4	7	4	5	4	8	4	6	12		66
CORs Received	2	0	2	2	4	2	1	1	0	0	2		16
TOFs Received	0	0	0	0	0	0	0	0	0	0	0		0
INVs Received	0	0	0	0	0	1	0	0	0	0	1		2

15/16 - PRF v PATIENT NUMBERS COMPARISON

Summary

Month	Emergency Calls responsed to (KA34)	Patient Journeys: Emergency	Urgent	Routine	Total	Completed PRFs (Formic)	Difference
April 2015	14699	12323	n/a	353	12676	15163	+2,487
May 2015	15151	12610	n/a	357	12967	15744	+2,777
June 2015	15031	12537	n/a	360	12897	15886	+2,989
July 2015	15052	12297	n/a	399	12696	15667	+2,971
August 2015	15491	12770	n/a	420	13190	16196	+3,006
September 2015	15220	12731	n/a	357	13088	15946	+2,858
October 2015	16096	13343	n/a	457	13800	16192	+2,392
November 2015	15683	13167	n/a	463	13630	15554	+1,924
December 2015	16805	13744	n/a	446	14190	16166	+1,976
January 2016	16666	13842	n/a	413	14255	14641	+386
February 2016	15608	12997	n/a	364	13361	3108	
March 2016							
Total	171502	142361		4389	146750	160263	

** Note: due to a change in protocol urgents calls were reclassified as Category C emergencies in June 2014*

Please note figures for 2015/2016 are provisional and will rise as data processing is ongoing.

NORTHERN IRELAND AMBULANCE SERVICE

TRUST BOARD REPORT

HUMAN RESOURCE AND CORPRATE SERVICES DIRECTORATE

Director of Human Resources and Corporate Services

07/04/2016

Section 1: Human Resources & Corporate Services
HRCS KPI: Shaping & Developing Future Workforce (Workforce Information, Recruitment, Job Evaluation)

WORKFORCE INFORMATION

DECEMBER 2015	TRUST TOTAL	CX/ BOARD	FINANCE/ ICT	HRCS	MEDICAL	OPERATIONS
FUNDED WTE	1274.54	7.00	30.63	68.15	8.00	1160.76
SUBSTANTIVE-IN-POST (WTE) PERM/(TEMP)	1163.83 (26.88)	1.00 (6.00)	26.10 (1.00)	60.94 (3.00)	8.00 (1.00)	1067.79 (15.88)
STAFF-IN-POST/HEADCOUNT	1218	7	28	65 (*76**)	9	1111 (*1125**)
VACANCY LEVELS (WTE)	-83.83	0.00	-3.53	-4.21	1.00	-77.09

The Trust's Corporate Workforce Information Report is produced retrospectively on a quarterly basis by the HR Department. Information is reported via the HRPTS system and reconciled between the HR, Finance and Operations Departments for validation purposes. The latest Corporate Workforce Information Report details information at 31 December 2015, for the purposes of this report and the table above shows the verified position as at this date.

NB: *Figures do not include Sessional GP's who constitute 0.14 WTE nor does it include individuals who support ELD clinical programmes, as required. These individuals have been included in Headcount figures (in brackets) in the respective Directorates.*

On the basis of the information above, the Trust has an overall vacancy level of **83.83** WTE posts @ 31 December 2015. This compares to an overall vacancy level of 213.70 WTE posts @ 30 June 2014. The reduction in vacancy levels is attributable to the commencement of a workforce stabilisation programme in June 2014 which included the undertaking of a rigorous recruitment campaign to recruit to front-line operational posts.

It should also be noted that it was reported to Trust Board in February 2016 that the NIAS funded establishment showed an increase from 1,245.54 in June 2014 to 1,295.54 in December 2015. This uplift was subsequently amended and consequently the funded establishment has changed to 1,274.54.

RECRUITMENT ACTIVITY

From June 2014 to date approximately 176 appointments have been made to the following operational posts: -

- 23 Paramedics
- 63 Ambulance Care Attendants (ACAs)
- 74 Emergency Medical Technicians (EMTs)
- 16 Emergency Medical Dispatchers (EMDs)

An estimated further 62 appointments to operational posts, taken from current waiting lists, are expected during 2016. This includes 42 ACA and 20 EMT posts.

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 indicating 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 through the production of a Job Evaluation report and NIAS are supporting the RQA team in the production of this report. Once the Job Evaluation report is provided, it will be made available to all relevant staff, who will have the right to request a review of the outcome. All relevant staff were advised of this position in December 2015 and will be formally notified of the outcome of their job evaluation process following completion of the Job Evaluation Report.

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

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

CORPORATE ABSENCE REPORT (AS AT 29 FEBRUARY 2016)

NIAS's sickness absence target, as agreed with the DHSSPSNI, is **"to improve or maintain sick absence rates on 2014/15 levels".** This report provides summary information of the Trust's sickness absence for the period 1 April 2015 to 29 February 2016. The information reported is from HRPTS and is in % hours lost (in line with HSC regional reporting).

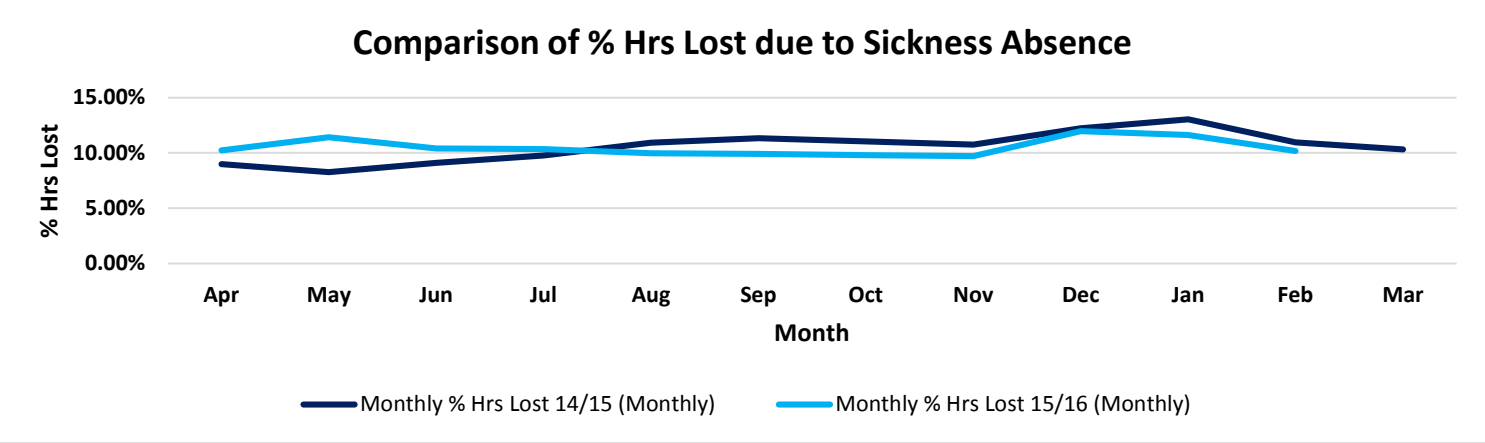
NB: (1) Prior to the introduction of HRPTS, the legacy system (HRMS) reported the sickness absence rate in % days lost. Consequently, NIAS's % absence rates have been recalculated for the previous reporting year (Apr 2014 – Mar 2015) for comparison purposes. % figures shown below are therefore based on the newly applied calculation.

(2) Whilst the majority of staff are shift workers (approx. 90%), the HRPTS calculation automatically divides working hours over a standard 5-day week (Monday – Friday, based on a 7.5 hr day).

(3) The figures exclude Bank Staff and the Non-Executive Team.

ATTENDANCE MANAGEMENT	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
DHSSPSNI Absence Target set	"IMPROVE OR MAINTAIN SICK ABSENCE RATES ON 2014/15 LEVELS"											
NIAS absenteeism monthly % hrs lost (15/16)	10.22%	11.42%	10.41%	10.36%	9.96%	9.91%	9.81%	9.70%	11.97%	11.62%	10.16	
NIAS absenteeism monthly % hrs lost (14/15)	8.98%	8.27%	9.11%	9.76%	10.93%	11.33%	11.05%	10.76%	12.22%	13.03%	10.96%	10.32%
Monthly % hrs lost (S/T)	2.49%	2.47%	2.00%	1.85%	1.61%	2.05%	1.97%	3.14%	3.68%	2.84	3.07	
Monthly % hrs lost (L/T)	7.73%	8.95%	8.41%	8.51%	8.35%	7.86%	7.84%	6.56%	8.29%	8.78	7.09	
Av. days lost per Empee per Mth	2.21	2.30	2.27	2.34	2.06	2.12	2.10	1.99	2.69	2.39	2.08	

NIAS ABSENTEEISM CUMULATIVE % HRS LOST	(2014/15) 10.57%	(2015/16 @ 29 Feb 2016) 10.49%



FLU VACCINE UPTAKE: 13.47%

133 OPS STAFF

34 CONTROL / ADMIN STAFF

REGIONAL UPDATE 2014/15 = APPROX 25%

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

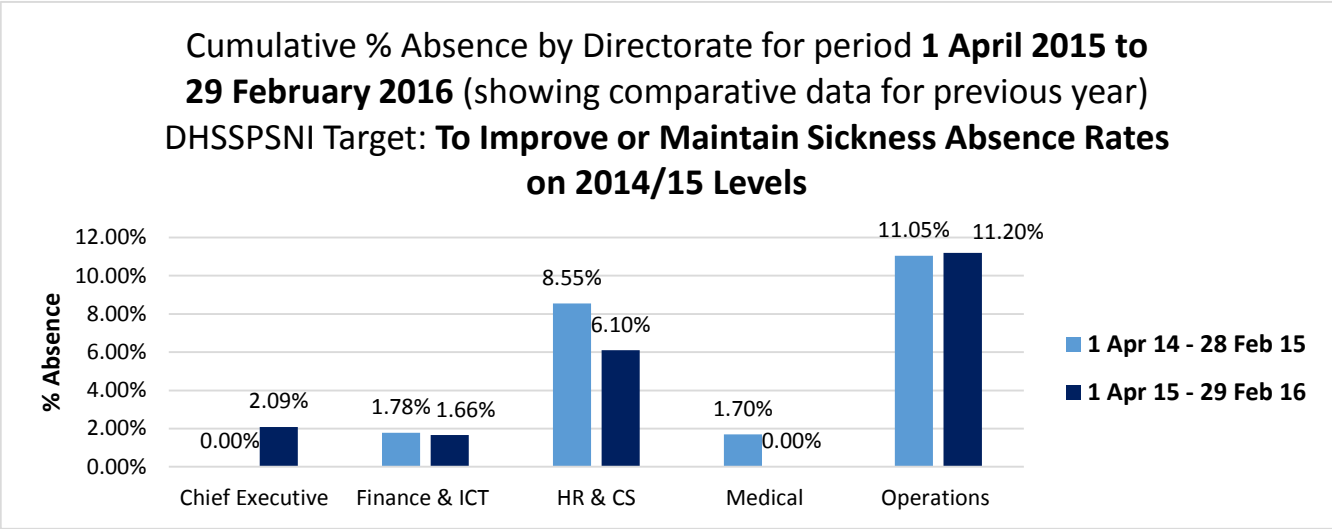
HRCS KPI: **Supporting Staff To Achieve High Quality Performance (Attendance Management)**

CUMULATIVE DIRECTORATE ABSENCE

The following table shows each Directorate's % absence, in terms of long term and short term absence, for the period 1April 2015 to 29 February 2016 against the previous period's absence. The table also shows the average days lost by Directorate.

NIAS % Directorate Absence by Short/Long Term Cumulative Absence for the period 1 April 2015 to 29 February 2016 (showing comparative data for previous year)

Directorate (WTE)	Total Scheduled Hrs (1 Apr 15 - 29 Feb 16)	Long Term		Short Term		Total % Absence Hrs (1 Apr 15 - 29 Feb 16)	Total % Absence Hrs (1 Apr 14 - 29 Feb 15)	Av Days Lost per Employee during Reporting Period
		Absence Hrs	% LT Hrs	Absence Hrs	% ST Hrs			
Chief Executive	1,792.50	0.00	**0.00%**	37.50	**2.09%**	2.09%	0.00%	0.45
Finance & ICT	49,278.75	630.00	**1.28%**	189.75	**0.39%**	1.66%	1.78%	0.35
HR & CS	158,574.98	7,402.50	**4.67%**	2,273.22	**1.43%**	6.10%	8.55%	1.72
Medical	16,439.00	0.00	**0.00%**	0.00	**0.00%**	0.00%	1.70%	0.00
Operations	1,874,515.25	164,596.04	**8.78%**	45325.30	**2.42%**	11.20%	11.05%	2.32
Grand Total	**2,100,600.48**	**172,628.54**	**8.22%**	**47,825.77**	**2.28%**	**10.49%**	**10.57%**	**2.22**

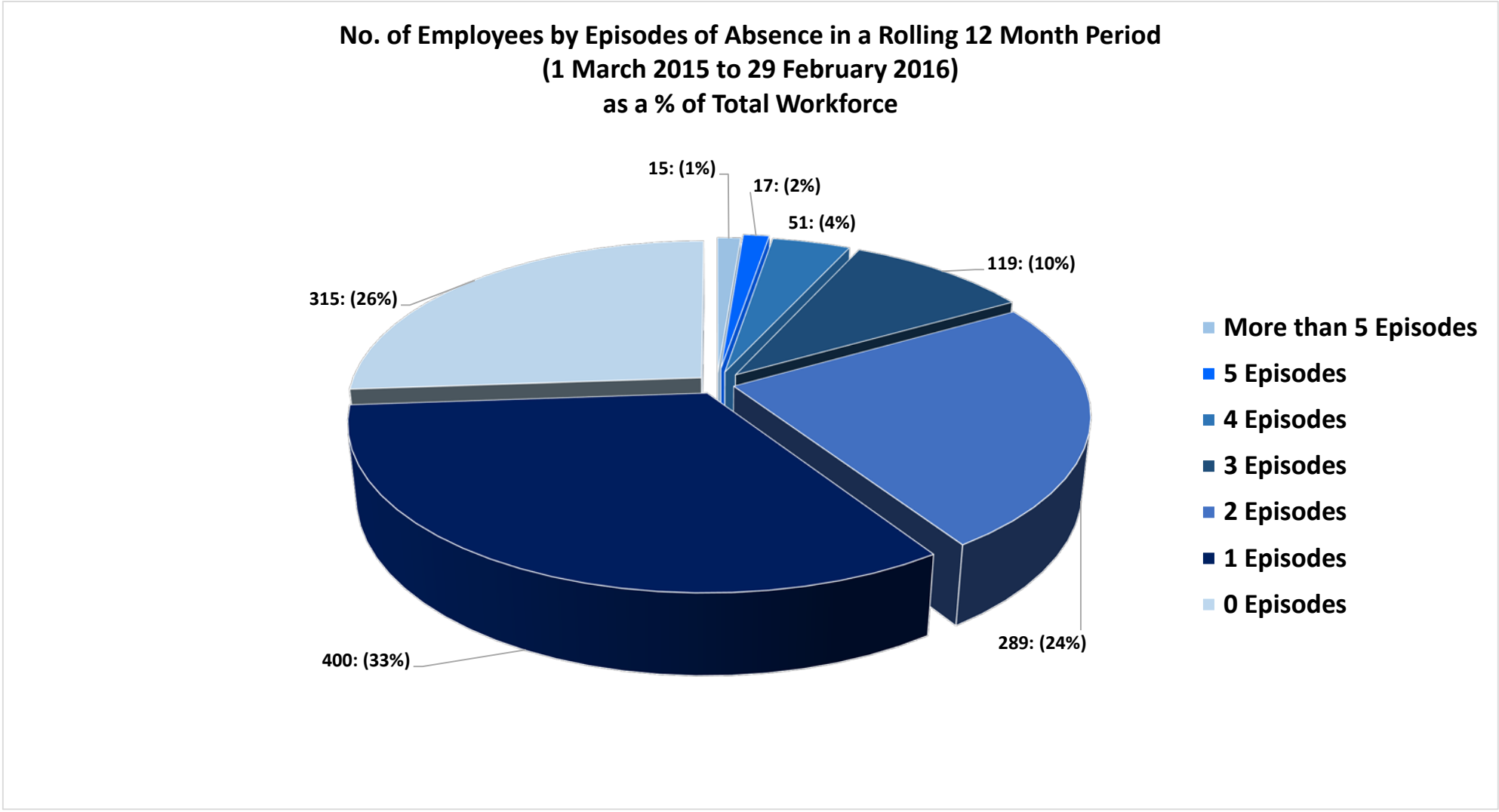


R	G	G	G	R

EPISODES OF ABSENCE

Absence continues to be managed in line with the Trust's Health and Wellbeing Attendance Management Action Plan and HR staff continue to provide professional advice and support to managers in managing attendance. A robust performance management system is in place to support the management of attendance. The NIAS Attendance Management Procedure is such that the management of escalation of an individual's sickness absence levels is in line with the number of episodes of absence they have ("trigger points").

The chart below shows the number of staff, by episodes, who were absent in a rolling 12 month period (1 March 2015 – 29 February 2016).



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

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

REASONS FOR ABSENCE

There are approximately 350 sickness reasons available within HRPTS for recording purposes. Each reason is grouped into one of 26 Categories. The chart below shows the top 5 Categories of Absence during the reporting period with all other Categories grouped as "Other" for the purposes of this report.

Mental Health related illnesses = includes Anxiety, Depression, Grief / Bereavement, Stress and Work Related Stress

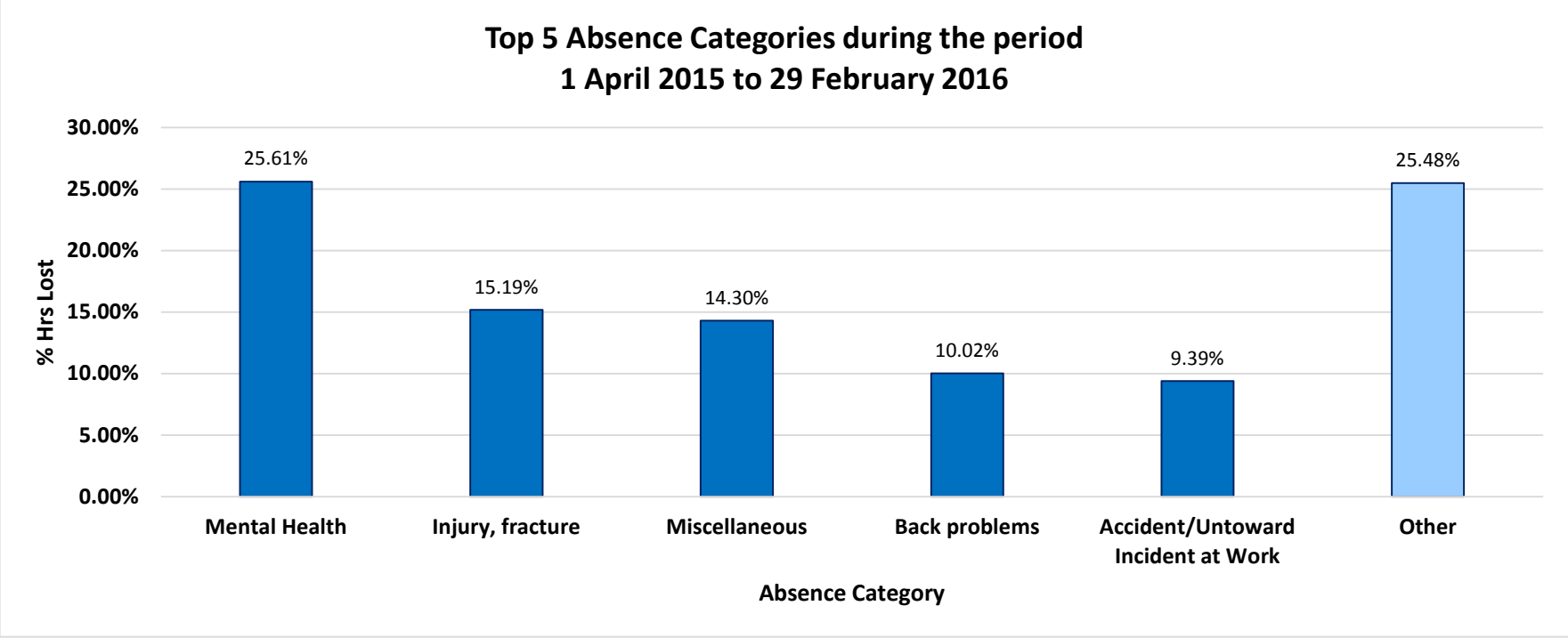
Injury, fracture related illnesses = includes All fractures, Sprains, Strains and Skeletal injuries

Miscellaneous related illnesses = includes Chronic Fatigue, General Debility, Hospital Investigations, Post Surgical Debility, and Post Viral Fatigue

Back Problems related illnesses = includes Back Ache/Pain, Disc problems, Lumbago, Sciatica, Scoliosis, Spinal Stenosis, Spondylitis, Spondylosis

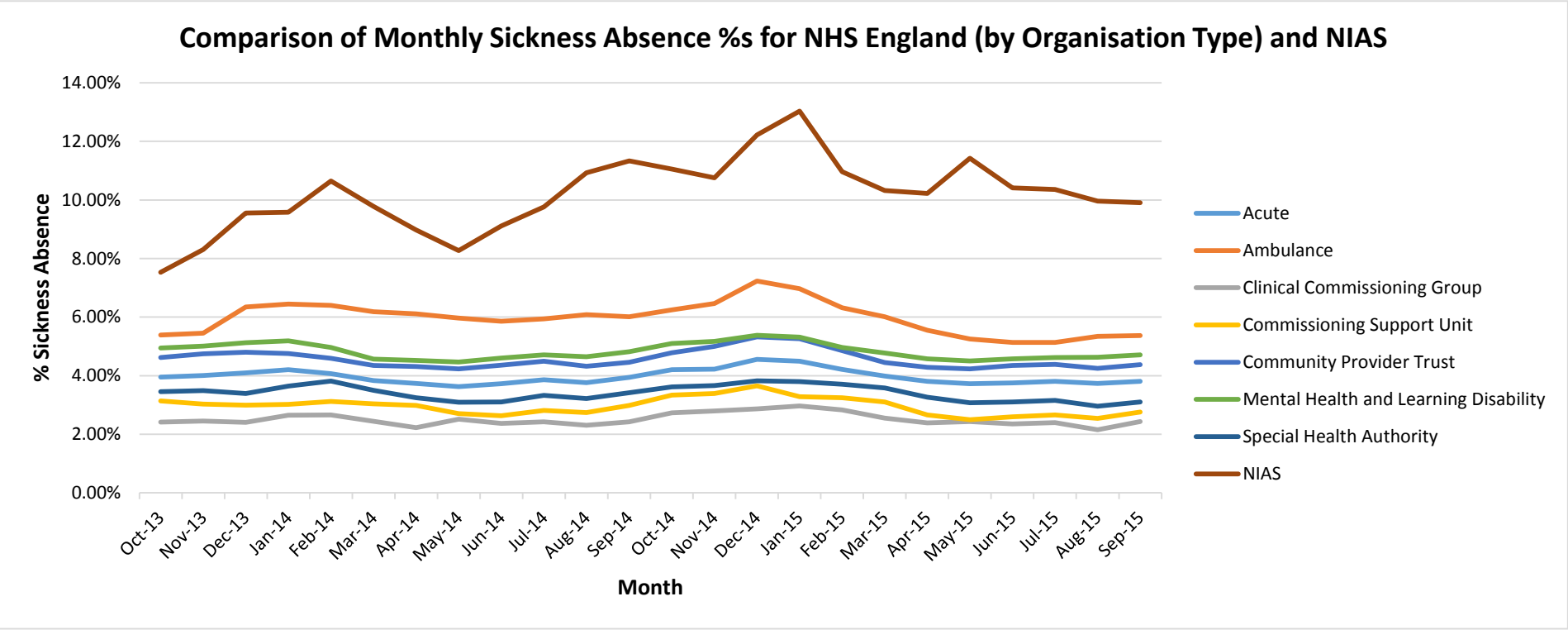
Accident / Untoward Incident at Work related illnesses = includes Industrial Injury, RTC, Work-Related Accident, and Untoward Incidents

Other = includes all other Categories of absence for example Cancer, Cardiac, ENT, Pregnancy related, 'Flu etc



Section 1:	Human Resources & Corporate Services
HRCS KPI:	Supporting Staff To Achieve High Quality Performance (Attendance Management)

The HR Dept conducts benchmarking exercises in respect of its absence information. At present, regional HSC information has not been published for the current financial year however NHS England Sickness Absence Rates are available, and have been used to compare the Trust's % absence figures, as depicted below for the period October 2013 – September 2015.



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 Feb 2016	TRUST TOTAL	Patient Care	Wilful Damage	Criminal Conduct	Fraud	Failure to comply with Trust Policy / Procedure
Total Ongoing Cases	**13**	**5**	**0**	**2**	**0**	**6**
HCPC Referrals	**0**	0	0	0	0	0
Suspensions	**2**	0	0	1	0	0
New Cases	**1**	**1**	**0**	**0**	**0**	**0**

Grievance Cases:

Position as at Feb 2016	TRUST TOTAL	Transfer	Application of T&C	Recruitment	Job Evaluation	Equal Opps	Employee Relations Processes	Promotion	Pay
Total Ongoing Cases	**26**	**2**	**16**	**1**	**1**	**1**	**2**	**2**	**1**
Informal Stage	4	0	3	0	1	1	1	0	1
Formal Stage 1	18	0	12	1	0	0	1	1	0
Formal Stage 2 (Appeal)	4	1	1	0	0	0	0	1	0
New Cases	**3**	**0**	**2**	**0**	**0**	**1**	**1**	**0**	**0**

Working Well Together / Harassment Cases:

Position as at Feb 2016	TRUST TOTAL
Total Ongoing Cases	**2**
Informal Resolution / withdrawn	0
Inv Ongoing	1
Formal Stage 1	1
Formal Stage 2 (Appeal)	0
New Cases	**0**

Commentary (Employee Relations/Industrial Relations):

NIAS continues to face significant industrial relations issues and challenges. From the day of industrial action which took place on 13 March 2015 and the overtime ban which took place in May 2015 (all relating to regional/national concerns in areas such as pensions and pay) more recently Trade Union Side have entered into dispute with NIAS regarding issues relating to Job Evaluation. Trade Union Side notified Management Side at NIAS Joint Consultative Negotiating Committee (JCNC) on 21 July 2015 that they were withdrawing from all job evaluation processes. Management is continuing to manage this situation. The Trade Union position remains unchanged.

Case File Closures:

Position as at Dec 2015	April	May	June	July	August	Septembe	October	November	December	January	February	March
Grievance	11	4	1	3	1	0	1	1	0	1	2	
Disciplinary	2	0	0	0	1	0	0	0	1	2	3	
Harassment	0	0	0	0	0	0	0	1	0	0	0	
Total	**13**	**4**	**1**	**3**	**2**	**0**	**1**	**2**	**1**	**3**	**5**	

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

HRCS KPI: **Modernisation & Reform (BSTP)**

HRPTS Deployment Within NIAS:

Aug 2015 Position	Trust Total	Operations	EAC/NEAC	RMC	HRCS	Finance & ICT	Medical
% staff with access to ESS/HRPTS (as % of total staff at end Aug 2015)	14.06%	4.41%	0.67%	0.92%	5.24%	2.16%	0.67%
% Managers with access to MSS/HRPTS (as % of total Managers at end Aug 2015)	82.22%	47.78%	7.78%	1.11%	15.56%	8.89%	1.11%

BSTP UPDATE

HRPTS:

The HRPTS system was implemented within NIAS on 18 February 2014 in line with the NIAS HRPTS Deployment Plan. The Deployment Plan recognised that deployment of HRPTS within NIAS would be significantly limited due to IT infrastructure issues and that it would only be possible to deploy Employee Self Service (ESS) to 18.9% of NIAS workforce. Currently 14% of NIAS employees, as at August 2015, are able to access ESS with 82% of NIAS Managers having access to MSS. Deployment of HRPTS within NIAS remains significantly hampered due to IT Infrastructure limitations particularly at station level where a substantial majority of NIAS employees are based. Work is currently ongoing regionally to explore alternatives to provide for full deployment. Work is planned to reinforce ESS/MSS usage within the Trust.

BENEFITS REALISATION:

Regional meetings continue to take place in relation to BSTP Benefits Realisation. NIAS continues to contribute to regionally activities aimed at ensuring continual improvement and system optimisation.

SHARED SERVICES

NIAS continues to engage with BSO Shared Services in planning the transition of the Recruitment & Selection (R&S) function.

The transition to Shared Services will impact directly on staff within the HR Department. Work is currently underway to support staff through this transitional period. In February 2015 the Trust saw the move of the NIAS Payroll function to the BSO Shared Services organisation. Fortnightly meetings continue to take place between BSO Payroll SS, Human Resources & NIAS Payroll to address transitional process issues.

Section 1: Human Resources & Corporate Services

HRCS KPI: Compliments, Complaints & Claims

HANDLING TIMES OF COMPLAINTS																
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Total**	***%***	**2014-15**	
Complaints Received	16	18	7	8	7	23	9	18	7	14			**127**		**229**	*100%*
Total A&E & PCS Activity	***28127***	***27962***	***28820***	***28795***	***28339***	***29209***	***29725***	***28961***	***30160***	***30313***			***290411***			
% Complaints/Activity	***0.06%***	***0.06%***	***0.02%***	***0.03%***	***0.02%***	***0.08%***	***0.03%***	***0.06%***	***0.02%***	***0.05%***			***0.04%***			
Acknowledged within 2 working days	16	18	7	8	7	23	9	18	7	14			**127**	*100%*	**229**	*99%*
Acknowledged after 2 working days	0	0	0	0	0	0	0	0	0	0			**0**	*0%*	**0**	*1%*
Response within 20 working days	0	2	0	0	2	10	5	8	3	5			**35**	*28%*	**29**	*13%*
Response after 20 working days	12	13	6	4	4	7	3	3	2	2			**56**	*44%*	**64**	*30%*
Complaints Investigations ongoing	4	3	1	4	1	6	1	7	2	7			**36**	*28%*	**136**	*36%*
Cases referred to NI Ombudsman (cases ongoing)	1(3)	0(4)	1(5)	0(5)	0(5)	0(5)	0(5)	0(5)	0(5)	0(5)			**5**		2	

SERVICE AREA OF COMPLAINTS																
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Total**	***%***	**2014-15**	
Accident & Emergency	8	5	4	7	4	5	5	10	4	10			62	*49%*	89	*39%*
Patient Care Service	0	4	1	1	2	2	0	0	3	2			15	*12%*	27	*12%*
Control & Communications	8	9	2	0	1	16	4	8	0	2			50	*39%*	103	*45%*
Other	0	0	0	0	0	0	0	0	0	0			0	*0%*	8	*3%*
Voluntary Car Service	0	0	0	0	0	0	0	0	0	0			0	*0%*	2	*1%*
TOTAL	**16**	**18**	**7**	**8**	**7**	**23**	**9**	**18**	**7**	**14**	**0**	**0**	**127**	*100%*	**229**	*100%*

Section 1: Human Resources & Corporate Services

HRCS KPI: Supporting Trust Priorities

NATURE OF COMPLAINTS RECEIVED																
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**2015-16**	***%***	**2014-15**	
Staff Attitude	6	4	3	5	4	8	5	5	3	9			52	*40.9%*	**85**	*37%*
Ambulance Late/No Arrival	8	11	4	2	3	15	4	9	3	3			62	*48.8%*	**103**	*45%*
Quality of Treatment & Care	2	3	0	0	0	0	0	1	1	1			8	*6.3%*	**18**	*8%*
Suitability of Equip/Vehicle	0	0	0	0	0	0	0	3	0	0			3	*2.4%*	**1**	*0%*
Other	0	0	0	1	0	0	0	0	0	1			2	*1.6%*	**21**	*9%*
Patient Property	0	0	0	0	0	0	0	0	0	0			0	*0.0%*	**1**	*0%*
TOTAL	**16**	**18**	**7**	**8**	**7**	**23**	**9**	**18**	**7**	**14**	**0**	**0**	**127**		**229**	

COMPLIMENTS RECEIVED

COMPLIMENTS RECEIVED															
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**2015-16**	**2014-15**	
RECEIVED	28	1	9	7	11	13	11	19	26	9			**134**	**186**	
SERVICE AREA OF COMPLIMENTS RECEIVED															
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**2015-16**	***%***	**2014-15**	
Accident & Emergency	27	1	9	6	11	13	10	17	26	9			**129**	*96.3%*	**176**	*95%*
Control	1	0	0	1	0	0	0	0	0	1			**3**	*2.2%*	**2**	*0%*
Patient Care Service	0	0	0	0	0	0	0	0	0	0			**0**	*0.0%*	**4**	*2%*
Voluntary Car Service	0	0	0	0	0	0	0	0	0	0			**0**	*0.0%*	**1**	*0%*
Other	0	0	0	0	0	0	1	2	0	0			**3**	*2.2%*	**3**	*2%*
TOTAL	**28**	**1**	**9**	**7**	**11**	**13**	**11**	**19**	**26**	**10**	**0**	**0**	**135**		**186**	

Section 1: Human Resources & Corporate Services

HRCS KPI: Supporting Trust Priorities

CLOSED COMPLAINTS DECEMBER 2015 – JANUARY 2016

Ref	Description	Outcome	Action taken/Learning Outcome
Comp/976	Complaint regarding the treatment of patient where the crew refused to lift the patient off the floor.	Complaint not upheld. Crew found to have acted appropriately.	Letter of apology issued. No further action identified.
Comp/996	Complaint regarding the crew's attitude towards a cancer patient where they made her walk to the door before putting in her a chair, even though she was in terrible pain.	Complaint not upheld. Crew found to have acted appropriately.	Letter of explanation issued. No further action identified.
Comp/997	Complaint regarding the non-arrival of ambulance where the patient had to be brought to hospital by relatives.	Complaint upheld. Control did not apply relevant protocols when dealing with the call.	Letter of apology and explanation issued. Call Taker to receive training to address issue highlighted.
Comp/999	Complain regarding the delay of an ambulance where it took over 9 hours to arrive.	Complaint upheld. Control were experiencing a high volume of calls.	Letter of explanation and apology issued. No further action identified.
Comp/1004	Complaint regarding an alleged motor accident which resulted in delay of the patient being conveyed to hospital.	Complaint upheld. An accident did occur which delayed the patient getting to hospital	Letter of explanation and apology issued.
Comp/1008	Complaint regarding the driving of an ambulance vehicle where it undertook a vehicle and then slammed on the brakes.	Investigation unable to substantiate allegation however the complaint has been upheld.	Letter of apology issued. No further action identified.
Comp/1010	Complaint alleging that staff are remotely watching complainant and wants the sirens and engine noises to stop.	Complaint not upheld. No evidence to support allegation found.	Letter issued. No further action identified.
Comp/1012	Complaint regarding the advice given by 999 calltaker and GP in Control where complainant was advised to put his daughter in the car and take her to hospital. On the way to hospital his daughter collapsed and he had to ring 999 again for assistance.	Complaint not upheld. Call had been categorised correctly given the information provided by the caller.	Letter of apology and explanation issued. No further action identified.
Comp/1014	Complaint regarding the behaviour of the crew who attended a terminally ill patient but did not bring him to hospital and he required another ambulance later that day and was taken to hospital.	Complaint upheld. Staff found to be have provided a poor service.	Letter of apology and explanation issued. Crew to be referred to HR under the Trust's Disciplinary Process.

Comp/1015	Complaint regarding the driving of an RRV where they allegedly came across the lane in front of the complainant leaving the motorway. When the complainant reached the lights he spoke to the driver who adamant he was in the correct lane.	Complaint upheld.	Letter of apology issued. Crew member will be reminded of his duty of care and the professional standards expected.
Comp/1016	Complaint regarding the delay of an ambulance where it took over 4 hours to arrive.	Complaint upheld. All available resources were dealing with calls of higher clinical priority.	Letter of explanation and apology issued. No further action identified.
Comp/1017	Complaint regarding the delay of an ambulance and the lack of communication in regard to the delay.	Complaint upheld. The call was not managed appropriately by control.	Letter of explanation and apology issued. Recommendations have been made which will involve new technology. The actions of the Officer concerned will also be dealt with through the appropriate channels.
Comp/1018	Complaint regarding the delay of an ambulance where it took over four hours to arrive.	Complaint upheld. Control were extremely busy at this time.	Letter of apology issued. No further action identified.
Comp/1019	Complaint regarding the driving of an ambulance where it narrowly missed a car when it came through a red light.	Complaint upheld. Crew have a duty of care to other road users.	Letter of apology issued. Crew to be reminded of their duty of care to other road users.
Comp/1021	Complaint regarding the attitude of a crew member to nursing home staff.	Complaint upheld. Staff member concerned admitted to being short with the nursing home staff.	Letter of apology issued. Crew member has been counselled on his attitude reminded of the expected code of conduct.
Comp/1022	Complaint regarding staff attitude towards staff at nursing home.	Complaint upheld.	Letter of apology issued. Staff member to be reminded that he is to remain professional at all times.
Comp/1023	Complaint regarding the non availability of non emergency transport to bring patient for a medical procedure which resulted in her family paying £125 for Pro Paramedics to make the transfer.	Complaint upheld. All available resources were booked up at the time of this appointment.	Letter of apology issued. No further action identified.
Comp/1024	Complaint regarding the driving of a RRV which was deemed to be dangerous where he overtook on the brow a hill.	Complaint upheld. RRV paramedic has confirmed that an incident did take place involving another vehicle which stopped suddenly in front of him which caused him to move to the other side of the road.	Letter of apology issued. Crew member has been counselled regarding his driving.
Comp/1025	Complaint regarding treatment of patient. Relative felt that they did not want to take the patient to hospital and stated that the patient did not need to go. The relative insisted that the patient be taken to hospital and was subsequently admitted.	Complaint not upheld. No evidence found that crew did not act appropriately.	Letter of apology and explanation issued. No further action identified.

Comp/1027	Complaint regarding the driving of an A&E vehicle where it is alleged that they went through lights without sirens.	Complaint upheld. A problem was identified with the equipment which did not activate the sirens.	Apology issued. Crew member has been counselled regarding the importance of using sirens whilst responding to emergency calls and the importance of carrying out a vehicle check on commencement of shift.	
Comp/1028	Complainant taken to hospital by PCS and was informed return journey would be taxi, patient waited for two hours and he was not picked up, resulting in him having to get a taxi home.	Complaint upheld. Taxi company had taken down patient's mobile number incorrectly and was unable to make contact with the patient.	Letter of apology issued. Control records have been updated in relation to patient's current medical condition.	
Comp/1029	Complaint regarding attitude of crew when they arrived at the patient's home as he was smoking, crew allegedly commented "you're not that sick".	Complaint not upheld. Complainant admitted to having drink taken when this incident occurred and has apologised to crew members.	Letter issued. No further action identified.	

Section 1: Human Resources & Corporate Services

HRCS KPI: Supporting Trust Priorities

Claims 2015/16

	C/O	A	M	J	J	A	S	O	N	D	J	F	M	Total
Employers Liability	**29**													
Claims Received		1	2	0	1	0	1	0	3	2	2			**12**
Claims Settled		1	0	0	0	0	0	2	2	0	3			**8**
Cases Ongoing														**38**
Public Liability	**2**													
Claims Received		0	0	0	0	0	2	0	0	0	0			**2**
Claims Settled		0	0	0	0	0	0	0	0	0	0			**0**
Cases Ongoing														**4**
Clinical Negligence	**8**													
Claims Received		0	0	1	0	0	2	0	0	1	0			**4**
Claims Settled		0	0	0	0	0	0	0	0	0	0			**0**
Cases Ongoing														**11**

Lessons Learned:

3 Employee Liability cases settled:

- Staff to be reminded/retrained in the disposal of sharps in ambulance vehicles
- Staff to be reminded/trained regarding the emptying of clinical waste bags at the end of every shift.
- Management to ensure that the source of any infection is traced as quickly as possible so that the injured party can be informed at the earliest opportunity of any associated risks which will minimise distress and costs.

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 2015/16

Categories	*Slips & Trips*	*Quality of Treatment*	*Needle Stick Injury*	*Equip / Vehicle Faults*	*RTA's*	*Other*
Employee Liability			*1*	*5*	*4*	*2*
Public Liability	*2*					
Clinical Negligence		*4*				

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

HRCS KPI: **Supporting Trust Priorities**

Concerns raised under Public Interest Disclosure (NI) 1998 (WHISTLEBLOWING)												
Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**2015-16**
0	0	0	0	0	0	0	0	0	0	0		0

Section 2: **Education, Learning & Development**

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

Development and delivery of the 2015/16 element of the agreed Education, Learning and Development Plan:

Delivery of the 2015/16 element of the ELD plan is on target. The ELD Plan reflects the Trust-wide changes in service delivery and has a specific focus on clinical priorities, particularly the provision of accredited training to support external and internal recruitment of emergency and non-emergency staff; a revised post-qualification assessment, training and development programme that maintains and updates clinical skills as well as introduces new topics to support the implementation of TYC-led initiatives and embed these into standard practice.

Knowledge and Skills Framework (KSF) Personal Development & Contribution Reviews (PDCR) 2015/16

Each Directorate has responsibility for ensuring staff within their remit have the opportunity to undertake an annual individual KSF PDCR and to monitor compliance. This provides staff and managers with the opportunity to reflect on and appraise how each individual has personally contributed to the Trust's Strategic Aims and Values. Overall Trust compliance will be reported on by the KSF management side lead on a 6 monthly basis i.e at 30/09/2015 and 31/03/16.

Directorate	Apr 15 – Sept 15	Oct 15 – Mar 16
Finance	Nil	*See below
HR & CS	Nil	*See below

ELD Highlight report:

- The withdrawal of IHCD Modules remains on the HRCS local risk register. An options appraisal identifying alternative programmes of delivery for paramedic training has been reviewed by SEMT. NIAS continues to engage with the DHSSPS and Commissioners regarding the future delivery of paramedic training in NI;
- Plans are in place to develop a Level 4 Diploma for Associate Practitioners to replace the IHCD EMT qualification and also to implement changes required to support this. This includes delivering a Level 3 Certificate in Assessing Vocational Achievement to all Training Officers and CSOs during 2016-17;
- Delivery of the RATC 2015-16 core clinical training programmes for EMTs and ACAs continued to be delivered to plan and the 2016-17 training timeline is being finalised to ensure effective delivery to meet the Trust's frontline operational workforce needs. To date in 2015-16 this has provided Operations with an additional 20 fully operational EMTs plus another 45 on practice placement. It has also delivered 64 qualified ACAs with an additional 22 in RATC undertaking their training;
- The 2015-16 CPD programme for emergency and non-emergency operational staff commended in September and continues to be rolled out. This programme is complemented with a refreshed workbook that includes mandatory and statutory training;
- The development of a new quality improvement project continues and is being undertaken in all Divisions. This will enable the implementation of a revised audit system with observation of practice to reinforce and evaluate the delivery of new clinical pathways into paramedic practice;

Medical	Nil	100%
Operations	Nil	*See below

***Year end data (to 31/03/16) will be collated during April 2016.**

- The introduction of new regulated driving courses for EMTs and ACAs is planned for 2016-17. These courses will provide EMTs with a Level 3 Certificate in Emergency Response Driving and ACAs with a Level 2 Award in Ambulance Driving

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 Trusts Equality and PPI Steering Group.
- The Trust works to 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.

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.
- Planning for participation in PRIDE events alongside other HSC organisations.
- Monitoring of access to telephone interpreting services provided to those who contact the 999 system and do not have English as a first language.
- 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.

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 particular Trust policy plans and 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 and Human Rights and 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.

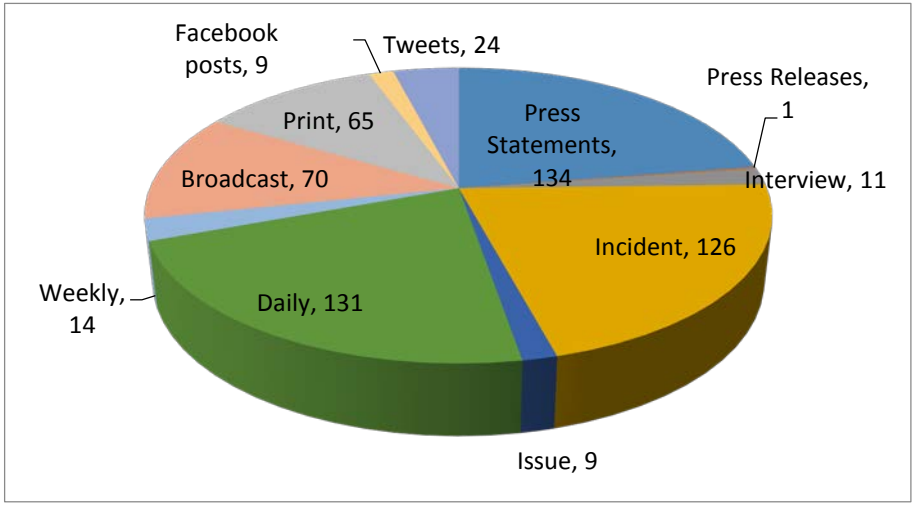
Section 3:	**Equality & Human Rights/Personal and Public Involvement/ Patient Experience/Media and Communication**
HRCS KPI:	**Supporting Trust Priorities; Transformation and Modernisation; Equality and Human Rights; Partnership & Employee Engagement**

NIAS Responses to Consultations January/February 2016

Date of Response	Consultation Title & Summary	Summary of NIAS Response	Link to Consultation
21-Jan-16	DHSSPSNI - Establishing a Helicopter Emergency Medical Service for Northern Ireland	The Trust believes that a Clinical Advisory Group is essential and should be comprised of clinicians with relevant knowledge, experience and expertise in pre-hospital care and HEMS. NIAS is the only regional organisation with the necessary infrastructure to support the proposed service. Irrespective of the funding model, it is essential that the funding is sufficient, recurrent and sustainable and does not reduce or compromise existing ambulance service provision. NIAS endorses a physician-led model, comprising a doctor and paramedic, due to the synergy the various skillsets of each role offers the proposed service. Base location should be determined by a formal options appraisal.	https://www.dhsspsni.gov.uk/consultations/consultation-key-issues-related-establishment-helicopter-emergency-medical-service

Date of Response	Consultation Title & Summary	Summary of NIAS Response	Link to Consultation
28-Jan-16	DHSSPSNI - Health and Social Care Reform and Transformation, Getting the Structures Right	NIAS welcomes the active stance adopted and is keen to play a full part in improving the HSC systems through the reform and transformation process. NIAS supports proposals to remove complexity from the systems outlined, but have concerns that appropriate measures and systems are established for the commissioning of regional services such as our own. We support and welcome the maintenance of regional commissioning of ambulance services under revised arrangements rather than dispersion of ambulance commissioning to five localities. The simplified and shorter line of accountability between providers and the Department may result in a better alignment of management of performance, quality, safety, financial outturn and capital. NIAS welcomes the opportunity to take on responsibility for planning those aspects of HSC services it delivers. Integrating planning and delivery has the potential to strengthen operational independence and streamline the existing system.	https://www.dhsspsni.gov.uk/consultations/health-and-social-care-reform-and-transformation-getting-structures-right

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**



Key Themes in Press Coverage

- Throughout January and February, NIAS issued 135 Press Statements in response to enquiries from the media.
- 11 media interviews were conducted during the period.
- The number of media outlets reached in this period totalled 135 (each response equates to 1 outlet reached)
- Press statements tend to be issued in response to particular incidents, which in this case include RTCs, stabbings and accidental deaths of children.
- Corporate issues which were addressed reactively, in response to media, included assaults on crews, response times and sickness levels.
- The Trust continues to engage with the public through social media, which includes the Trust Facebook and Twitter platforms.

Community Education

Number of Community Education Visits	109

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

General Media and Communication Work Streams

- The Trust website has been redeveloped which provides a more modern and accessible format for users. This will also enable greater ownership to maintain currency within Directorate areas.
- 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. Having completed a term as Chair of the National Ambulance Communications Group (sub-group of AACE), the Trust's Media and Communications Manager handed over the role of Chair, however continues to participate in the 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 includes 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 Modernisation – Transforming Your Care**
HRCS KPI:	**Modernisation and Reform**

- NIAS Transformation and Modernisation Programme Board meet monthly and is chaired by the Director of HR&CS. In relation to TYC the Programme structure has identified key deliverables and related process through the Project Initiation Document. The Programme Management includes consideration of related risks and progress on priority action plans. The Programme engages with key stakeholders, including Commissioners and Users on an ongoing basis.
- The projects include:
  - Implementation of a range of Appropriate Care Pathways
  - Pilot of a Clinical Support Desk in Ambulance Control
  - Implementation of a NIAS Directory of Services

Performance against key deliverables for NIAS Trust and the benefits realisation to the wider HSC is reported at each Programme Board and Trust Board.

Engagement

A Patient engagement event was held in February in association with Age NI and was very favourably evaluated by attendees. NIAS has been participating in a regional Care Pathway working group looking at the potential for an improved care pathway for patients with heart failure. A regional meeting was hosted by NIAS with Diabetes teams across NI to discuss the NIAS Treat, Leave and Refer pathway. The TYC team participated in workshops relating to improving care for patients with Palliative Care needs and also Diabetes.

Clinical Support Desk Highlight Report:

- The contingency plan of enhancing the current GP model for 3 months from 1st of December, 2015 to enable and extend "Hear & Refer" and "Hear & Treat" pathways continues to operate. The number of calls eligible to be passed to the GPs has been increased and a range of other tasks added.

Appropriate Care Pathways Highlight Report:

- **Diabetes/Minor Injury Units/Palliative Care/Cardiac/Frail Elderly/Respiratory/Medical Assessment Unit/Falls/Epilepsy Alcohol Recovery Centre:**

  These pathways continue to be used for referral in the Trusts/areas in which they are available.
- **Community Nursing:** this referral pathway went 'live' across the region on 22nd of February with all Trusts working with NIAS to agree a referral guideline and handover arrangements. This means patients with issues with catheters, syringe driver and peg tubes (as well as range of other issues) can be referred to the local Community Nurse for follow up.
- **Falls:** a service has now been made available in the Northern sector of the Western Trust for NIAS to refer patients over 65 who have had a fall without significant injury and this went 'live' on 1st of March, 2016.
- **Diabetes:** a service has now been made available in the Southern Trust and this went live on 1st of March, 2016.
- A range of local and regional meetings have been held in relation to progressing these and other pathways.
- A significant update to the Mobile Data Terminal in each ambulance is underway to improve how information is recorded regarding the number of referrals to each new pathway.
- Evaluation of the new ACPs is underway as part of the rollout of a new Quality Improvement Programme.

Directory of Services Highlight Report:

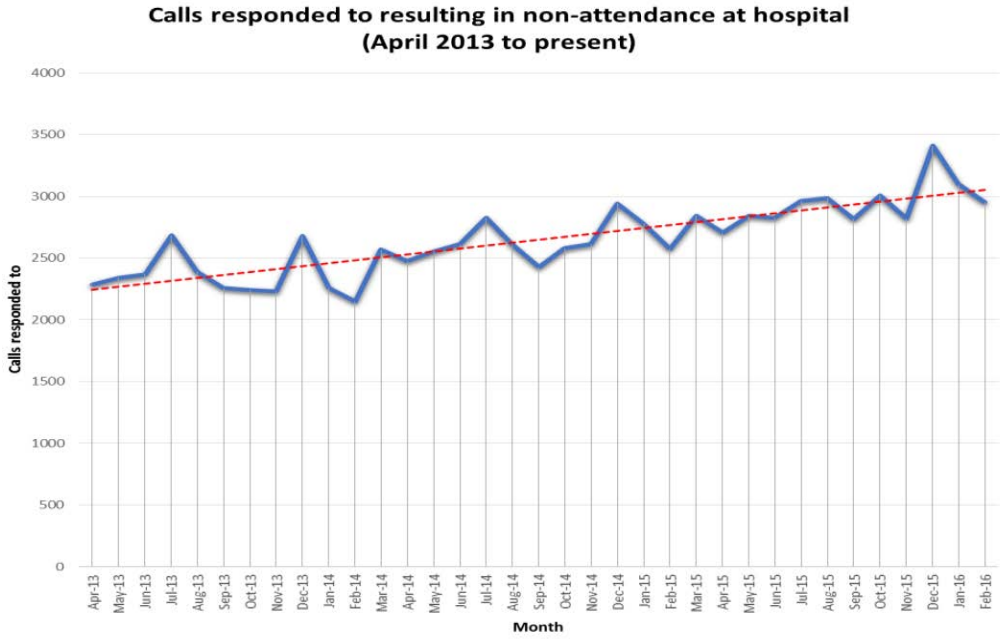
- The NIAS Directory of Services is 'live' in Emergency Ambulance Control and contains details of all the services highlighted above, and is searchable by postcode, town or using maps. It also contains links to the clinical protocols so that information can be given out by EAC staff to operational staff who phone in to Control.
- EAC staff have been trained in use of the DOS and feedback has been positive. More services and information relevant to ambulance service delivery is being added at the request of staff.

NIAS TRUST BOARD – REPORT ON IMPLEMENTATION OF TRANSFORMING YOUR CARE PROGRAMME.

The objective set by HSCB for the NIAS Transforming Your Care Programme was for a reduction of conveyances to the ED - of appropriate patients through implementation of 10 appropriate care pathways - by 10% by March 2016 which was calculated as 5672 patients.

This target has been met already, since in comparison with the first 11 months of 13/14 an additional 6555 patients were safely left at home and 1494 were safely conveyed to an alternative destination following paramedic referral.

The average number of patients not conveyed to hospital has grown from an average of 2351 to 2947 a month. The number of patients conveyed to hospital continues to average around 11,400 per month despite growth in emergency calls received and ambulance responses made. The proportion of patients, not attending hospital following ambulance response, has grown from 17.3% (2013/14) to 20.5% in 15/16.



In addition to the reduction in conveyances, in the 11 months from April to December 1494 patients were conveyed to 'alternative destinations' following paramedic referral. These include:

BCH Direct (Frail/Elderly Unit in Belfast City Hospital) Paramedic Referrals Healthcare Professional Referrals	 449 724
Cath Labs in the Royal Hospital and Altnagelvin Hospital	361
Type 3 Hospitals and Minor Injury Units	299
Antrim Area Medical Assessment Unit (Paramedic Referrals only)	69
Alcohol Recovery Centre (launched in Belfast mid December 2015)	3
	1905

Data analysis of the other Care Pathways is ongoing and will improve once a Trustwide MDT update is complete.

Transformation and Modernisation Programme Overview

Last updated **16/03/2016**

TYC Objectives	Sub Category	Deliverables	Responsible	Due	Projected date	NIAS Read-iness	Risk	Measures to address Risk	RAG Status - N Ireland	Belfast	South East	South	North	West
To deliver 10 new alternative pathways for patients instead of conveyance to ED.		Protocol designed and if available, appropriate services open to accept NIAS referrals. If no available service then Trusts engaged and aware of NIAS readiness to 'go-live', Commissioners aware.	PM	31/03/2016	31/03/2016		Frequent Callers policy is not in place.	TMPB have agreed that due to complexity and range of stakeholders involved this should be deferred beyond life cycle of project. All other pathways are on target for pilot and implementation in every area with relevant services by end of March 2016						
To reduce conveyance to ED by 10% (of appropriate Cat b and C calls = 5672 conveyances by end of March 2016.		From design and implementation of policies, pathways, awareness raising, staff training and monitoring through info/analytics of the above pathways. On target to deliver.	PM	31/03/2016	31/03/2016		As of December 2015 have delivered on target of 5672 (reduced conveyances plus conveyances to alternative destinations to date in 15/16) however some aspects of data capture is limited	Changes to MDT codes go live in February. Additional funding for staffing given to Info/Analytics team to help with analytics regarding TYC until end of March. Coding has improved with training of EAC staff in Dec. 2015						
Have in place a directory of services to support new response models, coordinated by NIAS in collaboration with the other five HSC Trusts by June 2014;		DOS in place and in use by ambulance control to give advice to staff.	PM	30/06/2014	01/12/2015		Delay due to appointment of PM (April 2014, and Control SIL October 2014) and delay due to implementation of CSD.	Contingency for CSD and DOS implementation was agreed by TMPB in October 2015 and DOS went live on 1st of December 2015.						
Ensure paramedic training (including CPD) is in line with drive to new response models and that there is evidence of increased confidence among paramedics to take protocol-based decisions which support new response models and have the autonomy to make referrals which avoid unnecessary hospital admissions;		Ensure PP includes appropriate components to support introduction of the new ACPs.	PM/AD ELD	20/03/2015	Ongoing		Due to competing pressures, not as much time was given to TYC within PP as was proposed by PM and CSIL.	The Medical Director and Dir of Ops agree training priorities. A training needs analysis is underway to determine training needs for 16/17.						
Minimise risk to the delivery of frontline services during the implementation of the new response models		Ensure appropriate project governance and risk management	SRO	31/03/2016	Ongoing		Risks are managed by Programme Board and Programme Team as appropriate	As before	N/A					

Programme Element	Sub Category	Deliverables	Responsible	Due	Projected date	NIAS Read-iness	Risk	Measures to address Risk	RAG Status - N Ireland	Belfast	South East	South	North	West
Alternative Care Pathways	Diabetes	Develop NIAS ACP Protocol	DMM/FR	01/07/2014										
		Issue NIAS ACP Protocol	DMM/FR	10/07/2014										
		Go Live with NIAS ACP Protocol	DMM/FR	17/07/2014			Trusts were to agree to accept referrals/NIAS readiness by 30/06/14	Both SHSCT & BHSCT to engage internally and then advise of a possible go live date. Being re-escalated to AD level in both Trusts. Update - Belfast has gone live and Southern working towards 1st of April.						
		Review Effectiveness	DMM/FR	31/01/2015	28/02/2016		Waiting on Audit proposal to be progressed; now agreed.	QI Programme Falls Pilot Reviewed on 26/02/16. Plan is to extend QI to include ACS. A contingency evaluation process of ACPs is being developed.						
		Evaluate Benefits	DMM/FR	31/01/2015	31/03/2016		Waiting on Audit proposal to be progressed; now agreed.	QI Programme Falls Pilot Reviewed on 26/02/16. Plan is to extend QI to include ACS. A contingency evaluation process of ACPs is being developed.						
Alternative Care Pathways	Cardiac (roll out in West)	Develop NIAS ACP Protocol	NR & Ops	TBC/2013										
		Issue NIAS ACP Protocol	NR & Ops	01/07/2014										
		Go Live with NIAS ACP Protocol	NR & Ops	01/08/2014										

		Review Effectiveness	NR & AV	31/10/2014			Waiting on Audit proposal to be progressed; now agreed.	Pilot of new QI process underway by two CSOs during Oct 2015. Regional Cardiac meetings are primary method of reviewing effectiveness of this pathway.							
		Evaluate Benefits	NR & AV	31/10/2014	31/03/2016		Waiting on Audit proposal to be progressed; now agreed.	QI Programme Falls Pilot Reviewed on 26/02/16. Plan is to extend QI to include ACS. A contingency evaluation process of ACPs is being developed.							
Alternative Care Pathways	Minor Injuries	Develop NIAS ACP Protocol	CMcK & NR	30/09/2014											
		Issue NIAS ACP Protocol	CMcK & NR	22/10/2014						N/A					
		Go Live with NIAS ACP Protocol	CMcK & NR	01/10/2014						N/A					
		Review Effectiveness	CMcK & NR	31/12/2014	31/03/2016		Waiting on Audit proposal to be progressed; now agreed.	QI Programme Falls Pilot Reviewed on 26/02/16. Plan is to extend QI to include ACS. A contingency evaluation process of ACPs is being developed.		N/A					
		Evaluate Benefits	CMcK & NR	31/01/2015	31/03/2016		Waiting on Audit proposal to be progressed; now agreed.	QI Programme Falls Pilot Reviewed on 26/02/16. Plan is to extend QI to include ACS. A contingency evaluation process of ACPs is being developed.		N/A					
Alternative Care Pathways	Falls	Develop NIAS ACP Protocol	NR & Ops	TBC/2013											
		Issue NIAS ACP Protocol	NR & Ops	TBC/2013											
		Go Live with NIAS ACP Protocol	CMcK&NR	31/12/2014			Lack of availability of appropriate services in Trusts is hindering ability to roll-out this pathway, Pathway went live in SET and NHSCT on 1st June 15	Continue to highlight to Commissioners. Meeting took place with Western Trust Sept 15. Belfast ICP currently developing pathway. Pathways went live in northern sector of Western Trust on 1st of March.							
		Review Effectiveness	CMcK&NR	31/03/2015	28/02/2016		Waiting on Audit proposal to be progressed; now agreed.	QI Programme Falls Pilot Reviewed on 26/02/16. Plan is to extend QI to include ACS. A contingency evaluation process of ACPs is being developed.							
		Evaluate Benefits	CMcK&NR	31/03/2015	28/02/2016		Waiting on Audit proposal to be progressed; now agreed.	QI Programme Falls Pilot Reviewed on 26/02/16. Plan is to extend QI to include ACS. A contingency evaluation process of ACPs is being developed.							
Alternative Care Pathways	Frail/Elderly	Develop NIAS ACP Protocol	NR & Ops	31/09/14				Met with Western ICP on 21st Oct to discuss the development of a frail / elderly unit. On SET and NHSCT teams re ACAH services							
		Issue NIAS ACP Protocol	NR & Ops	31/09/14											
		Go Live with NIAS ACP Protocol	CMcK&NR	31/12/2014			Lack of availability of appropriate services in Trusts is hindering ability to roll-out this pathway,	Continue to highlight to Commissioners							
		Review Effectiveness	CMcK&NR	28/02/2015	31/03/2016		Waiting on Audit proposal to be progressed; now agreed.	QI Programme Falls Pilot Reviewed on 26/02/16. Plan is to extend QI to include ACS. A contingency evaluation process of ACPs is being developed.							
		Evaluate Benefits	CMcK&NR	31/03/2015	31/03/2016		Waiting on Audit proposal to be progressed; now agreed.	QI Programme Falls Pilot Reviewed on 26/02/16. Plan is to extend QI to include ACS. A contingency evaluation process of ACPs is being developed.							
Alternative Care Pathways	Seizures	Develop NIAS ACP Protocol	CMcK & NR	31/01/2015			Waiting on Adastra in order to implement as a 'Treat and Leave'	Developed as 'Treat and leave' with no onward notification as per Medical Director							
		Issue NIAS ACP Protocol	CMcK & NR	15/08/2015	05/10/2015			Pathway now approved and implemented from 9th November							
		Go Live with NIAS ACP Protocol	CMcK & NR	01/09/2015	9th Nov 15		If liaison with GPs/action from GPs is required, this will take significant resource. Discussed with Medical Director once input received from Neurologists on protocol.	Guidance given from Medical Director implement as a 'Treat and leave' rather than 'Treat, leave and notify' with Medical Director on 5/10/15. Went 'live' on 9th November							
		Review Effectiveness	CMcK & NR	01/10/2015	31/03/2016			QI Programme Falls Pilot Reviewed on 26/02/16. Plan is to extend QI to include ACS. A contingency evaluation process of ACPs is being developed.							

		Evaluate Benefits	CMcK & NR	01/10/2015	31/03/2016			QI Programme Falls Pilot Reviewed on 26/02/16. Plan is to extend QI to include ACS. A contingency evaluation process of ACPs is being developed.							
Alternative Care Pathways	District Nursing	Develop NIAS ACP Protocol	CMcK & NR	15/01/2015											
		Issue NIAS ACP Protocol	CMcK & NR	01/02/2015	01/12/2015		Waiting on availability of CSD to signpost staff appropriately;delay to CSD recruitment due to job matching.	Contingency plan in place to enable go-live of DOS, separate from CSD, from 1st Dec 2015. Engagement with Trusts and negotiations re; winter pressures mean 'go-live' now February 2016							
		Go Live with NIAS ACP Protocol	CMcK & NR	01/09/2015	18/01/2016		There are 130+ phone numbers for Community Nursing throughout NI.	New pathway 'went live' on 22nd February 2016 now all Trusts are ready. Phone numbers have been loaded into the DOS and operational staff will phone control for details							
		Review Effectiveness	CMcK & NR	01/10/2015	31/03/2016			One month review will take place wk of 21st of March, 2016.							
		Evaluate Benefits	CMcK & NR	01/10/2015	31/03/2016										
Alternative Care Pathways	Palliative Care	Develop NIAS ACP Protocol	CMcK & NR	15/12/2014											
		Issue NIAS ACP Protocol	CMcK & NR	15/01/2015											
		Go Live with NIAS ACP Protocol	CMcK & NR	15/01/2015			OOH referral pathway now live since 20/04/15 in all areas except south sector of Western Trust. Formal in-hours pathway needed	Medical Director escalated lack of service in South sector of West to Western Commissioner; in hours pathway will be provided via District Nursing							
		Review Effectiveness	CMcK & NR	30/06/2015				QI Programme Falls Pilot Reviewed on 26/02/16. Plan is to extend QI to include ACS. A contingency evaluation process of ACPs is being developed.							
		Evaluate Benefits	CMcK & NR	30/06/2015	31/03/2016		Waiting on Audit proposal to be progressed; now agreed.	QI Programme Falls Pilot Reviewed on 26/02/16. Plan is to extend QI to include ACS. A contingency evaluation process of ACPs is being developed.							
Alternative Care Pathways	Respiratory (COPD)	Develop NIAS ACP Protocol	CMcK & NR	30/06/2015			Variety of Trust services available	A range of meetings held across HSC. NIAS COPD pathway agreed by Medical Director.							
		Issue NIAS ACP Protocol	CMcK & NR	01/12/2015			Training will support full usage of new protocols	PP training will support 'go live'Pathway now approved and dissemination process in place. NHSCT planning 'go-live' Meeting planned with SET. Escalation underway regarding Southern pathways.							
		Go Live with NIAS ACP Protocol	CMcK & NR	01/01/2016	9th Nov for Belfast and West										
		Review Effectiveness	CMcK & NR	01/01/2016	31/03/2016			QI Programme Falls Pilot Reviewed on 26/02/16. Plan is to extend QI to include ACS. A contingency evaluation process of ACPs is							
		Evaluate Benefits	CMcK & NR	01/01/2016	31/03/2016		Waiting on Audit proposal to be progressed; now agreed.	QI Programme Falls Pilot Reviewed on 26/02/16. Plan is to extend QI to include ACS. A contingency evaluation process of ACPs is being developed.							
Alternative Care Pathways	Alcohol Pathway	Develop NIAS ACP Protocol	CMcK & NR	31/11/2015	31/12/2015		Plans initiated by HSCB with BHSCT and NIAS invited to be key project team participants	Meetings ongoing however delay to agreement of model. Agreement reached in November 2015							
		Issue NIAS ACP Protocol	CMcK & NR	31/11/2015	31/12/2015			Protocol issued							
		Go Live with NIAS ACP Protocol	CMcK & NR	TBC	31/12/2015			NIAS went 'live' with ARC referrals in Dec 2015.							
		Review Effectiveness	CMcK & NR	01/11/2015	28/02/2016			Audit carried out by HSCB of appropriateness of referrals to ARC/conveyance to ED and NIAS decision-making has been confirmed as appropriate.							

		Evaluate Benefits	CMcK & NR	01/03/2016	31/03/2016			Pilot of new QI process completed and phase 1 rollout commencing in January across the regions to test the methodology with Falls as the first pathway to be audited. Review meeting planned for Feb 23rd.						
TYC	Clinical Support Desk	Develop NIAS CSD Guidelines/Polices & Procedures	FR/MD	31/03/2015	27/11/2015									
		Procure NIAS CSD Software	FR	30/04/2015	31/01/2016			Visit to Manchester to assess MTS in December 2015						
		Go Live with NIAS CSD	FR	01/05/2015	02/12/2015		Delay to JD matching has delayed recruitment to CSD	Contingency plans agreed at TMPB on 13/10/15 for 3 month pilot of enhanced GP model from 2nd December 2015. Enhanced model in place.						
		Review Effectiveness	FR/AV	30/06/2015	2016 due to capacity of CSO team			2 month review paper to be shared with TMPB on 12/02/16. Full review to be completed in March 2016.						
		Evaluate Benefits	FR	31/08/2015	2016 due to capacity of CSO team									
TYC	Directory of Services	Complete Options Paper and begin procurement process	FR	31/01/2015	01/12/2015									
		Develop NIAS DoS Guidelines/Polices & Procedures	FR/MD	31/09/2015	30/11/2015									
		Go Live with NIAS DoS	FR	01/12/2015										
		Review Effectiveness	FR	31/03/2016				Full review to be completed in March 2016.						
		Evaluate Benefits	FR	31/03/2016										
Alternative Care Pathways	Frequent Callers (deferred)	Develop Markers Policy and prepare for sign off;	SW	31/01/2015	30/04/2016		Significant work required to develop two policies and procedures and work with other agencies to ensure processes are safe and robust.	Pre consultation underway; agreement by TMPB that although pilot underway full implementation of the policy may not be completed by programme closure. Project now removed from Programme for 15/16 and mainstreamed.						
		Develop Frequent Callers Case Management guidance	FR & NR	31/01/2015										
		Issue NIAS Frequent Caller Guidance	FR & NR	01/10/2015			Development has required significant input	Pilot underway however this policy and procedure is linked to Information Markers P&P. See relevant risk on risk register. Project now removed from Programme for 15/16 and mainstreamed.						
		Go Live with NIAS Frequent Caller Guidance	FR & NR	01/11/2015										
		Review Effectiveness	FR & NR	01/03/2016										
		Evaluate Benefits	FR & NR	01/03/2016										
Alternative Care Pathways	Mental Health (deferred)	Develop NIAS ACP Protocol	CMcK & NR	01/07/2015	Jan 2016 due to slippage from NHSCT / BHSCT		Initial meetings demonstrate lack of available services to enable conveyance to an alternative destination	Two Trusts have now indicated willingness to undertake pilots. Range of meetings Trusts and liaison with PHA/HSCB continues; for discussion at TMPB on 16/02/16; agreed to defer delivery until 16/17 due to lack of forthcoming implementation plans from other Trusts.						
		Issue NIAS ACP Protocol	CMcK & NR	12/12/2015				Deferred to 16/17; continuing to engage with Commissioner						
		Go Live with NIAS ACP Protocol	CMcK & NR	01/01/2016	01/03/2016									
		Review Effectiveness	CMcK & NR	01/02/2016	31/03/2016									
		Evaluate Benefits	CMcK & NR	01/02/2016	31/03/2016									
Engagement and Comms	**Engagement**	Develop and implement programme Engagement and Communications Strategy	ML	Oct/Nov 14						n/a	n/a	n/a	n/a	n/a

EPRF	**EPRF OBC development**	Outline Business Case	OBC submitted to HSCB /DHSSPS	Complete			Delays in approval -	meetings organised with ehealth team						
ICT Innovation	**ICT Innovation**	Terms of Reference and workplan in place	PD	08/09/2015										

NORTHERN IRELAND AMBULANCE SERVICE

TRUST BOARD REPORT

MEDICAL DIRECTORATE

Medical Director
7/04/2016

Medical Directorate Performance Report for Trust Board (January-February 2016)

Emergency Planning & Business Continuity	
	Please refer to attached Emergency Planning Report for January-February 2016. As part of the ongoing two-yearly cycle of regular review, the updated Trust's Major Incident Plan was approved by Trust Board on 1 October 2015. A number of amendments as requested by Trust Board have been made. Reprinting and distribution of the Plan was delayed due to procurement considerations complicated by the sensitivity of the document. These have now been resolved and the reprint has now commenced. It will be distributed in both hard copy and electronic format for ease of access by Officers during an incident. Originally it had been expected that printing would have been completed by end December 2015 but is now anticipated end March 2016. Directorate business continuity leads participated in training delivered by the Home Office Emergency Planning College in September 2015. A facilitated workshop with Directors and Trust Directorate business continuity leads to undertake a business impact analysis scheduled to take place on 25 November 2015 was postponed at short notice due to a change in personnel in the Department of Finance & Personnel (DFP) who deliver the training. This has now taken place on 2 February 2016 with a presentation to Trust Directors on 26 January 2016. This will inform the development of new and review of existing business continuity plans during 2016/17 and will include a review of current escalation plans and the outcome of debriefs in relation to recent industrial action. A review of on call arrangements to support emergency planning incident response and business continuity is being undertaken and recommendations are still anticipated by end Q4. Implementation of any recommendations will now take place during 2016/17.

Risk Management	
Corporate Risk Register	Please refer to the Corporate Risk Register to end February 2016.
Incident Reporting Procedures	A review of the incident reporting procedure to enhance the reporting of patient-related incidents has commenced. However due to the retirement of the Risk Manager in December 2015, completion of this has been delayed. Following the appointment of an interim Risk Manager in January 2016, due to other pressures, it is anticipated that this will not now be completed until Q1 2016/17. The outcome of the Departmental review of regional serious adverse incident reporting procedures in which NIAS participated was anticipated in Q3 2015/16 but is still awaited. This will also be incorporated into the revised NIAS incident reporting procedure when available. Work has yet to commence on a joint Human Resources & Corporate Services and Medical Directorate programme to introduce systems and processes to further enhance and support individual and organisational learning from events such as untoward incidents, disciplinary investigations, claims, compliments, Serious Adverse Incidents (SAIs) etc. This will include the establishment of a scrutiny committee and facilitate feedback at organisational, local and individual levels. The formation of a Learning Outcomes Review Panel has been considered by the Trust's Transformation & Modernisation Programme Board in January 2016 and an initial meeting to consider Terms of Reference etc. is now scheduled for April 2016.
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. NIAS continues to review relevant NICE guidelines and has contributed to responses to a number of draft guidelines that were issued for consultation. Publication of a number of relevant guidelines including assessment and management of fractures, major trauma and spinal injury were published in February 2016. These have been reviewed for

	incorporation into future training, clinical protocols and guidelines. New resuscitation guidelines were published by the European Resuscitation Council in October 2015 and have been evaluated in relation to any change in practice and training implications, although these are not significant. NIAS also participated in a review of revised draft JRCALC National Clinical Guidelines which will be published during March 2016.
Clinical Care	
Regional Community Resuscitation Strategy	The Regional Community Resuscitation Strategy Implementation Group chaired by the NIAS Medical Director continues to meet. Progress reports from various sub-groups, including CPR training, automatic external defibrillators / public access defibrillation, communication and data and information sub-groups, were received and considered. Meetings involving the Medical Director have taken place with Red Cross, St John Ambulance, Order of Malta and a range of other first aid training providers to engage them in the implementation process. There have also been meetings with the DHSSPS and a large commercial organisation who are proposing to place AEDs for public access on all of their premises. NIAS is engaging with them and providing support and advice regarding this initiative. The CPR and PAD Sub-Groups have now been amalgamated and representation from DCAL and the Department of Education on the Implementation Group has been agreed. An electronic form for the “registration” of defibrillators has been developed and placed on the NIAS website for use by members of the public. Work is ongoing to enhance the mapping of defibrillator locations in Emergency Ambulance Control with agreement in June 2015 to participate in the development of a national Automatic External Defibrillator (AED) register and out of hospital cardiac arrest outcome study. NIAS has facilitated the activation of two further Community First Responder Groups and is liaising with a number of other groups, local Councils, sporting

	organisations and Government Departments regarding the establishment of public access defibrillator schemes. A further Community Frist Responder Group is currently being developed in the South West and engagement with them has commenced. NIAS continues to engage with a number of PAD schemes and initiatives and has indicated its support for the national 'Restart a Heart' day in October 2016. Otherwise the progress of implementation continues to be slow as confirmation of recurrent funding for Community Resuscitation Development Officers (CRDOs) from the Health & Social Care Board (HSCB) / Public Health Agency (PHA) was not received for 2015/16. Existing funding to support current training initiatives ended September 2015. Prior to this a number of other Trusts' CRDOs had already been redeployed to their normal roles. Current initiatives, particularly within Northern Trust area, beyond September 2015 have now been significantly curtailed until a decision regarding recurrent funding is made. The decision by HSCB/PHA regarding recurrent funding which was anticipated in September 2015 was deferred until March 2016, with support only being provided to existing initiatives in the interim. This has resulted in effectively only one part-time CRDO remaining in post to support one of the initiatives in the Northern Trust area. Correspondence has been received in March 2016 from HSCB indicating that no funding will be available for this initiative in 2016/17. It has also been confirmed by the other Trusts that all previous initiatives supported by them will cease by at the latest June 2016. Further implementation of the Strategy will potentially be significantly curtailed if funding is not agreed. This has been highlighted to the DHSSPSNI by the Medical Director and has been brought to the attention of the Minister, Permanent Secretary and CMO for resolution. This is now being taken forward by DHSSPSNI in the form of an alternative funding bid to DFP as the appointment of CRDOs is part of a Ministerial strategy. The Medical Director continues to engage with the Department of Health in order to attempt to progress.

Patient Report Form (PRF)	A revised Patient Report Form (PRF) to reflect new clinical guidelines, referral pathways and regional physiological early warning scores was successfully introduced on 1 August 2015. A user's guide detailing the procedure for the completion of the new report form was circulated. A small number of minor revisions have been identified and proposed by staff and have now been incorporated. Feedback from staff regarding the report form has been very positive and was presented to the Assurance Committee in January 2016. An associated revised policy for PRF completion is still being drafted and submission for approval has been delayed to Q1 2016/17.
Electronic Patient Report Form (ePRF)	The Outline Business Case was submitted to DHSSPS in November 2014 following a number of minor amendments requested by them. The Department have accepted that the Business Case is now ready for submission to the Department of Finance. Further progress of the business case is dependent on a letter of support from the Commissioners. In discussion with the Board and the Department, it was agreed that a letter of conditional support from Commissioners would allow the project to proceed to procurement. This will present an opportunity to obtain an accurate picture of overall costs, with any financial commitment subject to review and approval of the Full Business Case. This will ensure the project remains on target and avoid unnecessary delays. A decision regarding support for revenue funding was anticipated by end July 2015 in order to comply with proposed timescales and deadlines if support is agreed. However further correspondence from the Commissioner indicated that a decision was unlikely before end September 2015 but unfortunately no decision has been made as of end February 2016 despite a number of contacts with HSCB. This significant delay has now impacted on project deadlines and milestones.

	Ongoing engagement with HSCB has resulted in the Trust being informed of the development of a business case by HSCB for a regional Electronic Healthcare Record (EHCR) to replace as a minimum the current Patient Administration Systems (PAS) in hospitals. This will require significant capital and revenue investment and as part of the business case development, various options including the position of an ambulance ePRF are being considered within that project. This has effectively halted further progress to obtaining Commissioner support for the previously submitted OBC for the NIAS ePRF. Engagement with HSCB is still ongoing to scope if the ePRF should remain as a stand-alone initiative linking with the EHCR or should become an integral part of the EHCR development. While this engagement continues, it is disappointing to report that an ambulance ePRF was not included in the documentation as part of the recent launch of the eHealth & Care Strategy.
Annual Quality Report	The Trust 2014/15 Annual Quality Report was completed during October 2015, reviewed by DHSSPS and published in November 2015. The report was presented to Trust Board in December 2015. Work has commenced on a joint Finance and Medical Directorate programme to publish and communicate clinical performance information at levels of organisation, division, team and individual. In the meantime, an infographic has been developed for circulation to staff regarding elements of NIAS clinical performance and other data. Following completion of the work to compile the Annual Report, work will commence on developing the 2015/16 Annual Quality Report for publication in November 2016.
Alternative Care Pathways	An appropriate transport / referral policy and guideline approved by Trust Board in March 2015 has been circulated and implemented in July 2015. Work on the development of a number of policies continues including information markers and frequent callers. Completion of these has been delayed but it is

	anticipated these will now be circulated for consultation and comment within the Trust in Q1 2016/17. A Falls Referral pathway was introduced on 1 June 2015 in the Northern, Southern and South Eastern Trust areas and a Belfast Acute Care at Home pathway was also introduced and a Chronic Obstructive Pulmonary Disease (COPD) referral pathway commenced in the Belfast and Western Trust areas. The Minor Injuries Unit pathway was extended to include the Downe Hospital, and direct referral to an Acute Medical Assessment Unit in Antrim Area Hospital commenced. During the previous reporting period, a pilot for patients with a fractured neck of femur in the Southern Trust area commenced and is ongoing. A regional Treat & Leave protocol for epilepsy was also introduced regionally. The Southern Trust Acute Care at Home referral pathway was extended and a palliative care referral pathway was implemented regionally with the exception of the Southern sector of the Western Trust. During this reporting period, the diabetes hypoglycaemia pathway was introduced in the Belfast Trust area and it is anticipated will be fully regional by end March 2016. Further engagement in relation to diabetes is ongoing following the publication of the Regional Diabetes Strategy. A regional referral pathway to district nursing services commenced in February 2016 with the pathway being extended to 24 hours in the Belfast and South Eastern Trust areas. A number of direct referrals have now been made by NIAS to the Alcohol Recovery Centres in Belfast. A Directory of Services has been introduced in Ambulance Control containing details of all alternative care pathway information for use by Ambulance personnel. Decision support software for the pilot of a Clinical Support Desk (CSD) within Ambulance Control which had been procured was found to be unsuitable for use by paramedics and was therefore refunded. Other secondary triage tools in use by a number of other Ambulance Services have been assessed and the Manchester Triage Tool is felt to be the most suitable for use in NIAS. The establishment of the CSD in Emergency Ambulance Control (EAC) continues to be delayed by this and also pending the outcome of the Job

	Evaluation and Job Specification process. Work is continuing in preparing Ambulance Control systems and operational protocols for the CSD and the three month pilot of an enhanced NIAS GP CSD, which commenced on 1 December 2015, is currently being evaluated but initial assessment shows an increased number of calls being secondarily triaged by the GPs in the Emergency Control Room. The final outcome will be reviewed by the Trust's Transformation and Modernisation Programme Board.
Personal Public Involvement / Patient Client Experience	
Patient and Client Experience Standards (PCES)	Equality, PPI and Patient Experience staff continue to support the Trust's Medical Director in the delivery of the Personal and Public Involvement and Patient Client Experience agendas. This includes implementation of statutory and departmental priorities in respect of a methodology for the measurement of and learning from patient experience and systems of service user engagement and involvement. The Trust has worked to mainstream PPI and Patient Experience elements within policy development in the Trust. The Trust continues to be represented in regional work streams around the Minister's standards: Respect; Attitude; Behaviour; Communication; and Privacy and Dignity. The Trust has engaged with PHA to review the March 2016 Action Plan and agree priorities for 2016-17 for Patient Experience. The Trust has also reviewed systems for undertaking this methodology in order to mainstream the standards within core clinical practice. This includes reviewing systems of observations of clinical practice to include monitoring of the standards going forward. The Trust will hold a workshop and develop plans to mainstream Observations of Practice for patient client experience standards as part of core business with clinical observation and in a forthcoming pilot on the Quality Improvement work programme. A key focus in respect of this work is improved practice informed by learning outcomes.

	Patient stories have continued to be gathered through the 10,000 Voices project and are in process of being reviewed. 10,000 Voices has now been extended to include staff and how they are able to deliver patient experience. As at 31 December 2015, 260 patients and 4 members of staff had completed survey questionnaires. The majority of patient stories received so far have been positive. The Trust will continue gather more stories from patients and staff and will analyse and learn from the results to develop better services. The Trust plans to hold a work shop with service users to ensure analysis and learning from these.
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. PPI involvement with service users as part of the Transformation and Modernisation work streams has continued during the reporting period. A key priority was engagement around Transforming Your Care (TYC) and related Alternative Care Pathways. Service user workshops were held in Belfast and Derry during June 2015. Focus Groups with service users arranged in collaboration with Epilepsy Action and Age NI were held during February 2016. These provided an opportunity to outline the Trust's progress to date and future plans in respect of this agenda and to obtain feedback from those with experience of ambulance services. This feedback will be used to inform further development of TYC work streams. Those who participated were largely supportive of the Trust's direction of travel and provided constructive ideas for progressing the work and engaging further with the public around it. This will help inform a public awareness campaign for TYC specifically and NIAS's services generally.

EMERGENCY PLANNING REPORT

Report for January and February 2016 period

KPI No		Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb
2	**No of Potential Major Incidents**	**1**	**1**		**2**	**5**	**1**	**1**	**3**		**3**	
	No of Declared Major Incidents	**1**		**1**					**1**			
	No of Airport alerts											
	Belfast International Airport			**2**		**1**	**1**		**1**			
	Belfast City Airport							**1**				
	City of Derry Airport											
	St Angelo Airport											
	Newtownards Airfield	**1**										
	Other airfields											
	Business Continuity	**2**	**2**	**3**	**4**	**4**		**2**		**1**		
	Hazardous Material Incidents (HART calls)		**22**	**25**	**43**	**49**	**48**	**27**	**38**	**42**	**33**	**35**
	HART pre-planned deployments		**3**	**2**	**2**	**3**	**1**					
4	**Training sessions**	**2**	**3**	**1**			**3**	**1**	**4**		**1**	**2**
	Emergency Planning	**2**	**1**	**2**	**2**	**2**	**2**	**2**	**1**		**2**	**1**
	HART	**6**	**4**	**9**			**6**	**4**	**6**	**3**	**7**	**8**
	Business Continuity		**1**	**1**								**1**
5	**Exercises**											
	Live	**2**	**1**	**4**	**1**		**3**	**2**	**1**			
	Tabletop	**1**	**1**	**1**				**1**	**2**	**1**	**2**	
	Observer		**1**	**0**					**1**			
6	**Updates or amendments to MIP**										**1**	
	Events											
	HART Calls/ deployments											
	GOLD operational								**1**	**1**		

Potential Major Incident

On 20 January 2016 at 1840hrs NIAS received a call to a road traffic accident for an accident involving a lorry/van and a bus with 20 persons on board. Four A&E ambulances, 2 Intermediate Care Service ambulances, 3 Rapid Response Vehicles, 2 Doctors, 4 Officers, the Emergency Equipment Vehicle and the Mobile Control Vehicle were tasked to the scene. Also available but not despatched to scene were 3 Officers and the Voluntary Ambulance Services. The first Rapid Response Vehicle on scene assessed the situation and stood the incident down from a potential major incident at 1854hrs. The scene was than managed as per normal processes.

On 25 January 2016 at 1005hrs NIAS received a call to a dairy for a report of a gas leak. Two Rapid Response Vehicles, 1 A&E ambulance and an Officer were tasked to the scene. The incident was stood down by the Ambulance Incident Officer shortly after his arrival. Two adult males suffering from vapour exposure were treated having been working with an ammonia tank in which there had been a leak. The rest of staff on site had been successfully evacuated. All NIAS resources clear of scene at 1051hrs.

On 30 January 2016 at 0950hrs NIAS received a call to a nursing home in Enniskillen following a report of a fire in the home. Five A&E crews, 2 Rapid Response Vehicles, 5 Officers, 1 Doctor, 1 Voluntary Ambulance Service ambulance and the Emergency Equipment Vehicle and Mobile Control Vehicle were tasked to the scene. Three additional Officers were available but not deployed. Ten patients who were not able to be evacuated due to the lifts not working were moved to a place of safety within the building. All residents were checked by paramedics and when the fire was extinguished were returned to their rooms. No patients required transport to hospital. The incident was stood down at 1056hrs.

MAJOR INCIDENTS

There were no declared major incidents during this period.

Airport Alerts

There were no airport alerts during this period.

Of Note

The ten radiation pagers /monitors were serviced and recalibrated.

HAZMAT / Hazardous Area Response Team (HART) deployments

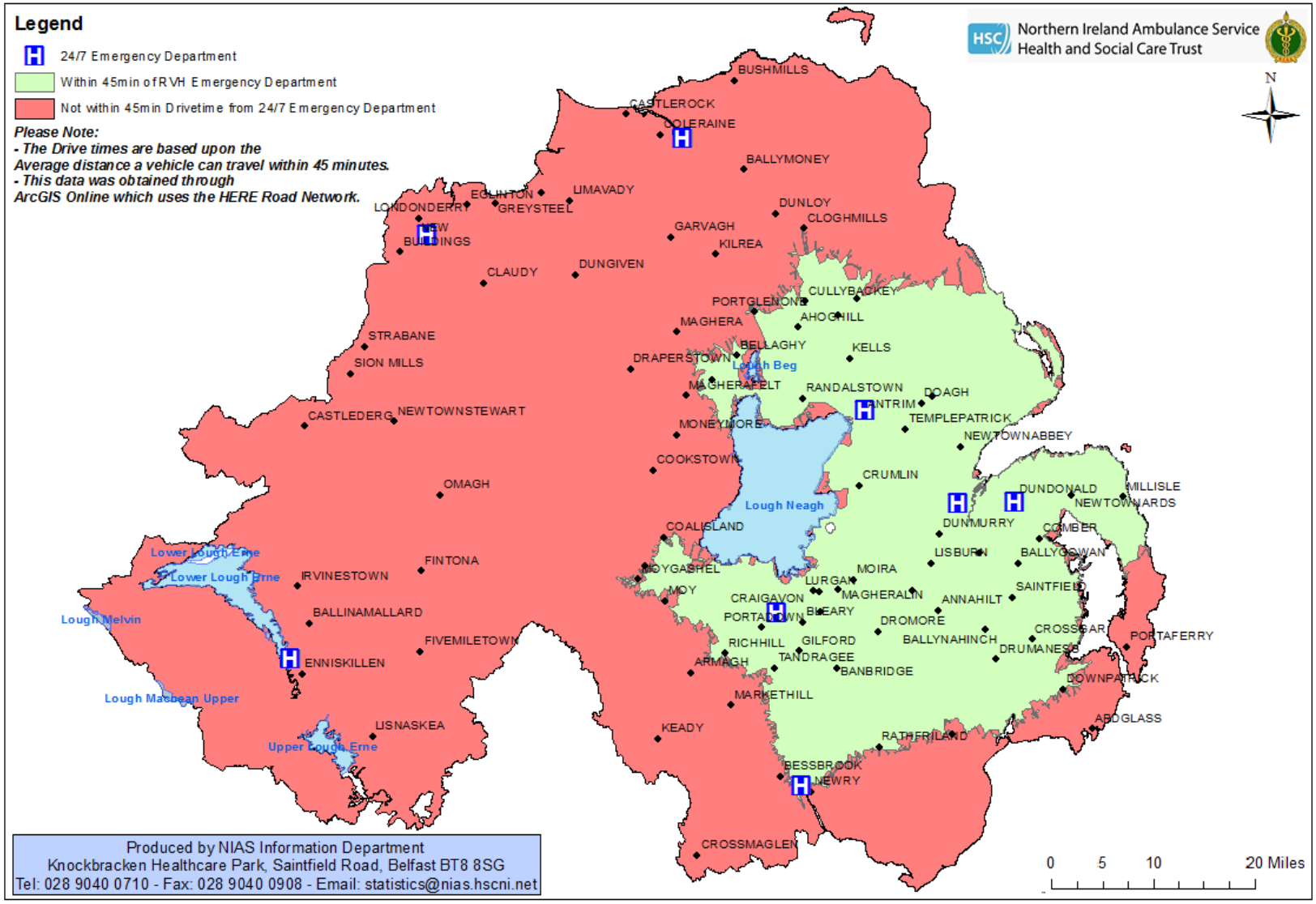
61 = Deployments with Breathing Apparatus skills/ HAZMAT deployments
3 = Restricted space
2 = Mountain rescue
2 = Incident at height

_____

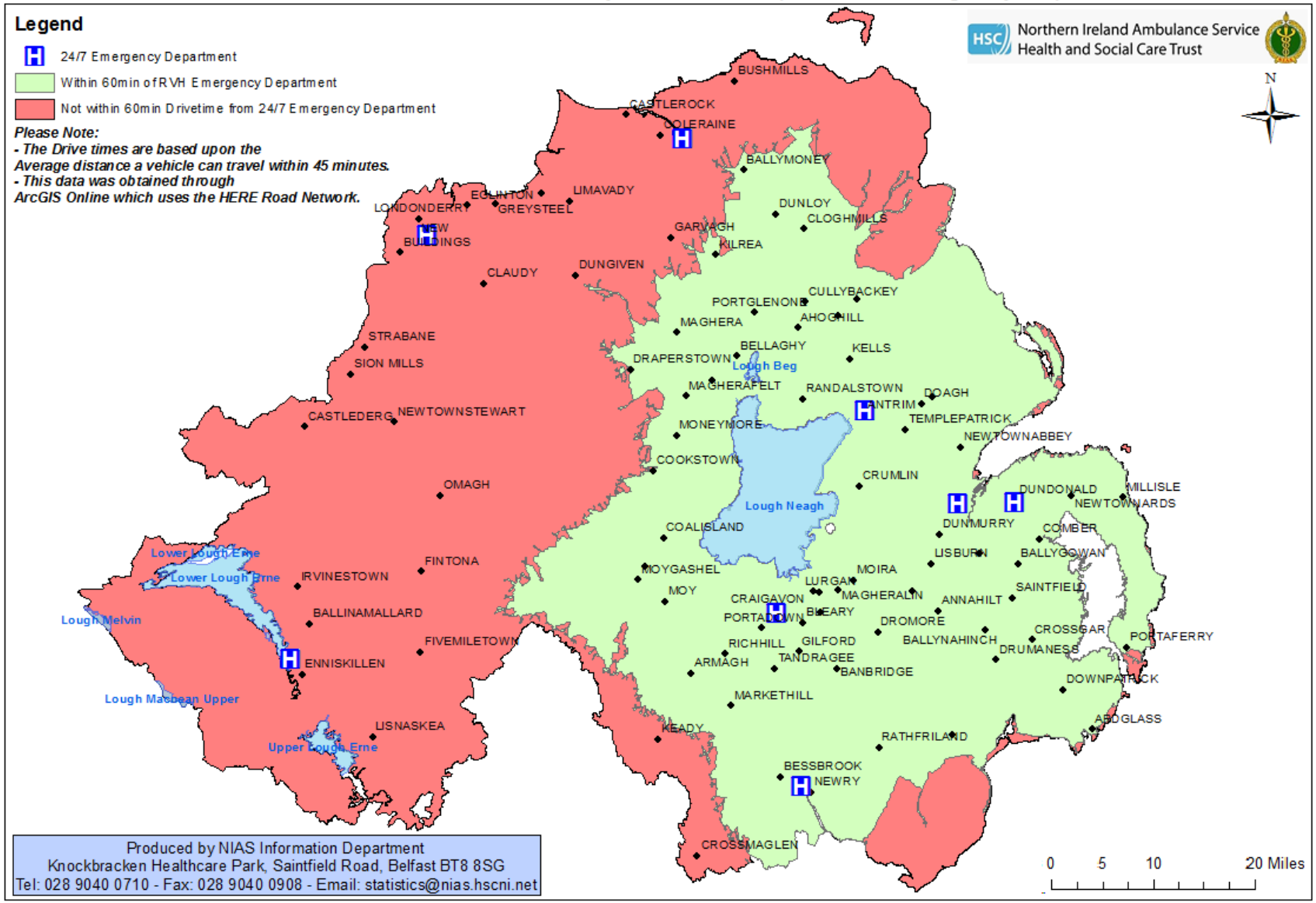
William Newton
EMERGENCY

NI Regional Trauma Network Development Ambulance Travel Times

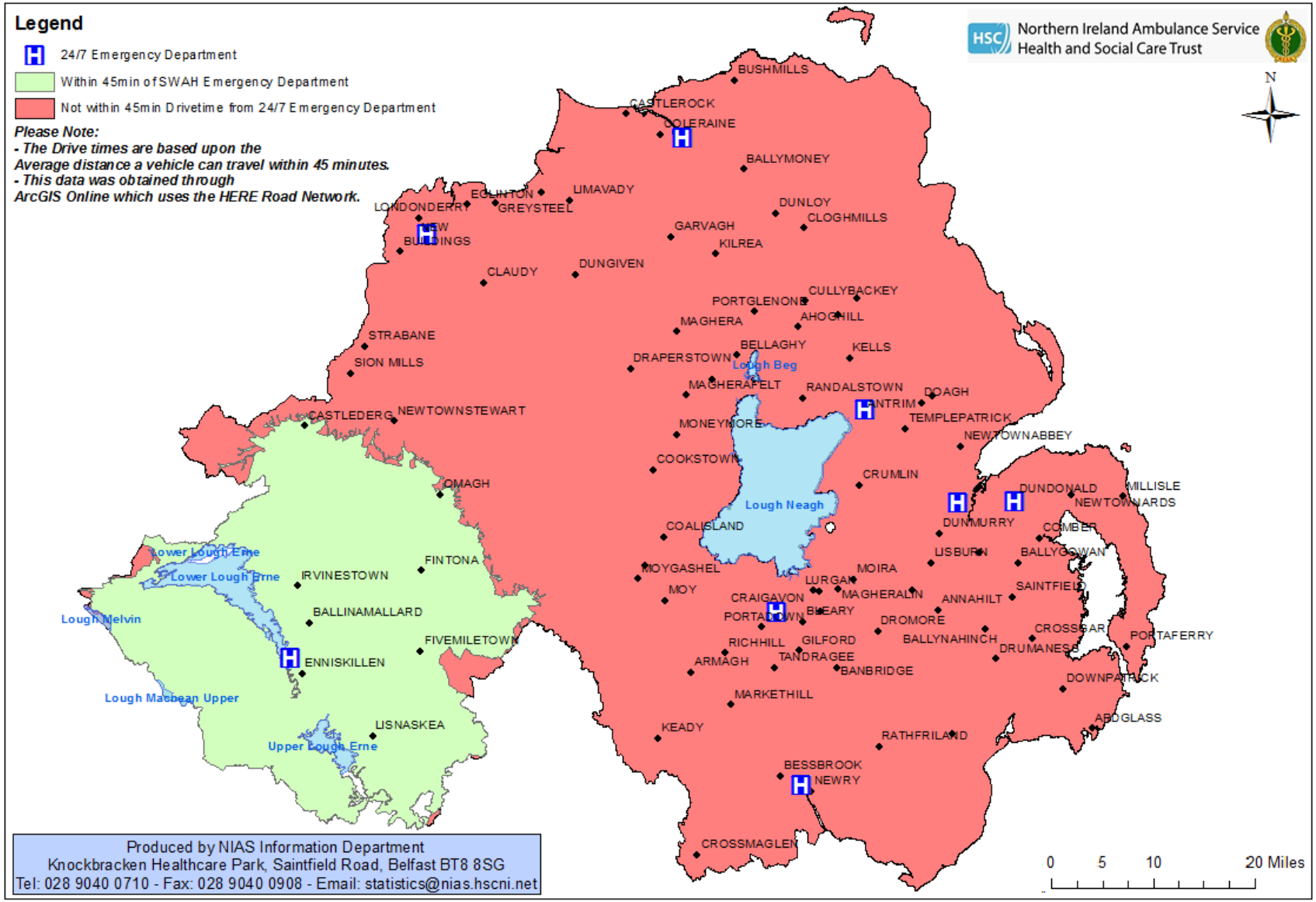
Area within a 45 minute Drivetime of Royal Victoria Hospital 24/7 Emergency Department



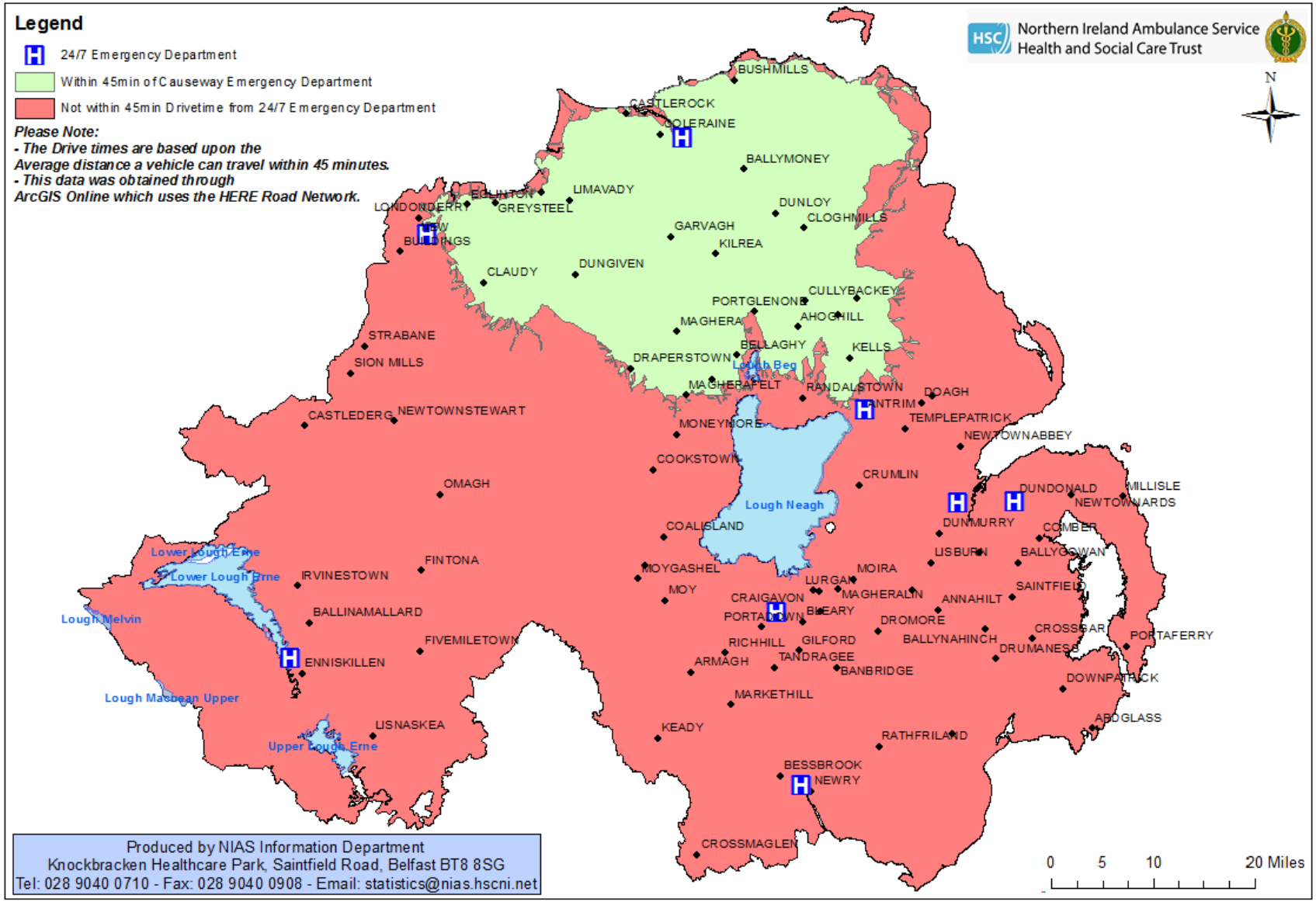
Area within a 60 minute Drivetime of Royal Victoria Hospital 24/7 Emergency Department



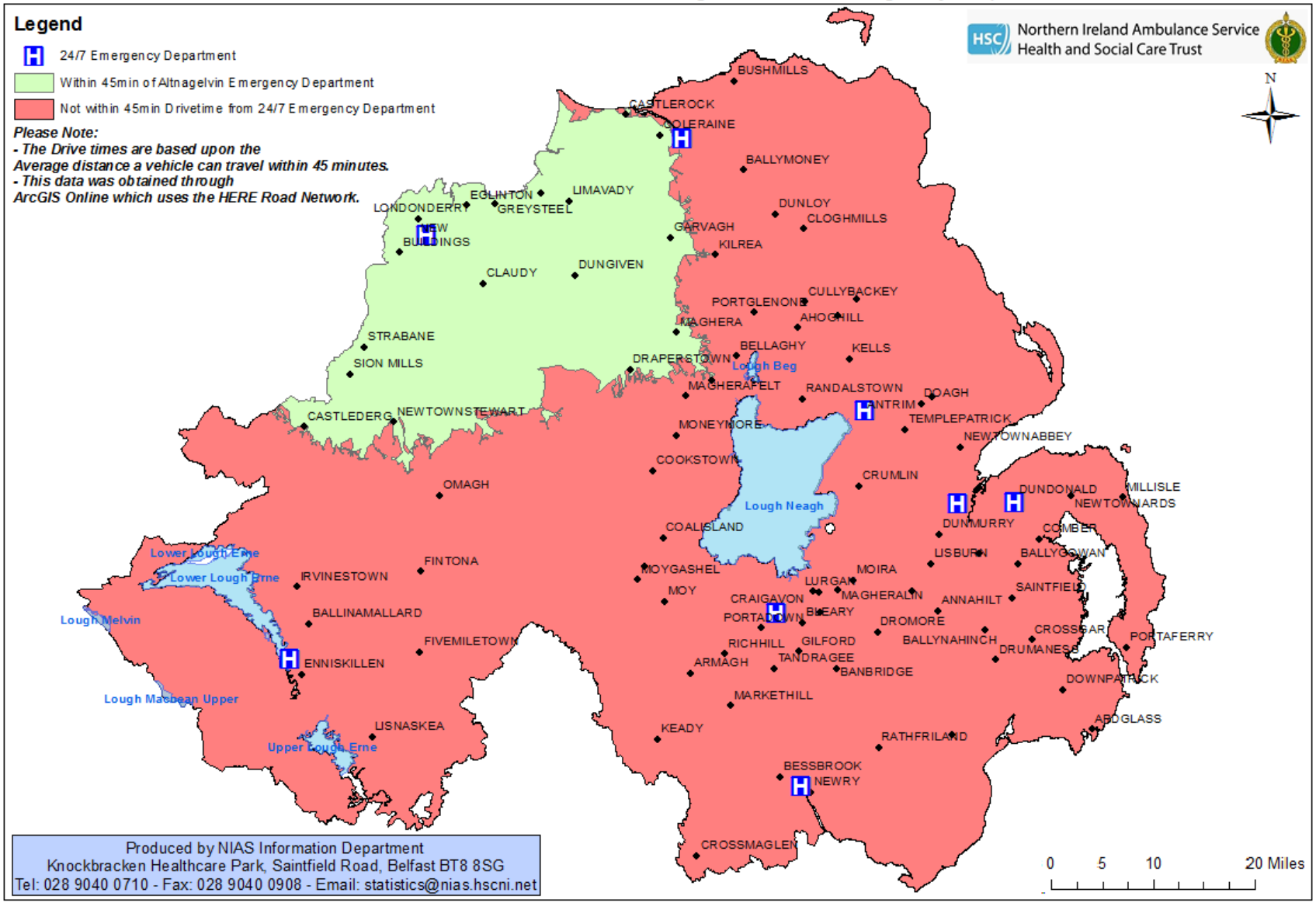
Area within a 45 minute Drivetime of South West Acute Hospital 24/7 Emergency Department



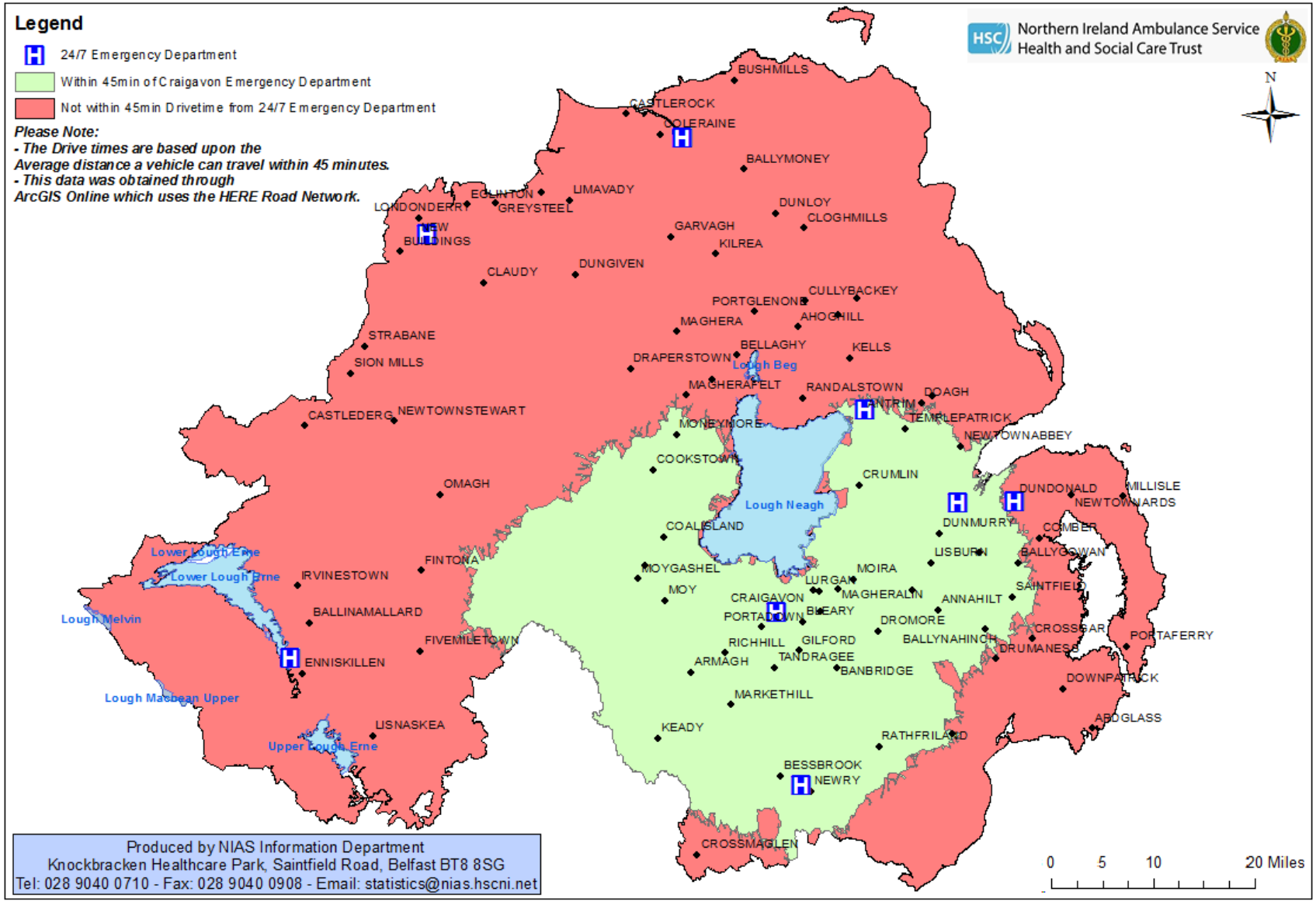
Area within a 45 minute Drivetime of Causeway 24/7 Emergency Department



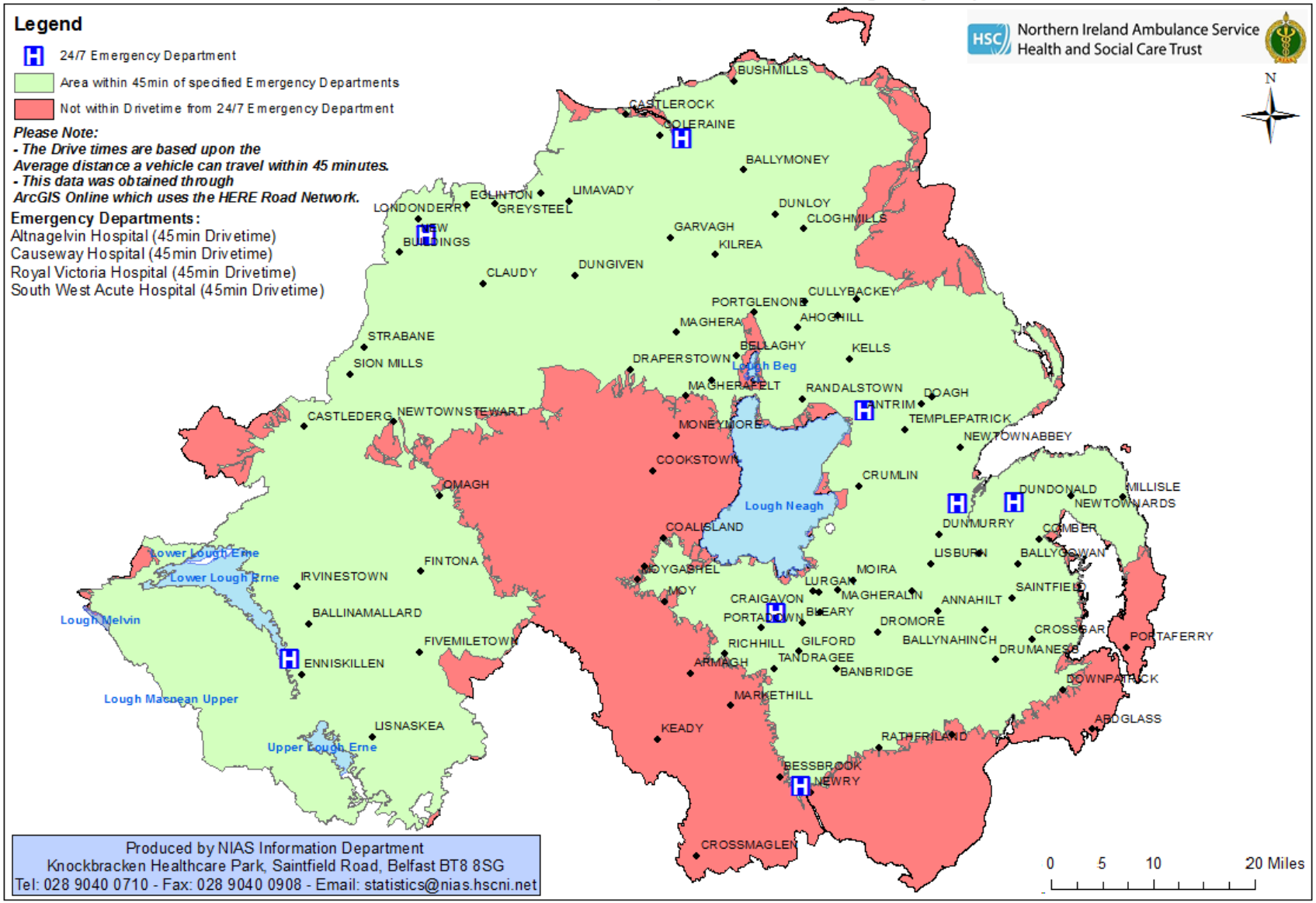
Area within a 45 minute Drivetime of Altnagelvin 24/7 Emergency Department



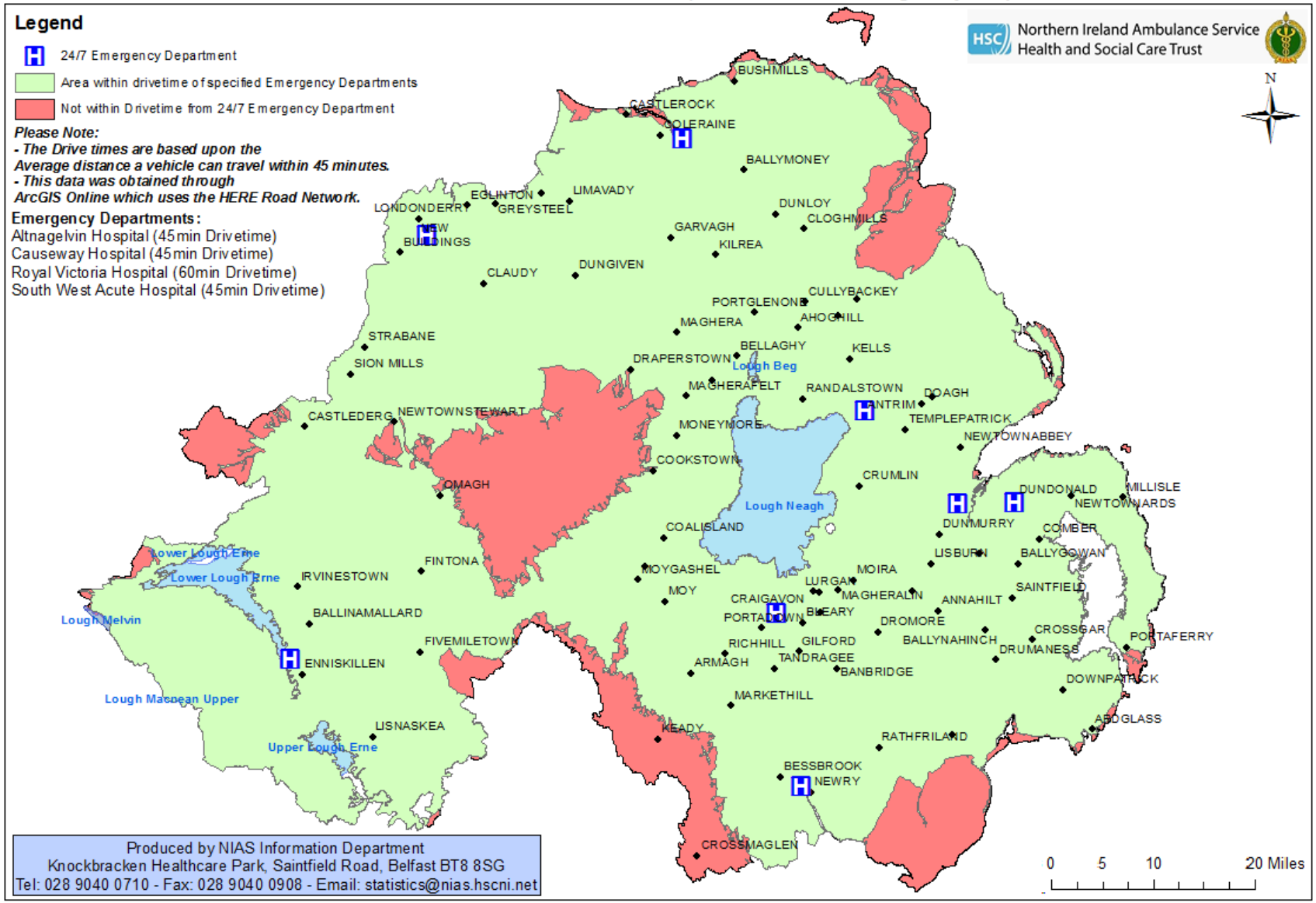
Area within a 45 minute Drivetime of Craigavon 24/7 Emergency Department



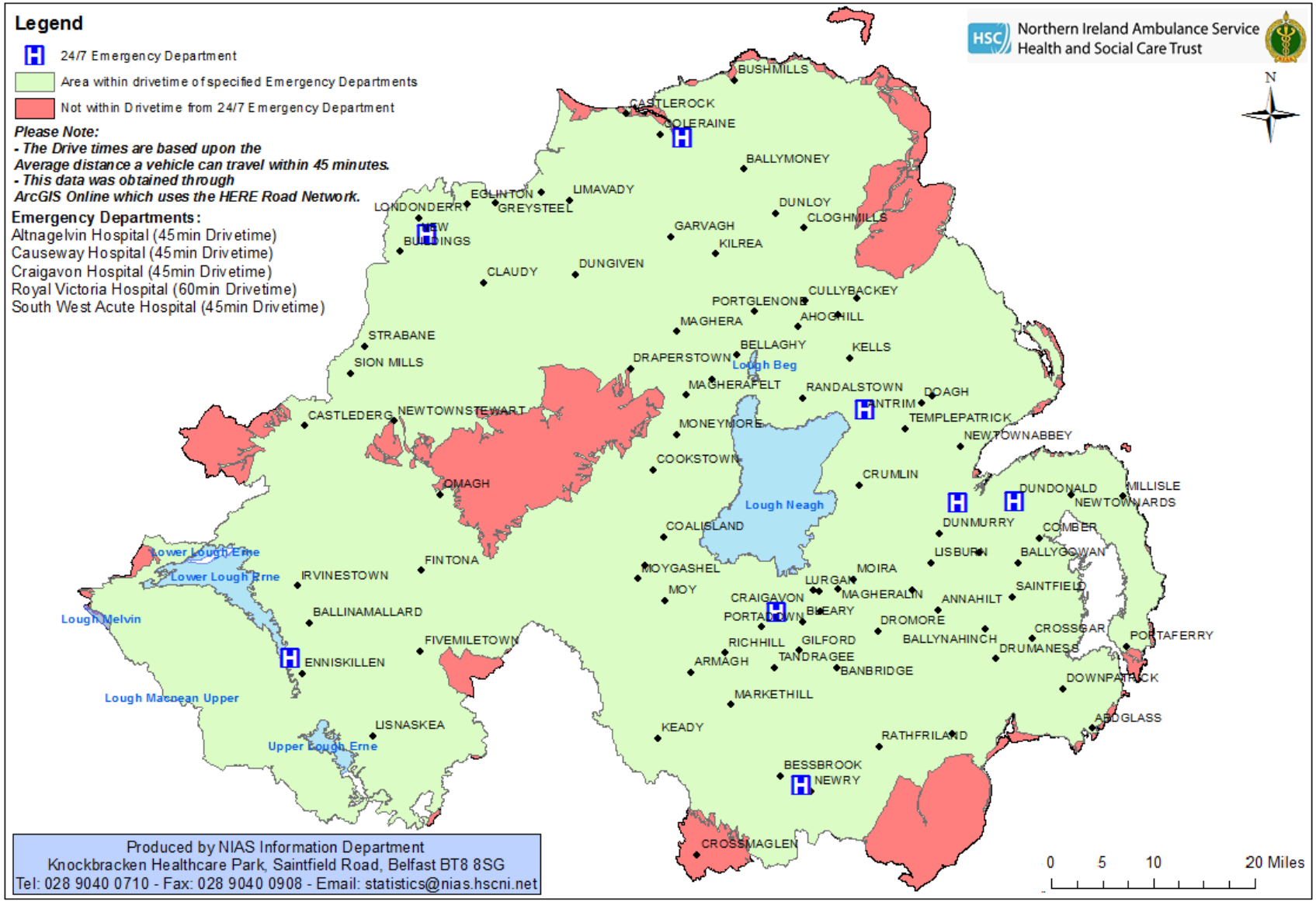
Area within a 45 minute Drivetime of specified 24/7 Emergency Departments



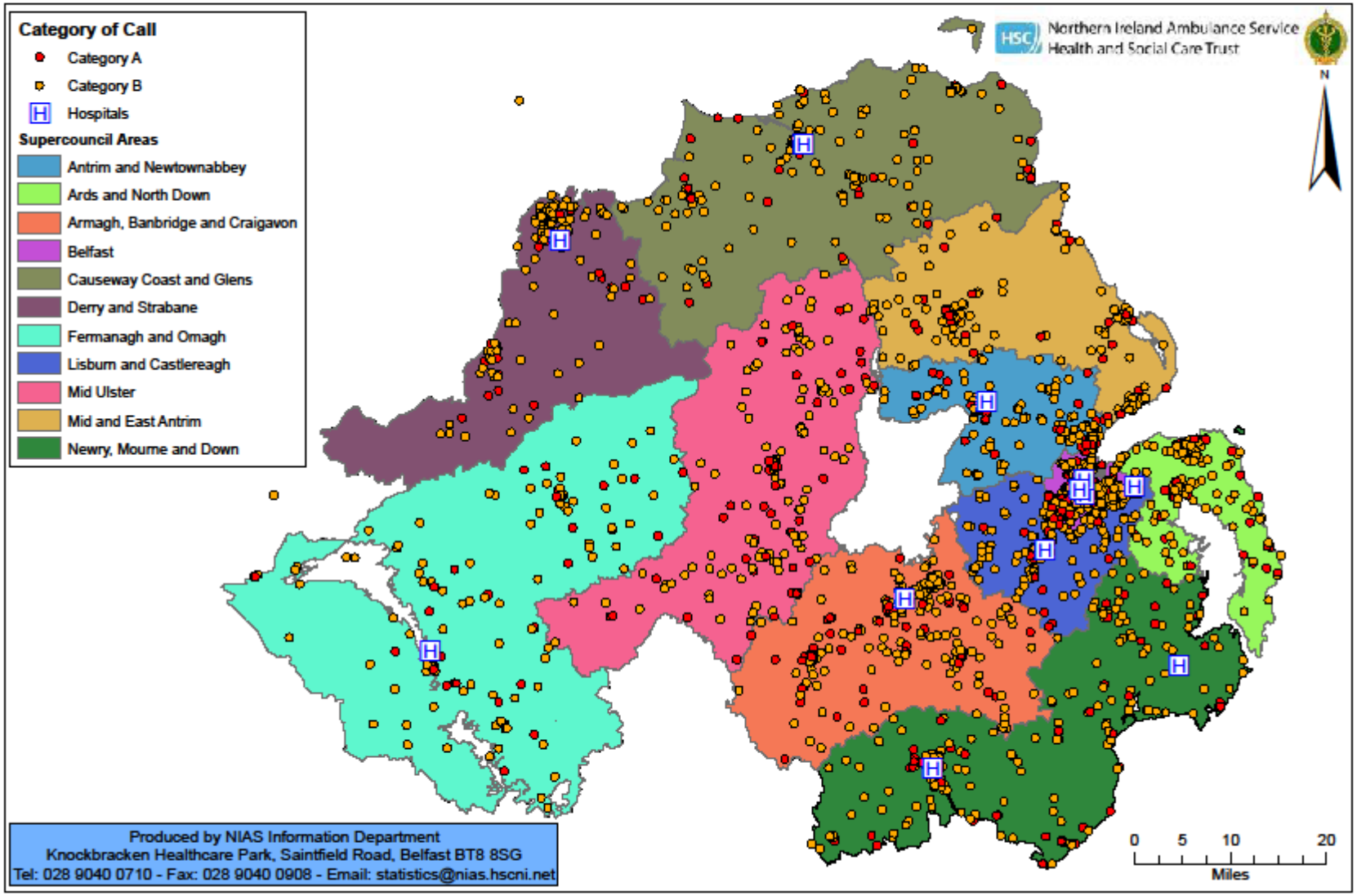
Area within a 45 or 60 minute Drivetime of specified 24/7 Emergency Departments



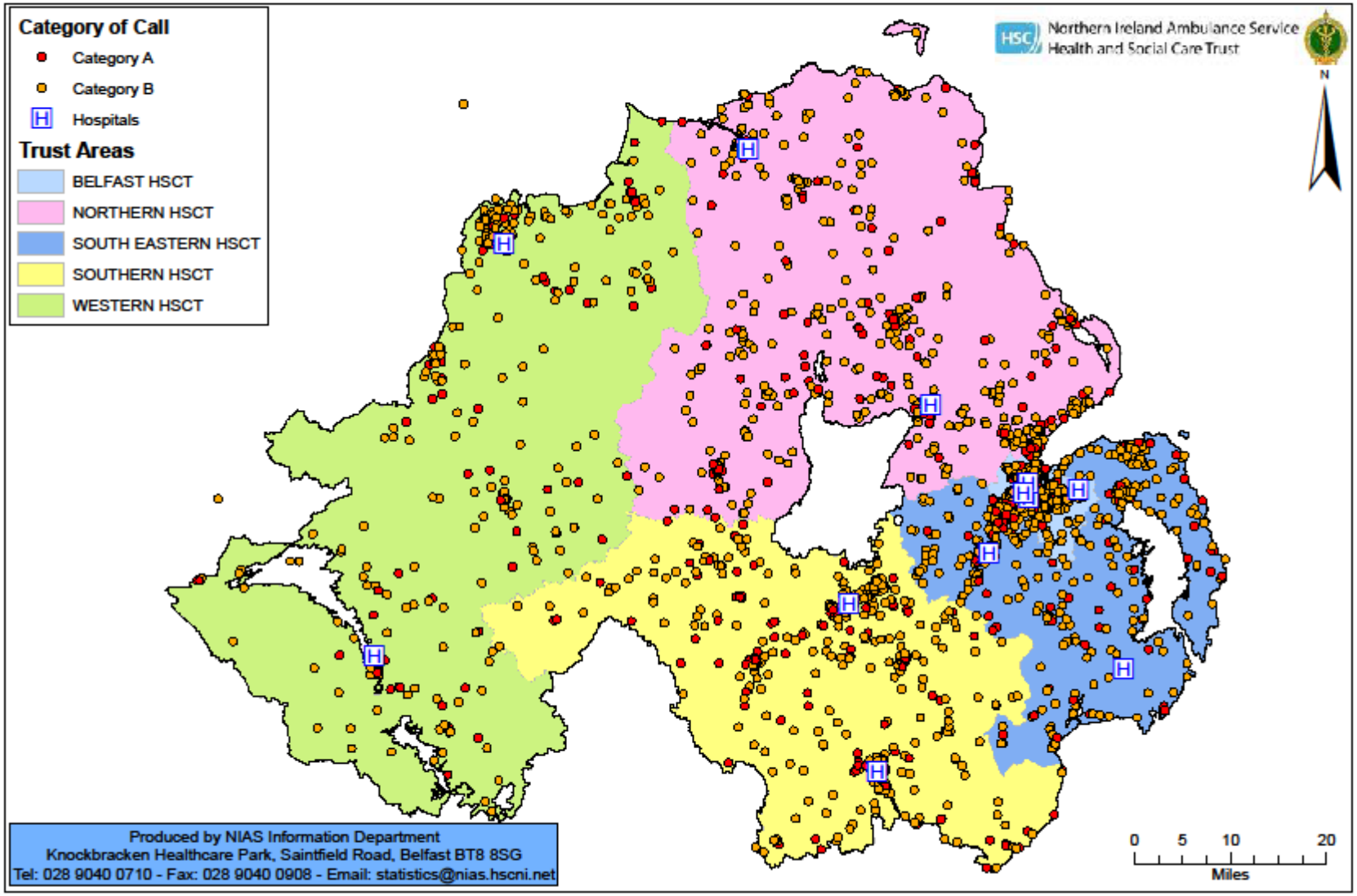
Area within a 45 or 60 minute Drivetime of specified 24/7 Emergency Departments



Location of Category A and B calls that are trauma-related, between April 2014 and March 2015



Location of Category A and B calls that are trauma-related, between April 2014 and March 2015



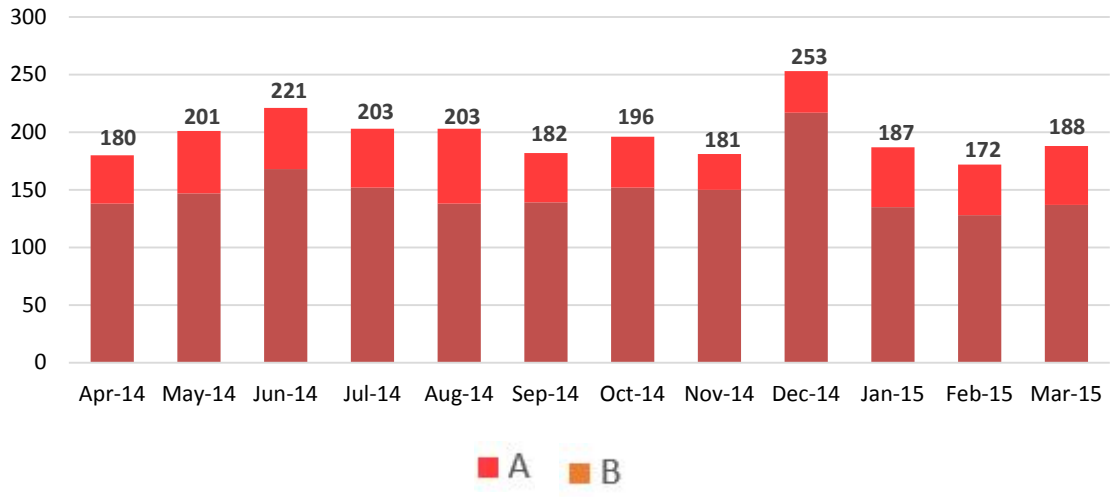
HEMS - DEMAND SUMMARY

HEMS DEMAND SUMMARY
CALLS SUITABLE FOR HELICOPTER RESPONSE BASED ON SELECTED DESPATCH CODES

**** Based on general trauma codes - excludes broader paediatric demand ****

	Monthly totals			Daily Average		
Month	**A**	**B**	**Total**	**A**	**B**	**Total**
Apr-14	42	138	180	1	5	6
May-14	54	147	201	2	5	6
Jun-14	53	168	221	2	6	7
Jul-14	51	152	203	2	5	7
Aug-14	65	138	203	2	4	7
Sep-14	43	139	182	1	5	6
Oct-14	44	152	196	1	5	6
Nov-14	31	150	181	1	5	6
Dec-14	36	217	253	1	7	8
Jan-15	52	135	187	2	4	6
Feb-15	44	128	172	2	5	6
Mar-15	51	137	188	2	4	6
Total	**566**	**1801**	**2367**	**2**	**5**	**6**

Number of calls suitable for helicopter response - 2014/2015



Northern Ireland Ambulance Service
Health and Social Care Trust

CLICK TO GET STARTED >>

Falls Audit Guidance Notes

Topic

Audit of PRFs relating to a Fall in a patient over 65 who has not been transported to the ED. A fall is defined as a patient who has come to rest on the floor having previously been in a standing / seated position.

Objective

To determine if patients over 65 who have fallen and have not been transported to hospital have been assessed appropriated and referred to a falls team.

Standards

1. The assessment criteria below will be met in all cases except those deemed exempt.

Evidence Base:

NICE guidelines
JRCALC guidelines
NIAS falls referral guideline

Standard	Target compliance	Exceptions	Definitions/ Instructions
Recorded assessment of cause of fall	95%	Patient refuses to provide history	

Recent history of falls documented	95%	None	If this is the patients first fall, this should be documented.
Documentation confirms patient has no illness or injury requiring ED admission	95%	Patient refuses transport to ED	Patient observations and free text documentation should indicate that it is appropriate for the patient to remain at home
Two timed set of observations documented	95%	Patient refuses observations / equipment failure	One set of observations should return a N value. Times of observations must be present to return a Y value.
Recorded assessment of mobility	95%	None	Assessment of mobility can include “patient immobile” / walks unaided / walks with assistance. Timed up and go test is also accepted as a means of assessing mobility
BM recorded	95%	Patient refuses / equipment failure	
FAST recorded	95%	None	
12 lead ECG recorded and interpreted	95%	None	A 3 lead is not acceptable and should return an N value

Documentation that the patient has been referred to a falls team (where this service is in place)	95%	No falls pathway available / patient refuses referral	All patients who have come to rest on the floor having previously been in a standing / sitting position must be referred to a fall team
Copy of PRF left with patient documented	95%	Patient refuses	
Documentation of appropriate "worsening care advice"	95%	None	Advice should be specific to the patient. Generic phrases such as “call 999 again” are not acceptable and should return an N value
Was the patient left in the care of a responsible person documented	95%	Patient lives alone	Where a patient lives alone, efforts should be taken to safety net e.g. ensure that the patient is wearing their lifeline necklace / bracelet.

Northern Ireland Ambulance Service
Health and Social Care Trust

FALL INCIDENTS - CLINICAL AUDITING TOOL

BELFAST

NORTHERN

SOUTH EASTERN

WESTERN

SOUTHERN

REPORTS

GUIDANCE NOTES

SOUTHERN DIVISION

ARMAGH - S01

BANBRIDGE - S02

CRAIGAVON - S03

S04 - DUNGANNON

KILKEEL - S05

NEWRY - S06

BALLYGAWLEY - S07

BACK TO MENU

Northern Ireland Ambulance Service
Health and Social Care Trust

MINOR INJURY CALLS - CLINICAL AUDITING TOOL

BELFAST

NORTHERN

SOUTH EASTERN

WESTERN

SOUTHERN

REPORTS

SOUTHERN DIVISION

ARMAGH - S01

BANBRIDGE - S02

CRAIGAVON - S03

S04 - DUNGANNON

KILKEEL - S05

NEWRY - S06

BALLYGAWLEY - S07

BACK TO MENU

	YES	NO	EXCEPTIONS
History of event indicates patient fallen			
Confirmation that the patient has no injury or illness that requires assessment at ED			
Two timed set of observations			
BM recorded			
FAST recorded			
12 lead ECG recorded and interpreted			
Documentation that the patient has been referred to a falls team (where this service is in place)			
Copy of PRF left with patient			
Documentation of appropriate "worsening care advice"			
Was the patient left in the care of a responsible person			

Trust

Station

<< HOME

Northern Ireland Ambulance Service
Health and Social Care Trust

CLICK TO GET STARTED >>

Acute Cardiac Syndrome Audit

Topic

Audit of PRFs relating to patients presenting with chest pain OR who have had aspirin OR GTN administered

Objective

To determine if patients presenting with an acute cardiac syndrome have received a cardiac care bundle and been transported to a PPCI lab where indicated.

Standards

1. The assessment criteria below will be met in all cases except those deemed exempt.

Evidence Base:

NICE guidelines
JRCALC guidelines
NIAS falls referral guideline

Standard	Target compliance	Exceptions	Definitions/ Instructions
History of event recorded	95%	Patient refuses assessment / patient unresponsive	

Standard	Target compliance	Exceptions	Definitions/ Instructions
Two timed set of observations documented	95%	Equipment failure / patient refuses /	Patients who have had only one set of observations should be recorded as an N
BM recorded	95%	Equipment failure / patient refuses	
Pre and post treatment pain scores documented	95%	Patient unresponsive	Both pre and post treatment scores required to return a Y value. If patient is pain free, this should be documented or 0 placed in the pain score box in order to obtain a Y value
12 lead ECG recorded and interpreted	95%	Equipment failure / patient refuses	A 3 lead ECG should return a N value.
Confirmed STEMI patients transported to cath lab	95%	Cath lab advise transport to ED	Patient refuses
Time of onset of symptoms recorded	95%	Patient unresponsive	
Oxygen administered as per JRCALC guidance	95%	Oxygen contra-indicated / patient refuses	
Aspirin administered as per JRCALC guidance	95%	Aspirin contra-indicated / patient refuses	
GTN administered as per JRCALC guidance	95%	GTN contra-indicated / patient refuses	

Standard	Target compliance	Exceptions	Definitions/ Instructions
Entonox administered as per JRCALC guidance	95%	Entonox contra-indicated / patient refuses / patient administered IV morphine	
IV morphine administered as per JRCALC guidance	95%	Unable to gain IV access / morphine contra-indicated / patient refuses	Patients who have been administered IV paracetamol should have an N value returned
Atropine administered as per JRCALC guidance	95%	Atropine contra indicated / patient refuses / unable to gain IV access	
Standby documented	95%	Patients who are pain free post treatment and not presenting with a STEMI	Patients with a confirmed STEMI should have a standby to the cath lab. Patients presenting with ACS symptoms but not a STEMI who still experience pain post treatment should have a standby placed

ACUTE CORONARY SYNDROME - CLINICAL AUDITING TOOL

BELFAST

NORTHERN

SOUTH EASTERN

WESTERN

SOUTHERN

REPORTS

GUIDANCE

SOUTHERN DIVISION

ARMAGH - S01

BANBRIDGE - S02

CRAIGAVON - S03

S04 - DUNGANNON

KILKEEL - S05

NEWRY - S06

BALLYGAWLEY - S07

BACK TO MENU

ID	**220**
Title	**Trade Unions 'Notice to Employer' of an official ballot for Industrial Action.**
Description	There is a risk to all aspects of service delivery, including the risk to safe delivery of patient care. Ballot for Industrial Action (i) in the form of Strike Action; or (ii) in the form of action short of a strike
Risk level (initial)	HIGH
Risk level (Target)	MEDIUM
Risk level (current)	HIGH
Lead Director	DIRHR
Initial Action Taken to Control/ Mitigate Risk	1. Management guidance for response to IA and contingency Plan for IA implemented 2.IA Management Team and related Silver Cell established to ensure the Trust has a formal structure in place which enables effective demand management and co ordination. 3. Regional HSC Protocol and MOU agreed with Unison, Unite and GMB Trade Unions to protect the provision of emergency services and clinically critical care to patients during the periods of IA. Commitment also given to support the delivery of contingencies where employers are demonstrably unable to make alternative arrangements. 4. IAMT will engage with TU's before and during IA 5. Escalation to NIAS BC Plans as appropriate. 6.Consultations mechanism established for IR issues. Continued engagement with Trade Unions throughout these. 7. A series of debriefs have been conducted following the IA and recommendations and action plans have been developed. 8. Chair and Chief Executive to engage with DHSSPS at Permanent Secretary level to address issues of dispute that are out with NIAS Trust influence. This meeting took place 22/01/15. 9. Formal debrief completed by Asst Dir Ops on the 3/11/15
Opened	11/08/2011
Review Date	23/02/2016
Action Plan to Address /Mitigate Risk	3. Recommendation and action plans will be used to inform a planned workshop to conduct Business Continuity Impact Analysis. 4. Ongoing engagement with Trade Unions continuing through a variety of groups and forums. 5.Recommendations from debriefs following IA will be incorporated into Business Continuity processes 6. HR elements of action plan to be discussed 15.03.16.

ID	**246**
Title	**Linking Funding to Demand**
Description	There is a risk to the Trust that increasing demand for ambulance response and transportation will outstrip capacity and compromise delivery of safe, high quality care due to the absence of a means of linking planned / approved budget to demand. Overall demand for ambulance has increased by 3% in 2014-15, with an increase of 14% for Category A calls. The increase in Category A calls has resulted in a sharp deterioration in % of Cat A calls responded to within 8 mins despite only moderate fall in absolute number of calls responded to within 8 mins.
Risk level (initial)	MEDIUM
Risk level (Target)	LOW
Risk level (current)	HIGH
Lead Director	DIROPS
Initial Action Taken to Control/ Mitigate Risk	1.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. 2.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. 3.NIAS financial planning prioritises provision of front-line resources. 4.NIAS has established Resource Management Centre (RMC) to align available resources with priority locations and times. 5.NIAS has identified priority locations and times for shift cover. 6.Financial resource and activity/performance are issues discussed with HSCB at PMSI meetings. 7.Financial resource and activity/performance are issues discussed at Trust Board. 8.NIAS has processes in place to secure additional funds linked to service change which could potentially be extended to deal with demand growth (subject to securing Commissioner support). 9 Introduce measures to manage demand which reduces demand for ambulance attendance and transportation. 9.1.NIAS Modernisation programme established 10.Introduce measures to manage demand which result in an alternative outcome which is more appropriate for the patient and better for NIAS/HSC. 10.1.NIAS Modernisation programme established
Opened	30/04/2013
Review Date	23/02/2016
Action Plan to Address /Mitigate Risk	1.Secure Commissioner support to engage in Demand/Capacity review as first step to linking demand to supply. 1.1.Dir Operations has engaged with Lead Ambulance Commissioner and secured support to progress 2.Establish metrics to show correlation/relationship between planned resource - demand - performance support bid for additional resources. 2.HSCB proposal to link planned budget to demand analysis to HSCB. E124 advance of completing demand/capacity review NIAS has sought to secure share of Demography funding in recognition of demand/activity growth (attempt to establish principle of funding growth) IPTG scheduled for submission to Trust Board on th August 2015. provide Call Prioritisation and Dispatch procedures to protect capacity to respond to & transport highest priority patients. provide Categorisation of HCPC calls to address 14% growth in-year and ensure call prioritisation is appropriate. Clinical Decision Support desk in Ambulance Control to provide additional means of managing calls. 9. This risk to be closed following Trust Board in th August 2015. It was agreed that this risk would be closed following Trust Board on the th July and replaced by a new risk 'Safe Care for the Public'. As this has not yet been developed and the decision regarding the Investment Proposal is still awaited. It is recommended that this risk remains at present. 10 D OPS to develop a new risk in relation to 'Safe care to the Public' 11. Reviewed by SEMT on 3/11/15 and a decision taken to retain in current form until alterative risk is developed.

ID	**273**
Title	**Financial Stability - Achieving Financial Balance 2015/16**
Description	There is a risk to the Trust that it will fail to meet its statutory duty to achieve financial balance. □ □
Risk level (initial)	HIGH
Risk level (Target)	LOW
Risk level (current)	MEDIUM
Lead Director	FINDIR
Initial Action Taken to Control/ Mitigate Risk	The Trust has returned a break-even financial position for the last ten years 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 NI public sector such as welfare reforms. The Trust has been advised at this date (July 2015) of a savings requirement of £1.2m in 2015/16.□ 2. Overspending against core budget. 3. Cost Pressures and Service changes (including Transforming Your Care) 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 /DHSSPS 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 DHSSPS 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.□ □ Controls are in place to mitigate each of these factors above 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 DHSSPS/HSCB re any emerging financial implications for HSC in the context of NI 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 of savings plan by NIAS for 2015/16 in conjunction with Trust Board. Engagement with staff and patient representatives and fulfillment of any statutory consultation requirements.□ i) Ongoing application of controls A to E above.□ □ The Trust Delivery Plan was approved by DHSSPS/HSCB in July 2015□ Savings plans were finalised, approved and implemented in July 2015.□ The Trust continues with the monthly completion and submission of Trust Monitoring Returns and Financial Stability Programme Board (FSPB) Savings Returns□ The Trust continues with the budgetary reporting cycle to Budget Holders, SEMT and Trust Board.
Opened	30/06/2015
Review Date	23/02/2016
Action Plan to Address /Mitigate Risk	The income and savings requirements identified as part of the planning process have materialised largely in line with planning assumptions.□ The Trust is forecasting a breakeven position, within tolerance, at 31 March 2016 subject to a number of assumptions, for example Agenda for Change, and also a reduced allocation in respect of Voluntary Early Severance. The Trust is also implementing an ambitious programme of activity and expenditure aimed at improving response time in March 2016.□ □ In addition to the above, the forecast breakeven position at 31 March 2016 is subject to:□ Completion of Draft Final Accounts (April/May 2016)□ Completion of External Audit (May/June 2016)□ Completion and Approval of Final Accounts by Trust Board and sign off by Accountable Officer (June 2016)□

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TRUST DELIVERY PLAN REPORT ON

COMMISSIONING PRIORITIES 2015-16

Commissioning Plan Direction	Commissioner Proposal	NIAS Response	Current Position
Commissioner will put in place plans to ensure meeting Ministerial emergency ambulance response targets by March 2016.	Commissioner, in collaboration with NIAS, will review demand for an emergency ambulance response against available commissioned capacity and in light of alternative care pathways.	Submit Proposal for Demand/Supply Analysis to HSCB in Q2.	Outline Proposal submitted by Director of Operations in Q1 2015-16. HSCB have indicated support to progress and fund from winter pressures money. Relevant planning and procurement options have been reviewed to progress but this is not possible within timeframes. NIAS will seek to progress in 2016-17.
Commissioner will support NIAS to continue to put in place alternative care pathways which avoid unnecessary hospital attendances.	Commissioner will seek to evaluate alternative care pathways with a view to maintaining where successful. The introduction of related, NIAS-managed Directory of Services with support from the 5 HSC Trusts will be essential in taking forward the pathways.	Provide Information to enable evaluation of Alternative Care Pathways (ACPs) in line with HSCB requirements. Introduce NIAS Directory of Services by Q3. Embed ACPs as Business as Usual.	Information is being provided in line with HSCB requirements. ACPs are progressing in line with plans. Key goals have been achieved and we are in line to exceed targets for ED avoidance. We project that we will bring fewer patients to ED this year than in 2013-14 despite an increase in demand and ambulance activity.
Commissioner will mainstream Hospital Ambulance Liaison Officers (HALOs) at the major acute hospitals to support patient flow and ambulance turnaround.	Commissioner will seek a proposal from NIAS to maintain HALOs at major acute hospitals	Review utilisation of HALOs to inform proposal. Submit proposal for HALOs by Q2.	HALO Investment Proposal was submitted to HSCB in Q2. Funding secured and recruitment undertaken to embed in normal business.
Commissioner, in partnership with NIAS, will, by November 2015, complete a public consultation on the future provision of non-urgent patient transport services.	Commissioner will work with NIAS to take forward recommendations following the review and public consultation of non-urgent patient transport services,	Work with HSCB in development of consultation document and in engagement process. NIAS will seek to ensure through this process that resource constraints are managed to prioritise	NIAS has input to development of proposal and awaits further direction. At this stage we have no indication that HSCB will progress to consultation in-year.

This will include the proposed introduction of eligibility criteria for non-emergency transport which seeks to prioritise mobility need in the face of limited capacity.	including the implementation of eligibility criteria.	provision of non-emergency ambulance transport based on clinical need.	
Healthcare Associated Infections (HCAIs).	Trusts, supported by PHA will develop and deliver improvement plans to reduce infection rates. This will be monitored via PHA surveillance programmes for HCAIs.	NIAS will continue to monitor HAIs in the ambulance operating environment and report on an exception basis.	Reporting continues through NIAS Assurance committee. No significant issues to report.
Flu immunisation	Trusts and Primary Care to increase uptake of flu immunisation among healthcare workers.	NIAS will review 2014-15 activity and measures taken in order to maximise effectiveness of staff vaccination programme in 2105-16.	NIAS continues to promote and prioritise flu vaccination for NIAS personnel. Measures have been identified which have the potential to increase rates of vaccination in future years.
Hazardous Area Response Team	HART in NI is a well-established specialist response team in NIAS that provides essential paramedic level care to casualties within the hazardous area of a CBRN: HAZMAT incident. PHA works closely with HART in training for and responding to CBRN: HAZMAT incidents and as such will continue to work with HSCB colleagues to ensure that the present capability of this vital service is maintained.	NIAS will use resources assigned to HART to maintain and develop capability in this area.	HART functionality remains as planned. HART activity is monitored through Medical Directorate. No issues to report.
The continued roll out of a range of measures to identify earlier and better meet patients' needs in community settings and to avoid the need for patients to attend hospital. These measures include:			

The establishment of Acute Care at Home models and other rapid response arrangements.		NIAS will support these developments through the Alternative Care Pathways programme already established.	ACPs are progressing in line with plans. NIAS supports both hospital-based and community models.
The establishment of a range of alternative care pathways, linked to the NI Ambulance Service, to provide alternatives for both patients and staff to hospital attendance.		NIAS will continue to develop and progress Alternative Care Pathways in line with the proposals previously endorsed and funded by HSCB through the Transforming Your Care Programme.	ACPs are progressing in line with plans.
The establishment on a pilot basis of an alcohol recovery centre in Belfast.		NIAS will support these developments through the Alternative Care Pathways programme already established.	This initiative was established by BHSCT pre-Christmas and is continuing to operate.
The reform of palliative care services, facilitating people to die in their place of choice – typically their own home - rather than a hospital bed. During 2015/16 this will include: The implementation of advance care planning arrangements across Northern Ireland to allow the needs and wishes of palliative care patients to be identified and planned for.		NIAS will support these developments through the Alternative Care Pathways programme already established.	ACPs are progressing in line with plans. NIAS has access to relevant services in the vast majority of NI out-of-hours. Further developments continue to be explored to enhance the service and achieve full coverage of NI. NIAS staff have welcomed the development and have been promoting its extension beyond the out-of-hours period.

TB/5 07/04/16

NORTHERN IRELAND AMBULANCE SERVICE

TRUST BOARD MEETING

7 April 2016

Title:	Performance Management Framework
Purpose:	Through the effective operation of the Performance Management Framework, the Trust will be able to provide assurance throughout the organisation and to external stakeholders its ability to achieve its objectives.
Content:	
Recommendation:	For Approval
Previous Forum:	SEMT
Prepared by:	Chief Executive
Presented by:	Chief Executive

AD/CE/47

Northern Ireland Ambulance Service
Health and Social Care Trust

NORTHERN IRELAND AMBULANCE SERVICE

PERFORMANCE MANAGEMENT FRAMEWORK

Approved by Trust Board on 2016

Performance management is a key element of the Trust's Assurance Framework through which the organisation can assure itself and others as to its ability to achieve its objectives.

There are a number of key drivers which require the Trust to have a robust and comprehensive Performance Management Framework and associated performance reporting systems. These include:

- The need to provide strategic direction, corporate priorities and annual performance targets for the organisation, and clarity in respect of the accountability and performance management arrangements.
- The drive for improved performance, effectiveness and efficiency to ensure best use of public funds.
- The commitment by this Trust to its core values.

Through the effective operation of the Performance Management Framework, the Trust will be able to provide assurance throughout the organisation and to external stakeholders that:

- its strategic objectives are being met,
- there is a focus on the continual improvement of service delivery, and
- there is effective utilisation of all its resources - financial, management and clinical - to support the achievement of high quality, safe and effective services and the delivery of other key organisational objectives and targets.

The Performance Management Framework must be integrated with and be complementary to the Trust's Governance arrangements, within the overarching Board Assurance Framework. The differentiating factor between the performance management and governance systems is:

- **Performance Management** will focus on those areas of the Trust's business where improvements are sought or targets must be achieved.
- **Governance** will provide assurance that the standards and obligations set for the Trust are met as a minimum, and that organisational, clinical and social care and financial governance systems are in place and operating effectively.

The output from the governance systems and reporting will provide a valuable and independent quality assurance of the performance management systems and reporting.

The diagram below provides an overview of this concept.

Trust Assurance Framework

Performance Framework assures:	**Governance Framework assures**
• Strategic Direction • Clear Corporate Objectives • Annual performance targets • Effective Performance monitoring and reporting • Identification of variance and reasons for same • Effective corrective action • Roll out of successful reform/innovation • Embedding of system and process reform	• Minimum standards are met (RQIA, Controls Assurance, Finance, etc) • Statutory obligations are met and statutory functions are delivered • Effective Risk Management is in place • Quality Assurance of Performance through reporting of complaints, Serious Adverse Incidents, etc.

Principles

There are a number of key principles underpinning the development of the Trust's performance management framework to ensure focus on the achievement of corporate objectives and the delivery of high quality, safe, effective services. These are that the Performance Framework will:

- Enable the establishment and review of strategic direction, translated into challenging Corporate Objectives and annual targets which describe expected levels of performance, clearly linked to performance goals for Directors, their teams and individual staff.

- Provide clear accountability for performance targets throughout all levels of the organisation.

- Create a supportive mechanism for measuring, managing and improving performance, with agreed indicators that clearly demonstrate whether the Trust is achieving its objectives and targets.

- Provide the internal source of assurance to the Board on performance as part of the Trust's Assurance Framework, and be complementary to the Governance Framework

In adhering to these principles, the Performance Framework will have the following key features:

1. **Strategic Direction, Corporate Objectives and annual delivery targets** which cascade throughout the organisation.

2. **Clearly defined responsibility and accountability** throughout the organisation for the delivery of the above.

3. **Integrated reporting of performance** which looks at a range of performance indicators under agreed domains to enable informed assessment of performance and the contributors to variations in performance (both above and under performance targets).

4. The integrated performance reporting will be **available at all levels of the organisation** in a format and level of detail appropriate to their management needs.

1. Strategic Direction, Corporate Objectives and annual delivery targets

The Performance Framework will set out the above through two key documents:

- The Corporate Plan which sets out 3-5 year objectives and annual targets
- The Trust Delivery Plan which details the Trust's response to annual commissioning priorities and targets.

2. Clearly defined responsibility and accountability

The broader accountability arrangements within the HPSS, including the accountability of Trust Board, are set out in the Standing Orders. In relation to Performance Management, the specific accountabilities are:

Trust Board	• Determine and review strategic direction • Set and approve Corporate Objectives • Approve annual Corporate Plan • Approve Trust Delivery Plan • Approve Performance Framework • Organisational Performance Monitoring • Agree the assessment of performance risks • Ensure plans for corrective action are in place
Senior Management Team	• Develop Strategic Direction and Corporate Objectives for approval by Trust Board • Develop Corporate Plan and TDP for approval by Trust Board • Develop Performance Framework and provide organisational performance reports which enable comparison through use of benchmarks. • Assign accountability for performance targets • Monitoring of performance risks • Develop plans for corrective action where required

The objectives and targets set out in the Corporate Plan are assigned to Directors in line with their areas of management, professional and clinical responsibility. These responsibilities will be reflected in:

- Directorate Work Plans which detail responsibilities, actions and timescales for the assigned targets. These Plans may be further refined into Team Work Plans
- Individual Personal Contribution Plans which outline the expected contribution of individual members of staff.

3. Integrated Reporting of Performance

Performance can be judged in a variety of ways and from a range of perspectives. It is critical that a range of perspectives are reported in an integrated way so that performance can be accurately judged across the crucial ingredients of success in financial, operational and quality terms. The key performance perspectives proposed for the Trust's Assurance Framework are aligned to the priorities identified by the Minister for Health through documents such as the Commissioning Plan Direction and incorporate indicators and measures as listed below:

- **Clinical and Social Care Quality** – a range of indicators that will be developed by working with each Director and their teams, and with clinical and professional staff particularly, drawing on accredited indicators from UK and beyond.
- **Patient and Client Satisfaction –** as part of the Trust's PPI Strategy, to develop ways of assessing user satisfaction with the services provided by the Trust.
- **Achievement of Access and Targets –** 'real time' (where possible) performance reporting against relevant targets, summarised to Trust Board on a monthly basis, supplemented by quarterly reports on progress against Trust-specific targets in Corporate Plan.
- **Efficient Delivery of Care** – a range of indicators that provide assurance that the organisation is making best use of resources.
- **Workforce –** a range of workforce issues can impact on performance (levels and duration of sickness, vacancy levels, etc.)
- **Finance –** Trusts are expected to perform at high levels and achieve financial balance, so it is critical to include financial performance indicators in any integrated performance framework.
- **Staff Satisfaction –** while it is difficult to identify measures of staff satisfaction in any 'real time' or even monthly basis, it is critical that the organisation evaluate the organisational 'climate' regularly and for Trust Board to consider the outputs of this evaluation in conjunction with other perspectives of performance.

- **Strategy and Effectiveness -** The perspective of strategy & effectiveness includes market and business development, key trends and forecasts.

4. Performance reporting available at all levels of the organisation

Performance measurement information will be provided at a strategic, tactical and operation level, offering an integrated view of operational performance across the Trust under the agreed domains. This performance management approach will allow the Trust to view performance from multiple perspectives, interpret information, gain insight and judgment and enable effective decision making.

Presentation tools such as 'Dash boards' will be developed to present organisational performance against the key performance indicators developed. This will provide assessment of performance and risks with 'traffic light' exception reporting where areas of both success and concern will be highlighted. Where possible, benchmarks will be included to provide a basis for judging performance against each indicator. The performance indicators must be suitable for regular reporting.

The content of the performance reports will be subject to continual review and iterative development, due to the changing nature of Departmental and Trust-specific performance targets, development of new performance measurements and benchmarks and in response to performance issues identified through governance and other management processes.

The information will cascade through the organisation through the performance reports, with each layer of the organisation having access to that level of detail appropriate to their management responsibilities, professional and clinical needs, but also providing the ability to 'drill down' to further detail if required.

It is critical that performance information is made available in the level of detail which recognises the responsibilities and accountabilities of that level of the organisation as set out below.

- Trust Board – Corporate and Directorate level
- Senior Management Team – Corporate and Directorate level

- Directors - Directorate and Service level
- Assistant Directors – Service level
- Heads of Service/Team Leaders – Service, Team level and practitioner level
- Governance leads – Service and Team level
- Individual staff - for their individual areas of responsibility.

While every effort will be made to make the reporting as comprehensive as possible, this will not be the only source of performance reporting within the Trust. Additional assurance on performance will be provided by a range of detailed quantitative and qualitative performance reports, provided monthly, quarterly, bi-annual or annually.

These include:

- DHSSPS/HSCB/PHA Priorities
- Progress against the Trust's Corporate Plan
- Patient/Client engagement/satisfaction
- Workforce Vacancies, sickness levels, etc
- Reform, Modernisation and Efficiency/Productivity
- Staff Training and Development
- Progress on skill mix across staff groups/Directorates
- Performance against Equality/Section 75 requirements
- Staff satisfaction

These reports are either in place or under development.
In addition to the above internal reporting arrangements, external reporting is required to DHSSPS and Commissioners. This includes regular reporting on Reform, Modernisation and Efficiency, and performance against Service and Budget Agreements including written reports on quality outcomes.

Summary

Trust Board will require a range of reports to assure itself that performance is at the expected level and properly managed.

- Corporate and Directorate-specific Performance reporting provided on a monthly basis. This provides a strategic overview through the use of performance-sensitive indicators.

- Monthly reports on performance against DHSSPS/HSCB/PHA targets: As these targets are the most high profile indicators of the Trust's performance, a report detailing performance and risk will be brought to Trust Board at each meeting.
- Reports on performance against Trust-specific targets in Corporate Plan.
- A range of detailed quantitative and qualitative performance reports, provided monthly, quarterly, bi-annual or annually. These include:

    - Patient/Client engagement/satisfaction
    - Workforce Vacancies, sickness levels, etc
    - Reform, Modernisation and Efficiency/Productivity
    - Staff Training and Development
    - Progress on skill mix across staff groups/Directorates
    - Performance against Equality Statutory Duty
    - Staff satisfaction

TB/6 07/04/16

NORTHERN IRELAND AMBULANCE SERVICE

TRUST BOARD MEETING

07 April 2016

Title:	Information and Communications Technology (ICT) Security Policy
Purpose:	To ensure that Trust staff understand the principles of ICT Security and their responsibilities
Content:	ICT Security guidance and roles and responsibilities.
Recommendation:	For Approval
Previous Forum:	Trust Board (2009)
Prepared by:	Mr Paddy Dornan, IT Manager Miss Alison Vitty, Corporate Manager
Presented by:	Mrs Sharon McCue, Director of Finance and ICT

Northern Ireland Ambulance Service
Health and Social Care Trust

INFORMATION AND COMMUNICATIONS TECHNOLOGY (ICT) SECURITY POLICY

Title:	Information and Communications Technology (ICT) Policy		
Purpose of Policy:	To ensure that Trust staff understand the principles of ICT Security and their responsibilities		
Directorate Responsible for Policy:	Finance and IT Directorate		
Name and Title of Author:	Mr Paddy Dornan, IT Manager Miss Alison Vitty, Corporate Manager		
Staff Side Consultation	HR Joint Working Group 10 September 2009. No Comments		
Equality Screened:	Yes		
Date Presented to:	ICT Steering Group	1 June 2009	
	Comments	Minor amendments made re: lockable windows	
	Trust Board	24 September 2009	
Publication Date:	01/10/2009	Review:	01/10/2012
Version:	NIAS/TW/IG/7 v3		
(01) 2004	This policy has now been superseded and should be removed from all Directorate areas.		
(02) October 2009	The policy has been completed re-structured to take consideration of information governance requirements. Further policies have now also been separately developed to give clear guidance on management of email use, internet use and password management.		
(03) January 2016	The Policy has been reviewed by ICT Manager to ensure legislative and good practice guidance has been adhered to.		

Circulation List:

This Policy was circulated to the following groups for consultation:

- Staffside (via HR Joint Working Group)
- Executive Directors and Senior Managers (during week of 1 June 2009)

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

- All Trust Staff
- Trust Internet/Intranet Site

1.0 Introduction

The Northern Ireland Ambulance Service Health and Social Care Trust (the "Trust") are managing a significant investment in the use of Information and Communications Technology (ICT). In many areas of the organisation, the work and use of ICT is vital and must be protected from any form of disruption or loss of service. It is therefore essential that the availability, integrity and confidentiality of the ICT systems and data are maintained at a level that is appropriate for the Trust's needs.

It is also essential that all Trust ICT systems are protected to an adequate level from business risks. Such risks include accidental data change or release, malicious user damage, fraud, theft, failure and natural disaster. It is important that a consistent approach is adopted to safeguard the Trust's information in the same way other tangible assets are secured, with due regard to the highly sensitive nature of some information held on both electronic and manual systems.

2.0 Scope

This ICT Security Policy applies to:

- ICT systems belonging to, or under the control of, NIAS HSC Trust;
- **All** users of our WiFi wireless communication services and to all our internet related services.
- Information stored, or in use, on NIAS HSC Trust systems;
- Information in transit across the Trust's voice or data networks;
- Control of information leaving the Trust;
- Information access resources;
- **All** parties who have access to, or use of ICT systems and information belonging to, or under the control of, NIAS HSC Trust.

3.0 Policy Statement

It is the duty of each Health and Social Care (HSC) body to establish and keep in place arrangements for the purpose of monitoring and improving the quality of healthcare provided by and for that body. The Trust has developed this ICT Security Policy to:

3.1 Provide direction and support for ICT security in accordance with business requirements, regulations and legal requirements;

3.2 State the responsibilities of staff, partners, contractors and any other individual or organisation having access to the Council's ICT systems;

3.3 State management intent to support the goals and principles of security in line with business strategy and objectives;

3.4 Provide a framework by which the confidentiality, integrity and availability of ICT resources can be maintained;

3.5 Optimise the management of risks, by preventing and minimising the impact of ICT security incidents;

3.6 Ensure that all breaches of ICT security are reported, investigated and appropriate action taken where required;

3.7 Ensure that supporting ICT security policies and procedures are regularly reviewed to ensure continued good practices and protection against new threats;

3.8 Ensure ICT information security requirements are regularly communicated to all relevant parties.

4.0 **Policy Objective**

4.1 To ensure that equipment, data and staff are adequately protected against any action that could adversely affect the Trust. These events will include accidents as well as behaviour deliberately designed to cause difficulties. Adherence to this policy and related policies and procedures will ensure that that risk of such occurrences is minimised.

4.2 To ensure that all staff are aware of and fully comply with all relevant legislation;

4.3 To create and maintain within the Trust a level of awareness of the need for ICT security to be integral part of the day to day business, so that all staff understand the need for ICT security and their own responsibilities in this respect.

5.0 **Roles and Responsibilities**

5.1 All staff are required to adhere to the ICT Security Policy and related policies and procedures. The sections below detail specific responsibilities for all staff and specific staff groups.

5.1.1 **All Staff**

All members of staff have a responsibility to:

General

- Ensure that no breach of ICT security results from their actions;
- Bring to their Manager's attention areas of concern regarding information security and report appropriately, as required under the Trust's Risk Management Strategy;
- Abide by the relevant legislation relating to ICT security.

Equipment Disposal

- Ensure the IT Helpdesk are informed of any ICT equipment that needs to be disposed of. Under no circumstances should staff pass on or dispose of equipment themselves.
- Reformat or rewrite or physically destroy all removable media before disposal to guard against unauthorised access to personal data. Staff should contact the IT Department on how to manage this.

Physical Security

- Ensure doors and windows are closed or locked (where appropriate) and secure when the area is left unattended in areas where ICT equipment is in use.
- Ensure, where possible, all portable equipment is secured when not in use.
- Do not leave equipment or removable media unattended when travelling.
- Do not leave portable media e.g. USB sticks, external hard drives, DVDs inside portable computers when travelling in case of theft.
- Ensure that unattended PCs/laptops have appropriate protection e.g. log off, lock screens or use password protection.
- Ensure all portable equipment i.e. laptops are encrypted and encryption software is running effectively. Staff should seek advice from the IT Department on how to manage this.

Information Security

- Store information on networked drives that are subject to authorisation and access controls.
- Ensure that all personal information is transferred in line with the standards set in associated policies and procedures.

5.1.2 **Line Managers**

Have a responsibility to:

General

- Ensure that all current, new and temporary staff are instructed in their security responsibilities and work in a manner consistent with the ICT Security Policy.
- Ensure that all their staff using computer systems/media are trained in their use.
- Ensure that the IT Helpdesk are notified through completion of appropriate paperwork of new and leaving employees to allow access rights to be appropriately established from effective dates and leaving employees access to be revoked. New users will not be assigned log-on credentials without completed user request forms from their line manager.
- Investigate and take relevant action on any potential breaches of this policy supported by the Risk Manager and other appropriate personnel in line with existing risk management strategy.

Information Security

- Ensure that no unauthorised staff are allowed to access any of the Trust's computer systems or information stores, as such access would compromise information integrity.
- Ensure that non-Trust employed staff e.g. contractors, students, temporary agency staff etc have signed the confidentiality code of conduct for non-Trust employed staff before accessing ICT equipment.
- Determine which individuals are to be given authority to access specific information; levels of access to specific systems should be based on job function, independent of status.
- Decide whether it is appropriate for their staff to use private equipment e.g. PDAs, USB memory sticks. This will include considering whether it is needed to carry out their duties and whether it may pose a confidentiality or security risk.
- Ensure that removable media used by their staff is disposed of securely, seeking guidance from the IT Department where appropriate.
- Ensure that the Checklist for Staff is completed before an employee leaves a job; that relevant accounts are closed and equipment returned e.g. mobile phones, PDAs, laptops etc

5.1.3 **Finance and ICT Directorate**

The Finance and ICT Directorate is managed by the Director of Finance and ICT. This area of management includes the IT Department and Information Department who are dedicated to the role of information

governance within the Trust and whose responsibility it is to develop and implement ICT security across the Trust.

To ensure ICT security, the IT Department has a responsibility to:

General

- Monitor and report on the state of ICT security within the Trust.
- Ensure that ICT Security Policy is implemented throughout the Trust.
- Develop and enforce detailed procedures to maintain security.
- Ensure that Trust personnel are aware of their responsibilities and accountability for information security.
- Provide advice on information security when required.
- Assess the impact of ICT provision of any major disruption and invoke appropriate action as per the Business Continuity Plan.
- Implement adequate processes to ensure that third parties with whom the Trust contracts are subject to, and comply with, information security requirements.

Information Security

- Monitor for actual or potential information security breaches.
- Develop procedures to investigate and report ICT security issues.
- Understand the risk to the computer assets and the information that is held on them.
- Implement specific measures where personal information is being transferred whether manually or electronically e.g. using portable computers, USB. This must include data encryption procedures.
- Ensure access controls are established and maintained for all staff to ensure appropriate access to information.
- Commission penetration testing to ensure network security.
- Ensure back-up procedures are established and maintained.

Physical Security

- Deploy appropriate security measures to reduce the threat and to reduce the impact of a threat that materialises.
- Ensure that new information systems provide an adequate level of security and do not compromise the existing infrastructure.
- Ensure appropriate revision of antivirus software and patches are installed on all servers and PCs.
- Produce and maintain an ICT asset register for software and hardware used by all Trust staff.
- Ensure server rooms are restricted to appropriate staff members.

- Ensure that all critical equipment is protected from power supply failures and bursts using Uninterruptable Power Supplies (UPS) and UPS are tested on a regular basis.
- Ensure that PCs, servers and other appropriate hardware are disposed of security in accordance with disposal schedule.

5.1.4 **Information Governance Steering Group**

The Trust is committed to the ongoing development and review of ICT Policies, procedures and guidelines to manage the risk of emerging threats to its systems and services. This work will be coordinated by the Information Governance Steering Group chaired by the Director of Finance and ICT.

The IG Steering Group has responsibility for developing and implementing ICT Security Policy and associated procedures and ensuring the Trust meet national and legislative requirements in relation to ICT Security. Other specific areas relating to information security including data protection, confidentiality and data quality are also overseen by this Group.

5.1.5 **Human Resources Directorate**

Has a responsibility to:

- Ensure necessary screening of staff is carried out through the recruitment process;
- Ensure every contract references employees' responsibilities with regard to information security and make it clear that employees are required to comply with the Trust's policies on information governance matters.
- Ensure that staffs are given access to relevant policies and procedures.
- To ensure that the Checklist for Staff is completed before an employee leaves a job.

6.0 Application

6.1 For the purposes of this document, the terms ICT/ICT system, ICT data or ICT user are defined as follows:

- **ICT** means any device or automatic storing and processing of data and includes mainframe computer, minicomputer, microcomputer, personal computer (whether hand-held laptop, portable, stand-alone, network or attached to a main server), workstation, word processing system, desktop publishing system, office automation system; messaging system or any other similar device;

- **ICT data** means any information stored and processed by ICT and includes programs, texts, picture and sound;
- **ICT user** applies to any Trust employee or other authorised person who uses the Trust's ICT system and/or data.

7.0 Definitions

7.1 **Encryption** is the process of converting information into a form unintelligible to anyone except holders of a specific key or password.

7.2 **External hard drive** sits outside the main computer in its own enclosure. This portable encasement allows the user to store information on a hard drive that is not part of the computer, but is connected via a high-speed interface cable normally a USB or fire wall.

7.3 **Hardware** in IT is a physical device such as a VDU or printer.

7.4 **Patches** are updates on computers, such as anti-virus, to ensure that the program is up to date or to fix a bug within a program.

7.5 **Mobile Device**, refers to a portable device that has several features including an address book, contacts list, calendar, memo and notepad e.g. Laptop, Ipad, smartphone etc.

7.6 **Removable Media** is a term used to describe any kind of portable data storage device that can be connected to and removed from a computer e.g. floppy discs, CDs/DVDs, USB flash memory sticks or pens.

7.7 **Software** are programs that run on a computer e.g. word processing software, spreadsheets etc.

7.8 **USB** (Universal Serial Bus) or Port connection, that are universally compatible with many types of devices such as wireless, printers, memory sticks etc.

7.9 **USB Memory sticks** are devices with flash memory card formats. These devices come in many sizes and are generally used for storage of data.

8.0 Legislation

8.1 The Trust is obliged to abide by all relevant UK and European Union legislation in relation to information security and ensure that all of its information systems adhere to this legislation. It must also ensure that individual responsibilities for meeting these requirements are clearly defined in local system documentation. Legislation of relevance to information security and monitoring includes (this is not an exhaustive list):

- The Data Protection Act 1998
- The Data Protection (Processing of Sensitive Personal Data) Order 2000
- The Copyright, Designs and Patents Act 1988
- The Computer Misuse Act 1999
- The Health and Safety at Work (NI) Order 1978
- The Human Rights Act 1998
- Regulation of Investigatory Powers Act 2000
- Freedom of Information Act 2000
- The Electronic Communications Act (2000)
- Privacy and Electronic Communications Regulations (2003)
- Fraud Act 2006

9.0 Assets

9.1 There are six major categories of information assets including information, software, physical (including hardware), services, people and less tangible assets such as reputation and image of the Trust. The key assets that this policy applies to are information hardware and software. Co-ordination with the Trust's financial system is also of key importance.

9.2 Asset Register

A complete ICT register which will include key hardware and software will be maintained by the IT Department for all health information assets. Procurement of new assets must be recorded in the asset register and allocated to the appropriate owner. Disposal of assets or the reassignment of assets must be recorded in the asset register.

9.3 Authorised Hardware and Software

9.3.1 Users requiring equipment to carry out authorised tasks are to apply for equipment and funding through Directorate Heads and in line with financial policy and procedures. With the introduction of any new project across the Trust, the ICT requirements should be considered from the outset, embedded within the project management environment.
Purchase of this equipment will then be carried out centrally by the IT Department following the release of the appropriate Business Case. This ensures that equipment purchased is compatible with existing systems.

9.3.2 Any new software must be authorised by the IT Department. Unauthorised software must not be used on Trust equipment or network.

9.3.3 If the Trust has purchased software, the IT Department will retain the purchase licence, should any reinstall be necessary.

9.3.4 The user must not modify the equipment. Such modifications that are required to ensure the efficiency of the PC will be provided and installed by IT staff (within budgetary constraints). Modifications include:

- Software installations unless delegated to the user by a member of the IT Department;
- Hardware and software upgrades.

9.4 **Use of Private Equipment**

9.4.1 Private equipment will not be used for the purpose of carrying out Trust business without prior permission from the individual's Line Manager. This private equipment may include laptops, PDAs, USB memory sticks and external hard drives.

9.4.2 It will then be the responsibility of the Line Manager to decide if it is necessary for the person to carry out their duties or whether it may pose a confidentiality or security risk. If needed, the IT Department can be contacted for further support.

9.5 **Maintenance**

9.5.1 The IT Department maintains ICT hardware and software for the Trust. A staff member cannot authorise any maintenance to be carried out by another agency.

9.6 **Information Storage and Back-Up**

9.6.1 Users are responsible for ensuring their information is saved appropriately and subject to regular back-up. Where a user has network access, all information should be saved to their network drive which is automatically backed up by the IT Department.

9.6.2 All information should be managed in accordance with supporting information governance policies and procedures.

10.0 Incident and Risks

10.1 All risks and incidents relating to ICT Security must be reported using the Trust's standard procedure for risk and incident reporting.

10.2 Breaches of this Policy and/or security incidents can be defined as events which could have, or have resulted in, loss or damage to NIAS assets, or an event which is in breach of NIAS security procedures and policies.

All NIAS employees, partner agencies, contractors and vendors have a responsibility to report security incidents and breaches of this policy as quickly as possible through the Trust's standard procedure for risk and incident reporting. This obligation also extends to any external organisation contracted to support or access the Information Systems of NIAS.

10.3 Reporting of risks and incidents is important to ensure that appropriate action is taken so that risks/incidents do not reoccur and to learn from them. No consecutive action can be taken if the Trust is not notified when things go wrong or there is a near miss.

11.0 **Access Control**

11.1 Access to business and confidential information must be controlled appropriately. All employees are entitled to use the network and office applications provided by the IT Department provided it is applicable to their particular role.

12.0 **User Access Management**

12.1 The Trust have formal registration and de-registration procedures which covers networked and non-networked sites, granting and managing access to network directories and systems. All users of the Trust's computer network are required to sign the Trust's network authorisation form which will indicate their access needs. The user request form must be countersigned by the user's line manager before submitting it to the IT Department for approval.

13.0 **Password Control**

13.1 Deliberate sharing of systems access passwords is a criminal offence under the Computer Misuse Act 1990. All staff are required to follow good security practices in the selection and use of passwords and should refer to the Trust's Policy on the Use and Management of Passwords for further guidance.

14.0 **Acceptable Use of Email and Internet**

14.1 The Trust needs to ensure that all staff are protected against viewing or accessing inappropriate materials. Further guidance is available in the Trust's Email and Internet Policies which have been developed to minimise the risk in relation to email and internet use and advice on best practice in this area. These policies must be read and adhered to by all staff to support ICT security and best practice.

15.0 Remote Access

15.1 Remote access occurs when a user logs onto the Trust network from a location where there is no direct access to the Trust's network e.g. a member of staff remotely accessing the network from home.

15.2 Critical business processes rely on easy and reliable access to clinical and corporate information systems. However remote access is not given as a right and will only be granted on a case by case basis and approval from relevant Executive Director.

16.0 Exchanges of Information and Software

16.1 It is imperative that utmost care is exercised when transferring information, especially information of a confidential nature e.g. staff, patient or service user information. This includes transferring information by telephone (voice and text), email, fax, courier and public mail. Encryption services must be engaged where available.

16.2 Regular exchanges of information outside of the HSC must be governed by an information sharing protocol using the Trust's standard template. Further guidance on this is available from the Trust's Corporate Manager and Information Department in general.

17.0 Systems Development and Maintenance

17.1 The Trust must ensure that security requirements are built into systems from the outset. Suitable controls must be in place to manage the purchase or development of new systems and the enhancement of existing systems, to ensure that information security is not compromised.

Security Requirements of Systems

17.1.1 Any individual responsible for implementing or modifying systems is responsible, in collaboration with the IT Department for ensuring:

- The statements of business requirements for new systems, or enhancements to existing systems specify the security controls required for that system;
- That all modifications to systems are logged and up to date documentation exists for their systems;
- The vendor supplied software used in systems is maintained at a level supported by the suppler, if beneficial to the Trust. Any decision to upgrade must take into account the security of the release;

- That physical or logical access is only provided to suppliers for support purposes when necessary, and must be with management and IT approval;
- That all supplier activity on the system is monitored;
- That copies of data must retain the same levels of security and access controls as the original data.
- That changes to central documentation are completed prior to any upgrade or modification of existing systems, or the introduction of a new system which may have an impact on existing systems.

18.0 **Business Continuity**

18.1 A Business Continuity Plan must exist to allow all critical systems to be maintained and to restore clinical systems in the event of a major disruption to service e.g. through a disaster or security failure.

19.0 **Review**

19.1 This policy will be reviewed every three years or at times considered necessary as a result of operational changes, legislative changes, risk assessments or when breaches in security have occurred.

Related Documentation:

This policy should be read in conjunction with:

ICT Strategy 2016/17-2020 (Draft)
Records Management Strategy 2006-2009
Records Management Policy and associated information sheets
Data Protection Policy 2008 and associated procedures
Freedom of Information Policy 2000 and associated procedures
Email Policy and associated information sheets
Passwords Policy
Risk Management Strategy

Signed: _____

Liam McIvor (Mr)
CHIEF EXECUTIVE

TB/7 07/04/16

NORTHERN IRELAND AMBULANCE SERVICE

TRUST BOARD MEETING

07 April 2016

Title:	Information Governance Strategy 2015-2018
Purpose:	This is to support the Information Governance Management Framework which is supported by policies, strategies and improvement plans which sets out how the organisation manages Information Governance.
Content:	The document sets an overarching framework for the strategic Information Governance agenda within NIAS and supports the embedding of information governance within the Trust.
Recommendation:	For approval
Previous Forum:	Information Governance Steering Group – 16/03/2016 SEMT
Prepared by:	Miss Alison Vitty, Corporate Manager
Presented by:	Mrs Sharon McCue, Director of Finance and ICT

Northern Ireland Ambulance Service
Health and Social Care Trust

1.0 Title:	INFORMATION GOVERNANCE STRATEGY 2015-2018		
2.0 Author(s)	Alison Vitty, Corporate Manager		
3.0 Ownership:	Finance and ICT Directorate		
4.0 Date of SEMT Approval:		**5.0 Date of Trust Board Approval:**	
6.0 Operational Date:		**7.0 Review Date:**	
Version No:	Version 0.1.4	**Supersedes:**	No Strategy to Supersede
8.0 Key words:	Information Governance		
9.0 Other Relevant Policies:	- Information Governance Policy - Information Risk Management Policy - Records Management Policy - Freedom of Information and Environmental Information Regulations Policy - Data Protection Policy - Data Protection Manual		

Version Control for Drafts:			
Date	**Version**	**Author**	**Comments**
	V0.1.1	AV	Initial draft.
	V0.1.2	AV	Further updated – June 2015
	V0.1.3	AV	Further updated – August 2015
	V0.1.4	AV	Minor amendments made based on comments from Senior Information Risk Owner and Personal Data Guardian/Caldicott Guardian 16/03/2016 – To Information Governance Steering Group. Approved

1.0 **Executive Summary**

This Strategy contains the Northern Ireland Ambulance Service HSC Trust information governance aims and deliverable programme for 2015-2019.

The Information Governance Assurance Framework (IGAF) is a national framework of standards that bring together all statutory, mandatory and best practice requirements concerning information management. The standards are set out in the Information Governance Control Assurance template as a road map enabling NIAS to plan and implement standards of practice and to measure and report compliance on an annual basis.

It confirms fully the Trust's commitment to compliance with information rights and legislative requirements.

It aims to set out an approach that will deliver all of the essential compliance elements, in a way that also enables and supports the delivery of corporate objectives and opportunities for organisational benefits. It is an approach that will be flexible and responsive to new or changed operational and legislative requirements and that will enable the Trust to take proportionate risk.

It demonstrates how effective information governance can help the Trust to make the best use of information, and as a consequence, assist in the delivery of our objectives and the improvement of our day to day processes.

It is an approach which will enhance our corporate objectives to be open and transparent about what we do, and to be held to account for the actions we take. It will give confidence to those who provide their personal information to us whether they are staff, patients or stakeholders that their information will be managed appropriately and securely.

We will ensure that we communicate and champion the Information Governance Strategy and information governance agenda throughout the Trust and wider public domain. Information plays a key part in all Directorate areas within Trust. The quality in the provision of services planning, performance measurement, assurance and financial management relies upon accurate, timely and available information.

Information is a key asset to the Trust and Information Governance is a corporate-wide agenda that will not succeed if it is seen in isolation from the integrated Corporate Assurance agenda and it should therefore be afforded appropriate authority.

The document sets an overarching framework for the strategic Information Governance agenda within NIAS.

2.0 INTRODUCTION

This strategy describes the continuing development, implementation and embedding of a robust information governance framework needed for the effective management and protection of the Trust's information.

Information governance describes the approach within which accountability, standards, policies and procedures are developed and implemented, to ensure that all information created, obtained or received by the Trust is held appropriately.

The Trust relies on good accurate quality information being available at the point of need in order to provide a quality service. Staffs need to have confidence in the quality of data they use to make decisions about patient care and treatment and the way in which we use resources and run our day to day business. All staff should understand their own responsibility for recording information to a consistently high manner and for keeping it secure and confidential. Public confidence in our ability to handle their data responsibly and efficiently is based on a good reputation for keeping their data safe and from their own personal experience when using our services.

The importance of IG was highlighted during 2008 when public concerns about high-profile data losses and protection of privacy were reported in the media and a range of standards and processes were developed for managing information risks and were subsequently mandated and incorporated into the DHSSPS Information Management Controls Assurance Standard.

The associated NHS review led to the existing IG agenda being strengthened to become an Information Governance Assurance Framework (IGAF). IGAF is formed by elements of statue and policy from which information governance standards are derived, and the activities and roles which individually and collectively ensure that those standards are clearly defined and met.

A particular feature of the IGAF was to introduce a framework of accountability for information risk with the mandated appointment of a Board level Senior Information Risk Owner (SIRO) who takes responsibility for managing information risk within the Trust and for providing assurance to the Accountable Officer on the content of the annual Statement of Internal Control in regards to IG.

At a local level, the framework enables the Trust to set annual objectives to achieve the required standards and to report organisational performance measures and assurance of compliance to Internal Audit and to the general public.

This document should be read fully in conjunction with the Information Governance Policy and other associated policies and procedures detailed in the cover sheet of the document.

3.0 Regulatory Environment

The IGAF is an encompassing term for a number of different areas. It brings together all legal requirements, standards and best practice guidance that apply to the handling and use of information and information assets. It is primarily driven by statues including but not limited to:

- Data Protection Act 1998
- Freedom of Information Act 2000
- Access to Health Records (NI) Order 1993
- The Environmental Information Regulations (NI) 1992
- Privacy and Electronic Communications Regulations 2003
- The Public Records Act 1958
- Disposal of Documents Order 1925
- The Re-Use of Public Section Information Regulations 2005
- Computer Misuse Act 1990
- The Common Law Duty of Confidentiality
- The Human Rights Act 1998
- Electronic Communications Act 2000
- The Regulation of Investigatory Powers Act 1995
- BS ISO/IEC 27001:2005; ISO/IEC 27001:2013.
- ISO/IED 27001.
- DHSSPSNI Code of Practice on Protecting the Confidentiality of Service User Information 2012.
- The Personal Data Guardian Manual 2012.
- Information security assurance
- Information quality assurance.
- Records Management
- The ICO's published guidance and Codes of Practice

4.0 Annual Information Management Assurance

The Annual Information Management Assurance is measured via an assessment process of compliance against the standards set out in the DHSSPSNI Controls Assurance Standard on Information Management.

If any gaps in compliance are identified an action plan will be produced to recover, improve or maintain the required performance levels. Through the development and routine reporting of agreed key performance indicators, identify risks, measure progress, oversee necessary remedial action is taken to ensure compliance.

However, this Strategy establishes the overall direction of IG and the baseline principles and objectives so that it will endure.

5.0 Statement of Compliance

The Trust will comply with all standards as laid out in the Information Management Control Assurance Standard and will seek to maintain substantive compliance on a yearly basis.

6.0 Information Governance Aims

The Trust's information governance aims are outlined below. Deliverables to support the achievement of these aims are described under Section 8.0 below. Achievement of these aims will deliver essential compliance elements but will also enable and support our organisation and deliver organisational benefits.

6.1 Policy

We will implement information governance policies and procedures which are embedded in the day to day operation of the Trust and which are compliant with relevant legislation, Standards and Codes of Practice and demonstrate good practice.

We will implement risk based information governance policies which are clear, accessible, and flexible and aligned with business requirements.

6.2 Awareness

We will ensure that the information governance assurance framework has a high level of awareness through the development and communication of policies, appointment of specific information governance roles across the Trust and develop processes to help achieve compliance and reduce the risk of non-compliance through human error. Please refer to the Trust's Information Policy for all IG roles appointed within the Trust.

We will foster a culture of personal responsibility, ownership and commitment to high standards in information handling to support and enable our organisational processes.

6.3 Monitoring and Assurance

We will ensure that there are processes in place to check that the information governance framework is being implemented and to measure the effectiveness of the control environment.

We will work across Directorate areas and with Information Asset Owners prompting feedback about the practical operation of policies and procedures to maximise the opportunity to learn from example of good practice.

The Trust's IG performance will be measured through the self-assessed baseline, improvement and annual IG Controls Assurance Standard and reported to the IGSG and DHSSPS. The Control Assurance Standard for Information Management sets the requirement for all HSC organisations to achieve substantive compliance against all relevant key criterions which is set at 75% and above. There are a total of 27 criterions for the IG Controls Assurance Standard with sub-criterions within each.

The Trust will develop key performance measures to monitor progress and highlight gaps, which are reportable to the Trust Board via the Assurance Committee.

Performance will also be measured and monitored through a programme of internal audit.

The NIAS Information Governance Steering Group (IGSG) will be responsible for challenging the performance report and ensuring actions are taken to address shortfalls.

The IGSG Chair (Director of Finance and ICT) will report the Trust's IG performance to the Assurance Committee and then to Trust Board.

6.4 Records and Information Management

We will ensure that effective processes are in place to manage our records and information. From creation, to receipt or through to disposal we will aim to meet our obligations under the records management agenda and Public Records Act and the records management guidance set out under Section 46 of the Freedom of Information Act 2000.

The integrity of information will be assured, monitored and maintained to ensure that it is of quality and reliable for use for the purposes that it is collected for.

6.5 Information Security

We will implement information security policies and procedures which take account of legislative requirements and codes of practice which we are subject to but which are proportionate, measured and part of Trust business as usual.

We will support our staff by ensuring that information security protocols and processes are clear and accessible, that help and guidance are available when needed and by providing appropriate training to minimise the risk of human error.

6.6 Collection and Use of Personal Information

Personal information received or obtained by the Trust will be managed and used responsibly, securely and fairly.

Information will be organised and managed in accordance with mandated and statutory standards and kept confidential where appropriate.

We will promote transparency and openness about how we handle personal information providing confidence to staff, service users and third parties who pass personal information to us.

The Trust will protect personal data held in its information systems through compliance with ICT Controls Assurance Standard, ICT Strategy and associated good practice standard of ISO/IEC 27002:2005.

The Trust will ensure that its Data Protection notification is reviewed and updated annually and accurately reports all processing of personal data within the organisation.

The Trust, as the legal person, will ensure that its personal data is controlled and managed in accordance with the terms of the Data Protection Act 1998 principles.

6.7 The Trust will ensure that adequate governance arrangements and resources are in place to support the IGAF agenda

The general purpose of the IG Strategy is set out the Trust's approach to IG. It aims to promote a culture of good practice around processing and management of information and the use of information systems throughout the Trust.

The IG Strategy cannot be viewed in isolation as information is central to all area of work within the Trust.

IG is also a key element of corporate, clinical and risk governance. This strategy is therefore closely linked with other Strategies and Policies to ensure integration with all aspects of the Trust's daily activities e.g Communications Strategy, ICT Strategy etc

The Trust will ensure that adequate governance resources are in place to support the current and evolving IGAF agenda. This will be achieved through compliance with the Information Governance Management Assurance standards.

The Trust's Information Governance Steering Group will be responsible for steering the Trust's IG Agenda (see Appendix A).

6.8 **The Trust will ensure patients and the public are effectively informed and know how to access their information and exercise their right of choice**

The Trust will develop and maintain a Communications Strategy to ensure that patients, stakeholders and the public are adequately informed about confidentiality and the way their information is used and shared, their rights as data subjects, in particular how they may access their personal data and how they may exercise those rights when consent is required to use their data for non-clinical purposes. Effective procedures will be introduced to address that detailed questions raised by patients and aim for their right of choice can to be exercised and respected.

6.9 **The Trust will provide assurance that all information risks are identified, managed and mitigated**

The Trust will establish clear lines of accountability for information risk management that lead directly to the Board through the appointment of a Senior Information Risk Owner (SIRO), IAOs (Information Asset Owners) and the development and maintenance of an Information Asset Register.

The SIRO (via IAOs) will report to the Accountable Officer for the management and mitigation of information risks and will provide assurance to that effect for the Annual Report and Statement of Internal Control.

7.0 Strategy Review

This Strategy establishes the overall direction of IG and the baseline deliverables and programme of work over the following years so that it will endure. The review period for this strategy has therefore been established at the tolerated maximum of three years.

The Annual Plan however will need to be refreshed and reviewed on an annual basis to monitor deliverables. The IGSG will ensure this strategy is reviewed on an annual basis along with associated Action Plans relating to IG management under the remit of the Controls Assurance Standard and/or Internal Audit Recommendations.

8.0 EQUALITY STATEMENT

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

8.2 The outcome of the screening exercise for this policy is:

Major Impact	
Minor Impact	
No Impact	x

9.0 SIGNATORIES

_____ **Date:** _____

Lead Author

_____ **Date:** _____

Lead Director

INFORMATION GOVERNANCE DELIVERABLES/IMPROVEMENT PLANS

The deliverables to support the achievement of the Trust's information governance aims over the next three years are detailed below. This includes deliverable action points, including resource implications and timescales for completion. Resources noted as Business as Usual (BSU) are covered by current job descriptions but may need fresh impetus or action.

12.1 Maintain Policy and Procedures and keep the Trust Board Informed

Deliverable	Delivering Compliance	Action Point	Lead	Timescale	Review Mechanism	Resource Implication	Benefit
A review of all information governance policies to include development of new policies and procedures as required	Policies which achieve legal compliance, demonstrate good practice and are in line with legislative requirement	Review IG framework Policies including (this is not an exhaustive list): Data Protection Policy Data Protection Manual 2013 Data Quality Policy Records Management Strategy Records Management Policy Freedom of Information Policy Freedom of Information Procedure Information Sheets ICT Strategy Email Policy Password Policy	Corporate Manager	March 2016 Ongoing	Policy Review Report	BAU	IG Policies and supporting framework documentation remain up to date and relevant

		Develop IG Strategy	Corporate Manager	Jan 2016 Ongoing	Ongoing improvement in line with IG Controls Assurance Standard	BAU	To develop an IG culture across the Trust that can be measured against SMART objectives and deliverables
		Develop IG Policy	Corporate Manager	October 2015 Ongoing	Ongoing improvement in line with IG Controls Assurance Standard	BAU	To develop an IG culture across the Trust that can be measured against SMART objectives and deliverables
		Provide Trust Board Update, IG Strategy and IG Policy Signed Off	Director of Finance and ICT	Jan 2016 Ongoing	Trust Board Minute	BAU	The Trust Board is responsible for is responsible for ensuring that the information governance function is appropriately managed in a manner which complies with relevant legislation and standards.
		Ensure retention of adequate resources and expertise in IG related functions	Director of Finance and ICT	Ongoing		BAU	Trust as all relevant expertise covered

9.1 Awareness

Deliverable	Delivering Compliance	Action Point	Lead	Timescale	Review Mechanism	Resource Implication	Benefit
Communication and promotion of the revised information governance policies to all staff and third parties who work with the Trust	High levels of awareness to minimise risks of non-compliance through human error	Redistribute to all staff IG policies and procedures with summary of content and responsibilities to develop an IG culture through the use of the Intranet and other associated communication tools	Corporate Manager Executive Directors Information Asset Owners	Ongoing	Feedback through monitoring; staff surveys; training sessions	BAU	Policies and procedures are managed and communicated appropriately
Maintain visibility of IG Training	Monitoring of IG training will enable timely compliance with agreed Learning and Development Plans for staff. Local ownership and accountability for information governance issues and driving compliance.	Regional Ambulance Training Centre to provide quarterly reports on IG training aspects including induction and refresher training for all staff	Director of Human Resources and Corporate Services	Quarterly basis	Training provision will be audited against IG training plan and training attendance levels	Staff Resources Financial Implications	Training is vital to support staff awareness and compliance
		Agreed IG training plan for all IG roles through the Trust to be developed for all staff and specific IG roles	Director of Finance Corporate Manager	Ongoing	IG Staff Training Strategy	Staff Resources Financial Implications	Training is vital to support awareness and compliance and to foster and IG culture

		Developed and implemented training programme for Information Asset Owners (IAOs)	Director of Finance Corporate Manager	Ongoing	Training Records	Staff Resources Financial Implications	Specialised training is vital to support staff awareness and compliance
		Developed and implemented training programme for Information Asset Assistants (IAAs)	Director of Finance Corporate Manager	Ongoing	Training Records	Staff Resources Financial Implications	Specialised training is vital to support staff awareness and compliance

9.2 Monitoring and Assurance

Deliverable	Delivering Compliance	Action Point	Lead	Timescale	Review Mechanism	Resource Implication	Benefit
A developed and embedded integrated information governance framework as part of day to day business with annual assessments eg DHSSPS Controls Assurance Standards Internal Audit	A tool to provide assurance to the Trust Board, SIRO and Audit Committee to monitor compliance	Annual assessment of DHSSPS Information Governance Controls Assurance Standard Partake in IG internal audits as required	Corporate Manager IAOs Corporate Manager IAOs	Annual Ongoing	Self-Assessment compliance level Self-Assessment Compliance Levels	Staff Resources Financial Implications Staff Resources Financial Implications	Compliance with requirements. Also structured opportunity for IAOs to consider information governance compliance. An opportunity to identify and address corporate issues identified by IAOs and self-assessments
Review Content of Staff Terms of Employment to ensure that IG requirements are detailed	Appropriate organisational measures to support IG framework	Liaise with HR and Corporate Services Directorate to ensure IG content evident in staff terms of employment	Corporate Manager	March 2016	Evidence of correct clauses used	BAU	Compliance with requirements on staff contracts

A review of the pre-employment security check processes and the adoption of any recommendations	Appropriate organisational measures to support IG framework to satisfy Principle 7 under the remit of the Data Protection Act 1998	Liaise with HR and Corporate Services Directorate to ensure IG content evident in staff terms of employment	Corporate Manager	March 2016	Evidence that processes are in place	BAU	Reduced risk of employing inappropriate staff potentially saving time and money
Review content of contractors terms and conditions relating to IG aspects to minimise potential breaches of confidentiality	Appropriate organisational measures to support IG framework	Liaise with relevant internal and external stakeholders e.g BSO regarding contract IG content	Corporate Manager	March 2016	Evidence of correct clauses used	Staff Resources	Compliance with requirements on contractors' contracts
Ensure correct clauses included in suppliers contracts (via Procurement)	Appropriate organisational measures to support IG framework	Liaise with relevant internal and external stakeholders e.g BSO regarding contract IG content	Corporate Manager	March 2016	Evidence of correct clauses used	Staff Resources	Compliance with requirements on procurement contracts
A review of IT processes including taking and storing IT back up media and the disposal of IT equipment and the adoption	Appropriate organisational measures to support IG framework to satisfy Principle 7 under the remit of the Data	Review of ICT Strategy and liaise with internal stakeholders ie ICT Manager	Corporate Manager IT Manager	March 2016	Evidence that processes are in place	Staff Resources	Confidence that information will be available to the Trust when required and information will be securely disposed of when no longer required

of recommendations	Protection Act 1998						
Physical Security Measures are tested, validated and assured by Audit and assessments	Appropriate organisational measures to support IG framework to satisfy Principle 7 under the remit of the Data Protection Act 1998	Partake in self-assessments and audits as required	Corporate Manager ICT Manager	March 2016	Evidence that processes are in place	Staff Resources Financial Implications	Reassurance to staff about their safety in the workplace, mechanisms to support the protection of personal information are evident and to minimise the risk of information security incident interrupting business continuity
Broaden Monitoring of Subject Access Requests under the remit of the Data Protection Act	Appropriate monitoring of legislative requirement for Subject Access Requests	Make direct requests more efficient	Corporate Manager	Ongoing	Reports to be provided to Trust Board and associated Committee structures	Staff Resources	Improved accuracy on logging and monitoring of Subject Access Requests
		Monitor Solicitor Requests	Corporate Manager	Ongoing	Reports to be provided to Trust Board and associated Committee structures	Staff Resources	Improved accuracy and monitoring on indirect requests
		Monitor Police Service of Northern Ireland requests	Corporate Manager	Ongoing	Reports to be provided to Trust Board and associated Committee structures	Staff Resources	Improved accuracy and monitoring on indirect requests

		Monitor Coroner Service for Northern Ireland requests	Corporate Manager	Ongoing	Reports to be provided to Trust Board and associated Committee structures	Staff Resources	Improved accuracy and monitoring on indirect requests
		Corporate Manager to regularly report on all patient DPA requests ie - Social Worker Enquiries - Police Ombudsman - HSC Trust investigation	Corporate Manager	Ongoing	Reports to be provided to Trust Board and associated Committee structures	Staff Resources	Improved accuracy and monitoring on indirect requests
Audit faxes locations throughout the Trust and identify safe haven faxing requirements	Appropriate organisational measures to support IG framework to satisfy Principle 7 under the remit of the Data Protection Act 1998	Information Asset Owners to take responsibility for audit of fax machines and to provide reports as required	Corporate Manager IAOs	March 2016	List on Telephone Directory	Staff Resources	Assurance that required faxes operate as safe haven and all staff are aware of same
Ensure all regular flows of data, internal and external are secure	Appropriate organisational measures to support IG framework	Information Audit and identification of information risk assets	IAOs	December 2015 (ongoing)	Information Asset Register	Staff Resources	

TB/8 07/04/16

NORTHERN IRELAND AMBULANCE SERVICE

TRUST BOARD MEETING

07 April 2016

Title:	Records Management Strategy
Purpose:	The Records Management Strategy purpose is to ensure: • A systematic and planned approach to records management covering records from creation to disposal; • Efficiency and best value through improvements in the quality and flow of information, and greater coordination of records and storage systems; • Compliance with statutory requirements; • Awareness of the importance of records management and the need for responsibility and accountability at all levels; and • Appropriate archiving of the Trust's important records.
Content:	This document sets out an overarching framework for integrating current records management initiatives, as well as recommending new ones. It defines a Strategy for improving the quality, availability and effective use of records in the Northern Ireland Ambulance Service HSC Trust (NIAS) and provides a strategic framework for all records management activities. This will enable overall co-ordination of all records management activities and ensure alignment with the NIAS corporate strategies
Recommendation:	For approval
Previous Forum:	16/03/2016 – Information Governance Steering Group SEMT
Prepared by:	Miss Alison Vitty, Corporate Manager
Presented by:	Mrs Sharon McCue, Director of Finance and ICT

Northern Ireland Ambulance Service
Health and Social Care Trust

1.0 Title:	RECORDS MANAGEMENT STRATEGY 2015-2020		
2.0 Author(s)	Alison Vitty, Corporate Manager		
3.0 Ownership:	Finance and ICT Directorate		
4.0 Date of SEMT Approval:	To IGSG – 16/03/16	**5.0 Date of Trust Board Approval:**	
6.0 Operational Date:		**7.0 Review Date:**	
Version No:	Version 0.1.1	**Supersedes:**	Records Management Strategy 2005-2009
8.0 Key words:	Records Management Strategy		
9.0 Other Relevant Policies:	Information Governance Strategy 2015-2018 Information Governance Policy Records Management Policy Retention and Disposal Schedule Freedom of Information Act 2000 and EIR 2004 Policy Data Protection Act 1998 Policy		

Version Control for Drafts:			
Date	**Version**	**Author**	**Comments**
January 16	V0.1.1	AV	Overrides previous Records Management Strategy. Updated to reflect IG framework and record management changes
16/03/2016	V0.1.1	AV	To IGSG. To be placed on Trust Board Agenda

1.0 Introduction

1.1 This document sets out an overarching framework for integrating current records management initiatives, as well as recommending new ones. It defines a Strategy for improving the quality, availability and effective use of records in the Northern Ireland Ambulance Service HSC Trust (NIAS) and provides a strategic framework for all records management activities. This will enable overall co-ordination of all records management activities and ensure alignment with the NIAS corporate strategies.

1.2 The Records Management Strategy should be read in conjunction with the Trust's Records Management Policy and DHSSPS Good Records, Good Management which has been adopted by the Trust.

2.0 Scope

2.1 This Strategy relates to all corporate, clinical and non-clinical records held in any format by the Trust as detailed in the DHSSPS Good Records Good Management Guidance (GMGR) ie

A record is information that has been received, created or maintained by an individual within NIAS as evidence of a business activity, patient/client care, treatment given, treatment planned and can be in any format – paper, electronic, digital and/or voice.

In the context of GMGR a record is anything which contains information (in any media) which has been created or gathered as a result of *any* aspect of the work by NIAS employees.

NIAS records are public records as defined under the Public Records Act 1923.

2.3 These include records held in all formats, for example:

- Paper records, reports, diaries and registers etc;
- Electronic records;
- Images;
- microform (ie microfiche and microfilm); and
- Audio and video tapes.

3.0 **Aims**

3.1 The aims of the Trust's Records Management Strategy are to ensure:

- A systematic and planned approach to records management covering records from creation to disposal;
- Efficiency and best value through improvements in the quality and flow of information, and greater coordination of records and storage systems;
- Compliance with statutory requirements;
- Awareness of the importance of records management and the need for responsibility and accountability at all levels; and
- Appropriate archiving of the Trust's important records.

4.0 **Key Elements**

4.1 The records management strategy comprises the following key elements:

4.1.1 Responsibility and Accountability

To provide a clear system of accountability and responsibility for record keeping and use

It is important that all individuals in the Trust appreciate the need for responsibility and accountability in the creation, amendment, management, storage of and access to all Trust records. A major target is therefore to have a clear chain of managerial responsibility and accountability for all records created by the Trust. This is the prerequisite for an effectively coordinated records management strategy.

4.1.2 Record Quality

To create and keep records which are adequate, consistent, and necessary for statutory, legal and business requirements

Trust records should be accurate and complete, in order to facilitate audit, fulfil the Trust's responsibilities, and protect its legal and other rights. Records should show proof of their validity and authenticity so that any

evidence derived from them is clearly credible and authoritative.

4.1.3 Management

To achieve systematic, orderly and consistent creation, retention, appraisal and disposal procedures for records throughout their life cycle

Record-keeping systems should be easy to understand, clear, and efficient in terms of minimising staff time and optimising the use of space for storage.

4.1.4 Security

To provide systems which maintain appropriate confidentiality, security and integrity for records in their storage and use

Records must be kept securely to protect the confidentiality and authenticity of their contents, and to provide further evidence of their validity in the event of a legal challenge.

4.1.5 Access

To provide clear and efficient access for employees and others who have a legitimate right of access to Trust records, and ensure compliance with Access to Health Records, Data Protection and Freedom of Information legislation

Access is a key part of any records management strategy. Fast, efficient access to records unlocks the information and knowledge they contain.

4.1.6 Audit

To audit and measure the implementation of the records management strategy against agreed standards

The performance of the records management programme will be audited.

4.1.7 Training

To provide training and guidance on legal and ethical responsibilities and operational good practice for all staff involved in records management

Effective records management involves staff at all levels. Training and guidance enables staff to understand and implement policies, and facilitates the efficient implementation of good record keeping practices.

5.0 **Implementation**

The action points, in the table below, have been developed from the Control Assurance Standard for Information Management which requires the following fundamentals to be present:

- Existence of an overall policy statement on how records (including electronic records) are to be managed;
- Endorsement of policy by senior management;
- Dissemination of policy to staff at all levels;
- Provision of corporate mandate for the performance of all records and information functions;
- Organisational commitment to create, keep and manage records which document activities ie creating, naming, filing structure, file/folder referencing, tracking/tracing, retention and disposal
- Definition of roles and responsibilities;
- Definition of responsibility of personnel to document actions and decisions in the records and to dispose of obsolete records; accurate audit trails of when records are created, accessed, etc
- Provision of framework for supporting appropriate standards, procedures and guidelines;
- Provision of monitoring mechanisms to ascertain compliance with appropriate standards, procedures and guidelines; and
- Review of policy at regular intervals (at least once every two years).

The key elements of this strategy will be implemented as follows – Strategic Goals:

Strategic Goal	Objective	Action
1 Responsibility and Accountability	To provide a clear system of accountability and responsibility for records	Establish a records management strategy with processes for ongoing monitoring and review
		Secure senior management 'buy-in' to improving records management, and the designation of a senior manager to be responsible for records management
		Establish a Records Management function (to manage all Trust records), with clearly defined terms of reference and links to other Information Governance functions eg Freedom of Information, Data Protection, Risk Management etc.
		Appoint a qualified Records Manager/ or designate the Information Governance Manager or another manager to have responsibility for Records Management
		Manage implementation of the records management strategy, including provision of advice on records management, establishment of good practice guidelines and of compliance with relevant legislation and DHSSPS guidance
		Provide contacts through which the Records Manager can aid and support departments, and provide better co-ordination of record keeping across the Trust. Individual Departments to nominate local records managers
		Ensure job descriptions, listing duties and essential attributes required for staff assigned records management roles (eg Records Manager, local records managers etc)

		Ensure that job descriptions across the Trust include relevant references to record keeping responsibilities
		Review Human Resource policies and practices to recruit and retain good quality personnel for the records management function
		Provide an appropriate competency framework, to identify the knowledge, skills and corporate competencies required for records and information management
		Provide a professional development programme for records management staff
		Ensure inclusion of records management and information issues and practices in induction training programmes for all new staff
		Allocate appropriate resources across the Trust to enable the maintenance of the records management function
2 Record Quality	To create and keep records which are adequate, consistent, and necessary for statutory, legal and business requirements	Develop guidance on good practice with the aim of establishing common and consistent standards of record creation and record keeping within the Trust, taking into account current Data Protection and Freedom of Information legislation
		Reduce the duplication of records to improve information sharing, reduce cost and save space
		Develop procedures and metadata (descriptive and technical documentation) to ensure the authenticity and evidential value of records held in electronic form

		When scanning, digitising and then storing records electronically, consider legal admissibility by adopting the procedures recommended in the BSI publication '*BIP 0008:2004 Code of practice for legal admissibility and evidential weight of information stored electronically*'
		Identify all records vital to the continuing functioning of the activities of the Trust in the event of disaster and make provision for their protection (to be cross-referenced with the Trust Risk Management Strategy)
3 Management	To achieve systematic, orderly and consistent creation, appraisal, retention and disposal procedures for records during their lifecycle	Review existing records management practices to establish what needs to be done to comply with DHSSPS Good Records, Good Management
		Undertake an inventory of all Trust records, both health and corporate records held in either hard copy or electronic formats. (This is to ensure that all record collections/information sets are identified along with the volume of records held, the type of media on which they are held, their physical condition, their location, the environmental conditions in which they are stored and the responsible manager.
		Produce Trust records retention schedules consistent with the DHSSPS Retention and Disposal Schedule
		Establish procedures for the continuous monitoring of the records management process to ensure that legal and statutory requirements are met and new types of records have a lifecycle determined at the point of creation

		Develop a selection policy to identify which records are likely to be suitable for permanent preservation. Establish contact with an approved archival institution with appropriate storage and public access facilities
		Establish a system for managing records' appraisal and for recording the disposal decisions made
		Establish procedures for the closure of records when no longer current, secure storage of archived records, and effective disposal, as soon as appropriate
		Identify a secure and confidential method for the disposal of records, and organise its implementation
		Maintain a log of records which have been destroyed showing their reference, description and date of destruction
		Assess the risks associated with the destruction of records or any delay in appraising them
		(Whilst electronic records are subject to the same creation, appraisal, retention and disposal process as paper records) develop guidance as appropriate to take into account the particular technical requirements of electronic media
4 Security	To provide systems which maintain appropriate confidentiality, security and integrity for records in their storage and use	Develop and promulgate policies and procedures to protect records from unauthorised alteration or erasure, to ensure that access to records is properly controlled, and to maintain adequate audit trails to track the use and location of records held

		Implement secure storage arrangements for information and documents, while allowing access by authorised personnel
		Organise appropriate storage accommodation for active paper records secure from fire, flood and theft, which is also secure and safe from unauthorised access
		Organise the relocation of paper records into appropriately secure storage when they are no longer required for the conduct of current business, to await disposal and at the same time meeting standards to ensure that no environmental damage is caused whilst also providing security and having strictly controlled access for authorised personnel only
		Develop appropriate Information Sharing Protocols and Subject Specific Information Sharing Agreements for the exchange of confidential and personal information
		Provide guidance on 'back-up', archiving processes and audit trails for electronic records, as well as on measures to prolong their access and use for as long as required, including migration across systems and onto different types of media
		Develop and ensure that standards for the safe and secure transportation of records are strictly applied especially when transported by users.
		Develop and implement a full and tested contingency or business recovery plan
5 Access	To provide clear and efficient access for employees and others who have a legitimate right of access to Trust records, and ensure compliance with	Implement effective tracking systems and audit trails, ensuring that information can be retrieved effectively and speedily when required

	current Data Protection and Freedom of Information legislation	
		Develop systems to determine any access restrictions at the point of records creation
		Implement policies and procedures to address the particular requirements of Freedom of Information in relation to agreed publication schemes and meeting requests for information by the public that follow the procedures established by the Trust's Freedom of Information and EIR Policy
6 Audit	To audit and measure the implementation of the records management strategy against agreed standards.	Establish standards for records management performance (eg response to subject access and Freedom of Information requests, record keeping, availability etc) and monitor the performance of the function
		Provide advice and support for records departments in meeting agreed standards
7 Training	To provide training and guidance on responsibilities and good practice for all staff involved with records.	Provide (for all staff, departmental managers, and in particular IAOs) procedure manuals and instructions, guidance on good practice, and advice on procedural issues and requirements. These instructions should cover all records management systems within the Trust, information quality and security, data protection, information handling, and legislative and statutory requirements
		Raise the profile of records management within the Trust through publicity about the issues involved and the staff responsible

		Develop training programmes and materials, including instruction on the concepts and basics of records management to be targeted at new and existing staff who need a basic awareness of the issues and procedures and those who need more detailed instruction on records management policies and procedures, in particular the local records managers
		Provide specific training and instruction on Data Protection and Freedom of Information legislation

6. Review

6.1 This strategy will be reviewed every two years (or sooner if new legislation, codes of practice or national standards are to be introduced).

Strategy Goals and Objectives will be monitored by the Trust's Information Governance Steering Group.

7. EQUALITY STATEMENT

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

7.2 The outcome of the screening exercise for this policy is:

Major Impact	
Minor Impact	
No Impact	x
Still Being Determined	

8.0 SIGNATORIES

_____ **Date:** _____

Lead Author

_____ **Date:** _____

Lead Director

TB/9 07/04/16

NORTHERN IRELAND AMBULANCE SERVICE

TRUST BOARD MEETING

07 April 2016

Title:	Information Risk Policy
Purpose:	• Protect the Trust, its staff and its patients from information risks where the likelihood of occurrence and the consequences are significant; • Provide a consistent risk management framework in which information risks will be identified, considered and addressed in key approval, review and control processes; • Encourage pro-active rather than re-active information risk management; • Provide assistance to and improve the quality of decision making throughout the Trust; • Meet legal or statutory requirements; and assist in safeguarding the Trust's information assets
Content:	An effectively supported Senior Information Risk Owner takes ownership of the organisation's information risk policy and information risk management strategy
Recommendation:	For approval
Previous Forum:	Information Governance Steering Group – 16/03/2016 SEMT
Prepared by:	Miss Alison Vitty, Corporate Manager
Presented by:	Mrs Sharon McCue, Director of Finance & ICT

Northern Ireland Ambulance Service
Health and Social Care Trust

1.0 **Title:**	**INFORMATION RISK POLICY**		
2.0 **Author(s)**	Alison Vitty, Corporate Manager		
3.0 **Ownership:**	Finance and ICT Directorate		
4.0 **Date of SEMT Approval:**		5.0 **Date of Trust Board Approval:**	
6.0 **Operational Date:**		7.0 **Review Date:**	
Version No:	Version 0.1.1	**Supersedes:**	No policy to supersede
8.0 **Key words:**	Information Risk Management		
9.0 **Other Relevant Policies:**	- Risk Management Strategy - Untoward Incident Reporting Procedure - Information Governance Strategy 2015-2018 - Records Management Strategy 2015-2020 - Records Management Policy - Freedom of Information Act 2000 and Environmental Information Regulations 2004 - Data Protection Act 1998 Policy Statement - Code of Practice on the Confidentiality of Service User Information - Email Policy - Password Policy		

Version Control for Drafts:			
Date	**Version**	**Author**	**Comments**
November 15	v0.1	AV	Initial draft.
February 16	V0.1.1	AV	Further updated by Corporate Manager
16/03/2016	V0.1.1	AV	To Information Governance Steering Group. Noted. To be placed on next Trust Board

1.0 **Introduction**

1.1 The Trust Board has approved the introduction and embedding of information risk management into the key controls and approval processes of all major business processes and functions of the Northern Ireland Ambulance Service Health and Social Care Trust (the Trust). This decision reflects the high level of importance placed upon minimising information risk and safeguarding the interests of patients, staff and the Trust itself.

1.2 Information risk is inherent in all administrative and business activities and everyone working for or on behalf of the Trust continuously manages information risk. The Board recognises that the aim of information risk management is not to eliminate risk, but rather to provide the structural means to identify, prioritise and manage the risks involved in all Trust activities. It requires a balance between the cost of managing and treating information risks with the anticipated benefits that will be derived.

1.3 The Data Handling Review by the Office of the First Minister in 2008 described the following actions to protect information and significantly mitigate risk:

- To develop relevant policies and procedures to ensure that staff are aware of the proper use of information, including at the planning stage of any project which involves person identifiable information through Privacy Impact Assessments and when services are being delivered
- To introduce obligatory use of protective measures including encryption and penetration testing and controls – these will protect personal data while recognising that some data require a greater degree of protection than others
- Mandatory training for those with access to protected information or involved in managing it, alongside action to make clear that any failure to apply protective measures is a serious matter potentially leading to dismissal.

1.4 The Board acknowledges that information risk management is an essential element of broader information governance and is an integral part of good management practice. The intent is to embed information risk management in a very practical way into business processes and functions. This is achieved through key approval and review processes / controls – and not to impose information risk management as an extra requirement.

1.5 This policy should be read in conjunction with the Trust's Risk Management Strategy/Untoward Incident Reporting Procedure and Information Governance Strategy which is the overriding strategic direction for the Trust in relation to information risk.

2.0 Purpose

2.1 The purpose of the Information Risk Policy is to:

- Protect the Trust, its staff and its patients from information risks where the likelihood of occurrence and the consequences are significant;
- Provide a consistent risk management framework in which information risks will be identified, considered and addressed in key approval, review and control processes;
- Encourage pro-active rather than re-active risk management;
- Provide assistance to and improve the quality of decision making throughout the Trust;
- Meet legal or statutory requirements; and
- Assist in safeguarding the Trust's information assets.

3.0 Scope

3.1 This policy is applicable to all areas of the Trust. Adherence should be included in all contracts for outsourced or shared services as responsibility remains with the Trust, even if an agent or sub-contractor processes data on our behalf. There are no exemptions.

3.2 For the purpose of this policy, "staff" is used to refer to all staff regardless of occupation, including but not restricted to permanent, temporary, agency, voluntary and students.

4.0 Accountability and Responsibility

Senior level ownership of information risk is central to achieving successful information management.

4.1 It is the responsibility of all staff, and anyone working on behalf of the Trust, to adhere to this policy.

4.2 Each Director must ensure that all staff, in their area responsibility, are aware of and adhere to this policy.

4.3 Managers are responsible for ensuring that all staff, in their area of responsibility are kept up-to-date with any changes and adhere to them.

4.4 The Senior Information Risk Officer (SIRO) is responsible for co-ordinating the development and maintenance of information management policies, procedures and standards for the Trust. The SIRO is also responsible for the ongoing development and day to day management of the information risk management process and any associated programmes of work. The SIRO shall advise the Chief Executive and the Trust Board on information risk management areas and provide periodic briefings and progress updates on any associated programmes of work.

4.5 The Information Asset Owners (IAOs) shall ensure that information risk assessments are performed on all information assets where they have been assigned 'ownership' following guidance from the SIRO on assessment method, format, content, and frequency. IAOs shall submit risk assessment results and associated mitigation plans to the SIRO for review, along with details of any assumptions or external dependencies.

Mitigation plans shall include specific actions with expected completion dates, as well as an account of residual risks.

4.6 The Information Asset Administrators (IAA) will ensure that policies and procedures are followed, recognise actual or potential security incidents, consult their IAO on incident management and ensure that information asset registers are accurate and up to date.

4.7 The Information Governance Steering Group (IGSG) is responsible for ensuring this policy is implemented, including any supporting guidance and training deemed necessary to support the implementation and for monitoring and providing Board assurance in this respect.

4.8 The Chief Executive is the accountable Officer responsible for the management of the Trust and for ensuring appropriate mechanisms are in place to minimise information risks and to safeguard the interest of patients, staff and the Trust itself. The Trust has a responsibility for ensuring that it corporately meets its legal responsibilities, and for the adoption of internal and external governance arrangements.

5.0 **Reporting and Monitoring**

5.1 The SIRO will provide the assessment method, format, content and frequency of reporting to the IAO. Please also refer to Appendix 1 - Procedure for IG Incidents and Investigations.

5.2 IAOs shall ensure that information risk assessments are performed annually on all assets they have been assigned ownership and submitted to the SIRO. The assessments must include plans, with specific action and completion dates along with details of assumptions or any external dependencies as well as an account of any residual risks.

5.3 The SIRO shall advise the IAOs and the Trust Board on information risk management reports and briefings on progress.

5.4 The SIRO will take ownership of risk assessment process for information risk including an annual information risk assessment to support and inform the statement of Internal Control.

5.5 The SIRO will review and agree actions in respect of identified information risks.

6.0 Risk Escalation and Event Reporting

6.1 The escalation and reporting process for the Trust is formalised through the Untoward Incident and risk management process and by using DATIX; the Trust incident and risk management application. Refer to Appendix A for the Guidance relating to Untoward Incident Reporting for Information Governance Incidents.

7.0 Definitions

7.1 Key definitions are:

- **Risk**
  The chance of something happening, which will have an impact upon objectives. It is measured in terms of *consequence* and *likelihood*.
- **Consequence**
  The outcome of an event or situation, expressed qualitatively or quantitatively, being a loss, injury, disadvantage or gain. There may be a range of possible outcomes associated with an event.
- **Likelihood**
  A qualitative description or synonym for probability or frequency.
- **Risk Assessment**
  The overall process of risk analysis and risk evaluation.
- **Risk Management**
  The culture, processes and structures that are directed towards the effective management of potential opportunities and adverse effects.
- **Risk Treatment**
  Selection and implementation of appropriate options for dealing with risk. Conceptually, treatment options will involve one or a combination of the following five strategies:
  - Avoid the risk
  - Reduce the likelihood of occurrence
  - Reduce the consequences of occurrence
  - Transfer the risk
  - Retain/accept the risk
- **Risk Management Process**
  The systematic application of management policies, procedures and practices to the tasks of establishing the context, identifying, analysing, evaluating, treating, monitoring and communicating risk.

7.2 The Information Risk Policy has been created to fit within the overall Trust Risk Management framework. Information risk should be managed separately from other business risks but should be considered a fundamental component of effective Health and Social Care information governance for the Trust.

8.0 Related Information

8.1 It is a core information governance objective that all information assets of the organisation are identified, that the business importance of those assets is established, that an information risk assessment is undertaken and that this is recorded on the Trust's Information Asset Register. The IAOs are responsible for ensuring this is undertaken.

8.2 Any residual information risks should be recorded, as per any other risk, in the Local Risk Register and managed as per the Trust's Risk Management process. Information risks that so warrant it will be on the Corporate Risk Register and managed as per the Trust's risk management process.

9.0 Review of Policy

9.1 The Policy will be reviewed by the Information Governance Steering Group every three years or as required in line with legislative or good practice guidance.

9.2 Monitoring of this policy will be informed by information governance trends reported along with any information governance Untoward Incidents which forms part of the risk management process.

10.0 Relevant Policies, Procedures and Guidance – Legislative Framework

The policy forms part of the Information Governance framework and should be read in conjunction with the following Trust policies and procedures (this is not an exhaustive list):

- Risk Management Strategy
- Untoward Incident Reporting Procedure
- Information Governance Strategy 2015-2018
- Information Risk Policy
- Records Management Strategy 2015-2020
- Records Management Policy
- Freedom of Information Act 2000 and Environmental Information Regulations 2004
- Data Protection Act 1998 Policy Statement
- Code of Practice on the Confidentiality of Service User Information
- Email Policy

11.0 EQUALITY STATEMENT

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

11.2 The outcome of the screening exercise for this policy is:

Major Impact	
Minor Impact	
No Impact	x
Still Being Determined	

12.0 SIGNATORIES

_____ **Date:** _____

Lead Author

_____ **Date:** _____

Lead Director

Information Governance
Directorate of Finance and ICT

Appendix 1

Guidance to Support Untoward Incidents Reporting Relating to Information Governance Incidents and Investigations

1.0 Introduction

1.1 The Northern Ireland Ambulance Service Health and Social Care Trust (the "Trust) has a responsibility to monitor all information governance related incidents that occur within the organisation that may breach security and/or confidentiality of personal information. The Trust also needs to ensure that all incidents are identified, reported and monitored.

1.2 This document provides advice for identifying, recording and monitoring information governance relations incidents.

2.0 Purpose

The aim of this guidance is to ensure that the Trust reacts appropriately to any actual or suspected security incidents relating to information systems and data including:

(a) Standardising the procedures for information governance (IG) investigations;
(b) Ensuring compliance with relevant legislation;
(c) There is a consistent approach to evaluating IG Untoward Incidents;
(d) Early reports of IG Untoward Incidents are sufficient to decide appropriate escalation, notification and communication to interested parties;
(e) Appropriate action is taken to prevent damage to patients, staff and the reputation of the HSC family;
(f) All aspects of Serious Untoward Incidents are fully explored and lessons learnt are identified and communicated;
(g) Appropriate corrective action is taken to prevent recurrence.

3.0 Risks

The Trust recognises that there are risks associated with users accessing and handling information in order to conduct official Trust business.

This procedure aims to mitigate the following risks:

(a) To reduce the impact of information security breaches by ensuing incidents are followed-up correctly;
(b) To help identify areas for improvement to decrease the risk and impact of future incidents.

4.0 Initial Reporting of Serious Untoward Incidents

An information governance incident may be defined as:

- The disclosure of confidential information to put any authorised person;
- The integrity of the system or data being put at risk
- The availability of the system or information put at risk
- An adverse impact e.g reputation of the Trust/HSC, threat to personal safety or privacy, legal obligation or penalty, financial loss, disruption of activity.

A breach of information governance can be a data protection and confidentiality issue, a registration authority incident, information security, records management either clinical or corporate, manual or electronic.

4.1 Suspected Incidents

Initial information is often sparse and it may be uncertain whether an Untoward Incident has actually taken place. Suspected incidents and "near misses" should be reported as Untoward Incidents as lessons can often be learnt from them and they can be closed when the full facts are known.

4.2 Early Notification

Where it is suspected that an IG Untoward Incident has taken place, it is good practice to informally notify key staff. These should include:

- Senior Information Risk Officer (SIRO): Director of Finance and ICT
- Caldicott Guardian/Personal Data Guardian : Medical Director
- Your lead Director
- Corporate Manager

They will take steps to notify the Chief Executive as required depending on the nature and level of the information risk identified.

4.3 Reporting Incidents

In line with the Trust's Untoward Incident Reporting Procedure, an Untoward Incident Form should be completed and used for reporting all incidents including information governance risks and should be made as soon as possible and no later than 24 hours of the incident or first becoming aware of the incident. Further information will become available as the investigation takes place.

4.4 The Risk Manager monitors all Untoward Incident Reports and will therefore be aware of all IG Untoward Incidents, although please note Point 5.2 regarding early notification. The Risk Manager will escalate the Untoward Incident Report as required depending on the level of risk identified.

4.5 As normal the Untoward Incident Report should be accurately and fully completed. It is important that a clear description of what has happened is clearly detailed, for example:

- Theft, accident loss, inappropriate disclosure, procedural failure etc
- The number of patients/staff (individual data subjects) involved;
- The number of records involved;
- The media (paper and/or electronic) records
- If electronic media, whether encrypted or not
- The type of record or data involved and sensitivity
- Whether the incident is in the public domain
- Whether the media (press etc) are involved are there is a potential for media attention;
- Whether the incident could damage the reputation of an individual, a work-team, an organisation or the HSC as a whole
- Whether there any legal implications for the Trust;
- Initial assessment level of the Untoward Incident;
- Immediate action taken, including whether any staff have been suspended pending the results of the investigation.

It is important to note that if at any time during the process described above either fraud, paedophilic images or criminal activity is suspected or confirmed then all investigations must cease and either the Trust's Counter Fraud Officer (Assistant Director of Finance and ICT) or the Trust Senior Information Risk Officer (Director of Finance and ICT) must be informed

It is important to keep as much information as possible of the incident and investigation confidential. No information should be discussed with anyone who is not directly involved with the incident.

6.0 Breaches of Confidentiality and Data Protection

6.1 In line the Trust's Risk Management Strategy and Untoward Incident Reporting procedure, all IG Untoward Incidents will be fully investigated by the Line Manager in the first instance and all details must be attached to the Untoward Incident reporting form.

6.2 All IG Untoward Incidents will be risk assessed in line with the Trust's Untoward Incident Reporting Policy and assessed to identify the gravity of incident and the risk to the organisation.

6.3 The Risk Manager will copy the Corporate Manager into all incidents relating to IG incidents pertaining to confidentiality and Data Protection. All incidents will be reviewed by the Corporate Manager as the Trust's Information Governance lead to ensure that the threat has been addressed or mitigated to a satisfactory level by containment activities; where required, an agreed corrective action plan had been defined and agreed that prevents reoccurrence of the vulnerability.

Information Governance
Directorate of Finance and ICT

What is an Information Governance Related Incident – Examples

1. An information governance related incident relates to breaches of security and/or the confidentiality of personal information which could be anything from users of computer systems sharing passwords, to a piece of paper identifying a patient being found in the high street.

2. An information security incident is defined as any event that has resulted or could result in:

    - The integrity of an information system or data being put at risk;
    - The availability of an information system or information being put at risk;
    - An adverse impact e.g.

        - Embarrassment to the HSC Family
        - Threat to personal safety or privacy
        - Legal obligation or penalty
        - Financial loss
        - Disruption of activities

Examples of Information Security Incidents that should be Reported:

Some more common areas are listed below but this list is not exhaustive and should be used as guidance only. If there is any doubt as to what you have found being an incident it is best to report it to the relevant personnel for their decision.

- Loss of computer equipment due to crime or an individual's carelessness
- Loss of computer media e.g. USB Stick, Compact Disc due to crime or an individual's carelessness
- Accessing any part of a database using someone else's authorisation either fraudulently or by accident
- Trying to access a secure part of the organisation using someone else's PIN number
- Finding the doors and/or windows have been broken and forced entry gained to a secure room/building
- Finding a computer printout with a header and a person's information on it at a location outside of any Trust premises/building
- Finding any paper records about a patient/member of staff or business of the organisation in any location outside of Trust premises/buildings e.g Patient Report Forms
- Being able to view patient records in an employee's car
- Discussing patient or staff personal information with someone else in an open area where the conversation can be overheard
- A fax being received by the incorrect recipient
- Viewing or downloading inappropriate material

- Attempted or actual fraud
- Giving information to someone who should not have access to it – verbally, in writing or electronically
- Sending a “sensitive” email to all staff by mistake
- Use of unapproved or unlicensed software on Trust equipment
- Printing or copying confidential information and not storing it correctly or confidentiality
- Theft or loss of a hard copy file

TB/10 07/04/16

Northern Ireland Ambulance Service
Health and Social Care Trust

Minutes of a Meeting of the Assurance Committee Monday 18 January 2016 11.00am, Board Room, NIAS Headquarters, Site 30, Knockbracken Healthcare Park, Saintfield Road, Belfast, BT8 8SG

PRESENT	Dr J Livingstone	Non-Executive Director (Chair)
	Mr N McKinley	Non-Executive Director
	Mr T Haslett	Non-Executive Director
IN ATTENDANCE	Dr D McManus	Medical Director
	Mr L McIvor	Chief Executive
	Mr B McNeill	Director or Operations
	Mrs S McCue	Director of Finance & ICT
	Mrs R O'Hara	Director of HR & Corporate Services
	Dr N Ruddell	Assistant Medical Director
	Mrs J McSwiggan	Note-taker

1.0 Apologies

No apologies were received.

2.0 Procedure

2.1 Declaration of Potential Conflicts of Interest

No potential conflicts of interest were declared.

2.2 Quorum

The Committee was confirmed as quorate.

2.3 Confidentiality of Information

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

3.0 Minutes of the Assurance Committee Meeting held on 6 October 2015

The Minutes were presented for noting by the Assurance Committee. The Minutes had been previously circulated, agreed and signed by the Committee Chair and had been presented to Trust Board on 3 December 2015.

4.0 Matters Arising

There were no matters arising not otherwise covered in the Agenda.

5.0 Chairman's Business

5.1 Schedule of Meetings for 2016

It was agreed that the May and December meetings be rescheduled to allow time for preparation of the Committee Minutes for inclusion with Trust Board papers.

It was noted that the Audit Committee's timetable is dictated by financial deadlines for the year. As the Audit Committee is normally held on the same day as the Assurance Committee to facilitate Non-Executive Directors, this will therefore be considered by the Audit Committee at their meeting this afternoon.

The Committee agreed that while it may be necessary to reschedule these two Assurance Committee meetings on different dates to the Audit Committee meetings, it is preferable that both take place on the same date.

The Committee also discussed the possibility of postponing the December 2016 meeting again, and decoupling the agendas of the Assurance Committee and Trust Board in the future.

The outcome of the Audit Committee discussions are awaited before a decision is made.

6.0 Standing Items

6.1 Assurance Framework as at 30 November 2015

Following discussion at the recent workshop, the Chief Executive presented for consideration the existing framework and a revised framework. The revised framework reflects the relationship and distinction between assurance and risk in relation to the Trust's three strategic aims. Work on presenting this in an electronic format is ongoing. The Chief Executive will continue to develop this with the new Risk Manager.

The Committee commended the clarity and coherence of the new format and suggested that risk be referenced within the meeting agendas of other groups which are presented to the Committee for noting. The Committee agreed that it would be helpful to see how the agendas reflect local and corporate risk register issues.

The Audit Committee will also be reviewing the revised framework.

6.2 Local Risk Register Review as at 30 November 2015

The Medical Director presented the Medical Directorate Local Risk Register for consideration by the Committee:

4 – Business Continuity

The Committee noted that the completion of training of functional leads is anticipated by year end.

188 – Pandemic Flu Risk

No current issues to be raised.

252 – Staffing Structure in respect of Risk Management, Patient Safety and Datix Administration
The Committee considered how the role of Risk Manager has evolved and continues to evolve particularly in regard to governance. This will continue to be reviewed.

278 – Staffing Structures within the Emergency Planning Department to Service the New Emergency Planning and Civil Contingencies Structure
The Committee noted operational pressures arising from required attendance at all sub-group meetings which may require joint escalation between the Operations and Medical Directorates to facilitate a corporate decision on NIAS representation. It was noted that the Chief Executive represents the Trust on the Regional Civil Contingencies Group and while it was important that major health issues were dealt with regionally, a consistent approach to these across the eleven councils was essential.

80 – Manual Handling of Paramedic Bags
The Medical Director explained why this issue has taken a long time to resolve, but advised that it is now nearing completion, with a final decision expected at the next meeting of the Medical Equipment Group.

6.3 Controls Assurance Standards
The Committee noted that this remains a Standing Item on the Agenda, and that once a new report for 2015/16 is issued by Internal Audit, this will be brought to the Committee.

6.4 Untoward Incidents as at 30 November 2015

6.4.1 Clinical Incidents as at 30 November 2015
Changes previously requested to the presentation of the report were noted but will continue to be reviewed by the new temporary Risk Manager.

The distinction between “inappropriate” and “abusive” language in the context of verbal assaults on staff was clarified.

A typographical error in “Comment on Top Ten Incidents” was noted.

A proposal to disaggregate patient safety issues from other issues was made. This is already being considered and the intention is for the incident reporting procedure to be revised to clearly reflect this distinction.

The Committee requested that a narrative be provided with data tables for clarity and assurance.

The Committee noted the importance of a balance between the presentation of unfiltered data, and data presented following a review of significance by local and senior managers.

These issues will be considered when reviewing the incident reporting policy and procedures.

6.5 Serious Adverse Incidents as at 30 November 2015

It was proposed and agreed by the Committee that three incidents which are now closed be removed from the report:

- SAI GL Independent Review January 2013
- NRLS RefL 15356238
- UIR 35689 SAI A7125 0 RRV desk

6.6 Coroner's Reports & Letters

There were no Coroner's Report and Letters within this reporting period.

6.7 Medical Device Alerts

There were no relevant Medical Device Alerts within this reporting period.

6.8 PHA Safety & Quality Reminder of Best Practice Guidelines

While this relates primarily to Emergency Department staff in hospitals, the Committee was assured of the procedure in place for reviewing such alerts / reminders. In this case, a reminder will be issued to NIAS staff who already do this as part of the pre-arrival handover.

It was requested that any future recommendations to the Committee within a paper be noted on the cover sheet for clarity.

6.9 Pharmacy & Medicines Management Update

Ongoing inspections continue and reports remain satisfactory with no significant issues being identified.

Omagh Station is improving its practices regarding tallying packs in stock with those recorded as having been received as a result of their inspection.

Two recent queries regarding suspected mislaid or lost controlled drugs were quickly resolved using the Trust's robust controlled drugs systems, allowing NIAS to account for how these had been legitimately used.

6.10 Reports from Groups and Committees

Dr Ruddell gave a presentation to the Group on the remit and work of the Medical Equipment Group. The Committee thanked Dr Ruddell for a very useful and helpful presentation.

6.10.1 Health & Safety Committee – Notes of Meeting 23 April 2015

Noted.

6.10.2 Health & Safety Committee – Draft Notes of Meeting 24 September 2015

Noted.

6.10.3 Fire Compliance Group – Notes of Meeting 14 May 2015

Noted.

6.10.4 **Fire Compliance Group – Draft Notes of Meeting 15 September 2015**
Noted.

It was noted that reference made to no progress having been made on the issue of storage of paper and associated fire risk was misleading. Work is ongoing to improve arrangements and the risk is much less than previously stated.

6.10.5 **Medical Equipment Group – Notes of Meeting 29 July 2015**
Noted.

6.10.6 **Medical Equipment Group – Notes of Meeting 24 September July 2015 (including Terms of Reference)**
Noted.

6.10.7 **Infection Prevention & Control Group – Notes of Meeting 7 September 2015**
Noted.

6.10.8 **Infection Prevention & Control Group – Notes of Meeting 12 November 2015 (including Terms of Reference)**
Noted.

6.10.9 **Emergency Preparedness & Business Continuity – Notes of Meeting 29 October 2015**
Noted.

6.10.10 **Information Governance Steering Group – Notes of Meeting 1 April 2015**
Noted.

7.0 Quality Improvement Pilot Plan

The Committee welcomed this development and the commencement of the pilot. The first outcome report will be presented to the Committee in September 2016. The Committee will then decide on the frequency of future outcome reports to provide assurance of compliance with the programme.

8.0 Regional Interagency Protocol on the Operation of Place of Safety & Conveyance to Hospital under the Mental Health (NI) Order 1986

The Committee noted that the protocol had been implemented in January 2016 following multi-agency agreement.

9.0 Control Telephony Failure Report

The Committee noted the NIAS report into the incident which had received some media and political attention. It was noted that the incident was due to failure of an item of telephony equipment, and been managed well with no delays and no missed calls. All learning has been actioned. A copy of the BT report into the incident was available to view but had not been circulated due to being commercial in confidence.

10.0 PRF Feedback and Sign-Off

The Committee noted that the new PRF is now in use and welcomed this development.

11.0 Any Other Business

No other business to be discussed.

Signed:  **Date:** 8 February 2016

(Dr Livingstone, Chairman)

TB/11 07/04/16

NORTHERN IRELAND AMBULANCE SERVICE

Minutes of a meeting of the Audit Committee held on Monday 18 January 2016 at 2pm in the Board Room, Ambulance Headquarters, Site 30 Knockbracken Healthcare Park, Saintfield Road, Belfast, BT8 8SG

PRESENT:	Mr N McKinley	Non-Executive Director (Chair)
	Mr J Livingstone	Non-Executive Director
	Mr W Abraham	Non-Executive Director
IN ATTENDANCE:	Mrs S McCue	Director of Finance & ICT
	Mr P Nicholson	Assistant Director of Finance
	Mr A Phillips	Financial Accounts Manager
	Ms A McMaw	ASM External Audit
	Mr T Wilkinson	NIAO External Audit
	Mrs C McKeown	BSO Internal Audit
	Mr G McCloskey	BSO Head Of Shared Services
	Mrs J Murray	Minute Taker

Welcome and Introduction to the Meeting

Mr McKinley welcomed all committee members to the first meeting of the Audit Committee in 2016. All members introduced themselves for the benefit of new members.

1.0 Apologies

None

2.0 Declaration of Potential Conflict of Interest & Confirmation of Quorum

No conflicts of interest were expressed and the meeting was declared to be quorate.

NOTE

Mr McKinley offered a special welcome to Mr McCloskey (Head of Shared Services, BSO) and suggested the committee start by discussing agenda item 10.2 maximise the benefit of Mr McCloskey's attendance.

10.2 Business Service Transformation Programme (BSTP)

Mr McCloskey began by providing a summary of:

- Paper 7 – Shared Services Assurance Report Quarter ended 30 September 2015.
- Paper 8 – HRPTS Internal Audit Report (Issued September 2015) – Limited Assurance

He explained that for this period, Shared Services had thirteen Key Performance Indicators (KPIs) for NIAS reported each month. The three KPIs which did not meeting the required standard for this period were:

- % of invoices paid within 10 working days (target 60%)
- % of invoices paid within 30 calendar days (target 95%)
- Creditors Management – unpaid invoices over 30 days (target 5%)

However, Mr Greg also noted that the FPM approval process has only been fully operational since January 2015 and Accounts Payable Shared Services recognise that the current prompt payment results are similar to the HSC average at the same stage of adoption.

Mr Greg provided further reassurance by explaining that in the quarter from October 2015 – December 2015, the 95% target had been achieved. He described this achievement as a culmination of a lot a hard work over recent months from both NIAS and BSO team. He explained that it has taken time to train staff not experienced in healthcare setting and added that monthly meetings with Mr Nicholson and his team have vastly improved performance and understanding of Trust issues.

Mr McKinley asked Mr McCloskey asked about performance within the Payroll Shared Service Centre (PSSC). Mr McCloskey explained that one of the main issues affecting payroll was the number of pay cycles (e.g. weekly, fortnightly and monthly payments). He advised that work was ongoing as part of the Benefits Realisation Programme to move to a Single Pay Frequency for all organisations in the new financial year. Mr McCloskey also outlined the large volume of paper based claims still being submitted and processed by PSSC and the plans to increase automation in this area. NIAS are currently processing their own travel expenses but that this would transfer to the PSSC in due course. Internal Audit had identified a number of issues within PSSC. Measures to address these issues have been put in place.

Mr McCloskey also advised of significant pieces of work in relation to system upgrades, for example annual Country Legal Changes (CLC's) and other system upgrades that were due to take place. This represented a significant programme of work and improvements for BSO Shared Services.

Mr Livingstone referred to the conclusion of the report which states: 'with the exception of those areas specifically identified above, BSO Shared Services can give NIAS an assurance that Finance and HR Shared Services have been delivered in accordance with SLA obligations'. He asked for verification that his is the case. This was confirmed by Mr McCloskey and Mr Nicholson and was monitored closely as part of regular Customer Forum meetings between NIAS and BSO. Mrs McKeown explained that although limited assurance has been provided in term of payroll, all internal audit recommendations are referenced in Shared Services Assurance Report. She also confirmed that audit will continue to focus on this area and review progress on the implementation of previous internal audit recommendations. This will be reported to the NIAS Audit Committee.

Mr McKinley asked what is next for NIAS in terms of Shared Services. Mr McCloskey stated that travel expenses, recruitment, and moving as much of invoicing as possible to electronic processing are key priorities. Mr Nicholson also noted that Shared Services have recently moved to newly refurbished accommodation which are much improved compared to the previous temporary facilities.

Mr McCloskey concluded his report by thanking NIAS staff for their help and support both in delivering improvements in NIAS performance and also for support of new systems and Shared Services generally.

Mr McCloskey left the meeting.

3.0 Minutes of Previous Meeting of the Audit Committee held on 14 October 2014

The minutes of the previous meeting were noted and agreed by the committee. These were then signed by Mr McKinley as Chair of Audit Committee.

4.0 Matters Arising

4.1 Mid Year Assurance Statement

Mrs McCue advised the committee that the Mid Year Assurance Statement had been signed by the Chief executive and submitted to DHSSPS. The final document had been shared with all Trust Board members.

4.2 Operations – Fleet Management

Mrs McCue informed the group that Mr Snoddy was unavailable and that a Fleet Management audit update would be provided at the next meeting.

5.0 Chairman's Business

5.1 Tender for Audit of Annual Accounts

Mr Wilkinson advised that the tender for audit service was complete and that ASM were the successful firm who won the tender for the audit of NIAS annual accounts. The contract is for a period of three years commencing with the 2015/16 accounts, with the possibility of extension for a further two years. Mr Wilkinson concluded by welcoming Amanda McMaw from ASM.

6.0 Internal Audit

6.1 Progress Report

Mrs McKeown provided a summary of internal audit progress to date for both NIAS audits and audits of Shared Services. She apologised for a number of typographical errors within the report.

A Satisfactory level of assurance was provided in relation to Efficiency Savings and Service Reform. One Priority One weakness was identified in respect of reporting and monitoring progress of transformation and modernisation objectives. Three Priority Two weaknesses were identified in respect of modernisation and reform objectives, reporting and oversight arrangements. No priority three weaknesses were identified. All recommendations have been accepted by management.

A Satisfactory level of assurance was provided in relation to Budgetary Control 2015/16. No Priority One weaknesses were identified. Two Priority Two weaknesses were identified in respect of corporate oversight of financial performance and also directorate budgetary pressures. All recommendations have been accepted by management.

The Committee agreed that sharpening up of processes particularly around administration and reporting was required to improve controls in these areas.

7.0 External Audit

7.1 Audit of 2015/16 Financial Statements – Audit Strategy

Ms McMaw provided a summary of paper 4. She highlighted the following sections to the committee for noting:

- Actions for those charged with governance (section 1.3)
- Use of contractors (section 2.3)
- Materiality (section 2.15)
- Error reporting threshold (section 2018)
- Risks of material misstatement in the financial statements (section 3.1 & 3.2)
- Other risk factors (section 3.4)

- Audit timetable, staffing and fees (section 5.2)
- Staffing (section 5.5)

Mr McKinley referred to the key target audit dates and the challenge that this would create. Also, the scheduling of Audit and Assurance Committees would need to be factored into the timetable. It was agreed that Mr McKinley and Mrs McCue would discuss this and report back to Audit Committee.

8.0 For Approval

Mrs McCue referred the group to paper 5 – Audit Committee Terms of Reference. She explained that this is an annual review of the existing terms of reference document. The update to the document was shown via tracked changes. Mr McKinley asked if a statement regarding reflection and professional development of the committee should be included? (e.g. commitment to self-assessment). It was agreed that this suggested change would be captured in revised terms of reference. All other changes were accepted by the committee for recommendation to Trust Board.

The Audit Committee Self-Assessment Checklist was also discussed. Mr McKinley proposed that this document, along with last year's submission, is shared offline and can be reviewed and refined as part of the 2015/16 self-assessment.

9.0 For Noting

9.1 Procurement Working Group (Notes from meeting held on 8 December 2015)

Mrs McCue referred the committee to paper 6 for noting. She outlined the progress in terms of vehicle maintenance contracts.

9.2 Revised Financial Management Arrangements

Update provided by Mrs McCue. She explained that budget holders now have online access to their own departmental budgets. This information can now be used in performance meetings between Directors and Senior Managers. It is also easier to highlight over and under spends and more detailed reports can be provided to Trust Board. Mr Nicholson added that as part of the roll out, budget holders will be offered additional training.

10.0 Any Other Business

10.1 Fraud Update

Mr Nicholson provided an update to the Committee. He confirmed that a potential fraud case identified at last meeting regarding contract management had been investigated and no evidence of fraud had been identified. Mr Phillips provided an update in relation to National Fraud Initiative data matches.

10.2 Business Services Transformation Project (BSTP)

Discussed earlier in meeting.

10.3 Planning Process 2016/17

Mrs McCue provided an update on the financial planning process for 2016/17.

11.0 Date, Time and Venue of Next Meetings

The next meeting of the Audit Committee is scheduled for Thursday 10 March 2016 at 2.00pm in the Boardroom, NIAS Headquarters.

Further meetings are planned for:

Thursday 19 May 2016
Thursday 16 June 2016
Thursday 8 December 2016

Please note that dates may be subject to change and/or additional dates may be scheduled to accommodate Departmental deadlines, in particular Final Accounts.

Signed 

(Chairman)

Date **23 March 2016**