



***A Meeting of Trust Board to be held at 2.00pm on
Thursday, 3 December 2015 in The Burrendale Hotel and Country Club,
51 Castlewellan Road, Newcastle, Co Down, BT33 0JY***

Welcome, Introduction and Format of Meeting		Paper Enclosed	Timing Guide
1.0	<u>Apologies</u>		14:00
2.0	<u>Procedure:</u> Declaration of potential Conflict of Interest: Quorum:		
3.0	<u>Minutes of the previous meeting of the Trust Board held 1 October 2015</u> (for approval and signature)	TB/1 03/12/15	14:05
4.0	<u>Matters Arising:</u> Action Log from 1 October 2015:	TB/2 03/12/15	14:10
5.0	<u>Chairman's Business</u>		
5.1	Chairman's Update		14:20
5.2	Visit to Newcastle Ambulance Station		14:25
6.0	<u>Chief Executive's Business</u>		
6.1	Chief Executive's Update		14:30
7.0	<u>Performance Report as at 31 October 2015</u>		
7.1	Highlight Reports by each Director: Operations, Finance, Human Resources, Medical	TB3 3/12/15	14:40
7.2	Chief Executive Report – Trust Delivery Plan Report on Commissioning Priorities 2015-16	TB4 03/12/15	15:20
8.0	<u>Items for Approval</u>		
8.1	Fleet Strategy 2014-2019	TB/5 3/12/15	15:30
9.0	<u>Items for Information</u>		
10.0	<u>Items for Noting</u>		
10.1	Minutes of Assurance Committee held on 6 October 2015	TB/6 03/12/15	15:45
10.2	Annual Quality Report 2014/15	TB/7 03/12/15	15:50

11.0	<u>Application of Trust Seal</u>		15:55
12.0	<u>Forum for Questions</u>		16:00
13.0	<u>Any Other Business</u>		16.05
14.0	<u>Summary & Forward Agenda</u>		16:10
		Total Approx Time:	2hrs 10 min

Next meeting of Trust Board will be held on Thursday, 4 February 2016 in the Southern Division (venue to be confirmed)

Standing Orders

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

Admission of Public and the Press

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

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

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

3.18 Observers at Board meetings

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

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

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

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

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

Questions must be put to the Board in written form and must be passed to the 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, 3 December 2015 at 2.00 pm in
The Burrendale Hotel and Country Club, 51 Castlewellan Road
Newcastle, County Down, BT33 OJY***

TB/1 03/12/15



***Minutes of a Trust Board Meeting held on
Thursday, 1 October 2015 at 2.00pm, in The Royal Hotel,
64-72 Old Coagh Road, Cookstown, BT80 8NG***

Present:

Mr P Archer	Chairman
Mr L McIvor	Chief Executive
Mrs S McCue	Director of Finance & ICT
Dr D McManus	Medical Director
Ms R O'Hara	Director of Human Resources & Corporate Services
Mr J Wright	Acting Director of Operations
Mr T Haslett	Non-Executive Director
Mr A Cardwell	Non-Executive Director
Mr W Abraham	Non-Executive Director
Dr J Livingstone	Non-Executive Director

In Attendance

Miss K Baxter	Executive Administrator (T)
Mrs J Pattison	Senior Secretary (T)

Welcome and Format of the Meeting

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

1.0 Apologies

Mr B McNeill, Director of Operations
Mr N McKinley, Non-Executive Director

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 6 August 2015.

The members accepted the minutes as a true reflection of discussions held on the proposal of Mr T Haslett, seconded by Mr J Wright.

Action: Approved

4.0 Matters Arising; Action Log

All actions completed and can be removed from the log.

Matters Arising

- 4.1** The Chairman highlighted on Page 5 of the minutes the withdrawal of IHCD Modules by 31 March 2016. The Director of HR&CS informed members of other educational routes available for Paramedic Training and that appropriate controls had been placed within the Local Risk Register.
- 4.2** The Chairman highlighted on Page 5 the delay in the completion of Ballymena Ambulance Station. The Chief Executive informed members that the Station was being delivered on budget with a relatively small delay.

5.0 Chairman's Business

5.1 Chairman's Update

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

5.2 Visit to Cookstown Ambulance Station

The Chairman on behalf of the Board paid tribute to the staff and officers of Cookstown Ambulance Station. The Chairman stated that this was an interesting visit as members were able to talk to staff some of which had just returned from an emergency call which had been received towards the end of the night shift. It was noted that the facilities were compact however with only two/three crew members using the facility at any one time, they were suitable.

6.0 Chief Executive's Business

6.1 Chief Executive's Update

Deferred as Chief Executive left the room. Will be picked up later in Agenda.

7.0 Performance Report as at 31 August 2015

7.1 Operations

The Acting Director of Operations updated members on the report. The following issues/comments were raised:

As at the 31st August 2105:-

- The Acting Director of Operations informed the Board that the Operations Directorate Report is comprised of three sections:-

- (1) an analysis of performance against demand and the various contributing factors;
 - (2) a brief synopsis of key Controls & Communications elements of the service and the relevance to performance; and
 - (3) Fleet and Estates.
- The Board were directed to page 2, Category A Performance and in particular trends over the last five years. The Acting Director highlighted the increase in Category A demand over the past this period and a corresponding decrease in Category B performance.
 - The Board was informed of a 4.5% reduction in Category A performance for August 15 compared to the same period last year.
 - The Board were directed to Page 5, Category A performance for individual monthly Regional and LCG positions. The Acting Director highlighted that performance is currently steady and that we would be aiming for an upward pressure on performance through implementing the Performance Improvement Plan.
 - The Board were directed to Page 10, the Performance Improvement Plan (PIP). The Acting Director of Operations highlighted that the PIP for 2015/16 was completed and had been shared with the Commissioners and that the PIP was developed with a prioritised list of actions specifically to address improving Category A performance.
 - The Board were directed to Page 12 which relates to Control & Communications and was appraised of assurance measures in respect of call handling.
 - The Acting Director of Operations gave a brief update on Fleet and Estates and it was noted that Ballymena had a completion date of February 2016 and that Enniskillen is progressing.

Finance and ICT

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

As at the 31st August 2015:

- The Board were directed to page 1, NIAS Savings Proposals Summary 2015/16. It was highlighted that the Trust is working to deliver a savings of £1.2m in 2015/16 and was on track to achieve.
- The Board were directed to page 2, Financial Performance. The Director of Finance and ICT indicated that the financial position at the end of August 2015 was breakeven and the Trust is currently forecasting a breakeven position at year end (31 March 2016), subject to a number of key risks and assumptions. Accident and Emergency staff are currently being paid without prejudice, at Band 4 and Band 5 on account, subject to the outcome of the matching process. The Trust continues with the assumption that the HSC Board will fund any additional costs of Agenda to Change for NIAS which result at the conclusion of the matching process.
- The Board were directed to page 3, Capital Spend. The Director of Finance & ICT indicated that the Trust had received a Capital Resource

Limit (CRL) of £7.481m for 2015/16. This has been allocated against Fleet Replacement, Estate and IT and General Capital. The Trust has made a formal request for a further £0.7m to complete the planned fleet replacement programme for 2015/16.

- The Board were directed to page 5, Prompt Payment of Invoices. The Director highlighted that the target of 95% of invoices paid within 30 days had not been achieved in 2014/15. This was largely due to the days of processing lost due to implementation of the new Finance, Procurement and Logistic (FPL) System. However for 2015/16 plans have been developed to identify trends and most frequent breaches of targets with actions to improve performance during the rest of the year towards the achievement of a monthly target of 95%. The established 10 working day target is currently at 50% and will be working towards the regional target of 60%.
- The Director of Finance updated the Board on page 7, Information Technology Systems – System Availability.
- The Board were directed to page 11 and the Director of Finance highlighted summary of new projects carried out by the Information Team to support operational performance management which includes daily, weekly and monthly analysis.
- The Board were directed to page 13, Freedom of Information activity. The Director of Finance indicated that 75% of requests had been processed within 20 working days from 01/07/15 – 30/08/15. This includes an additional 8 questions received against the same monitoring period of 2014/15. The Director also highlighted that from 01/04/15 – 31/08/15 75% of requests were processed within 40 calendar days.

Human Resources and Corporate Services

The Director of HR&CS updated members on the report. The following issues/comments were raised:

As at the 31st August 2015:

- The Director of HR&CS informed the Board that she had a small dedicated team working in the very active Human Resources Department and a visit to the Human Resources Department by Trust Board Members would be welcome. The Director also paid tribute to the HR Team for their hard work involving the recent recruitment process.
- The Board were directed to page 2, Recruitment Activity. The Director informed members that further offers for Ambulance Care Attendants (ACA) have been made and will commence 2 October 2015 along with offers for further Trainee Emergency Medical Technicians (EMT) to commence November 2015. In addition permanent offers were made to qualified ACAs.
- The Board were directed to page 3, Attendance Management. The Director highlighted that the % absence calculation within HRPTS has recently been fixed and further Trust Board Reports will include % sickness figures. It was also highlighted that the HR Department supports Attendance Management in line with its Health & Wellbeing

Attendance Management Action Plan and HR provide professional advice and support to managers to support management of attendance. SLA meetings continue between HR and Occupational Health as do meetings with Care Call to address prevalent issues related to staff absence e.g. Stress Management.

- The Board were directed to page 4, Job Evaluation. The Director of HR&CS highlighted that NIAS continues to face significant industrial relations issues and challenges. The Trade Unions notified Management Side on 21 July 2015 at Joint Consultative Negotiating Committee (JCNC) that they were withdrawing from all job evaluation processes. Management are continuing to manage this situation.
- The Director of HR&CS briefed the members on Complaints and highlighted that there is a Complaints Workshop on 2 October 2015.

Medical

The Medical Director updated members on the report. The following issues/comments were raised:

As at the 31st August 2015:

- Implementation of the Regional Community Resuscitation Strategy has been slow. The Implementation Group, chaired by the Medical Director, continues to meet and a number of workstreams are ongoing. NIAS submitted a bid for recurrent funding in December 2014 to support a team of Community Resuscitation Development Officers in accordance with the Strategy but are still awaiting a decision from HSCB. The Board were advised that if funding is declined, further implementation of the initiative will be significantly curtailed. However NIAS continues to support the Strategy and tribute was paid for the staff involved and for their ongoing work which, in the absence of funding, is in addition to their normal roles. An electronic map is being developed to show the location of defibrillators which will further enhance responses involving the public.
- A revised Patient Report Form (PRF) was introduced in August 2015. Some minor amendments were identified and these have been addressed. Feedback from staff has been positive.
- Electronic Patient Report Form (ePRF) – an outline Business Case has been submitted to the Department and agreed by them and is now ready for submission to the Department of Finance (DFP). NIAS are still awaiting confirmation of conditional support for revenue funding from Commissioners and a decision has been delayed and is now expected at the end of September 2015. NIAS will continue to press the HSCB for a decision to avoid any further delays which would impact on project deadlines.
- The Annual Quality Report is due for completion by end September 2015 for review by DHSSPS and Trust Board prior to publication in November 2015. While a regional template has been developed for the report, it is accepted that NIAS differ from the other Trusts

and relevant sections have been amended accordingly. This has delayed the completion of the report and an extension has been sought and granted. When finalised, the Report will be sent to DHSSPS for review and it is anticipated that a draft of the Report will be available for next Trust Board meeting.

Action: Draft Annual Report to be tabled at next Trust Board.

7.2 Chief Executive Report

Trust Delivery Plan Report on Commissioning Priorities 2015-16

The Chief Executive updated the Board on the above.

6.0 Chief Executive Business

This item which was deferred from earlier was addressed.

6.1 Chief Executive Update

The Chief Executive gave a brief outline of some of his activities since the last Board Meeting which include the following:-

- 20 August 2015 – Meeting with Newry & Mourne District Council. The Chief Executive commented that this meeting was well received.
- 24 August 2015 – Meeting with Trade Unions
- 3 September 2015 – NIAS hosted a visit from the Health Minister, Mr Simon Hamilton.
- 3 September 2015 – Trust Board Workshop on the Assurance Framework.

8.0 Items for Approval

8.1 Whistleblowing Policy

It was noted that with effect from the 1 October 2015 Mr W Abraham would replace Dr J Livingstone as Whistleblowing Officer. This was approved by the Board

Action: Approved

8.2 Information Governance Policy

The Director of Finance presented the Information Governance Policy. Subject to a few typographical changes the policy was approved by the Chairman, seconded by Mr W Abraham.

Action: Approved

8.3 Freedom of Information Act 2000 & Environmental Regulations Act 2000 Policy

The Director of Finance presented the above policy. Subject to a few typographical changes the policy was approved by the Mr T Haslett, seconded by Mr W Abraham.

Action: Approved

9.0 Items for Information

9.1 Proposed Trust Board, Committee and Workshop Dates for 2016

Noted

Action: Board members to secure dates in diaries

9.2 HSCB Approval of Trust Delivery Plan 2015-16

Noted

9.3 Lifeline Consultation

The Medical Director updated the Board on the Lifeline Consultation. Some discussion took place and it was highlighted by the members of the Board that this was a significant piece of work.

9.4 Complaints Workshop

It was noted by the Board that the Complaints Workshop would take place on the 2nd October at 10am in NIAS Headquarters.

10.0 Items for Noting

10.1 Equality Commission NI Annual Progress Report

Noted

11.0 Forum for Questions

No questions were received.

12.0 Any other Business

None

13.0 Summary & Forward Agenda

No Items

Date, Time and Venue of Next Meeting

The next meeting of Trust Board will be held on Thursday, 3 December 2015 at 2.00pm in South Eastern Division (venue to be confirmed).

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

Signed: _____
Chairman

Date: _____

TB/2 03/12/15



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
1 October 2015	1	7.0	Performance Report: Annual Quality Report	Medical Director	Draft Annual Report to be tabled at next Trust Board meeting on 3 December 2015.
	2	9.1	2016 Dates for Trust Board, Committees and Workshops	All	Board Members to secure dates in diaries

TB/3 03/12/15

**PERFORMANCE REPORT AS
AT 31 OCTOBER 2015**

NORTHERN IRELAND AMBULANCE SERVICE

**TRUST BOARD REPORT
OPERATIONS DIRECTORATE**

**Director of Operations
03/12/2015**

The Operations Directorate report is comprised of three sections:

Section 1 is an analysis of performance against demand and the various contributing factors. The report highlights pressures and resulting performance and includes information on proposals to address the current position

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.

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SECTION 1 - PERFORMANCE

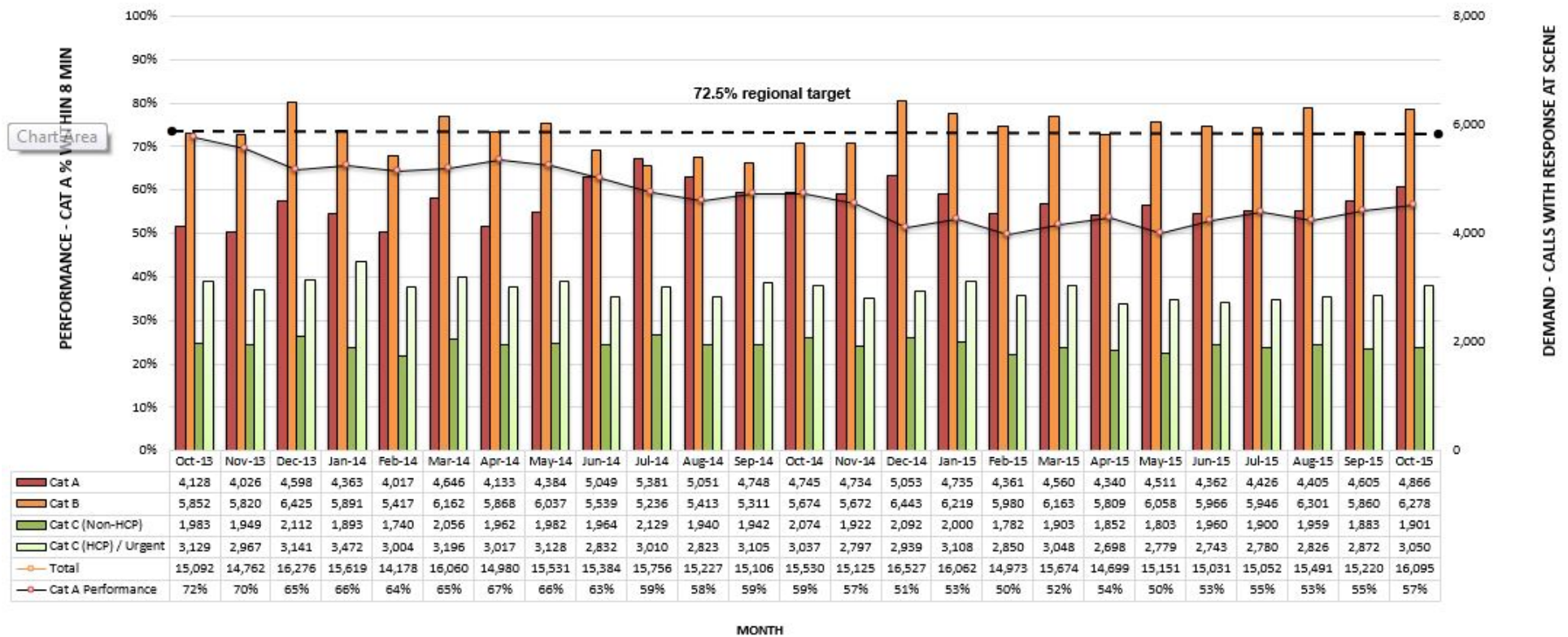
1. CATEGORY A PERFORMANCE

(i). Trends over the last 24 months

Monthly Category A Performance -v- Demand 2015-16

NI

Emergency Responses by Category

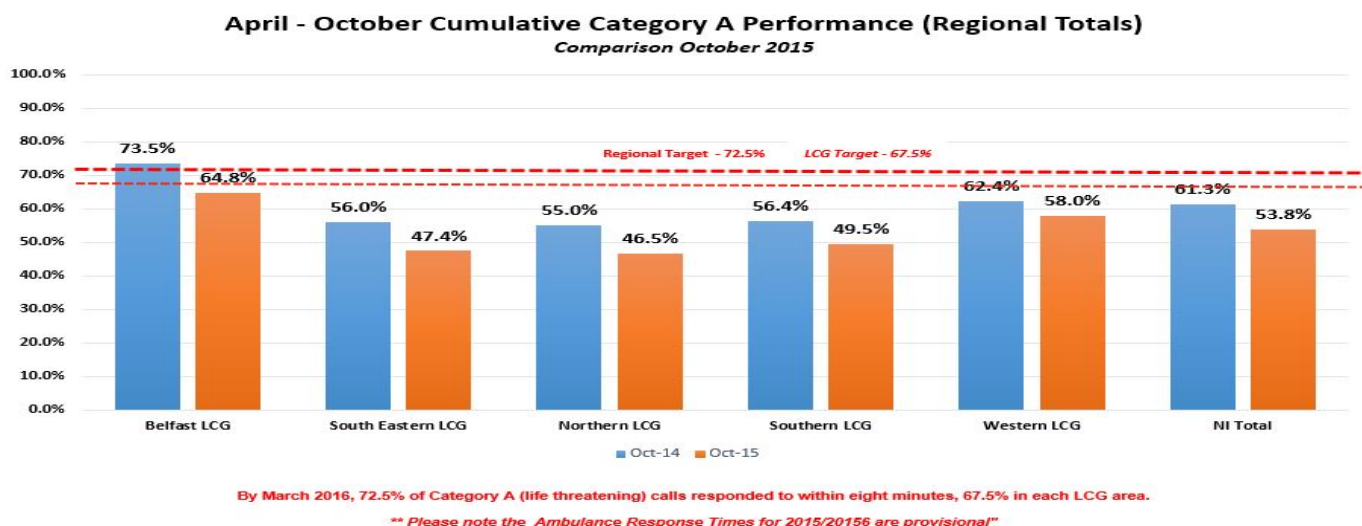


There was an increase of 2.6% in Cat A calls, an increase of 10.6% in Cat B calls, a reduction of 8.3% in Cat C calls and a 0.4% reduction in Cat C HCP/Urgent call compared to the same time last year (October 2014).

This has resulted in a 3.6% increase in overall Emergency Activity compared to the same time last year which equates to over 18 additional emergency calls each day.

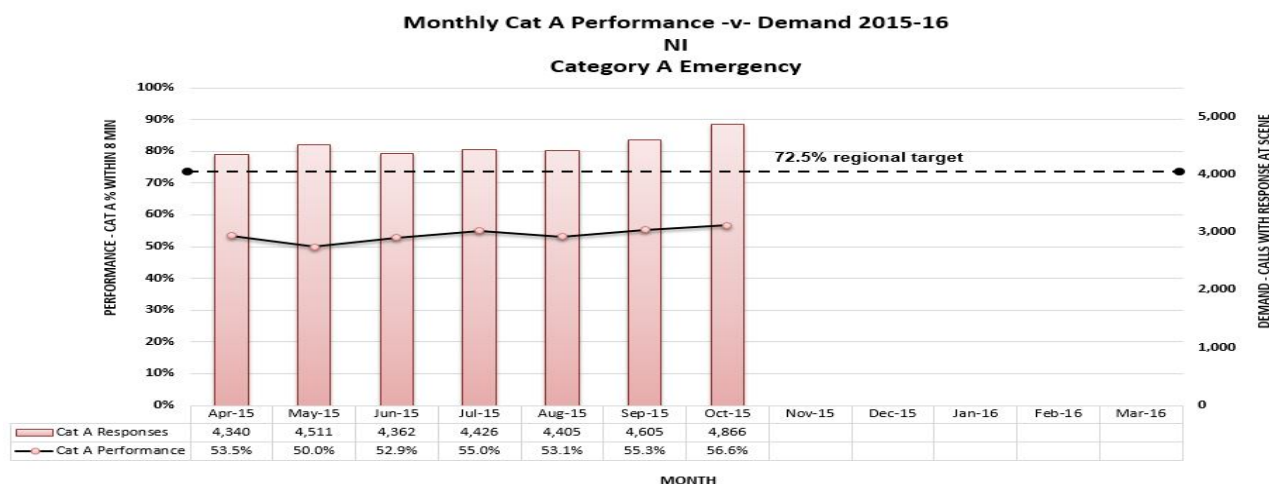
Furthermore emergency activity has increased (by 5.7%) in line with seasonal trends when compared to last month (Sep 2015). This has resulted in an additional 29 emergency calls each day.

(ii) Cumulative Cat A performance



- From the chart above, 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 LCG area.
- Cumulatively Cat A demand has fallen by 5.9% compared to the same timeframe last year (Apr-Oct). In addition the cumulative number of Cat A calls that we have attended to within the 8 minutes targets has also reduced by 17.3% which equates to approx. 16 calls less in standard EAC day since April 2015.
- NIAS receives approximately 157 Cat A calls each day

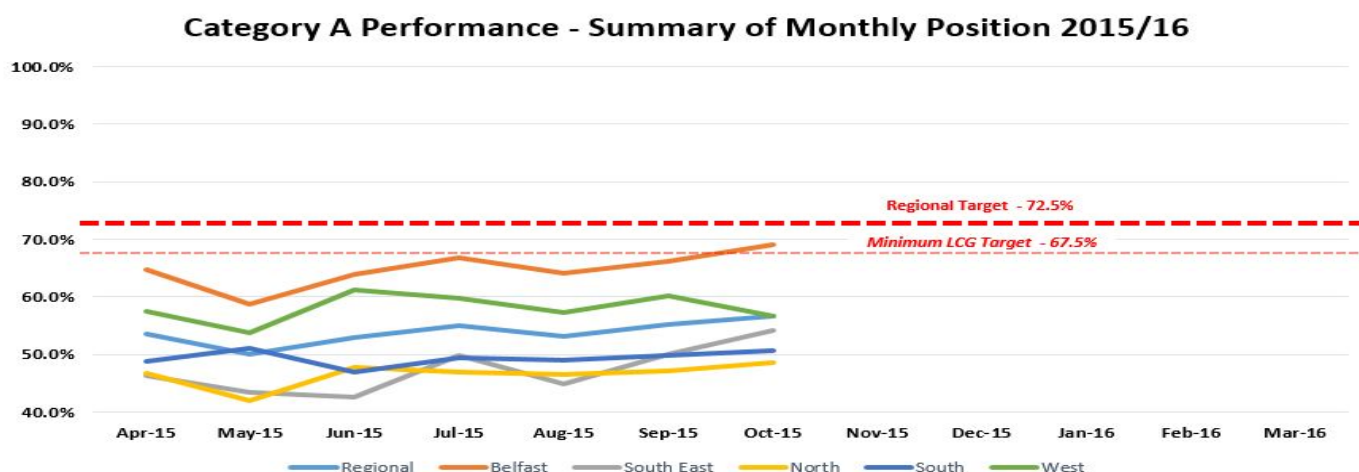
(iii) Monthly Cat A performance



- There has been a 2.4% reduction in Cat A performance for the month of October 2015 compared to October 2014. However the monthly Cat A performance is improving compared to the previous month (increasing by 1.3% compared to Sep 2015).
- As mentioned above Cat A demand has increased by 2.6% which equates to an extra 4 Cat A calls each day compared to same month last year. The greatest increase in demand in October was in the Belfast (up by 7.3%) and South Eastern (up by 8.7%) LCG areas.

(iv) Regional and LCG Category A performance

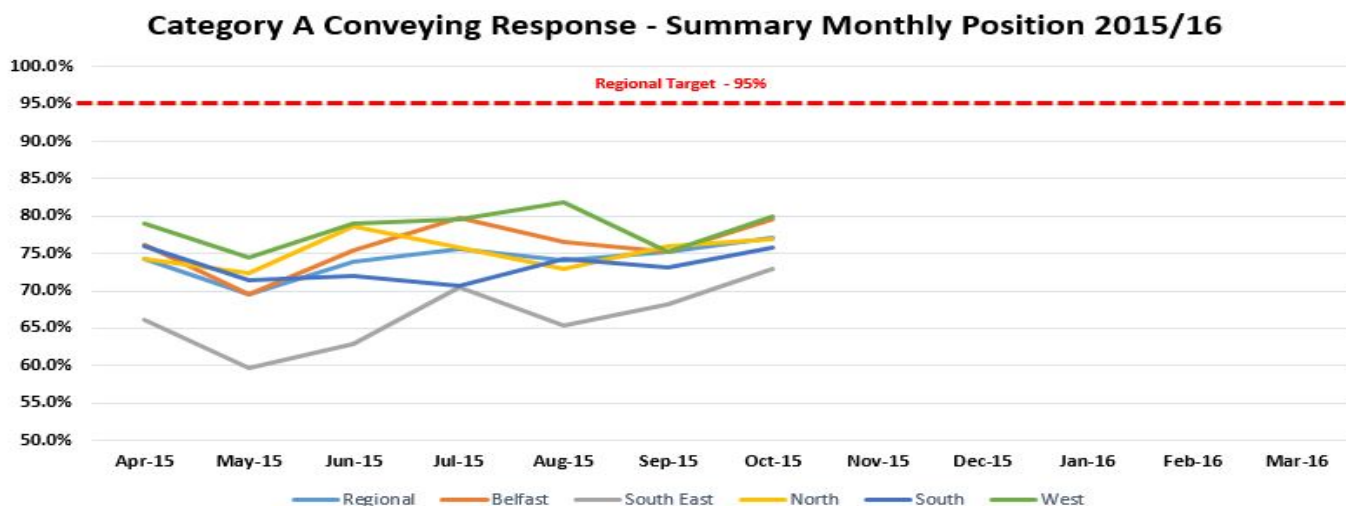
HSCB 2015/16 Target – “NIAS should ensure an average of 72.5% of Category A (life-threatening) calls are responded to within 8 minutes (and not less than 67.5% in any LCG area)”



- This above graph indicates that our Cat A performance is improving since August 2015 and we aim for continued upward trend with the assistance of our Performance Improvement Plan 2015/16.

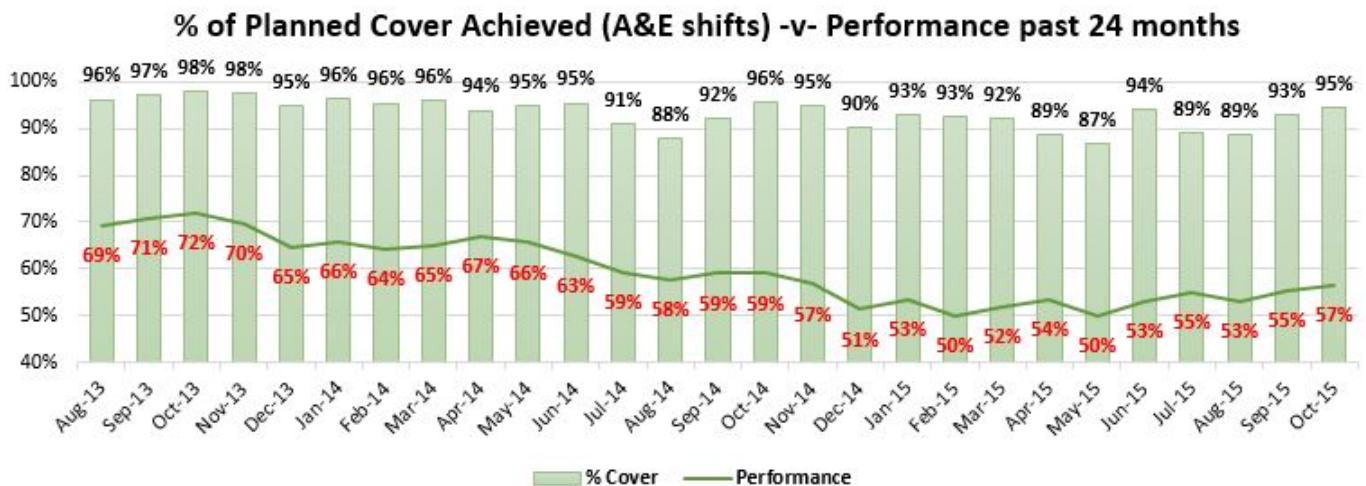
(v) Monthly Regional and LCG Category A conveying response

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”



- The chart above illustrates that NIAS' conveying standard is not being achieved in any of the LCGs. However the chart shows an upward trend across all LCGs since August 2015.
- The increase in emergency activity generally coupled with lengthy ambulance turnarounds at hospitals, increased patient transfers with longer journey times especially out of divisional area play a part in reducing the availability of emergency ambulances and therefore impact on the conveying performance.

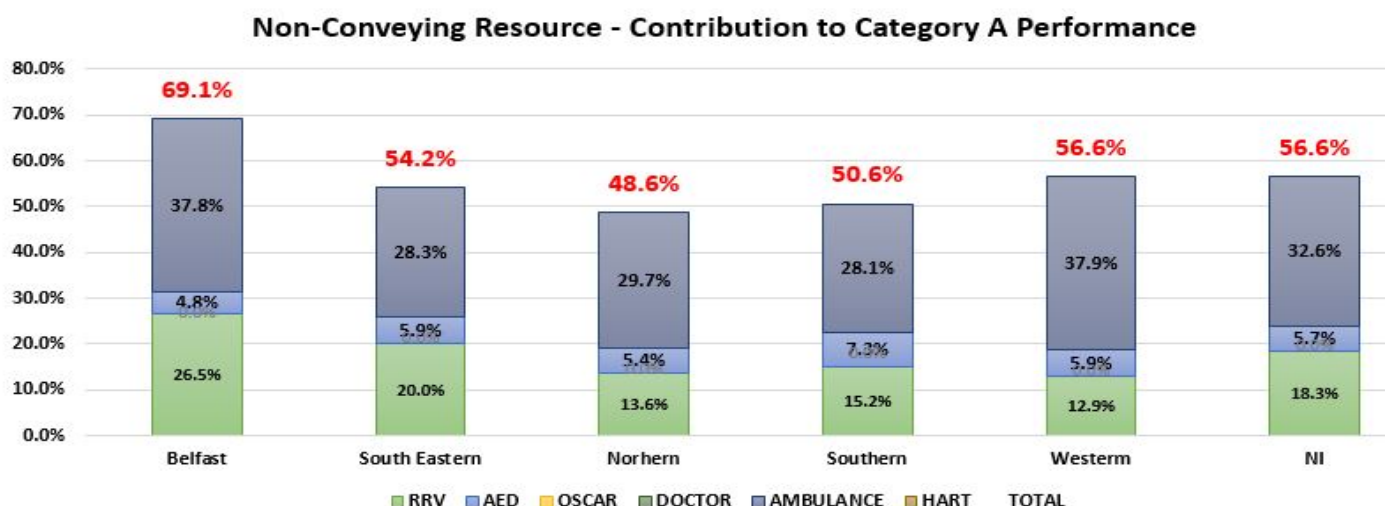
2. PLANNED v ACTUAL COVER



- 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 cover levels are exacerbated by higher levels of annual leave during the summer months and seasonal holidays such as Christmas and New Year.
- Compliance against planned productions hours is even greater for RRVs and PCS shifts.

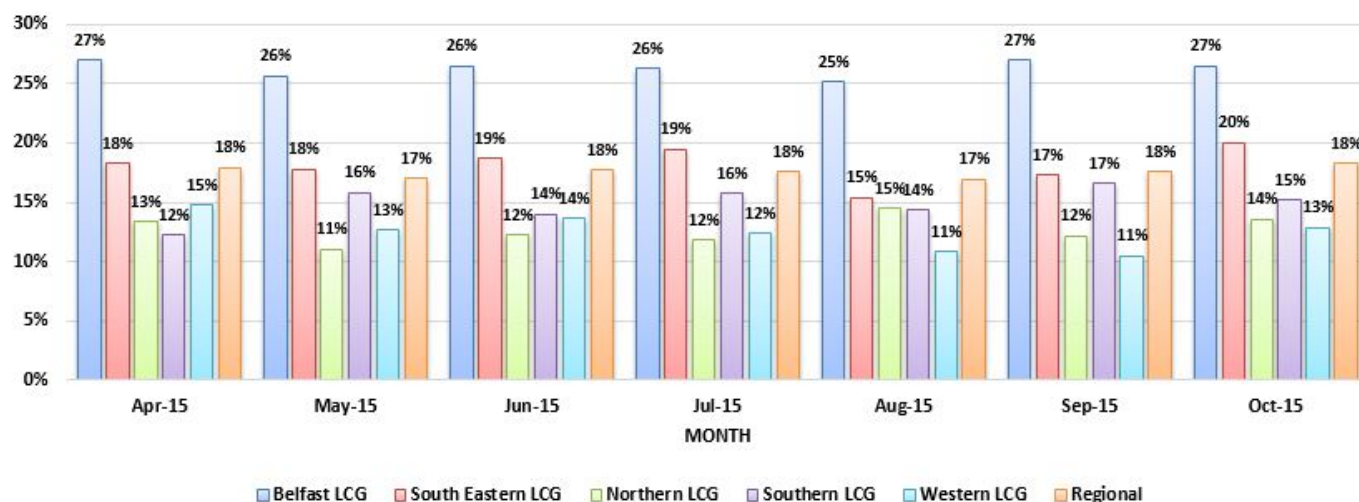
3. NON CONVEYING RESOURCE CONTRIBUTION TO CATEGORY A PERFORMANCE

- As can be seen from the chart below the greatest contributors to Cat A Performance, after an ambulance, are the Rapid Response Vehicles (RRV).



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

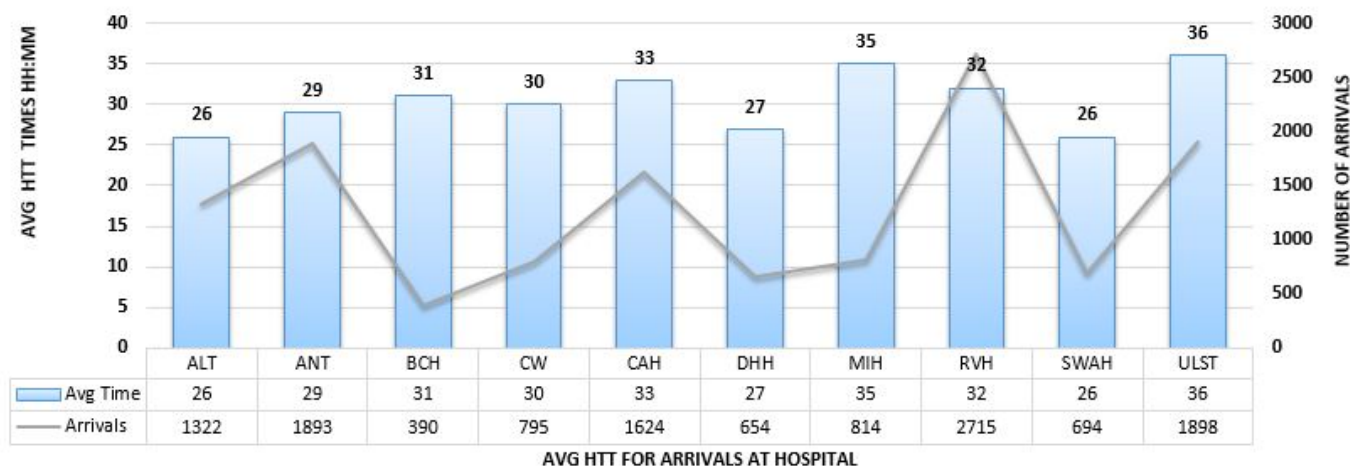
NIAS - RRV CAT A CONTRIBUTION - AT SCENE IN 8 MINS APRIL - OCTOBER 2015



- The above chart shows that the ratio of contribution across the divisions is fairly stable across the different months of the year, with greater contribution to Cat A performance in urban environments such as large towns and cities.

4. AMBULANCE TURNAROUND TIMES

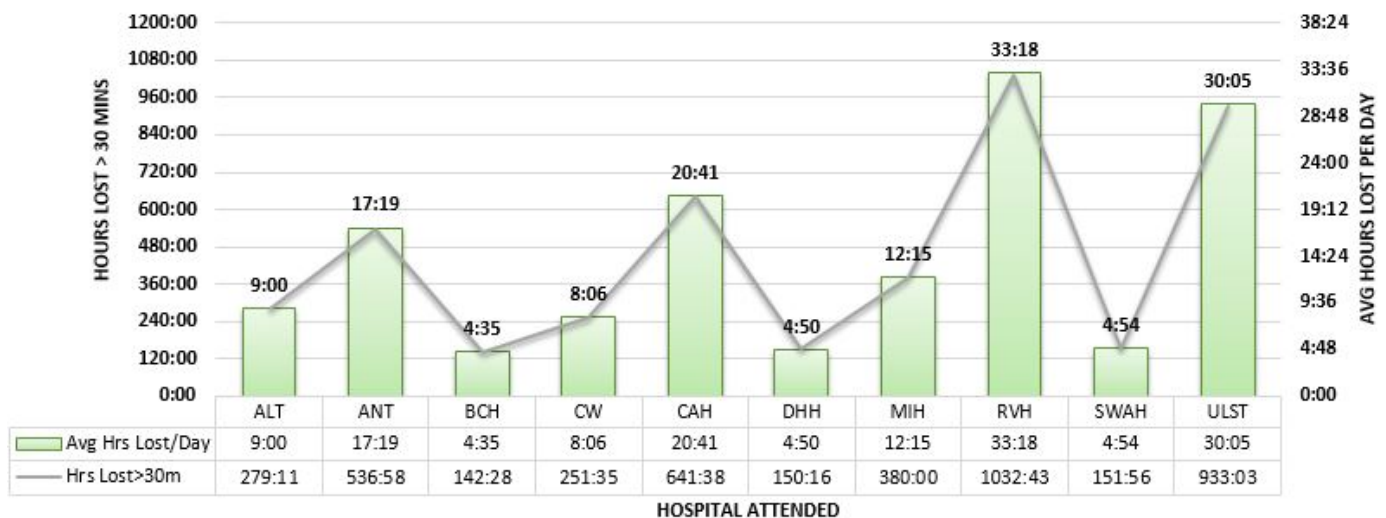
**AVERAGE AMBULANCE TURNAROUND TIMES (HH:HH) AND TOTAL ARRIVALS AT HOSPITAL
October 2015**



- The above table shows the average ambulance turnaround time at the respective hospitals, based on the agreed national standard (of 30 minutes or less from ambulance arriving at hospital to ambulance being ready for the next call).

HOURS LOST >30 MINS AT HOSPITAL AND AVERAGE HOURS LOST PER DAY

October 2015



- 51.8% of ambulance turnaround times in October were in standard (i.e. completed within 30 mins) compared to 53.1% in October 2014. However this is a noticeable improvement compared to August 2015 when only 48.2% of all ambulance turnaround were in standard
- There was a 16.7% reduction in number of lengthy ambulance turnaround times (greater than 1 hour) across the main EDs regionally in October 2015 when compared to the same time last year.
- The total loss of production hours due to out of standard ambulance turnaround times (e.g. over 30 mins) has risen very slightly (by 0.4%) compared to same time last year, with a slight increase of 21 ambulance hrs lost in October 2015 compared to same time last year.
- This loss of NIAS ambulance production hours equates to 6.3 ambulances lost each day, which is the same as last year in October. Of the 6.3 ambulances, 1.4 were lost at the RVH ED, 1.3 at the Ulster ED, 0.7 at the Antrim ED and 0.9 at Craigavon ED.

5. DIVERTS

- October 2015 saw 19 more divers (equal to a 54% increase) than the same month last year. Half of all divers that occurred in October 2015 took place at Daisyhill Hospital.
- This increase in the number of divers resulted in an additional 77 hrs in October 2015 (compared to October 2014) of impact on ambulance services, including lengthier travelling times with patients on board as well as lengthier ambulance turnaround times due to increased arrivals at congested EDs.
- 57% of all hours of ambulance being diverted in October 2015 were due to the Daisyhill divers.

6. ACTIONS FOR IMPROVEMENT

- Recruitment programme to stabilize workforce is ongoing:

EMT Training:

- Cohort 1 fully qualified 30/10/15 (20)
- Cohort 2 on placement from 2/11/15 (22)
- Cohort 3 on placement from 15/2/16 (23)
- Cohort 4 scheduled to start 28/03/16 and placement by 18/7/16 (21)
- Cohort 5 Planned for September 2016 and fully qualified by March 2017 (TBC)

ACA Training

- Three cohorts already qualified and operational (63)
 - Cohort 4 qualified by 18/03/16 (22)
 - Cohort 5 qualified by 19/8/16 (TBC)
 - Cohort 5 EMT will require a new recruitment process as the waiting list has been exhausted. In addition the actual qualification and training course is changing affecting previous workforce planning assumptions.
 - Cohort 5 of ACAs will exhaust the current waiting list (approximately 15 people on as end of October 2015) and any future cohorts for ACAs will need a new recruitment process. Furthermore the Cohort 5 training has had to change slightly to better meet future training needs and is therefore slightly longer in duration.
 - There are currently 12x qualified Paramedics working as EMTs who it is hoped will be successful in gaining permanent Paramedic posts following an imminent recruitment drive to support the workforce stabilization as well as the Demographic funding proposals.
 - NIAS has offered Bank Hour Contracts to x3 paramedics and is expecting to be able to offer x6 Qualified EMTs a similar Bank contract.
- The Operations Directorate continues with the application of the agreed actions as outlined in the Performance Improvement Plan for 2015/6.
 - The Plan distributes actions across four key Objectives:
 - Increasing Response Capacity
 - Improving Tactical Deployment of Resources;
 - Improving Timeliness of response in key elements of the Call timeline;
 - Addressing Staff Issues.
 - NIAS has secured £150k recurrent financial support from Commissioners for HALO roles. The recruitment of permanent HALO posts in RVH, AAH, CAH and UHD will take place in the New Year and may involve a review of the job descriptions and job design to ensure fitness for purpose.
 - Following the Commissioners' agreement to provide £400k non-recurrently towards winter pressures, NIAS is considering providing additional HALO hours at EDs especially at night and weekends. The main thrust of winter pressures initiatives is facilitating timely hospital discharge and inter-hospital transfers through utilisation of the regional taxi contract to

manage a proportion of our walking and low dependency patients thereby freeing up SCV crews for HPC demand.

- Management side are currently considering a number of Trade Union counter-proposals in relation to casual leave and late finishes with a view of being able to implement necessary changes in early 2016/17. Operational managers have already implemented a number of improvements to support more effective and responsive allocation and granting of casual leave requests. These improvements have been welcomed by staff and staff side representatives.
- Continue with rolling out of Alternative Care Pathways across a number of agreed conditions (Falls, Diabetes, COPD, Chest Pain, etc.) in association with TYC colleagues. These initiatives not only reduce unnecessary transportation to EDs in particular, but also enable patients to be safely treated at the scene/home.
- Increased support from Voluntary and Private Ambulance Services at known times of pressure (e.g. weekends and Monday afternoons) in full compliance with procurement process following contract tender. This supports the release of emergency ambulances to respond to Cat A calls thereby improving response times.
- Continue the revision of the Operational Business Continuity Plan alongside Regional Escalation Ambulance Plans and Major Incident Plans to facilitate effective and proactive management of resources, distribution and responsiveness, especially in view of ongoing acute service changes across HSCT Trusts (such as the ongoing divert from Mater Hospital).
- Introduced additional hours of RRV support at change over times in Southern and South Eastern LCG.

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 efficiency 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.

Skills

Accredited Centre of Excellence (ACE): The International Academies of Emergency Dispatch (IAED) recognition of an agency as an Accredited Centre of Excellence. Specific to quality assurance is the audit of 999 phone calls and continuous feedback to EMDs measured against agreed Academy standards. This continuous feedback has been shown to be essential for improving compliance and performance and for assuring accuracy of system application.

Q Process: NIAS is committed to reviewing a percentage of calls as per Academy guidelines in line with annual call volume. This equates to 2.71% of all 999s or approximately 60 calls per week (not including Special Case Review, complaints etc.). Calls are measured across 7 areas including customer service and final coding. Each call is reviewed in line with Academy standards and deviations are identified in 4 categories:

CRITICAL, MAJOR, MODERATE, MINOR

Based on the level and number of deviations, each case is then assigned one of 5 possible compliance levels:

HIGH COMPLIANCE, COMPLIANT, PARTIAL COMPLIANCE, LOW COMPLIANCE, NON-COMPLIANT

Progress: Consistent Q in progress since September '14 with full audit volume covered since April '15. Overall trend sees a reduction in the deviations within the CRITICAL and MAJOR categories as they filter through to the less severe MODERATE and MINOR.

This minimises RISK and WASTE in terms of response and increases the quality of standardised patient care.

Continued to exceed IAED standards in 4 of the 7 areas of protocol compliance – Chief Complaint, Key Questions, Final Coding and Customer Service.

With increasing audit volume and continuous feedback we can now use the data to begin to directly focus training/CDE on the areas causing the most difficulties and target specific compliance issues.

ACE PERFORMANCE STANDARD									
	Standard	Jul-15		Aug-15		Sep-15		part Oct-15	
	% less than	No. of cases	Percent	No. of cases	Percent	No. of cases	Percent	No. of cases	Percent
High Compliance		30	12%	55	22%	59	24%	43	23%
Compliant		91	36%	87	35%	82	33%	72	38%
Partial Compliance	10%	27	11%	19	8%	27	11%	15	8%
Low Compliance	10%	21	9%	14	6%	19	8%	7	7%
Non-Compliant	7%	81	32%	75	30%	63	25%	54	28%
Total		250		250		250		191	
DEVIATIONS									
	Target	% Achieved							
	% less than	Jul-15	Aug-15	Sep-15	part Oct-15				
Critical	3.00%	3.95%	3.10%	2.58%	2.85%				
Major	3.00%	2.30%	2.07%	1.94%	1.64%				
Moderate	3.00%	5.30%	3.81%	3.06%	3.25%				
Minor	3.00%	4.08%	3.39%	3.94%	3.68%				

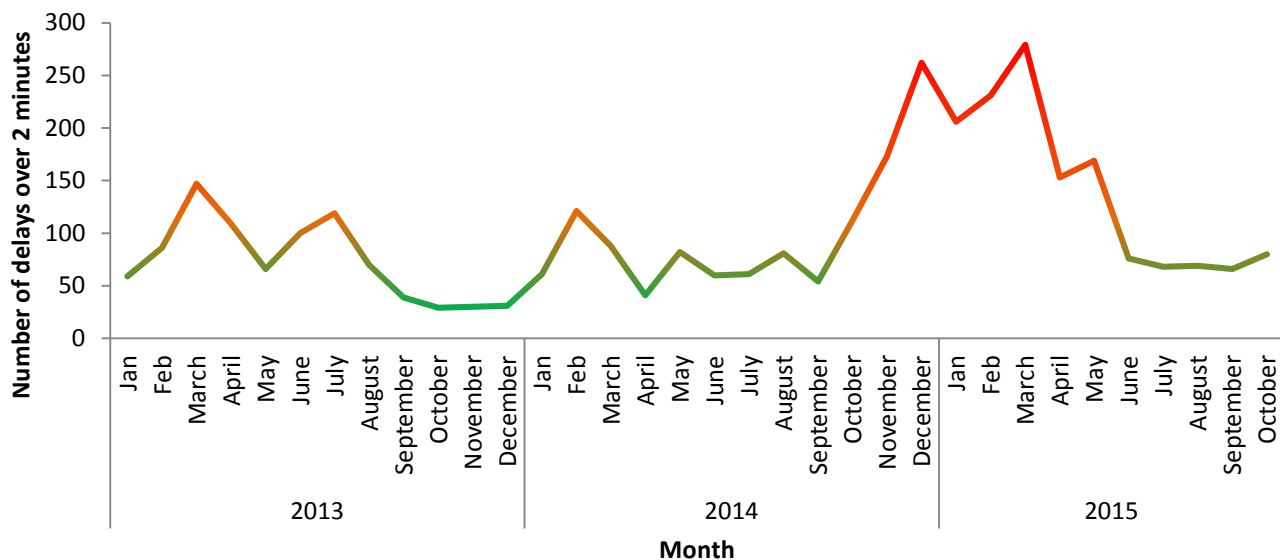
The information above illustrates that our EMDs are constantly striving to improve performance. Regular and reliable delivery of Quality Assurance / Quality Improvement is critical to reaching ACE standards.

Recognition of this improvement is in the form of an EMD award scheme consisting of certificates & badges for randomly selected calls with overall “High Compliance” and for calls with exemplary (100%) Customer Service. To date 25 EMDs have attained Bronze awards (25 calls) and 4 EMDs have attained Silver awards (50 calls) with Exemplary Customer Service. Two EMDs have attained Bronze Awards (25 calls) with High Compliance.

Other awards are for Baby Born, Cardiac Life Saver & Non-Cardiac Life Saver. In order to attain these awards the call must be reviewed as “Compliant” or “High Compliance”. We have an EMD who has an award for baby delivery and an award for cardiac life saved and another EMD who awaits an award for cardiac life saved.

Aside from quality assuring the skills of our EMDs we need to ensure we have sufficient numbers on duty to manage the call demand. One measure of our success in doing this is low numbers of call delays experienced by 999 callers. It is impossible to avoid these all together because there will always be occasions when incoming emergency calls outstrip call handlers however we strive to minimise these occasions. The graph below shows the levels of call delays being experienced and is in line with UK levels:

Number of Delays Over Two Minutes by Month from January 2013 to October 2015



We have recently established a 999 call queue announcement on the advice of our telephone operator and this is in line with other UK emergency services. It enables callers who are content to do so to remain on hold rather than be passed between incoming lines.

After a period of time callers are transferred to Scotland our Buddy service if we cannot answer them either due to demand or technology failure. We provide the same service to Scotland.

Technology

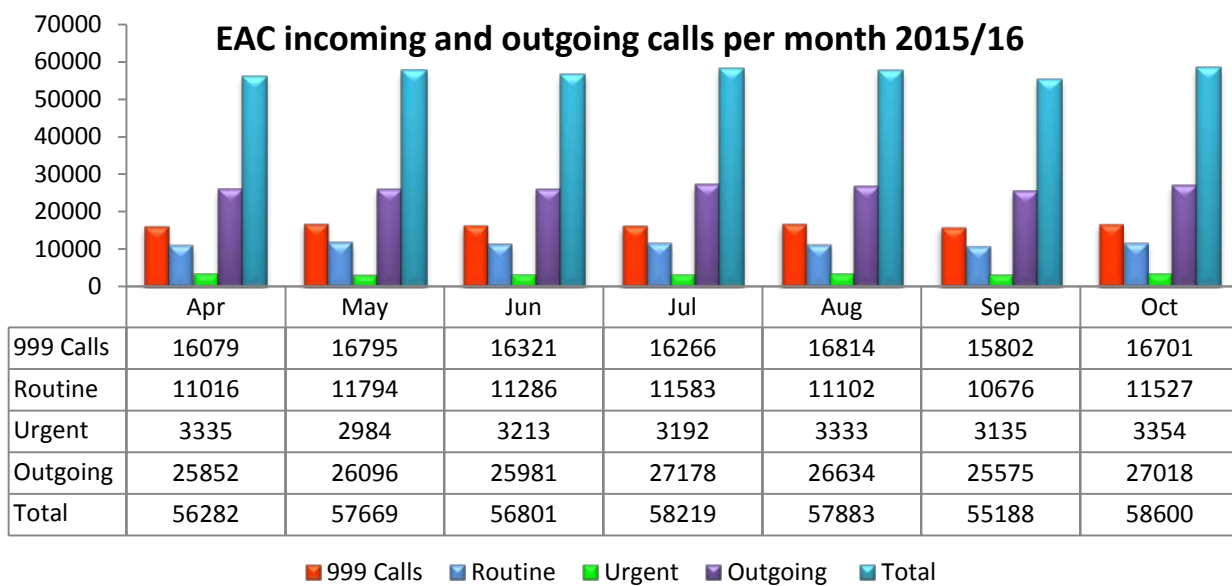
Automated Call Distribution is the computer system that handles the incoming and outgoing calls and allows for fair and timely distribution of incoming calls.

The system facilitates interpretation and analysis of our call-taking performance and what follows is a brief summary of some initial findings:

- ACD gives the Management team access to reports on efficiency, productivity and performance on timeframes ranging from daily, monthly to quarterly.
- Managers can proactively adjust settings to meet particular demands and to deal in real time with any adverse situations that would exceed normal call volumes (e.g. Scotland telephone exchange failure)

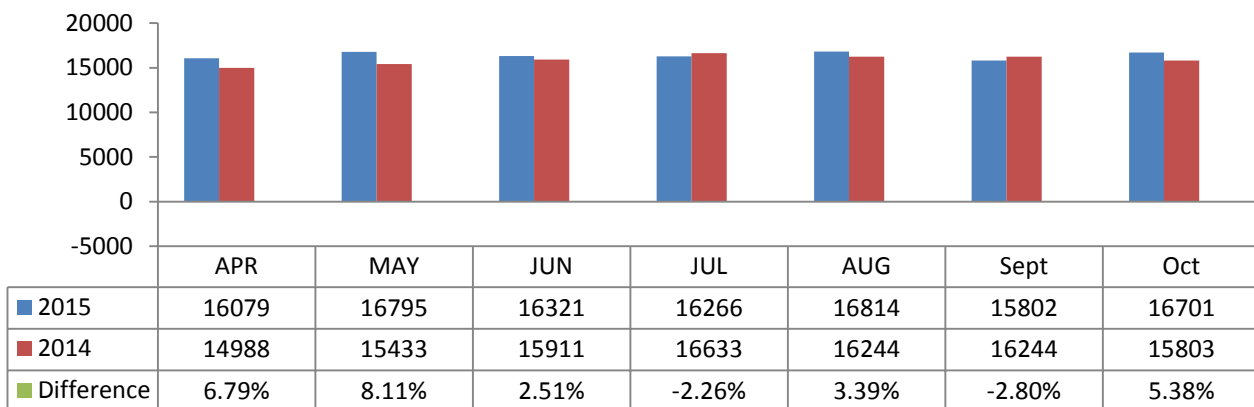
Overall Call Numbers

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



It is worth noting that for many emergency incidents NIAS receives multiple incoming telephone calls. Equally for every incident we are dealing with, there can be multiple outgoing calls made by control room staff in the management of that incident.

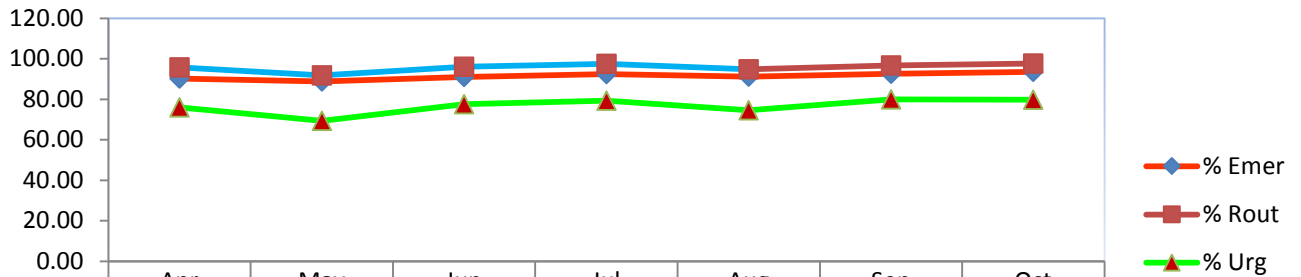
999 Call activity from 2014-2015



999 Call Answer Times

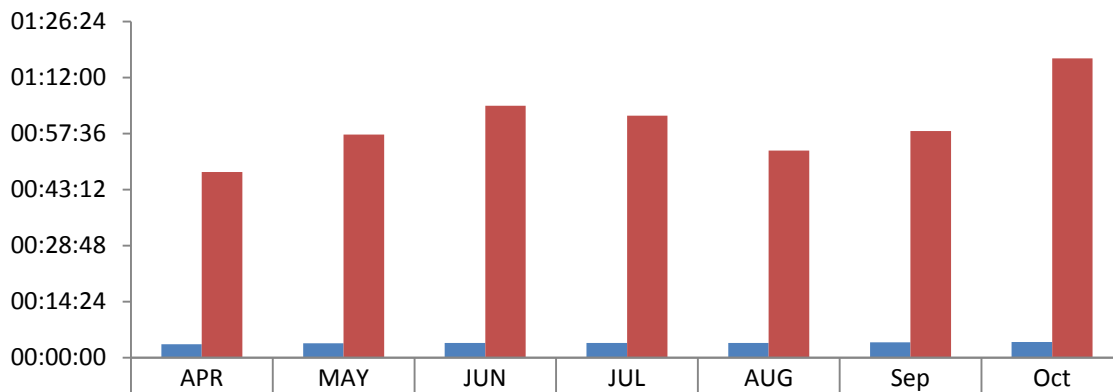
We aim to answer our telephone calls as quickly as possible and the delay between the call hitting our telephone switch and being picked up is 2 seconds. This requires a call-taker to be available. Call delays occur when there is no call-taker free when the call comes in.

Automatic Call Distribution - 95% Target



Call answering shows a higher achieved target for Routine calls due to all skill sets being able to handle them.

The target of 95% 999 call taking is yet to be achieved – new recruitment in EMD levels would be expected to improve this performance level.



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

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					
Non-Emergency Ambulances	94.3	94.3	87.7	86.8	83.0	83.0	83.0					
Rapid Response Vehicles	73.8	73.8	73.8	76.2	83.3	85.7	85.7					
Support Vehicles	36.7	36.7	36.7	40.0	40.8	40.8	44.9					
PERFORMANCE COMMENTARY: Additional Vehicles retained not in Establishment: 8, over 5 years old. 2014/15 Commissioning is ongoing.												

A&E: 21 vehicles operational out of 22. PCS: commissioning in November. RRV, cars: 9 operational out of 11 Specialist Vehicle: control. commissioning in November
--

FLEET IMPROVEMENT PROPOSALS FOR 2015/2016:

Commissioning is ongoing and vehicles will be rolled out as this is completed.
Introduction of new carry chair with clip-on tracks to aid descent of stairs will be rolled out with new vehicles.

Fleet Maintenance contract has been awarded in West.
Fleet recovery contract issued quarterly pending completion of tender.

2015/16

A&E and PCS conversion awarded.
PaLS will not allow award for 3 year period, must be quoted annually.

2016/17

November 2015, CRL adjusted to fund chassis purchase for 2016/17 conversion.

ESTATE CAPITAL PROGRAMME

BALLYMENA:

Building weatherproofed. Internal M&E fit out commenced.
Furniture and equipment specification and procurement initiated by NIAS team.
IT specs reviewed and procurement commenced.

ENNISKILLEN:

Archaeological survey methods agreed and licence granted.
Site occupied by 3-5 caravans, Western trust and PSNI serving notice.

OTHER

Uniform – National procurement finalised. NIAS in contract for National green uniform but retaining NIAS crest and HSC logo.

Estates – NIAS participating in Regional Minor Works Design Consultancy tender, NIAS Building Survey tender and NIAS Facilities Management tender.

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

Energy – NIAS participating in Regional CAG re energy contracts for 2016

NORTHERN IRELAND AMBULANCE SERVICE

TRUST BOARD REPORT

FINANCE DIRECTORATE

Director of Finance and ICT
01/12/2015

NIAS Savings Proposals Summary 2015/16

01.12.15

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 2015/16.

Ref #	Scheme	Detail Per TDP	Current Year Effect (£k)	OVERALL STATUS	Screening	Engagement	Monitoring of Impact	Monitoring of Finance	Update 08 September 2015
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, where 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 will commence 8 October 2015. Savings requirement allocated to Directorates to achieve non recurrently against management and administration (non front line) budget lines.
4	Non Pay Expenditure	Reduction in expenditure derived from further scrutiny and streamlining/re-provisioning of non-pay expenditure.	100	Started - on track	Started - on track	Not Required	Not Required	Started - on track	On Track Recurrently
5	Reduction in expenditure associated with 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 without impacting on delivery of mandatory clinical training.	300	Started - on track	Started - on track	Started - on track	Started - on track	Started - on track	On Track Recurrently
6	Fuel Savings	Specific saving associated with reduced price of fuel.	100	Started - on track	Started - on track	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	Started - on track	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	Started - on track	Started - on track	Started - on track	Started - on track	On Track Non Recurrently

FINANCIAL PERFORMANCE

Financial Breakeven

The Trust is currently forecasting a breakeven position at year end, 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. 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 October 2015 (Month 7) is a small surplus of £3k.

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					
Other Expenditure		1,651	2,593	3,467	4,347	5,282	6,200					
Expenditure Total		9,741	14,786	19,785	24,901	30,000	35,080					
Income		73	110	182	224	262	299					
Net Expenditure		9,668	14,676	19,603	24,677	29,738	34,781					
Net Resource Outturn		9,668	14,676	19,603	24,677	29,738	34,781					
Revenue Resource Limit (RRL)		9,668	14,685	19,620	24,677	29,737	34,784					
Surplus/(Deficit) against RRL		0	9	17	0	(1)	3					

Capital Spend

The Trust has received a Capital Resource Limit (CRL) of £7.608m (previously £7.481m). 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's allocation of £0.563m, to allow for the completion of the planned fleet replacement programme for 2015/16, is included in the CRL of £7.608m.

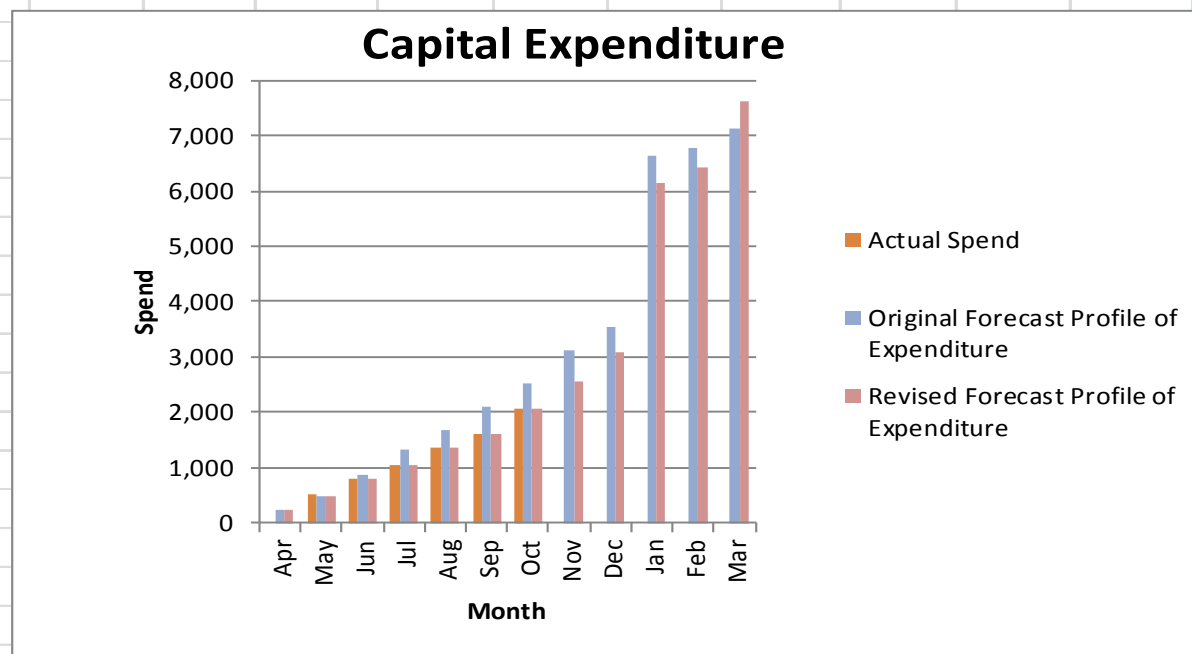
Cumulative capital spend at the end of October 2015 (Month 7) is shown in the table overleaf.

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					
Actual Disposals		10	22	27	39	39	40					

Cumulative Capital Spend (£k)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Fleet		0	114	114	114	114	114					
Estate		490	670	924	1,244	1,479	1,934					
Medical Equipment		0	0	0	0	0	0					
IT Equipment		0	0	0	0	0	0					
General Capital		12	0	0	16	16	16					
Actual Spend		502	784	1,038	1,374	1,609	2,064					
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	2,561	3,099	6,142	6,415	7,608



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 October 2015 (Month 7). Performance for the month has met and exceeded the targets set for the first time in the year.

A range of plans are in place to improve and maintain performance in this area over the rest of the year, however the cumulative target of 95% of invoices within 30 calendar days 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%.

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						10,031
Total bills paid within 30 calendar days of receipt of undisputed invoice	1,161	867	1,484	779	1,227	1,519	1,273						8,310
% bills paid on time	81.0%	74.5%	78.1%	92.8%	78.7%	84.1%	95.8%						82.8%
Total bills paid within 10 working days (14 calendar days)	733	646	974	506	884	1,043	995						5,781
% bills paid on time	51.2%	55.5%	51.3%	60.3%	56.7%	57.8%	74.9%						57.6%

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 October 2015 were not available in time for this report. Performance against these KPI's to the end of September 2015 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						
Percentage of Products Supplied on First Request % (Target 95%)	99.60%	99.04%	99.35%	98.96%	99.66%	98.52%						
Number of Lines Issued (Stock and Non Stock Line)	1,224	1,014	972	1,068	864	887						
Value of Spend £k (Stock and Non Stock)	135	158	135	571	1,414	315						

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.

17 September 2015 – Loss of DTR Data Services

PSNI arranged with NIAS to upgrade the Digital Trunk Radio (DTR) system out of hours to minimise disruption to staff. During this 4 hour period, on the desk contingencies for voice radio communications were invoked. Following the upgrade the DTR interface was re-enabled, tested and all working within specification with minimal disruption to service.

28 September 2015 – Radio Failure

A fault on the ICCS Radio server resulted in loss of voice radio communications for 5.5 hours. After extensive diagnostics by ICT out of hours support and the system support providers the fault was identified as a faulty power supply. The power supply was replaced by NIAS ICT and system restored to users. During downtime contingency systems were invoked with minimal impact on service delivery.

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 34 sites migrated to the new network and 13 sites still pending. A small number of sites are Problematic but a target date for completion of the project is 21 December 2015.

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.

ICT Help Desk Performance

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

	Sept			Oct		
Target to Respond to 95%	No of Calls	Within time	Actual	No of Calls	Within time	Actual
Immediate	6	6	100%	7	7	100%
Urgent	34	34	100%	36	36	100%
High	19	19	100%	30	30	100%
Medium	512	506	99%	535	531	99%
Low	684	684	100%	756	756	100%
Total	1255			1364		

ICT Planned Maintenance September 2015 – system upgrades Critical Systems

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

ICT Planned Maintenance September 2015 – system upgrades Corporate Systems

	Availability	Maximum down time	Actual	Exceeded Maximum Down Time	These are business support systems which need to be available on a 24/7 365 basis. It is anticipated however that up to 4hrs per month may be required to ensure that these systems are up to date and that the appropriate upgrades are in place. This target therefore aims to highlight any occasions when this planned 4hr period is exceeded.
E-mail	216	4 Hours	0	No	
File Server	216	4 Hours	0.10	No	
Virtual Server	218	2 Hours	0	No	
BlackBerry	216	4 Hours	1	No	
Promis	216	4 Hours	0	No	

ICT Planned Maintenance October 2015 – system upgrades Critical Systems

	Availability	Maximum down time	Actual	Exceeded Maximum Down Time	These are business critical systems which manage front line resources and need to be available on a 24/7 365 basis. It is anticipated however that up to 4hrs per month may be required to ensure that these systems are up to date and that the appropriate upgrades are in place. This target therefore aims to highlight any occasions when this planned 4hr period is exceeded.
C3 A&E	740	4 Hours	2.25	No	
C3 PCS	740	4 Hours	4	No	
Pro-QA	740	4 Hours	0	No	
ICCS A&E	740	4 Hours	0	No	
ICCS PCS	740	4 Hours	0	No	
DTR	740	4 Hours	0	No	
Voice Recorder	740	4 Hours	0.10	No	
Mobile Data	740	4 Hours	0	No	

ICT Planned Maintenance October 2015 – system upgrades Corporate Systems

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

Information Governance – Developments: 01/09/2015 to 31/10/2015

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

- ***Ongoing work on policy and procedures to support Information Governance across the Trust including Information Markers, Patient Report Form Policy. In addition a wide range of IG policies and procedures are planned for review and amendment in 2015/16.***
- ***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, roll of Directory Of Services, clinical quality indicators etc***
- ***Engagement with Resource Management Centre on informatics potential re: Global Rostering System (GRS)***
- ***Datasets to external stakeholders included – Antrim Area Hospital Medical Assessment Unit, road traffic collision data and maps, turnaround times, Nursing Homes datasets etc***
- ***Assessment of potential contribution to Cat A performance undertaken ref: first responders, AEDs,***
- ***Data to support viability of existing deployment points for local Area Managers***
- ***Ongoing work on policy and procedures to support Information Governance across the Trust including Information Markers, Patient Report Form Policy. In addition a wide range of IG policies and procedures are planned for review and amendment in 2015/16.***

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 31/10/2015

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 (2015-16)	Total (2014-15)
Number of Requests Received	4	11	11	8	6	15	19						74	93
Number of Questions Received	20	32	64	48	31	43	52						290	271
Completed Requests processed within 20 days or less	4	8	8	7	4	11	14						56	76
Completed Requests exceeding 20 days	0	3	2	1	0	4	0						10	14
REQUESTS Still Being Processed	0	0	0	0	0	0	4						4	
REQUESTS Still being processed (outside 20)	0	0	1	0	2	0	0						3	
Stood Down	0	0	0	0	0	0	1						1	
Number of Records Fully Disclosed	20	25	53	43	17	43	24						225	
Vexatious Requests	0	0	0	0	0	0	0						0	
Number of Records for which records not held	0	0	0	4	0	0	0						4	
Requests where exemptions wholly/partially applied	0	7	3	1	0	0	1						12	
Questions stood down	0	0	0	0	0	0	9						9	
QUESTIONS Still Being Processed	0	0	0	0	0	0	18						18	
QUESTIONS Still Being Processed (outside 20)	0	0	8	0	14	0	0						22	
Referrals for Independent Review	1	1	0	0	0	0	0						2	
Appeals to the Information Commissioner	0	0	0	0	0	0	0						0	
Requestor Type														
Member of Public	3	2	4	5	2	3	7						26	
Local Government	0	1	1	0	0	1	0						3	
Staff Member	1	5	2	1	1	8	4						22	
Media	0	1	0	2	1	1	2						7	
Student	0	0	0	0	0	0	4						4	
Commercial Company	0	0	2	0	1	0	0						3	

Solicitor	0	0	0	0	0	0	0						0	
WhatDoTheyKnow.com	0	2	2	0	1	1	1						7	
NHS	0	0	0	0	0	0	0						0	
Trade Union	0	0	0	0	0	0	1						1	

- From 01/04/2015 to 31/10/2015- 76% of requests have been processed within 20 working days
- For the same period of monitoring, there was an additional 19 questions received than in 2014/15, with requests in total being down by 19

DATA PROTECTION ACT 1998 – SECTION 7: SUBJECT ACCESS MONITORING

REPORT FOR DPA PROCESSING (SUBJECT ACCESS) FOR THE PERIOD OF 01/04/2015 to 31/10/2015

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 – Oct 15
Number of Requests Received	2	4	2	1	3	1	1						14
Completed Requests processed within 40 days or less	2	2	1	0	1	1	1						8
Completed Requests exceeding 40 days	0	1	0	1	-	0	0						2
Identity Not Confirmed and therefore could not be further processed	0	1	1	0	2	0	0						4
Patient	0	1	1	0	2	0	0						4
NIAS Staff Member	2	2	1	1	1	0	1						8
External Agency	0	1	0	0	0	1	0						2
Relative of Patient	0	0	0	0	0	0	0						0

- **From 01/04/2015 to 31/10/2015: 80% 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 31/10/2015

Purpose:

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

<i>Requests will relate 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</i>	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr 15 – Oct 15	Apr 14 – Oct 14
Number of Requests Received (based on receipt of correspondence date)	25	18	28	21	44	27	31						194	221

SOLICITOR ENQUIRIES for the Period of 01/04/2015 to 31/10/2015

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 – Oct 15	Apr 14 – Oct 14
Number of Requests Received (based on receipt of correspondence date)	42	37	31	48	43	65	62						328	312

DEPARTMENT OF HEALTH AND SOCIAL SERVICES – REQUEST FOR INFORMATION for Period of 01/04/2015 to 31/10/2015

DHSSPS/AQ's/CORs/TOF's/INV's	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April 15 – Oct 15
Assembly Questions (Oral)	0	0	0	0	0	0	0						0
Assembly Questions (Written)	3	9	4	7	4	5	4						36
CORs Received	2	0	2	2	4	2	1						13
TOFs Received	0	0	0	0	0	0	0						0
INVs Received	0	0	0	0	0	1	0						1



15/16 - PRF v PATIENT NUMBERS COMPARISON

Summary		Patient Journeys				Completed PRFs (Formic)	Difference
Month	Emergency Calls responded to (KA34)	Emergency	Urgent	Routine	Total		
April 2015	14699	12323	n/a	353	12676	15158	+2,482
May 2015	15151	12610	n/a	357	12967	15743	+2,776
June 2015	15031	12537	n/a	360	12897	15879	+2,982
July 2015	15052	12297	n/a	399	12696	15651	+2,955
August 2015	15491	12770	n/a	420	13190	16093	+2,903
September 2015	15220	12731	n/a	357	13088	15782	+2,694
October 2015	16096	13343	n/a	457	13800	12537	-1,263
November 2015							
December 2015							
January 2016							
February 2016							
March 2016							
Total	106740	88611	2703	91314	106843		

* 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 CORPORATE SERVICES DIRECTORATE

Director of Human Resources and Corporate Services

02/12/2015

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

September 2015 Position	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)	1129.25 (50.88)	7.00	25.63 (2.00)	62.94 (3.00)	8.00 (1.00)	1031.68 (38.88)
Staff-in-Post Headcount	1210	7	29	67 (74*)	9	1098 (1112*)
Vacancy Levels	-94.41	0.00	-3.00	-5.21	1.00	-91.20

Commentary:

The Trust's Workforce Information Report is produced on a quarterly basis by the HR Department. Information is extracted from the HRPTS system and reconciled between the HR, Finance and Operations Departments for validation purposes. NIAS funded establishment on 30 September 2015 was a total of 1274.54 WTE. At this date NIAS total Substantive in Post (permanent & temporary contracts) was 1180.13 WTE including 50.88 WTE made up of 110 part-time staff (Headcount). The total Staff in Post (Headcount) figure was 1210. In addition, there are currently 27 seconded staff i.e staff working temporarily in posts other than their substantive posts.

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.

Job Evaluation for Paramedics, RRV Paramedics and EMTs

Job Evaluations for Paramedics, RRV Paramedics and EMTs remain ongoing. Trust Board is aware that the Regional Quality Assurance (RQA) team, who are considering the NIAS jobs under the NHS Job Evaluation Scheme, have submitted questions to both management and staff side representatives for each of the three Job Evaluation Questionnaires. RQA team have requested a set of agreed answers to these questions, signed off by both management and staff side for each individual job. The RRV Paramedic response has already been agreed by the post holder representative and management representative and sent back to the RQA team. For the Paramedic and EMT posts, separate responses from the post holder representative and management representative have been forwarded and accepted by the RQA team. The Trust awaits the outcome from the RQA team and continues to request progress updates on a monthly basis.

Recruitment Activity

Further to report to Trust Board in October 2015, 23 Ambulance Care Attendants have commenced, with their training nearing completion and 23 Emergency Medical Technicians are to commence training in November. Work is ongoing to finalise offers for a further cohort of EMT's and ACA's in 2016.

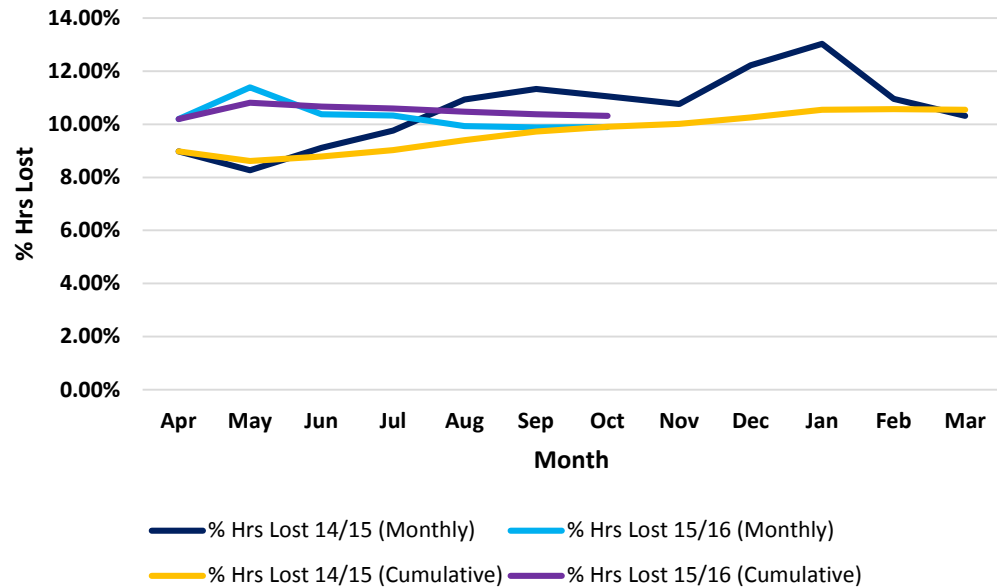
Section 1: Human Resources & Corporate Services

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

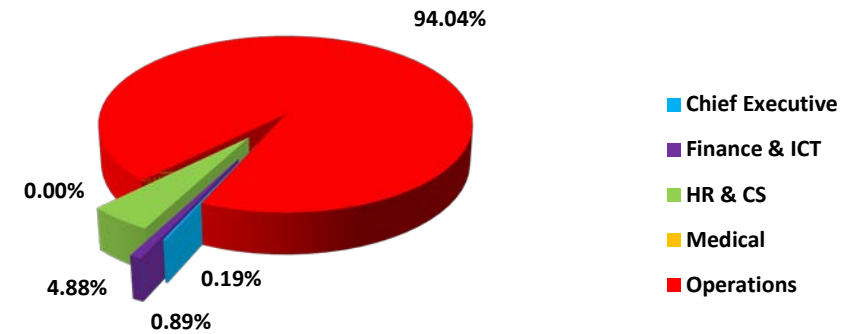
% Hours Lost Due to Sickness Absence in NIAS

Hrs Lost	A	M	J	J	A	S	O	N	D	J	F	M
14/15 (Monthly)	8.98	8.27	9.11	9.76	10.93	11.33	11.05					
15/16 (Monthly)	10.20	11.39	10.38	10.33	9.93	9.88	9.89					
Emp/ees ½ pay	14	17	16	18	19	16	18					
Emp/ees no pay	8	7	11	11	10	10	9					
14/15 (Cumul.)	8.98	8.62	8.78	9.03	9.40	9.72	9.91	10.01	10.26	10.54	10.57	10.55
15/16 (Cumul.)	10.20	10.81	10.67	10.59	10.47	10.37	10.31					

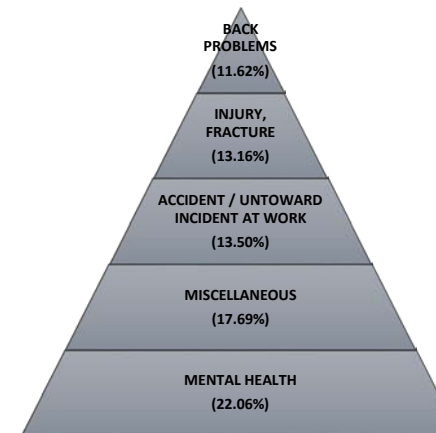
Comparison of % Hrs Lost due to Sickness Absence



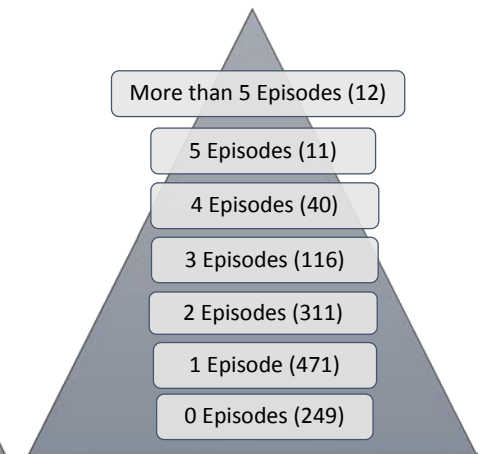
Hours Lost by Directorate (Oct 2015)



(Top 5)Reasons for Absence (Oct 2015)



No. of Episodes of Absence (1-Nov-14 – 31-Oct-15)



Commentary:

The % absence calculation within HRPTS has now been fixed and Trust Board reports now show % sickness figures. It has been agreed regionally to report sickness absence as a percentage of hours lost. HR staff continue to participate in regional absence reporting workshops to share good practice and develop an agreed suite of regional absence reports and are reviewing internal absence reports as a consequence of this.

In relation to the Top 5 Reasons for Absence, 22.06% of the total hours lost during October 2015 were attributed to Mental Health related reasons. Additionally, the Trust is now in a position to further define reasons, which had previously been attributed to Musculoskeletal, into 'Back Problems' and 'Injury, Fracture'. The category entitled 'Miscellaneous' includes 'General Debility', 'Post Surgical Debility', 'Chronic Fatigue Syndrome' and 'Hospital Investigation'.

Attendance continues to be managed in line with the Trust's Health and Wellbeing Attendance Management Action Plan. 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. SLA meetings continue between HR and Occupational Health as do meetings with Care Call to address prevalent issues related to staff absence e.g. Stress Management. The Trust's Attendance Management Policy/Procedure is currently under review and will ensure that the Trust's approach to this matter is consistent with the regional HSC Policy Framework of Best Practice for Managing Attendance with has recently been agreed at Regional JNF.

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 Oct 2015	TRUST TOTAL	Patient Care	Willful Damage	Criminal Conduct	Fraud	Failure to comply with Trust Policy / Procedure
New Cases	3	1	0	0	0	2
HCPC Referrals	0	0	0	0	0	0
Suspensions	3	0	0	3	0	0
Total Active Cases	17	7	0	3	2	5

Grievance Cases:

Position as at Oct 2015	TRUST TOTAL	Transfer	Application of T&C	Recruitment	Job Evaluation	Equal Opps	Employee Relations Processes	Promotion	Pay
New Cases	0	0	0	0	0	0	0	0	0
Informal Stage	2	0	1	0	1	0	0	0	0
Formal Stage 1	19	2	13	1	0	0	1	2	0
Formal Stage 2 (Appeal)	3	0	1	0		0	1	1	0
Total Active Cases	24	2	15	1	1	0	2	3	0

Working Well Together / Harassment Cases:

Position as at Oct 2015	TRUST TOTAL
New Cases	0
Informal Resolution / withdrawn	0
Inv Ongoing	2
Formal Stage 1	1
Formal Stage 2 (Appeal)	0
Total Active Cases	3

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.

Case File Closures:

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

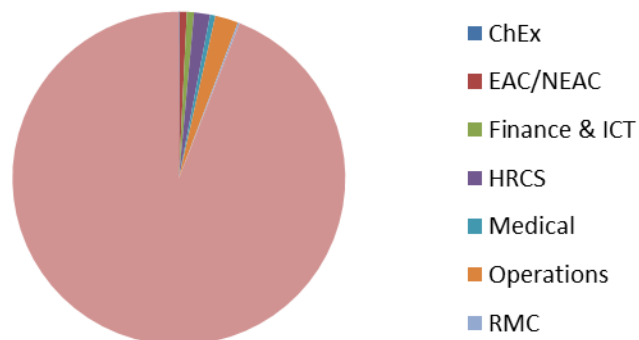
Section 1: Human Resources & Corporate Services

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%

% of Staff with ESS access



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. Deployment within NIAS remains significantly hampered due to ongoing IT Infrastructure limitations (deployment figures remain as at August 2015 figures) particularly at station level where a substantial majority of NIAS employees are based. Work is currently ongoing 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. As a consequence of regional workshops which took place during May–September 2015, change requests for system enhancements are being prioritised processes and system capability are optimised.

SHARED SERVICES

The Recruitment & Selection (R&S) function of the HR Department was scheduled to move to BSO Shared Services in September 2015, however, this has been slightly delayed and work is ongoing to ensure transition in early 2016. The transition will impact directly on staff within the HR Department and staff will be supported during 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 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.

	April to September	Oct	Nov	Dec	Jan	Feb	Mar
Operations Directorate	N/A	N/A					
Medical Directorate	N/A	N/A					
Finance & ICT Directorate	N/A	N/A					
HR & CS Directorate	N/A	N/A					

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.
- Delivery of the RATC 2015/16 core clinical training programme for 4 EMT cohorts and 4 ACA cohorts continues to be delivered to plan and the 2016/17 training plan is being finalised to ensure effective delivery to meet the Trust's workforce needs. To date in 2015 this has provided Operations with an additional 43 EMTs (23 currently on practice placement) and 64 fully operational, newly qualified ACAs.
- The delivery of a new CPD programme for emergency and non-emergency operational staff commenced in September 2015. This programme is complemented with a refreshed work book that includes mandatory and statutory training.
- Evaluation of the pilot for a new quality improvement project is currently being undertaken by the project team. 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.
- Introduction of new OFQUAL regulated clinical and driving courses for EMTs and ACAs is planned for 2016/17. These courses which are within the Qualification Credit Framework (QCF) will provide EMTs with a level 4 and ACAs with a level 2 qualification that will allow greater capacity for future educational progression of our operational workforce.

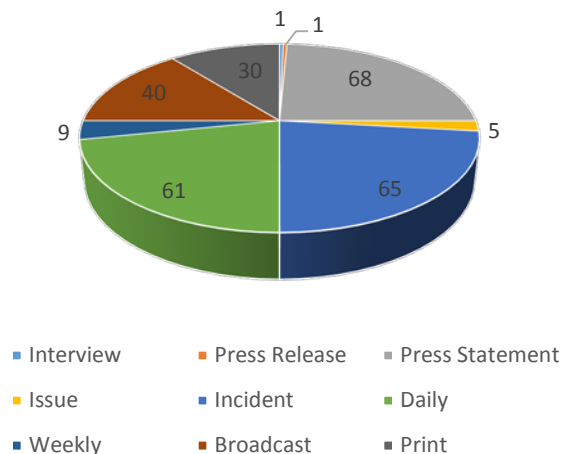
Section 3: Equality & Human Rights/Personal and Public Involvement/ Patient Experience/Media and Communication
HRCS KPI: Supporting Trust Priorities; Transformation and Modernisation; Equality and Human Rights; Partnership & Employee Engagement

<u>NIAS Responses to Consultations September/October 2015</u>			
Date of Response	Consultation Title & Summary	Summary of NIAS Response	Link to Consultation
9/9/2015	Southern Trust – Proposal for the Closure of Armagh MIU	NIAS has introduced Alternative Care Pathways to direct patients with minor injuries away from EDs to more appropriate care in MIUs. Closure of Armagh MIU would limit the scope and effectiveness of the ACP and would necessitate the use of less appropriate services such as Craigavon Hospital ED.	http://www.southerntrust.hscni.net/consultations
18/9/2015	Southern Trust – Proposal for the Future of Statutory Care for Older People	The proposal may result in an expectation that NIAS would be involved in transporting patients to alternative centres of treatment. This would require appropriate resourcing and funding.	http://www.southerntrust.hscni.net/consultations
22/9/2015	HSC Pensions Policy/HMRC – Pensions Tax Relief	The complexity of the current pensions tax relief system does not appear to undermine the incentive to save into a pension. The benefits of paying into a pension during working life are not promoted sufficiently. An easier to understand system which clearly sets out the benefits is likely to result in greater engagement in pensions saving.	https://www.gov.uk/government/consultations/strengthening-the-incentive-to-save-a-consultation-on-pensions-tax-relief

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	
Equality Scheme implementation <ul style="list-style-type: none"> • In line with the Trust's Equality Scheme policy screening for potential impact on 9 Section 75 categories is undertaken for policies across directorate areas. Screening outcomes are published in quarterly reports. Recent policy screening work within this reporting period has included a focus on Information Governance, placement of Information Flags and service developments linked to the Trust's Transformation Modernisation Project. 	Key Work Streams <ul style="list-style-type: none"> • The Trust continues to participate in work streams led by the DHSSPS Equality and Human Rights Steering Group. This includes a collaborative approach across HSC to statutory requirements. Current regional discussions include forthcoming age discrimination legislation in respect of access to goods facilities and services and e-learning for HSC Staff in respect of access to goods facilities and services. • 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 equality and PPI/Patient Experience elements within policy development in the Trust.
Human Rights <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • 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, PPI and Patient Experience considerations. • Recent work has included work to support policy development in respect of Information Markers, budget plans, shift planning and Transformation and Modernisation initiatives. Outcomes of the team's involvement have included service user engagement in policy development and feedback, patient experience questionnaires designed for Alternative Care Pathways and the development of an equality and human rights framework within which to plan the Trust's policy for the placement of Information Markers.

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 Media Activity Sept & Oct 2015



Key Themes in Press Coverage

- Throughout July and August, NIAS issued 1 proactive press release and 68 Press Statements in response to enquiries from the media.
- 1 media interview was conducted during the period.
- The number of media outlets reached in this period totalled 72 (each response equates to 1 outlet reached)
- Press statements tend to be issued in response to particular incidents which in this case included RTC's, collapse in public place, stabbings.
- Press releases in this period related to:
 - A successful resuscitation in the Banbridge area
- Other Corporate issues which were addressed reactively, in response to media, staff issues in Omagh and the impact on provision of emergency cover following rumours of the closure of ED in Daisy Hill Hospital. This issue was referred to Southern Trust.
- 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	33
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- 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 is underway 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, 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 presentation was made to patients at a Diabetes UK group. Meetings with the HR Commission, Community/Private Ambulance providers were held.

The Programme Manager and Clinical Service Improvement lead presented at the PHA 'Making Lives Better' strategy launch

Results

Between April 2015 and 31st of October 2015 an additional 3585 patients were safely and effectively managed without conveyance to ED in comparison with the same period in 13/14 and 539 patients were conveyed to an alternative destination following paramedic referral such as the Cath lab, BCH Direct, Minor Injury Units or Medical Assessment Units.

Appropriate Care Pathways Highlight Report:

- **Diabetes Treat, Leave and Refer/Minor Injury Units/Palliative Care/Cardiac/Frail Elderly/Medical Assessment Unit/Falls services:**

These pathways continue to be used for referral in the Trusts/areas in which they are available.

- **Respiratory:** a pilot pathway for referral of appropriate patients with COPD straight to Community Respiratory nurses in BHSCT and WHSCT for specialist assessment was launched on 9th of November.
- **Acute Care at Home:** on 9th of November NIAS began referring appropriate patients to a new service provided by BHSCT Older People's services in patients' homes.
- **Epilepsy:** a regional Treat and Leave protocol for patients with confirmed Epilepsy was implemented on 9th of November 2015.
- **Mental Health:** plans for a pilot are underway for patients with mental health issues who do not require medical treatment are still being discussed with Clinical and managerial staff in each Trust with support from PHA and HSCB.
- A range of local and regional meetings have been held in relation to progressing these and other pathways.

Clinical Support Desk Highlight Report:

- Since the proposed paramedic led CSD cannot be progressed at present a contingency plan of enhancing the current GP model for 3 months from 1st of December, 2015 has been agreed to enable and extend "Hear & Refer" and "Hear & Treat" pathways.

Directory of Services Highlight Report:

- The NIAS Directory of Services is being installed and tested. Staff in EAC are being trained and the DOS will 'go live' on 1st of December, 2015.

Transformation and
Modernisation
Programme
Overview

Last updated 18/11/2015

Programme Element	Sub Category	Deliverables	Responsible	Due	Projected date	NIAS Read-iness	Risk	Measures to address Risk	Status					
									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.						
		Review Effectiveness	DMM/FR	31/01/2015	28/02/2016		Waiting on Audit proposal to be progressed; now agreed.	Pilot of new QI process completed in Belfast with analysis shared. Mtg planned regarding rollout; CSO workload is a constraint						
		Evaluate Benefits	DMM/FR	31/01/2015	28/02/2016		Waiting on Audit proposal to be progressed; now agreed.	Pilot of new QI process completed in Belfast with analysis shared. Mtg planned regarding rollout; CSO workload is a constraint						
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	28/02/2016		Waiting on Audit proposal to be progressed; now agreed.	Pilot of new QI process completed in Belfast with analysis shared. Mtg planned regarding rollout; CSO workload is a constraint						
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	28/02/2016		Waiting on Audit proposal to be progressed; now agreed.	Pilot of new QI process completed in Belfast with analysis shared. Mtg planned regarding rollout; CSO workload is a constraint		N/A				

		Evaluate Benefits	CMcK & NR	31/01/2015	28/02/2016		Waiting on Audit proposal to be progressed; now agreed.	Pilot of new QI process completed in Belfast with analysis shared. Mtg planned regarding rollout; CSO workload is a constraint		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.							
		Review Effectiveness	CMcK&NR	31/03/2015	28/02/2016		Waiting on Audit proposal to be progressed; now agreed.	Pilot of new QI process completed in Belfast with analysis shared. Mtg planned regarding rollout; CSO workload is a constraint							
		Evaluate Benefits	CMcK&NR	31/03/2015	28/02/2016		Waiting on Audit proposal to be progressed; now agreed.	Pilot of new QI process completed in Belfast with analysis shared. Mtg planned regarding rollout; CSO workload is a constraint							
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	28/02/2016		Waiting on Audit proposal to be progressed; now agreed.	Pilot of new QI process completed in Belfast with analysis shared. Mtg planned regarding rollout; CSO workload is a constraint							
		Evaluate Benefits	CMcK&NR	31/03/2015	28/02/2016		Waiting on Audit proposal to be progressed; now agreed.	Pilot of new QI process completed in Belfast with analysis shared. Mtg planned regarding rollout; CSO workload is a constraint							
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	9th Dec 15			1 month review of pathway to take place							

[illegible]

[illegible]

[illegible]

Section 1: Human Resources & Corporate Services

HRCS KPI: Support Trust Priorities

Complaints / Compliments Report

September Position	Trust Total	A&E	PCS	Control & Comms	Other	VCS
Number of Complaints	79	33	10	36	0	0
Complaints Responded to within 20 Days (%)	18%					
Compliments Received	69	67	0	2	0	0

Main Issues Raised Through Complaints

The main issues raised are delay/non arrival of ambulance and staff attitude.

The Trust actively encourages feedback from our service users including complaints, compliments or enquiries. Such feedback helps identify areas where high quality care is being provided and, where this is not the case, use these as an opportunity for learning and improving services.

We aim to respond to complaints within 20 working days, where possible, and strive to ensure that there is a full, fair and objective investigation of the issues and concerns raised and that an effective response / outcome is provided. We will continue to do our utmost to resolve complaints however this may not be possible in all cases.

Compliments and suggestions/comments made by service users are acknowledged and shared with relevant staff / teams. The main areas in which compliments are received relate to the service provided by Accident and Emergency staff.

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	37													
Claims Received		1	2	0	1	0	1							42
Claims Settled		1	0	0	0	0	0							1
Cases Ongoing														41
Public Liability	4													
Claims Received		0	0	0	0	0	2							6
Claims Settled		0	0	0	0	0	0							0
Ongoing														6
Clinical Negligence	6													
Claims Received		0	0	1	0	0	2							3
Claims Settled		0	0	0	0	0	0							0
Ongoing														9

Lessons Learned:

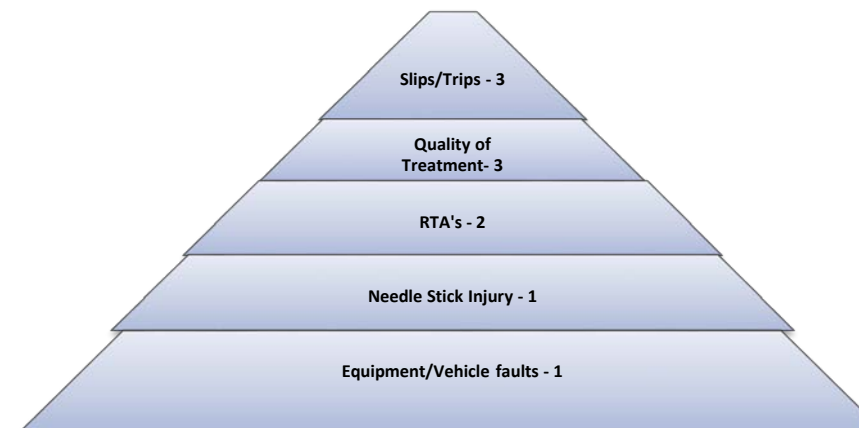
1 case settled – No learning identified.

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



NORTHERN IRELAND AMBULANCE SERVICE

TRUST BOARD REPORT

MEDICAL DIRECTORATE

Medical Director
17 November 2015

Medical Directorate Performance Report for Trust Board (September-October 2015)

Emergency Planning & Business Continuity	
	<p>Please refer to attached Emergency Planning Report for September-October 2015.</p> <p>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 and the Plan is currently being printed and will be distributed in both hard copy and electronic format for ease of access by Officers during an incident.</p> <p>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 took place on 25 November 2015. This will inform the development of new and review of existing business continuity plans during 2015/16. This will include a review of current escalation plans and the outcome of debriefs in relation to recent industrial action.</p> <p>A review of on call arrangements to support emergency planning incident response and business continuity is being undertaken and recommendations will be brought forward in Q4.</p>
Risk Management	
<i>Corporate Risk Register</i>	Please refer to the Corporate Risk Register to end October 2015.
<i>Incident Reporting Procedures</i>	A review of the incident reporting procedure to enhance the reporting of patient-related incidents has commenced. However due to the imminent retirement of the Risk Manager, completion of this will be delayed but it is anticipated that it

	<p>will be complete by Q4. 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.</p> <p>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.</p>
<i>Outcomes from Reports, Alerts, etc.</i>	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, for example significant trauma, are anticipated in February 2016. New resuscitation guidelines were published by the European Resuscitation Council in October 2015 and are currently being evaluated in relation to any change in practice and training implications, although these do not appear to be significant.
Clinical Care	
<i>Regional Community Resuscitation Strategy</i>	The Regional Community Resuscitation Strategy Implementation Group chaired by the NIAS Medical Director met in June 2015 and again in September 2015. 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

	<p>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.</p> <p>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.</p> <p>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.</p> <p>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) is still awaited. Existing funding to support current training initiatives ended September 2015. Prior to this a number of Trust CRDOs redeployed to 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 has now been deferred until March 2016, with support only being provided to existing initiatives in the interim. 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 will now be brought to the attention of the Minister, Permanent Secretary and CMO for resolution.</p>
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<i>Patient Report Form (PRF)</i>	<p>A revised Patient Report Form (PRF) to reflect new clinical guidelines, referral pathways and regional physiological early warning scores was 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 will be presented to the Assurance Committee in December 2015.</p> <p>An associated revised policy for PRF completion is currently being drafted.</p>
<i>Electronic Patient Report Form (ePRF)</i>	<p>The Outline Business Case was submitted to DHSSPS 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.</p> <p>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 has been agreed that a letter of conditional support from Commissioners will 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.</p> <p>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 would indicate that a decision was unlikely before end September 2015 but unfortunately no decision has been made as of end November 2015 despite a number of contacts with HSCB. It is a matter of concern that this significant delay will now impact on project deadlines and milestones. Engagement with HSCB is ongoing in order to secure a decision.</p>

<p><i>Annual Quality Report</i></p>	<p>Meetings with DHSSPS in relation to the 2014/15 Annual Quality Report as part of Quality 2020 have taken place. The Trust 2014/15 Annual Quality Report was completed during October 2015, reviewed by DHSSPS and published in November 2015. The report will be presented to Trust Board in December 2015.</p> <p>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.</p>
<p><i>Alternative Care Pathways</i></p>	<p>An appropriate transport / referral policy and guideline approved by Trust Board in March 2015 has been circulated and implemented in July 2015.</p> <p>A number of policies are in the final stages of development and will be circulated for consultation and comment within the Trust. These include information markers and frequent callers.</p> <p>During the previous reporting period 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. A Falls Referral pathway was introduced on 1 June 2015 in the Northern, Southern and South Eastern Trust areas.</p> <p>During this reporting period a Belfast Acute Care at Home pathway was 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. 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 introduced.</p>

	<p>A Directory of Services has now 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 such as the Manchester Triage Tool in use by a number of other Ambulance Services is currently being assessed. The establishment of the CSD in Emergency Ambulance Control (EAC) has been 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. A three month pilot of an enhanced NIAS GP CSD will commence on 1 December 2015.</p>
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Personal Public Involvement / Patient Client Experience	
<p><u>Patient and Client Experience Standards (PCES)</u></p>	<p>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.</p> <p>The Trust continues to be represented in regional work streams around the Minister's standards: Respect; Attitude; Behaviour; Communication; and Privacy and Dignity.</p> <p>The Trust has 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</p>

	<p>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.</p> <p>A key focus in respect of this work is improved practice informed by learning outcomes. A report detailing this work for the period 2014-15 was provided to the PHA in July 2015.</p>
<u>Personal and Public Involvement (PPI)</u>	<p>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. Within this framework, 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. 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.</p>



EMERGENCY PLANNING REPORT for September and October 2015

KPI No		April	May	June	July	August	September	October
2	No of Potential Major Incidents	1	1		2	5	1	1
	No of Declared Major Incidents	1		1				
	No of Airport alerts							
	Belfast International Airport			2		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
	Hazardous Material Incidents (HART calls)		22	25	43	49	48	27
	HART pre-planned deployments		3	2	2	3	1	
4	Training sessions	2	3	1			3	1
	Emergency Planning	2	1	2	2	2	2	2
	HART	6	4	9			6	4
	Business Continuity		1	1				
5	Exercises							
	Live	2	1	4	1		3	2
	Tabletop	1	1	1				1
	Observer		1	0				
6	Updates or amendments to MIP							

Potential Major Incident

On 10 September 2015 at 02.07 NIAS received a call to Ahoghill for a report of two explosions. A potential Major Incident was called. Five A&E crews, one Doctor and two Officers were tasked to the scene. The Emergency Equipment Vehicle, the Mobile Control Vehicle, another Doctor and two Officers were also available but not deployed. Two hospitals were alerted to the potential Major Incident. The scene was declared clear of any casualties and incident was stood down 02.25.

On 5 October 2015 at 21.28 NIAS received an emergency call to Londonderry for report of an explosion at a private dwelling. A potential Major Incident was called and two A&E crews, one Rapid Response Vehicle crew, three Officers, the Emergency Equipment Vehicle and the Mobile Control Vehicle were tasked to the scene. Five officers were also available but not despatched. The incident was stood down after the first crew arrived on scene and confirmed with PSNI that it had been due to a firework. No casualties were found at the scene.

Major Incidents

There were no declared major incidents during this period.

Airport Alerts

On 6 September 2015 at 00.32 NIAS received an airport alert to the Belfast International Airport for a report of a helicopter with engine failure. The initial report was that there were three persons on board the helicopter. Two A&E crews and an Officer were tasked to the scene. The Emergency Equipment Vehicle & the Mobile Control Vehicle were available but not despatched. The incident was stood down by air traffic control at 00.33 as the helicopter had landed safely.

During this alert there was an issue reported with the direct dial line from the airport to Ambulance Control, with the airport stating that they also could not get through on the 999 line. This has been investigated and was found to be due to operator error at the airport. This will be raised at the next airport meeting.

On 27 October 2015 at 19.57 NIAS received an airport alert to the Belfast City Airport for an aircraft making an emergency landing with a report of an engine failure. The initial call from air traffic control stated 220 passengers on board, however this was reviewed down to 115. Six A&E crews, seven Intermediate Care Vehicles / Patient Care Service crews, one Rapid Response Vehicle, six Officers, two Doctors, the Emergency Equipment Vehicle and the Mobile Control Vehicle were tasked to the airport rendezvous point south. At 20.15 the NI Fire & Rescue Service (NIFRS) called to say that they were being diverted to the Belfast International

Airport. This was confirmed with NIFRS at the Belfast City Airport and all resources were then diverted to Belfast International Airport. Five hospitals were alerted to the potential for patients and were only stood down at 20.57.

A number of issues were identified, for example the road markings at the new rendezvous point at the Belfast International Airport are difficult to see in the dark and the need for additional signage to assist crews to park in the correct lane.

HAZMAT / Hazardous Area Response Team (HART) Deployments

61 = Deployments with Breathing Apparatus skills / HAZMAT deployments

6 = Restricted space

5 = Incident at height

0 = Inaccessible area (mountain rescue)

2 = Rope rescue

1 = Inland Water Operation



William Newton
EMERGENCY PLANNING OFFICER



NIAS STEMI KPI DEFINITIONS

DIRECT ADMISSION = PATIENT TRANSPORTED FROM SCENE OF INCIDENT DIRECTLY TO CATH LAB BY NIAS

NON-DIRECT ADMISSION = PATIENT EITHER SELF-PRESENTED AT A HOSPITAL OR WAS TAKEN TO AN EMERGENCY DEPARTMENT BY NIAS AND WAS THEN SUBSEQUENTLY TRANSFERRED TO A CATH LAB

KPI1: RESPONSE TIME

% Category A calls for patients with a main complaint of chest pain or breathlessness, who are accepted for pPCI via NIAS referral (including emergency transfer requests from another hospital), with a response time of 8 mins from call to arrival on scene.

KPI2: PRE-HOSPITAL ECG

% patients accepted for pPCI with ST elevation on pre-hospital ECG who are transported directly to cath labs for pPCI.

KPI3: TIME AT SCENE

% patients accepted for pPCI via NIAS referral with an on-scene time of less than 25 mins.

KPI 4: DRIVE TIME

% patients accepted for pPCI with a drive time of less than or equal to 90 mins.

KPI 5: APPOINTMENT TIME

% patients who have been collected for repatriation within +/- 1 hour of requested target time.

KPI 6: CALL TO BALLOON

% patients accepted for pPCI with CTB (Call to Balloon) of less than 150 mins.



STEMI OVERVIEW - DIRECT ADMISSIONS PER TYPE OF CALL

October 2013 - October 2015

Direct Admissions

Month	RVH Cath Lab					ALT Cath Lab					Direct Cath Total				
	Cat A	Cat B	Cat C	Urgent	Totals	Cat A	Cat B	Cat C	Urgent	Totals	Cat A	Cat B	Cat C	Urgent	Totals
Oct 2013	27	7	1		35						27	7	1		35
Nov 2013	19	10			29						19	10			29
Dec 2013	25	6			31	1				1	26	6			32
Jan 2014	30	10			40						30	10			40
Feb 2014	19	7			26						19	7			26
Mar 2014	24	15			39						24	15			39
Apr 2014	20	6		1	27	3	3			6	23	9		1	33
May 2014	23	10	1	1	35	3	3			6	26	13	1	1	41
Jun 2014 *	21	4	1		26	8	1			9	29	5	1		35
Jul 2014	27	1			28	6				6	33	1			34
Aug 2014	19	3			22	4	1			5	23	4			27
Sep 2014	20	1	1		22	7				7	27	1	1		29
Oct 2014 **	24	1	1		26	3	2			5	27	3	1		31
Nov 2014	32	3			35	10				10	42	3			45
Dec 2014	16	3	1		20	6	1			7	22	4	1		27
Jan 2015	26	1			27	8	1			9	34	2			36
Feb 2015	25	4	1		30	9	1	1		11	34	5	2		41
Mar 2015	24	5	1		30	5	1			6	29	6	1		36
Apr 2015	24	2			26	4				4	28	2			30
May 2015	36	6			42	6	1			7	42	7			49
Jun 2015	30	4	1		35	3				3	33	4	1		38
Jul 2015	31	3			34	8				8	39	3			42
Aug 2015	23	3			26	14				14	37	3			40
Sep 2015	24	5			29	4	2			6	28	7			35
Oct 2015	29	3	1		33	3				3	32	3	1		36
Total	618	123	10	2	753	115	17	1		133	733	140	11	2	886

* RVH Cath Lab opened June 2014

** Altnagelvin Cath Lab opened October 2014

Please note: On 15/06/2014 NIAS ceased classifying calls as 'urgent'. These calls became Category C HCP emergencies. Category C HCP calls are included in the overall Category C total from this date onwards

Due to a time lag in the data collection process, figures for Altnagelvin Cath Lab referrals are usually updated retrospectively.
Totals presented above are likely to represent 'under-reporting'.

Data Disclaimer

This data may be subject to further amendment at any point in the future pending updates from the Cath Labs at RVH and at Altnagelvin and data quality auditing by NIAS.
Please use this data with appropriate caution and all necessary disclaimers.



STEMI OVERVIEW - NON-DIRECT (HOSPITAL) ADMISSIONS

October 2013 - October 2015

Referring hospital	Admitted to		
	RVH Cath Lab	ALT Cath Lab	Totals
ALTNAGELVIN HOSP	7		7
ANTRIM AREA HOSPITAL	89		89
ARMAGH COMMUNITY HOSPITAL	3		3
BELFAST CITY HOSPITAL	9		9
CAUSEWAY HOSPITAL	10	27	37
CRAIGAVON AREA HOSPITAL	73		73
DAISYHILL NEWRY	60		60
DOWNE HOSPITAL	26		26
HOLYWELL ANTRIM	1		1
LAGAN VALLEY LISBURN	19		19
MATER INFIRMORUM	69		69
MUSGRAVE PARK	4		4
ROYAL VICTORIA	1		1
SOUTH TYRONE HOSPITAL D/GANNON	1		1
SOUTH WEST ACUTE HOSPITAL	1	18	19
TYRONE COUNTY HOSPITAL OMAGH		11	11
ULSTER HOSPITAL	95		95
OTHERS (HEALTH CENTRES)	7	3	10
Total	475	59	534

RVH Cath Lab opened June 2014, Altnagelvin Cath Lab opened October 2014

Data Disclaimer

This data may be subject to further amendment at any point in the future pending updates from the Cath Labs at RVH and at Altnagelvin and data quality auditing by NIAS.

Please use this data with appropriate caution and all necessary disclaimers.



STEMI OVERVIEW - BEST RESPONSE TIME BY CATEGORY OF CALL

October 2013 - October 2015

Direct Admissions

Month	RVH Cath Lab				ALT Cath Lab			
	Cat A	Cat B	Cat C	Urgent	Cat A	Cat B	Cat C	Urgent
Oct 2013	0:07:58	0:25:39	0:05:10					
Nov 2013	0:07:10	0:08:32						
Dec 2013	0:08:59	0:08:27			00:06:27			
Jan 2014	0:07:40	0:06:54						
Feb 2014	0:06:59	0:13:12						
Mar 2014	0:10:57	0:10:35						
Apr 2014	0:09:08	0:05:28		0:53:10	00:09:08	00:11:32		
May 2014	0:08:48	0:08:32	0:02:54	0:43:18	00:06:55	00:04:35		
Jun 2014 *	0:10:12	0:12:45	0:14:20		00:06:45	00:03:43		
Jul 2014	0:08:09	0:18:34			00:15:51			
Aug 2014	0:06:58	0:07:45			00:16:00	00:06:59		
Sep 2014	0:11:15	0:17:57	0:28:44		00:10:40			
Oct 2014 **	0:10:09	0:05:35	0:04:40		00:04:47	00:07:34		
Nov 2014	0:10:20	0:13:28			00:10:51			
Dec 2014	0:10:14	0:20:49	0:20:02		00:08:29	00:08:59		
Jan 2015	0:08:45	0:05:49			00:06:28	00:11:59		
Feb 2015	0:12:36	0:27:46	0:05:18		00:10:54	00:01:57	00:02:39	
Mar 2015	0:16:12	0:10:49	1:28:29		00:13:46	00:09:23		
Apr 2015	0:09:37	0:08:16			00:03:50			
May 2015	0:09:41	0:16:25			00:07:21	00:15:15		
Jun 2015	0:09:29	0:06:18	0:01:56		00:10:51			
Jul 2015	0:09:08	0:03:26			00:15:05			
Aug 2015	0:10:09	0:09:05			00:07:04			
Sep 2015	0:13:18	0:22:03			00:16:59	00:14:24		
Oct 2015	0:08:11	0:04:34	0:21:37		00:06:52			
Total	0:09:41	0:11:45	0:19:19	00:48:14	00:09:52	00:08:51	00:02:39	

* RVH Cath Lab opened June 2014

** Altnagelvin Cath Lab opened October 2014

Please note: On 15/06/2014 NIAS ceased classifying calls as 'urgent'. These calls became Category C HCP emergencies. Category C HCP calls are included in the overall Category C total from this date onwards

Based on best response time of any resource.
Figures include times of rapid response vehicles, AED etc.

Data Disclaimer

This data may be subject to further amendment at any point in the future pending updates from the Cath Labs at RVH and at Altnagelvin and data quality auditing by NIAS. Please use this data with appropriate caution and all necessary disclaimers.



STEMI OVERVIEW - CONVEYING RESPONSE TIME BY CATEGORY OF CALL October 2013 - October 2015

Direct Admissions

Month	RVH Cath Lab				ALT Cath Lab			
	Cat A	Cat B	Cat C	Urgent	Cat A	Cat B	Cat C	Urgent
Oct 2013	0:13:02	0:35:56	0:05:10					
Nov 2013	0:10:42	0:15:34						
Dec 2013	0:11:33	0:11:29			0:06:27			
Jan 2014	0:14:01	0:09:55						
Feb 2014	0:11:36	0:14:39						
Mar 2014	0:15:15	0:14:16						
Apr 2014	0:12:15	0:13:11		0:53:10	0:09:08	0:23:26		
May 2014	0:13:35	0:30:07	0:02:54	0:43:18	0:12:15	0:09:35		
Jun 2014 *	0:20:18	0:24:54	0:14:20		0:08:12	0:03:43		
Jul 2014	0:16:22	0:18:34			0:18:23			
Aug 2014	0:16:33	0:10:22			0:16:00	0:20:53		
Sep 2014	0:19:49	0:17:57	0:28:44		0:14:27			
Oct 2014 **	0:16:22	0:05:35	0:10:04		0:04:47	0:07:34		
Nov 2014	0:17:37	0:20:37			0:17:11			
Dec 2014	0:20:13	0:23:14	0:20:02		0:11:43	0:14:56		
Jan 2015	0:22:03	0:55:06			0:14:47	0:11:59		
Feb 2015	0:21:53	0:37:38	0:05:18		0:13:36	0:02:26	0:02:39	
Mar 2015	0:20:19	0:23:07	1:28:29		0:13:46	0:09:23		
Apr 2015	0:19:17	0:15:22			0:22:41			
May 2015	0:23:09	0:17:03			0:09:22	0:15:15		
Jun 2015	0:20:05	0:11:40	0:01:56		0:10:51			
Jul 2015	0:21:27	0:11:21			0:21:46			
Aug 2015	0:18:10	0:35:19			0:08:58			
Sep 2015	0:19:01	0:25:47			0:24:51	0:16:38		
Oct 2015	0:16:11	0:09:29	0:21:37		0:16:01			
Average	0:17:27	0:19:18	0:19:51	0:48:14	0:13:57	0:13:18	0:02:39	

* RVH Cath Lab opened June 2014

** Altnagelvin Cath Lab opened October 2014

Please note: On 15/06/2014 NIAS ceased classifying calls as 'urgent'. These calls became Category C HCP emergencies. Category C HCP calls are included in the overall Category C total from this date onwards

Based on best response time of conveying resource .
Figures based on times of ambulances capable of transporting a patient

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NIAS STEMI KPI 1 - RESPONSE TIME

October 2013 - October 2015

CATEGORY A CALLS - ALL CHIEF COMPLAINTS

Month	Direct Admissions												Non Direct Admissions				Destination			Totals			
	KPI 1 (RVH Cath Lab)				KPI 1 (ALT Cath Lab)				KPI 1 (Cath Total)				KPI 1 (Hospital)				KPI 1 (Hospital)			KPI 1 (Totals)			
	Best Response time (CAT A)				Best Response time (CAT A)				Best Response time (CAT A)				Best Response time (CAT A)				Summary by Cath Lab Attended			Best Response time (CAT A)			
	Target = 65%				Target = 65%				Target = 65%				Target = 65%				n/a			Target = 65%			
	< 8 mins	> 8 mins	N	%	< 8 mins	> 8 mins	N	%	< 8 mins	> 8 mins	N	%	< 8 mins	> 8 mins	N	%	RVH	ALT	N	< 8 mins	> 8 mins	N	%
Oct 2013	15	12	27	56%					15	12	27	56%	20		20	100%	20		20	35	12	47	74%
Nov 2013	13	6	19	68%					13	6	19	68%	20		20	100%	20		20	33	6	39	85%
Dec 2013	14	11	25	56%	1		1	100%	15	11	26	58%	20	1	21	95%	21		21	35	12	47	74%
Jan 2014	18	12	30	60%					18	12	30	60%	21		21	100%	21		21	39	12	51	76%
Feb 2014	13	6	19	68%					13	6	19	68%	17		17	100%	17		17	30	6	36	83%
Mar 2014	12	12	24	50%					12	12	24	50%	21		21	100%	20	1	21	33	12	45	73%
Apr 2014	13	7	20	65%		3	3	0%	13	10	23	57%	14	1	15	93%	14	1	15	27	11	38	71%
May 2014	14	9	23	61%	2	1	3	67%	16	10	26	62%	19		19	100%	19		19	35	10	45	78%
Jun 2014 *	11	10	21	52%	5	3	8	63%	16	13	29	55%	18		18	100%	18		18	34	13	47	72%
Jul 2014	17	10	27	63%	2	4	6	33%	19	14	33	58%	17		17	100%	15	2	17	36	14	50	72%
Aug 2014	12	7	19	63%		4	4	0%	12	11	23	52%	16		16	100%	14	2	16	28	11	39	72%
Sep 2014	10	10	20	50%	3	4	7	43%	13	14	27	48%	23	1	24	96%	22	2	24	36	15	51	71%
Oct 2014 **	13	11	24	54%	3		3	100%	16	11	27	59%	25		25	100%	22	3	25	41	11	52	79%
Nov 2014	17	15	32	53%	5	5	10	50%	22	20	42	52%	15	1	16	94%	13	3	16	37	21	58	64%
Dec 2014	7	9	16	44%	3	3	6	50%	10	12	22	45%	11		11	100%	9	2	11	21	12	33	64%
Jan 2015	17	9	26	65%	6	2	8	75%	23	11	34	68%	17	2	19	89%	18	1	19	40	13	53	75%
Feb 2015	10	15	25	40%	4	5	9	44%	14	20	34	41%	18	1	19	95%	17	2	19	32	21	53	60%
Mar 2015	6	18	24	25%	1	4	5	20%	7	22	29	24%	17		17	100%	16	1	17	24	22	46	52%
Apr 2015	12	12	24	50%	4		4	100%	16	12	28	57%	18		18	100%	13	5	18	34	12	46	74%
May 2015	19	17	36	53%	5	1	6	83%	24	18	42	57%	20		20	100%	16	4	20	44	18	62	71%
Jun 2015	12	18	30	40%	2	1	3	67%	14	19	33	42%	18		18	100%	12	6	18	32	19	51	63%
Jul 2015	17	14	31	55%	3	5	8	38%	20	19	39	51%	17	3	20	85%	15	5	20	37	22	59	63%
Aug 2015	12	11	23	52%	8	6	14	57%	20	17	37	54%	21	2	23	91%	22	1	23	41	19	60	68%
Sep 2015	8	16	24	33%	1	3	4	25%	9	19	28	32%	13		13	100%	9	4	13	22	19	41	54%
Oct 2015	16	13	29	55%	2	1	3	67%	18	14	32	56%	15		15	100%	14	1	15	33	14	47	70%
Cumulative	328	290	618	53%	60	55	115	52%	388	345	733	53%	451	12	463	97%	417	46	463	839	357	1196	70%

AVERAGE
9mins 41secs

AVERAGE
9mins 52secs

AVERAGE
9mins 42secs

AVERAGE
1min 42secs

AVERAGE
6mins 37secs

* RVH Cath Lab opened June 2014

** Altnagelvin Cath Lab opened October 2014

Please note: On 15/06/2014 NIAS ceased classifying calls as 'urgent'. These calls became Category C HCP emergencies. Category C HCP calls are included in the overall Category C total from this date onwards

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NIAS STEMI KPI 1 - RESPONSE TIME
October 2013 - October 2015

CATEGORY B CALLS - ALL CHIEF COMPLAINTS

	Direct Admissions								Non Direct Admissions				Destination			Totals							
	KPI 1 (RVH Cath Lab)				KPI 1 (ALT Cath Lab)				KPI 1 (Cath Total)				KPI 1 (Hospital)				KPI 1 (Hospital)			KPI 1 (Totals)			
	Best Response time (CAT B)				Best Response time (CAT B)				Best Response time (CAT B)				Best Response time (CAT B)				Summary by Cath Lab Attended			Best Response time (CAT B)			
	Target = n/a				Target = n/a				Target = n/a				Target = n/a				n/a			Target = n/a			
Month	< 21 mins	> 21 mins	N	%	< 21 mins	> 21 mins	N	%	< 21 mins	> 21 mins	N	%	< 21 mins	> 21 mins	N	%	RVH	ALT	N	< 21 mins	> 21 mins	N	%
Oct 2013	6	1	7	86%					6	1	7	86%	1		1	100%	1		1	7	1	8	88%
Nov 2013	9	1	10	90%					9	1	10	90%								9	1	10	90%
Dec 2013	5	1	6	83%					5	1	6	83%								5	1	6	83%
Jan 2014	10		10	100%					10		10	100%								10		10	100%
Feb 2014	6	1	7	86%					6	1	7	86%	1	1	2	50%	2		2	7	2	9	78%
Mar 2014	14	1	15	93%					14	1	15	93%	1		1	100%	1		1	15	1	16	94%
Apr 2014	6		6	100%	2	1	3	67%	8	1	9	89%								8	1	9	89%
May 2014	9	1	10	90%	3		3	100%	12	1	13	92%								12	1	13	92%
Jun 2014 *	3	1	4	75%	1		1	100%	4	1	5	80%								4	1	5	80%
Jul 2014	1		1	100%					1		1	100%								1		1	100%
Aug 2014	3		3	100%	1		1	100%	4		4	100%								4		4	100%
Sep 2014	1		1	100%					1		1	100%								1		1	100%
Oct 2014 **	1		1	100%	2		2	100%	3		3	100%	4	1	5	80%	4	1	5	7	1	8	88%
Nov 2014	3		3	100%					3		3	100%	2		2	100%	1	1	2	5		5	100%
Dec 2014	2	1	3	67%	1		1	100%	3	1	4	75%	1	2	3	33%	3		3	4	3	7	57%
Jan 2015	1		1	100%	1		1	100%	2		2	100%	2		2	100%	1	1	2	4		4	100%
Feb 2015	2	2	4	50%	1		1	100%	3	2	5	60%	4		4	100%	3	1	4	7	2	9	78%
Mar 2015	5		5	100%	1		1	100%	6		6	100%	4	1	5	80%	5		5	10	1	11	91%
Apr 2015	2		2	100%					2		2	100%	8		8	100%	4	4	8	10		10	100%
May 2015	3	3	6	50%	1		1	100%	4	3	7	57%	6		6	100%	6		6	10	3	13	77%
Jun 2015	4		4	100%					4		4	100%	3		3	100%	2	1	3	7		7	100%
Jul 2015	3		3	100%					3		3	100%	5		5	100%	5		5	8		8	100%
Aug 2015	3		3	100%					3		3	100%	7		7	100%	6	1	7	10		10	100%
Sep 2015	3	2	5	60%	2		2	100%	5	2	7	71%	5		5	100%	3	2	5	10	2	12	83%
Oct 2015	3		3	100%					3		3	100%	7		7	100%	6	1	7	10		10	100%
Cumulative	108	15	123	88%	16	1	17	94%	124	16	140	89%	61	5	66	92%	53	13	66	185	21	206	90%
	AVERAGE 11mins 45secs				AVERAGE 8mins 51secs				AVERAGE 11mins 24secs				AVERAGE 5mins 14secs				AVERAGE 9mins 25secs						

* RVH Cath Lab opened June 2014

** Altnagelvin Cath Lab opened October 2014

Please note: On 15/06/2014 NIAS ceased classifying calls as 'urgent'. These calls became Category C HCP emergencies. Category C HCP calls are included in the overall Category C total from this date onwards

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NIAS STEMI KPI 1 - RESPONSE TIME

October 2013 - October 2015

CATEGORY C CALLS - ALL CHIEF COMPLAINTS

Month	Direct Admissions												Non Direct Admissions				Destination			Totals			
	KPI 1 (RVH Cath Lab)				KPI 1 (ALT Cath Lab)				KPI 1 (Cath Total)				KPI 1 (Hospital)				KPI 1 (Hospital)			KPI 1 (Totals)			
	Best Response time (CAT C)				Best Response time (CAT C)				Best Response time (CAT C)				Best Response time (CAT C)				Summary by Cath Lab Attended			Best Response time (CAT C)			
	Target = n/a				Target = n/a				Target = n/a				Target = n/a				n/a			Target = n/a			
	< 60 mins	> 60 mins	N	%	< 60 mins	> 60 mins	N	%	< 60 mins	> 60 mins	N	%	< 60 mins	> 60 mins	N	%	RVH	ALT	N	< 60 mins	> 60 mins	N	%
Oct 2013	1		1	100%					1		1	100%								1		1	100%
Nov 2013																							
Dec 2013																							
Jan 2014																							
Feb 2014																							
Mar 2014																							
Apr 2014																							
May 2014	1		1	100%					1		1	100%								1		1	100%
Jun 2014 *	1		1	100%					1		1	100%								1		1	100%
Jul 2014																							
Aug 2014																							
Sep 2014	1		1	100%					1		1	100%								1		1	100%
Oct 2014 **	1		1	100%					1		1	100%								1		1	100%
Nov 2014																							
Dec 2014	1		1	100%					1		1	100%								1		1	100%
Jan 2015																							
Feb 2015	1		1	100%	1		1	100%	2		2	100%								2		2	100%
Mar 2015		1	1	0%						1	1	0%									1	1	0%
Apr 2015																							
May 2015																							
Jun 2015	1		1	100%					1		1	100%								1		1	100%
Jul 2015																							
Aug 2015																							
Sep 2015																							
Oct 2015	1		1	100%					1		1	100%								1		1	100%
Cumulative	9	1	10	90%	1		1	100%	10	1	11	91%								10	1	11	91%
AVERAGE					AVERAGE				AVERAGE											AVERAGE			
19mins 19secs					2mins 39secs				17mins 48secs											17mins 48secs			

* RVH Cath Lab opened June 2014

** Altnagelvin Cath Lab opened October 2014

Please note: On 15/06/2014 NIAS ceased classifying calls as 'urgent'. These calls became Category C HCP emergencies. Category C HCP calls are included in the overall Category C total from this date onwards

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NIAS STEMI KPI 2 - PRE-HOSPITAL ECG

October 2013 - October 2015

KPI 2	
Pre-hospital ECG	
Target = 95%	
Month	%
N/a	100%
	<i>Assumed to be 100% monthly and cumulatively as a patient would not be transported to Cath Lab if ST elevation on pre-hospital ECG was not recorded</i>
Cumulative	100%

* RVH Cath Lab opened June 2014

** Altnagelvin Cath Lab opened October 2014

Please note: On 15/06/2014 NIAS ceased classifying calls as 'urgent'. These calls became Category C HCP emergencies. Category C HCP calls are included in the overall Category C total from this date onwards

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NIAS STEMI KPI 3 - TIME AT SCENE

October 2013 - October 2015

ALL TYPES OF CALL - ALL CHIEF COMPLAINTS

Month	Direct Admissions								Non Direct Admissions				Destination			Totals			
	KPI 3 (RVH Cath Lab)				KPI 3 (ALT Cath Lab)				KPI 3 (Hospital)				KPI 3 (Hospital)			KPI 3 (Totals)			
	Time at scene less than 25 minutes				Time at scene less than 25 minutes				Time at scene less than 25 minutes				Summary by Cath Lab Attended			Time at scene less than 25 minutes			
	Target = 60%				Target = 60%				Target = 60%				n/a			Target = 60%			
	< 25 mins	> 25 mins	N	%	< 25 mins	> 25 mins	N	%	< 25 mins	> 25 mins	N	%	RVH	ALT	N	< 25 mins	> 25 mins	N	%
Oct 2013	11	24	35	31%					11	24	35	31%	21		21	32	24	56	57%
Nov 2013	10	19	29	34%					10	19	29	34%	20		20	28	21	49	57%
Dec 2013	7	24	31	23%		1	1	0%	7	25	32	22%	21		21	26	27	53	49%
Jan 2014	14	26	40	35%					14	26	40	35%	21		21	33	28	61	54%
Feb 2014	7	19	26	27%					7	19	26	27%	19		19	26	19	45	58%
Mar 2014	10	29	39	26%					10	29	39	26%	21	1	22	30	31	61	49%
Apr 2014	12	15	27	44%	1	5	6	17%	13	20	33	39%	14	1	15	24	24	48	50%
May 2014	12	23	35	34%	3	3	6	50%	15	26	41	37%	19		19	33	27	60	55%
Jun 2014 *	12	14	26	46%	2	7	9	22%	14	21	35	40%	18		18	29	24	53	55%
Jul 2014	10	18	28	36%	4	2	6	67%	14	20	34	41%	15	2	17	30	21	51	59%
Aug 2014	7	15	22	32%	1	4	5	20%	8	19	27	30%	14	2	16	21	22	43	49%
Sep 2014	10	12	22	45%	3	4	7	43%	13	16	29	45%	22	2	24	35	18	53	66%
Oct 2014 **	7	19	26	27%	1	4	5	20%	8	23	31	26%	26	4	30	34	27	61	56%
Nov 2014	10	25	35	29%	4	6	10	40%	14	31	45	31%	17	1	18	31	32	63	49%
Dec 2014	5	15	20	25%	2	5	7	29%	7	20	27	26%	13	2	14	20	21	41	49%
Jan 2015	12	15	27	44%	3	6	9	33%	15	21	36	42%	19	2	21	34	23	57	60%
Feb 2015	10	20	30	33%	1	10	11	9%	11	30	41	27%	20	3	23	32	32	64	50%
Mar 2015	9	21	30	30%	1	5	6	17%	10	26	36	28%	21	1	22	31	27	58	53%
Apr 2015	11	15	26	42%	3	1	4	75%	14	16	30	47%	17	9	26	39	17	56	70%
May 2015	17	25	42	40%	1	6	7	14%	18	31	49	37%	22	4	26	38	37	75	51%
Jun 2015	16	19	35	46%	1	2	3	33%	17	21	38	45%	14	7	21	36	23	59	61%
Jul 2015	15	19	34	44%	3	5	8	38%	18	24	42	43%	20	5	25	39	28	67	58%
Aug 2015	11	15	26	42%	4	10	14	29%	15	25	40	38%	28	2	30	40	30	70	57%
Sep 2015	11	18	29	38%	2	4	6	33%	13	22	35	37%	12	6	18	30	23	53	57%
Oct 2015	11	22	33	33%	2	1	3	67%	13	23	36	36%	20	2	22	31	27	58	53%
Total	267	486	753	35%	42	91	133	32%	309	577	886	35%	473	56	529	782	633	1415	55%

AVERAGE
29mins 15secs

AVERAGE
32mins 02secs

AVERAGE
29mins 40secs

AVERAGE
16mins 25secs

AVERAGE
24mins 43secs

* RVH Cath Lab opened June 2014

** Altnagelvin Cath Lab opened October 2014

Please note: On 15/06/2014 NIAS ceased classifying calls as 'urgent'. These calls became Category C HCP emergencies. Category C HCP calls are included in the overall Category C total from this date onwards

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NIAS STEMI KPI 3 - TIME AT SCENE

October 2013 - October 2015

CATEGORY A CALLS - ALL CHIEF COMPLAINTS

Month	Direct Admissions												Non Direct Admissions				Destination			Totals			
	KPI 3 (RVH Cath Lab)				KPI 3 (ALT Cath Lab)				KPI 3 (Cath Total)				KPI 3 (Hospital)				KPI 3 (Hospital)			KPI 3 (Totals)			
	Time at scene less than 25 minutes				Time at scene less than 25 minutes				Time at scene less than 25 minutes				Time at scene less than 25 minutes				Summary by Cath Lab Attended			Time at scene less than 25 minutes			
	Target = 60%				Target = 60%				Target = 60%				Target = 60%				n/a			Target = 60%			
	< 25 mins	> 25 mins	N	%	< 25 mins	> 25 mins	N	%	< 25 mins	> 25 mins	N	%	< 25 mins	> 25 mins	N	%	RVH	ALT	N	< 25 mins	> 25 mins	N	%
Oct 2013	8	19	27	30%					8	19	27	30%	20		20	100%	20		20	28	19	47	60%
Nov 2013	7	12	19	37%					7	12	19	37%	18	2	20	90%	20		20	25	14	39	64%
Dec 2013	5	20	25	20%		1	1	0%	5	21	26	19%	19	2	21	90%	21		21	24	23	47	51%
Jan 2014	11	19	30	37%					11	19	30	37%	19	2	21	90%	21		21	30	21	51	59%
Feb 2014	6	13	19	32%					6	13	19	32%	17		17	100%	17		17	23	13	36	64%
Mar 2014	8	16	24	33%					8	16	24	33%	19	2	21	90%	20	1	21	27	18	45	60%
Apr 2014	9	11	20	45%		3	3	0%	9	14	23	39%	11	4	15	73%	14	1	15	20	18	38	53%
May 2014	8	15	23	35%	1	2	3	33%	9	17	26	35%	18	1	19	95%	19		19	27	18	45	60%
Jun 2014 *	10	11	21	48%	2	6	8	25%	12	17	29	41%	15	3	18	83%	18		18	27	20	47	57%
Jul 2014	9	18	27	33%	4	2	6	67%	13	20	33	39%	16	1	17	94%	15	2	17	29	21	50	58%
Aug 2014	7	12	19	37%	1	3	4	25%	8	15	23	35%	13	3	16	81%	14	2	16	21	18	39	54%
Sep 2014	10	10	20	50%	3	4	7	43%	13	14	27	48%	22	2	24	92%	22	2	24	35	16	51	69%
Oct 2014 **	5	19	24	21%	1	2	3	33%	6	21	27	22%	22	3	25	88%	22	3	25	28	24	52	54%
Nov 2014	9	23	32	28%	4	6	10	40%	13	29	42	31%	15	1	16	94%	13	3	16	28	30	58	48%
Dec 2014	4	12	16	25%	2	4	6	33%	6	16	22	27%	10	1	11	91%	9	2	11	16	17	33	48%
Jan 2015	11	15	26	42%	3	5	8	38%	14	20	34	41%	17	2	19	89%	18	1	19	31	22	53	58%
Feb 2015	9	16	25	36%		9	9	0%	9	25	34	26%	18	1	19	95%	17	2	19	27	26	53	51%
Mar 2015	6	18	24	25%	1	4	5	20%	7	22	29	24%	16	1	17	94%	16	1	17	23	23	46	50%
Apr 2015	11	13	24	46%	3	1	4	75%	14	14	28	50%	18		18	100%	13	5	18	32	14	46	70%
May 2015	15	21	36	42%	1	5	6	17%	16	26	42	38%	14	6	20	70%	16	4	20	30	32	62	48%
Jun 2015	14	16	30	47%	1	2	3	33%	15	18	33	45%	16	2	18	89%	12	6	18	31	20	51	61%
Jul 2015	14	17	31	45%	3	5	8	38%	17	22	39	44%	17	3	20	85%	15	5	20	34	25	59	58%
Aug 2015	9	14	23	39%	4	10	14	29%	13	24	37	35%	19	4	23	83%	22	1	23	32	28	60	53%
Sep 2015	10	14	24	42%	2	2	4	50%	12	16	28	43%	12	1	13	92%	9	4	13	24	17	41	59%
Oct 2015	11	18	29	38%	2	1	3	67%	13	19	32	41%	14	1	15	93%	14	1	15	27	20	47	57%
Total	226	392	618	37%	38	77	115	33%	264	469	733	36%	415	48	463	90%	417	46	463	679	517	1196	57%

AVERAGE
28mins 40secs

AVERAGE
31mins 40secs

AVERAGE
29mins 08secs

AVERAGE
16mins 26secs

AVERAGE
24mins 13secs

* RVH Cath Lab opened June 2014

** Altnagelvin Cath Lab opened October 2014

Please note: On 15/06/2014 NIAS ceased classifying calls as 'urgent'. These calls became Category C HCP emergencies. Category C HCP calls are included in the overall Category C total from this date onwards

Data Disclaimer

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NIAS STEMI KPI 3 - TIME AT SCENE

October 2013 - October 2015

ALL TYPES OF CALL - ALL CHIEF COMPLAINTS

Month	Direct Admissions												Non Direct Admissions				Destination			Totals			
	KPI 3 (RVH Cath Lab)				KPI 3 (ALT Cath Lab)				KPI 3 (Cath Total)				KPI 3 (Hospital)				KPI 3 (Hospital)			KPI 3 (Totals)			
	Time at scene less than 30 minutes Target = 60%				Time at scene less than 30 minutes Target = 60%				Time at scene less than 30 minutes Target = 60%				Time at scene less than 30 minutes Target = 60%				Summary by Cath Lab Attended n/a			Time at scene less than 30 minutes Target = 60%			
	< 30 mins	> 30 mins	N	%	< 30 mins	> 30 mins	N	%	< 30 mins	> 30 mins	N	%	< 30 mins	> 30 mins	N	%	RVH	ALT	N	< 30 mins	> 30 mins	N	%
Oct 2013	17	18	35	49%					17	18	35	49%	21	21	21	100%	21		21	38	18	56	68%
Nov 2013	11	18	29	38%					11	18	29	38%	19	1	20	95%	20		20	30	19	49	61%
Dec 2013	14	17	31	45%		1	1	0%	14	18	32	44%	20	1	21	95%	21		21	34	19	53	64%
Jan 2014	26	14	40	65%					26	14	40	65%	19	2	21	90%	21		21	45	16	61	74%
Feb 2014	11	15	26	42%					11	15	26	42%	19		19	100%	19		19	30	15	45	67%
Mar 2014	19	20	39	49%					19	20	39	49%	20	2	22	91%	21	1	22	39	22	61	64%
Apr 2014	15	12	27	56%	1	5	6	17%	16	17	33	48%	14	1	15	93%	14	1	15	30	18	48	63%
May 2014	19	16	35	54%	3	3	6	50%	22	19	41	54%	18	1	19	95%	19		19	40	20	60	67%
Jun 2014 *	17	9	26	65%	3	6	9	33%	20	15	35	57%	18		18	100%	18		18	38	15	53	72%
Jul 2014	17	11	28	61%	4	2	6	67%	21	13	34	62%	17		17	100%	15	2	17	38	13	51	75%
Aug 2014	14	8	22	64%	2	3	5	40%	16	11	27	59%	15	1	16	94%	14	2	16	31	12	43	72%
Sep 2014	15	7	22	68%	5	2	7	71%	20	9	29	69%	22	2	24	92%	22	2	24	42	11	53	79%
Oct 2014 **	12	14	26	46%	1	4	5	20%	13	18	31	42%	26	4	30	87%	26	4	30	39	22	61	64%
Nov 2014	16	19	35	46%	5	5	10	50%	21	24	45	47%	18		18	100%	14	4	18	39	24	63	62%
Dec 2014	10	10	20	50%	4	3	7	57%	14	13	27	52%	13	1	14	93%	12	2	14	27	14	41	66%
Jan 2015	16	11	27	59%	3	6	9	33%	19	17	36	53%	19	2	21	90%	19	2	21	38	19	57	67%
Feb 2015	14	16	30	47%	3	8	11	27%	17	24	41	41%	21	2	23	91%	20	3	23	38	26	64	59%
Mar 2015	15	15	30	50%	2	4	6	33%	17	19	36	47%	21	1	22	95%	21	1	22	38	20	58	66%
Apr 2015	15	11	26	58%	3	1	4	75%	18	12	30	60%	25	1	26	96%	17	9	26	43	13	56	77%
May 2015	23	19	42	55%	1	6	7	14%	24	25	49	49%	21	5	26	81%	22	4	26	45	30	75	60%
Jun 2015	23	12	35	66%	1	2	3	33%	24	14	38	63%	19	2	21	90%	14	7	21	43	16	59	73%
Jul 2015	21	13	34	62%	3	5	8	38%	24	18	42	57%	22	3	25	88%	20	5	25	46	21	67	69%
Aug 2015	15	11	26	58%	7	7	14	50%	22	18	40	55%	29	1	30	97%	28	2	30	51	19	70	73%
Sep 2015	15	14	29	52%	3	3	6	50%	18	17	35	51%	17	1	18	94%	12	6	18	35	18	53	66%
Oct 2015	17	16	33	52%	2	1	3	67%	19	17	36	53%	21	1	22	95%	20	2	22	40	18	58	69%
Total	407	346	753	54%	56	77	133	42%	463	423	886	52%	494	35	529	93%	470	59	529	957	458	1415	68%

AVERAGE
29mins 15secs

AVERAGE
32mins 02secs

AVERAGE
29mins 40secs

AVERAGE
16mins 25secs

AVERAGE
24mins 43secs

* RVH Cath Lab opened June 2014

** Altnagelvin Cath Lab opened October 2014

Please note: On 15/06/2014 NIAS ceased classifying calls as 'urgent'. These calls became Category C HCP emergencies. Category C HCP calls are included in the overall Category C total from this date onwards

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NIAS STEMI KPI 3 - TIME AT SCENE

October 2013 - October 2015

CATEGORY A CALLS - ALL CHIEF COMPLAINTS

Month	Direct Admissions												Non Direct Admissions				Destination			Totals			
	KPI 3 (RVH Cath Lab)				KPI 3 (ALT Cath Lab)				KPI 3 (Cath Total)				KPI 3 (Hospital)				KPI 3 (Hospital)			KPI 3 (Totals)			
	Time at scene less than 30 minutes				Time at scene less than 30 minutes				Time at scene less than 30 minutes				Time at scene less than 30 minutes				Summary by Cath Lab Attended			Time at scene less than 30 minutes			
	Target = 60%				Target = 60%				Target = 60%				Target = 60%				n/a			Target = 60%			
	< 8 mins	> 8 mins	N	%	< 8 mins	> 8 mins	N	%	< 8 mins	> 8 mins	N	%	< 8 mins	> 8 mins	N	%	RVH	ALT	N	< 8 mins	> 8 mins	N	%
Oct 2013	13	14	27	48%					13	14	27	48%	20		20	100%	20		20	33	14	47	70%
Nov 2013	8	11	19	42%					8	11	19	42%	19	1	20	95%	20		20	27	12	39	69%
Dec 2013	11	14	25	44%		1	1	0%	11	15	26	42%	20	1	21	95%	21		21	31	16	47	66%
Jan 2014	20	10	30	67%					20	10	30	67%	19	2	21	90%	21		21	39	12	51	76%
Feb 2014	10	9	19	53%					10	9	19	53%	17		17	100%	17		17	27	9	36	75%
Mar 2014	14	10	24	58%					14	10	24	58%	19	2	21	90%	20	1	21	33	12	45	73%
Apr 2014	11	9	20	55%		3	3	0%	11	12	23	48%	14	1	15	93%	14	1	15	25	13	38	66%
May 2014	12	11	23	52%	1	2	3	33%	13	13	26	50%	18	1	19	95%	19		19	31	14	45	69%
Jun 2014 *	14	7	21	67%	3	5	8	38%	17	12	29	59%	18		18	100%	18		18	35	12	47	74%
Jul 2014	16	11	27	59%	4	2	6	67%	20	13	33	61%	17		17	100%	15	2	17	37	13	50	74%
Aug 2014	13	6	19	68%	2	2	4	50%	15	8	23	65%	15	1	16	94%	14	2	16	30	9	39	77%
Sep 2014	14	6	20	70%	5	2	7	71%	19	8	27	70%	22	2	24	92%	22	2	24	41	10	51	80%
Oct 2014 **	10	14	24	42%	1	2	3	33%	11	16	27	41%	22	3	25	88%	22	3	25	33	19	52	63%
Nov 2014	15	17	32	47%	5	5	10	50%	20	22	42	48%	16		16	100%	13	3	16	36	22	58	62%
Dec 2014	8	8	16	50%	3	3	6	50%	11	11	22	50%	10	1	11	91%	9	2	11	21	12	33	64%
Jan 2015	15	11	26	58%	3	5	8	38%	18	16	34	53%	17	2	19	89%	18	1	19	35	18	53	66%
Feb 2015	12	13	25	48%	2	7	9	22%	14	20	34	41%	18	1	19	95%	17	2	19	32	21	53	60%
Mar 2015	12	12	24	50%	2	3	5	40%	14	15	29	48%	16	1	17	94%	16	1	17	30	16	46	65%
Apr 2015	14	10	24	58%	3	1	4	75%	17	11	28	61%	18		18	100%	13	5	18	35	11	46	76%
May 2015	21	15	36	58%	1	5	6	17%	22	20	42	52%	15	5	20	75%	16	4	20	37	25	62	60%
Jun 2015	20	10	30	67%	1	2	3	33%	21	12	33	64%	16	2	18	89%	12	6	18	37	14	51	73%
Jul 2015	20	11	31	65%	3	5	8	38%	23	16	39	59%	18	2	20	90%	15	5	20	41	18	59	69%
Aug 2015	13	10	23	57%	7	7	14	50%	20	17	37	54%	23		23	100%	22	1	23	43	17	60	72%
Sep 2015	13	11	24	54%	2	2	4	50%	15	13	28	54%	12	1	13	92%	9	4	13	27	14	41	66%
Oct 2015	16	13	29	55%	2	1	3	67%	18	14	32	56%	15		15	100%	14	1	15	33	14	47	70%
Total	345	273	618	56%	50	65	115	43%	395	338	733	54%	434	29	463	94%	417	46	463	829	367	1196	69%

AVERAGE
28mins 40secs

AVERAGE
31mins 40secs

AVERAGE
29mins 08secs

AVERAGE
16mins 26secs

AVERAGE
24mins 13secs

* RVH Cath Lab opened June 2014

** Altnagelvin Cath Lab opened October 2014

Please note: On 15/06/2014 NIAS ceased classifying calls as 'urgent'. These calls became Category C HCP emergencies. Category C HCP calls are included in the overall Category C total from this date onwards

Data Disclaimer

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NIAS STEMI KPI 3 - TIME AT SCENE October 2013 - October 2015

ADDITIONAL INFORMATION - DIRECT ADMISSIONS TO RVH AND ALT CATH LABS COMBINED

KPI 3
Time at scene
Target = n/a

Month	Within 25 mins	Within 30 mins	Within 35 mins	Within 40 mins	Within 45 mins	Over 45 mins	Grand Total
Oct 2013	11	6	12	2	2	2	35
Nov 2013	10	1	9	8	1		29
Dec 2013	7	7	9	4	1	4	32
Jan 2014	14	12	9	2	3		40
Feb 2014	7	4	5	7		3	26
Mar 2014	10	9	4	8	6	2	39
Apr 2014	13	3	7	7	1	2	33
May 2014	15	7	6	7	3	3	41
Jun 2014 *	14	6	6	2	2	5	35
Jul 2014	14	7	5	4	1	3	34
Aug 2014	8	8	3	3	2	3	27
Sep 2014	13	7	6	2		1	29
Oct 2014 **	8	5	8	6	2	2	31
Nov 2014	7	7	6	3	1	3	27
Dec 2014	14	7	11	8	1	4	45
Jan 2015	15	4	10	2		5	36
Feb 2015	11	6	8	9	2	5	41
Mar 2015	10	7	6	7	2	4	36
Apr 2015	14	4	5	4	2	1	30
May 2015	18	6	10	3	6	6	49
Jun 2015	17	7	5	4	1	4	38
Jul 2015	18	6	4	8	5	1	42
Aug 2015	15	7	7	4	6	1	40
Sep 2015	13	5	2	9	2	4	35
Oct 2015	13	6	10	3	1	3	36
Grand Total	309	154	173	126	53	71	886

Cumulative						
N	309	463	636	762	815	886
%	35%	52%	72%	86%	92%	100%

* RVH Cath Lab opened June 2014

** Altnagelvin Cath Lab opened October 2014



NIAS STEMI KPI 4 - DRIVE TIME
October 2013 - October 2015

ALL CALLS - ALL CHIEF COMPLAINTS

Month	Direct Admissions												Non Direct Admissions				Destination			Totals			
	KPI 4 (RVH Cath Lab)				KPI 4 (ALT Cath Lab)				KPI 4 (Cath Total)				KPI 4 (Hospital)				KPI 4 (Hospital)			KPI 4 (Totals)			
	Drive time less than 90 minutes				Drive time less than 90 minutes				Drive time less than 90 minutes				Drive time less than 90 minutes				Summary by Cath Lab Attended			Drive time less than 90 minutes			
	Target = 95%				Target = 95%				Target = 95%				Target = 95%				n/a			Target = 95%			
	< 90 mins	> 90 mins	N	%	< 90 mins	> 90 mins	N	%	< 90 mins	> 90 mins	N	%	< 90 mins	> 90 mins	N	%	RVH	ALT	N	< 90 mins	> 90 mins	N	%
Oct 2013	35		35	100%					35		35	100%	21		21	100%	21		21	56		56	100%
Nov 2013	28	1	29	97%					28	1	29	97%	19	1	20	95%	20		20	47	2	49	96%
Dec 2013	31		31	100%	1		1	100%	32		32	100%	20	1	21	95%	21		21	52	1	53	98%
Jan 2014	40		40	100%					40		40	100%	21		21	100%	21		21	61		61	100%
Feb 2014	26		26	100%					26		26	100%	19		19	100%	19		19	45		45	100%
Mar 2014	39		39	100%					39		39	100%	22		22	100%	21	1	22	61		61	100%
Apr 2014	27		27	100%	6		6	100%	33		33	100%	15		15	100%	14	1	15	48		48	100%
May 2014	35		35	100%	6		6	100%	41		41	100%	19		19	100%	19		19	60		60	100%
Jun 2014 *	26		26	100%	8	1	9	89%	34	1	35	97%	18		18	100%	18		18	52	1	53	98%
Jul 2014	28		28	100%	6		6	100%	34		34	100%	17		17	100%	15	2	17	51		51	100%
Aug 2014	22		22	100%	5		5	100%	27		27	100%	16		16	100%	14	2	16	43		43	100%
Sep 2014	22		22	100%	7		7	100%	29		29	100%	24		24	100%	22	2	24	53		53	100%
Oct 2014 **	26		26	100%	5		5	100%	31		31	100%	29	1	30	97%	26	4	30	60	1	61	98%
Nov 2014	35		35	100%	10		10	100%	45		45	100%	18		18	100%	14	4	18	63		63	100%
Dec 2014	20		20	100%	7		7	100%	27		27	100%	14		14	100%	12	2	14	41		41	100%
Jan 2015	27		27	100%	8	1	9	89%	35	1	36	97%	21		21	100%	19	2	21	56	1	57	98%
Feb 2015	29	1	30	97%	11		11	100%	40	1	41	98%	23		23	100%	20	3	23	63	1	64	98%
Mar 2015	30		30	100%	6		6	100%	36		36	100%	22		22	100%	21	1	22	58		58	100%
Apr 2015	26		26	100%	4		4	100%	30		30	100%	26		26	100%	17	9	26	56		56	100%
May 2015	42		42	100%	7		7	100%	49		49	100%	26		26	100%	22	4	26	75		75	100%
Jun 2015	35		35	100%	3		3	100%	38		38	100%	20	1	21	95%	14	7	21	58	1	59	98%
Jul 2015	34		34	100%	8		8	100%	42		42	100%	25		25	100%	20	5	25	67		67	100%
Aug 2015	26		26	100%	14		14	100%	40		40	100%	30		30	100%	28	2	30	70		70	100%
Sep 2015	29		29	100%	6		6	100%	35		35	100%	18		18	100%	12	6	18	53		53	100%
Oct 2015	33		33	100%	3		3	100%	36		36	100%	22		22	100%	20	2	22	58		58	100%
Total	751	2	753	100%	131	2	133	98%	882	4	886	100%	525	4	529	99%	470	59	529	1407	8	1415	99%

AVERAGE
22mins 36secs

AVERAGE
30mins 07secs

AVERAGE
23mins 44secs

AVERAGE
25mins 19secs

AVERAGE
24mins 20secs

* RVH Cath Lab opened June 2014

** Altnagelvin Cath Lab opened October 2014

Please note: On 15/06/2014 NIAS ceased classifying calls as 'urgent'. These calls became Category C HCP emergencies. Category C HCP calls are included in the overall Category C total from this date onwards

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NIAS STEMI KPI 5 - REPATRIATION APPOINTMENT TIME

October 2013 - October 2015

KPI 5				
Arrival at patient side within 60 minutes of agreed appointment time				
Target = 90%				
Month	< 60 mins	> 60 mins	N	%
Oct 2013	15	5	20	75%
Nov 2013	20	9	29	69%
Dec 2013	23	5	28	82%
Jan 2014	17	7	24	71%
Feb 2014	19	4	23	83%
Mar 2014	20	12	32	63%
Apr 2014	14	2	16	88%
May 2014	22	4	26	85%
Jun 2014 *	18	7	25	72%
Jul 2014	7	1	8	88%
Aug 2014	6	5	11	55%
Sep 2014	12	3	15	80%
Oct 2014 **	7	7	14	50%
Nov 2014	8	2	10	80%
Dec 2014	6	4	10	60%
Jan 2015	5	2	7	71%
Feb 2015	8	5	13	62%
Mar 2015	10	3	13	77%
Apr 2015	1	8	9	11%
May 2015	14	3	17	82%
Jun 2015	10	5	15	67%
Jul 2015	15	9	24	63%
Aug 2015	10	7	17	59%
Sep 2015	13	2	15	87%
Oct 2015	8	6	14	57%
Total	308	127	435	71%

AVERAGE
56mins 49 secs

* RVH Cath Lab opened June 2014

** Altnagelvin Cath Lab opened October 2014.

Please note, data is based only on calls where PPCI Repatriation is clearly specified - if this is not recorded accurately, data is EXCLUDED i.e. under-reporting is taking place.

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NIAS STEMI KPI 5 - REPATRIATIONS October 2013 - October 2015

ADDITIONAL INFORMATION

KPI 5
<i>Repatriations - Destination Hospital</i>
Target = 90%

Repatriated To	Repatriated from		
	RVH Cath Lab	ALT Cath Lab	Totals
ALTNAGELVIN HOSP	8		8
ANTRIM AREA HOSPITAL	69		69
BELFAST CITY HOSPITAL	26		26
CAUSEWAY HOSPITAL	25	20	45
CRAIGAVON AREA HOSPITAL	76		76
DAISYHILL NEWRY	29	1	30
DOWNE HOSPITAL	1		1
LAGAN VALLEY LISBURN	28		28
MATER INFIRMORUM	59		59
ROYAL VICTORIA	2	1	3
SOUTH WEST ACUTE HOSPITAL	3	3	6
ULSTER HOSPITAL	84		84
Cumulative	410	25	435

RVH Cath Lab opened June 2014, Altnagelvin Cath Lab opened October 2014

Please note, data is based only on calls where PPCI Repatriation is clearly specified. If this is not recorded accurately, data is EXCLUDED i.e. under-reporting is taking place. Non direct admissions = 534, repatriations = 435.

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SUMMARY BY CHIEF COMPLAINT - DIRECT ADMISSIONS

October 2013 - March 2014

Chief Complaint C3	Apr		May		Jun		Jul		Aug		Sep		Oct		Nov		Dec		Jan		Feb		Mar		Total
	RVH	ALT	RVH	ALT	RVH	ALT	RVH	ALT	RVH	ALT	RVH	ALT	RVH	ALT	RVH	ALT	RVH	ALT	RVH	ALT	RVH	ALT	RVH	ALT	
BREATHING PROBLEMS													1				3				1				5
CARDIAC / RESPIRATORY ARREST/DEATH														1						1					2
CHEST PAIN (Non-Traumatic)													25	16		23		27		13		25			129
FALLS													1	1						1					3
GP CAT A (8 MIN RESPONSE)													2					4		4		1			11
GP CAT B (21 MIN RESPONSE)													3	8		3		6		4		12			36
HAEMORRHAGE / LACERATIONS																		1							1
HEADACHE														1											1
HEART PROBLEMS / A.I.C.D.													2			1		1							4
OVERDOSE / POISONING (Ingestion)																						1			1
Sick Person (Specific Diagnosis)																		1							1
STROKE (CVA)														2						2					4
UNCONSCIOUS / FAINTING (Near)													1			1	1								3
Totals													35		29		31	1	40		26		39		201

SUMMARY BY CHIEF COMPLAINT - HOSPITAL ADMISSIONS

October 2013 - March 2014

Chief Complaint C3	Apr		May		Jun		Jul		Aug		Sep		Oct		Nov		Dec		Jan		Feb		Mar		Total
	RVH	ALT	RVH	ALT	RVH	ALT	RVH	ALT	RVH	ALT	RVH	ALT	RVH	ALT	RVH	ALT	RVH	ALT	RVH	ALT	RVH	ALT	RVH	ALT	
CHEST PAIN (Non-Traumatic)													1												1
EMERGENCY TRANSFER													19	20		21		21		17		20	1		119
GP CAT B (21 MIN RESPONSE)													1							2		1			4
Totals													21		20		21		21		19		21	1	124



SUMMARY BY CHIEF COMPLAINT - DIRECT ADMISSIONS

April 2014 - March 2015

Chief Complaint C3	Apr		May		Jun		Jul		Aug		Sep		Oct		Nov		Dec		Jan		Feb		Mar		Total
	RVH	ALT	RVH	ALT	RVH	ALT	RVH	ALT	RVH	ALT	RVH	ALT	RVH	ALT	RVH	ALT	RVH	ALT	RVH	ALT	RVH	ALT	RVH	ALT	
ABDOMINAL PAIN/PROBLEMS									1								1								2
AMPDS Manual Over-ride																	1								1
BREATHING PROBLEMS			1				1				1	1	2		2	1			3		1		2		15
CARDIAC / RESPIRATORY ARREST/DEATH	1		1			2	2								1	1					2				10
CHEST PAIN (Non-Traumatic)	16	2	20	2	19	4	20	3	11	5	12	4	17	4	21	5	14	6	12	6	18	8	14	4	247
CONVULSIONS / FITTING													1												1
EMERGENCY TRANSFER			1																						1
FALLS																			1						1
GP CAT A (8 MIN RESPONSE)		1	1	1	1	1																			5
GP CAT B (21 MIN RESPONSE)	5	3	8	3	2	1																			22
HAEMORRHAGE / LACERATIONS													1												1
HCP ADMISSION					2	1	5	3	10		6	2	3	1	8	3	2	1	9	2	6	2	8	2	76
HEADACHE																					1				1
HEART PROBLEMS / A.I.C.D.					1						1				1		1		1	1					6
Sick Person (Specific Diagnosis)	1		1												1		1				1		1		6
STROKE (CVA)																					1		1		2
TRAFFIC / TRANSPORTATION INCIDENTS	1																								1
UNCONSCIOUS / FAINTING (Near)	2		1								1		2		1				1		1	4			13
Unknown - User Left Call					1						1														2
UNKNOWN PROBLEM (Collapse-3rd Pty)	1		1																						2
Totals	27	6	35	6	26	9	28	6	22	5	22	7	26	5	35	10	20	7	27	9	30	11	30	6	415

SUMMARY BY CHIEF COMPLAINT - HOSPITAL ADMISSIONS

April 2014 - March 2015

Chief Complaint C3	Apr		May		Jun		Jul		Aug		Sep		Oct		Nov		Dec		Jan		Feb		Mar		Total
	RVH	ALT	RVH	ALT	RVH	ALT	RVH	ALT	RVH	ALT	RVH	ALT	RVH	ALT	RVH	ALT	RVH	ALT	RVH	ALT	RVH	ALT	RVH	ALT	
AMPDS Manual Over-ride													1		1										2
CHEST PAIN (Non-Traumatic)													1												1
EMERGENCY TRANSFER	14	1	19		9		1																		44
HCP ADMISSION					8		14	2	14	2	22	2	24	3	13	4	12	2	19	2	20	3	21	1	188
MI					1																				1
NICCATS TRANSFER														1											1
Totals	14	1	19		18		15	2	14	2	22	2	26	4	14	4	12	2	19	2	20	3	21	1	237



SUMMARY BY CHIEF COMPLAINT - DIRECT ADMISSIONS

April 2015 - March 2016

Chief Complaint C3	Apr		May		Jun		Jul		Aug		Sep		Oct		Nov		Dec		Jan		Feb		Mar		Total
	RVH	ALT	RVH	ALT	RVH	ALT	RVH	ALT	RVH	ALT	RVH	ALT	RVH	ALT	RVH	ALT	RVH	ALT	RVH	ALT	RVH	ALT	RVH	ALT	
ABDOMINAL PAIN/PROBLEMS	1						1																		2
BREATHING PROBLEMS					3	1			1		2		1												8
CARDIAC / RESPIRATORY ARREST/DEATH	1		1		1								1												4
CHEST PAIN (Non-Traumatic)	14	3	30	4	19	2	24	6	16	11	18	3	24	1											175
CONVULSIONS / FITTING	1																								1
FALLS									1		1		1												3
HCP ADMISSION	7	1	9	1	10		5	2	6	3	4	2	5	1											56
HEART PROBLEMS / A.I.C.D.			1								2														3
Sick Person (Specific Diagnosis)			1		1								1												3
STROKE (CVA)					1				1																2
TRAUMATIC INJURIES (Specific)							1																		1
UNCONSCIOUS / FAINTING (Near)	2			2			3		1		2	1													11
DIABETIC PROBLEMS														1											1
Totals	26	4	42	7	35	3	34	8	26	14	29	6	33	3											270

SUMMARY BY CHIEF COMPLAINT - HOSPITAL ADMISSIONS

April 2015 - March 2016

Chief Complaint C3	Apr		May		Jun		Jul		Aug		Sep		Oct		Nov		Dec		Jan		Feb		Mar		Total
	RVH	ALT	RVH	ALT	RVH	ALT	RVH	ALT	RVH	ALT	RVH	ALT	RVH	ALT	RVH	ALT	RVH	ALT	RVH	ALT	RVH	ALT	RVH	ALT	
HCP ADMISSION	17	9	22	4	14	7	20	5	28	2	12	6	20	2											168
Totals	17	9	22	4	14	7	20	5	28	2	12	6	20	2											168

ID	220
Principal Aim, Objective, Value	To deliver a Safe, High Quality Ambulance Service providing emergency and non emergency care and transportation which is appropriate, accessible, timely and effective
Risk Type	CORP
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. <input type="checkbox"/> 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	<p>1. Management guidance for response to IA and contingency Plan for IA implemented <input type="checkbox"/></p> <p>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. <input type="checkbox"/></p> <p>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. <input type="checkbox"/></p> <p>4. IAMT will engage with TU's before and during IA <input type="checkbox"/></p> <p>5. Escalation to NIAS BC Plans as appropriate. <input type="checkbox"/></p> <p>6. Consultations mechanism established for IR issues. Continued engagement with Trade Unions throughout these. <input type="checkbox"/></p> <p>7. A series of debriefs have been conducted following the IA and recommendations and action plans have been developed. <input type="checkbox"/></p> <p>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.</p>
Opened	11/08/2011
Review Date	03/11/2015
Action Plan to Address /Mitigate Risk	<p>3. Recommendation and action plans will be used to inform a planned workshop to conduct Business Continuity Impact Analysis. <input type="checkbox"/></p> <p>4. Ongoing engagement with Trade Unions continuing through a variety of groups and forums. <input type="checkbox"/></p> <p>5. Recommendations from debriefs following IA will be incorporated into Business Continuity processes <input type="checkbox"/></p> <p>6. Formal debrief completed by Asst Dir Ops on the 3/11/15 <input type="checkbox"/></p>

ID	273
Principal Aim, Objective, Value	To deliver a Safe, High Quality Ambulance Service providing emergency and non emergency care and transportation which is appropriate, accessible, timely and effective
Risk Type	CORP
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. <input type="checkbox"/> <input type="checkbox"/>
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.□																																			
□																																			
<table><tr><th>CONTROL</th><th>ADDITIONAL ACTIONS REQUIRED</th><th>WHO</th><th>WHEN</th></tr><tr><td>□</td><td></td><td></td><td></td></tr><tr><td>A</td><td>Monthly Budget Reporting</td><td>Assistant Director of Finance</td><td>Monthly□</td></tr><tr><td>B</td><td>Approval of TDP</td><td>DHSSPS/HSCB</td><td>Jul-15□</td></tr><tr><td>C</td><td>Monthly Trust Monitoring Returns</td><td>Assistant Director of Finance</td><td>Monthly□</td></tr><tr><td>D</td><td>Monthly Trust Monitoring Returns</td><td>Assistant Director of Finance</td><td>Monthly□</td></tr><tr><td>E</td><td>Savings Plans Finalised</td><td>Trust Board</td><td>Jul-15□</td></tr><tr><td></td><td>Savings Plans Implemented</td><td>SEMT</td><td>Jul-15□</td></tr></table>				CONTROL	ADDITIONAL ACTIONS REQUIRED	WHO	WHEN	□				A	Monthly Budget Reporting	Assistant Director of Finance	Monthly□	B	Approval of TDP	DHSSPS/HSCB	Jul-15□	C	Monthly Trust Monitoring Returns	Assistant Director of Finance	Monthly□	D	Monthly Trust Monitoring Returns	Assistant Director of Finance	Monthly□	E	Savings Plans Finalised	Trust Board	Jul-15□		Savings Plans Implemented	SEMT	Jul-15□
CONTROL	ADDITIONAL ACTIONS REQUIRED	WHO	WHEN																																
□																																			
A	Monthly Budget Reporting	Assistant Director of Finance	Monthly□																																
B	Approval of TDP	DHSSPS/HSCB	Jul-15□																																
C	Monthly Trust Monitoring Returns	Assistant Director of Finance	Monthly□																																
D	Monthly Trust Monitoring Returns	Assistant Director of Finance	Monthly□																																
E	Savings Plans Finalised	Trust Board	Jul-15□																																
	Savings Plans Implemented	SEMT	Jul-15□																																
Opened	30/06/2015																																		
Review Date	03/11/2015																																		
Action Plan to Address /Mitigate Risk																																			

ID	246
Principal Aim, Objective, Value	To deliver a Safe, High Quality Ambulance Service providing emergency and non emergency care and transportation which is appropriate, accessible, timely and effective
Risk Type	CORP
Title	Linking Funding to Demand
Description	<p>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. □</p> <p>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. □</p>
Risk level (initial)	MEDIUM
Risk level (Target)	LOW
Risk level (current)	HIGH
Lead Director	DIROPS

Initial Action Taken to Control/Mitigate Risk	<p>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.□</p> <p>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.□</p> <p>3.NIAS financial planning prioritises provision of front-line resources.□</p> <p>4.NIAS has established Resource Management Centre (RMC) to align available resources with priority locations and times.□</p> <p>5.NIAS has identified priority locations and times for shift cover.□</p> <p>6.Financial resource and activity/performance are issues discussed with HSCB at PMSI meetings. □</p> <p>7.Financial resource and activity/performance are issues discussed at Trust Board. □</p> <p>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).□</p> <p>9 Introduce measures to manage demand which reduces demand for ambulance attendance and transportation.□</p> <p>9.1.NIAS Modernisation programme established□</p> <p>10.Introduce measures to manage demand which result in an alternative outcome which is more appropriate for the patient and better for NIAS/HSC.□</p> <p>10.1.NIAS Modernisation programme established</p>
Opened	30/04/2013
Review Date	03/11/2015
Action Plan to Address /Mitigate Risk	<p>1.Secure Commissioner support to engage in Demand/Capacity review as first step to linking demand to supply.□</p> <p>1.1.Dir Operations has engaged with Lead Ambulance Commissioner and secured support to progress □</p> <p>2.Establish metrics to show correlation/relationship between planned resource - demand - performance support bid for additional resources.□</p> <p>2.HSCB proposal to link planned budget to demand analysis to HSCB. □</p> <p>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.□</p> <p>provide Call Prioritisation and Dispatch procedures to protect capacity to respond to & transport highest priority patients.□</p> <p>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.□</p> <p>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. □</p> <p>10 D OPS to develop a new risk in relation to 'Safe care to the Public'□</p> <p>11. Reviewed by SEMT on 3/11/15 and a decision taken to retain in current form until alterative risk is developed.□</p>

TB/4 03/12/15

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. Currently under consideration by HSCB. At this point in time we have been advised that there are no funds to progress.
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. Directory of Services (DoS) technology platform has been procured and is scheduled for December go-live. ACPs are progressing in line with plans.
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 plans to embed in normal business in development.
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.

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 (HCIs).	Trusts, supported by PHA will develop and deliver improvement plans to reduce infection rates. This will be monitored via PHA surveillance programmes for HCIs.	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.	No action to report at this stage.
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.
<p>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.</p> <p>These measures include:</p>			

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 development remains at the planning stage. NIAS awaits HSCB direction.
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.

TB/5 03/12/15

NORTHERN IRELAND AMBULANCE SERVICE

TRUST BOARD MEETING

3 December 2015

Title:	Fleet Strategy 2014-2019
Purpose:	This strategy will assist in the provision of a professionally managed, safe and reliable ambulance fleet which supports the operational model for service delivery. It is a key enabler for the NIAS mission, and will assist in the delivery of an ambulance service fleet which meets the needs placed upon it.
Content:	The Fleet Strategy outlines the current arrangements, the context, demand, targets, environmental issues and staff and patient safety. It describes the future model and size of fleet to meet these conditions with benefits and risks.
Recommendation:	For approval
Previous Forum:	SEMT
Prepared by:	Bryan Snoddy, Assistant Director of Operations (Estate & Fleet)
Presented by:	John Wright, Director of Operations (Acting)



Northern Ireland Ambulance Service
Health and Social Care Trust



FLEET STRATEGY

2014-2019

NORTHERN IRELAND AMBULANCE SERVICE

3 November 2014

Version 2

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1 Introduction

NIAS was established on the 1 April 1995 under the Health and Personal Social Services (Northern Ireland) Order 1991 and the (Establishment) Order (Northern Ireland) 1995, thereby becoming a regional service.

The mission of the service is to “provide safe, effective, high quality, patient-focused care and services to improve health and well being by preserving life, preventing deterioration and promoting recovery”. Annual Report 2013/14

The ambulance service is managed on a regional and a divisional basis. There are currently 5 operational divisions coterminous with each existing Health and Social Care Trust area.

NIAS responds to the need of over 1.8 million people across an area of 5,450 square miles in a pre-hospital, inter hospital and post hospital environment within Northern Ireland. It employs over 1100 staff who are deployed across 62 properties including stations and deployment points, an emergency ambulance control, a non-emergency ambulance control, a Regional Training Centre and Headquarters. There is a Resource Management Centre which houses Resource Management, the Fleet Section and other support functions. NIAS also has a small fleet maintenance garage at Broadway undertaking repairs and servicing.

The Northern Ireland Ambulance Service (NIAS) fleet is a core resource in delivering pre-hospital care to the population of Northern Ireland. The fleet of over 300 vehicles currently has a replacement value of approximately £17.3m.

In 2013/14 NIAS responded to, cared for and transported over 393,000 patients which averages one in five of the population of Northern Ireland. NIAS ambulances, A&E and PCS, covered over 7.35 million miles in carrying out their vital work. The fleet is an integral and indispensable resource which requires a strategic approach to its procurement, use, maintenance, repair and disposal. This document will examine the current fleet operation, strategic influences on it and make recommendations for the next five years.

2 Strategy

The vision for the NIAS Fleet Strategy is to:

“provide a professionally managed, safe and reliable ambulance fleet which supports the operational model for service delivery.”

This strategy is a key enabler for the NIAS mission “The Northern Ireland Ambulance Service will provide safe, effective, high-quality, patient-focused care and services to improve health and well being by preserving life, preventing deterioration and promoting recovery”....

This fleet strategy is to assist the delivery of an ambulance service fleet which meets the needs placed upon it. There will be patients requiring emergency care as result of 999 calls involving accidents or sudden illness; patients receiving more routine care in transport to medical facilities, and also ambulance service response to major or special incidents such as transport accidents and pandemics ie SARS (Severe Acute Respiratory Syndrome).

Aims

The aim of NIAS Fleet Strategy is to provide a fit for purpose and cost effective Accident and Emergency, Patient Care and support fleet to enable NIAS to safely deliver its service. NIAS therefore must have:

- the right type of vehicle suited to its particular role.
- the right number of those vehicles to meet the demand
- effective deployment of the fleet across Northern Ireland
- adequate support systems in place to maintain, manage and maximize fleet availability.

The strategic recommendations for the fleet will be drawn out in the discussion on the future model after consideration of the current arrangements and the strategic influencing factors as they apply to NIAS fleet.

3 Current Fleet Arrangements

NIAS provides a full range of ambulance services that include emergency pre-hospital, urgent and routine care. The fleet currently consists of just over 300 vehicles fulfilling a variety of roles. The fleet is made up of Accident and Emergency (A&E) Ambulances, Patient Care Service (PCS) ambulances and Rapid Response Vehicles (RRV). Major and hazardous incident response requires specialized vehicles designed for the specific role and NIAS support services such as maintenance, logistics, operational support and training. Each of these groups is discussed more fully after the table which shows the current fleet type and quantity by Division.

Fleet by Division at September 2014

	A&E	PCS	RRV	Support	
North	32	28	9	EPV	12
South	22	21	8	HART	3
Belfast	15	19	8	Divisional	17
South East	21	14	9	EDU	3
West	24	24	8	Maintenance	2
HQ	2			Regional	3
				Stores	2
				Training	7
	116	106	42		49
Grand Total					313

There has been significant growth in A&E provision, linked to acute hospital service change and the reconfiguration of local hospitals resulting in longer journey times. Often with more seriously ill patients, paramedic monitoring and intervention is required en route.

Vehicle Type

All vehicles are built to relevant standards and guidelines. The European standard CEN 1789:2007 applies to A&E and stretcher capable PCS ambulances.

A&E Ambulances

These ambulances are specifically designed for the treatment, outside of hospital and transport of the most seriously ill patients. Patients are provided with the highest standard of pre-hospital care at the scene of their illness or injury and during their journey to hospital. A&E ambulances are based on light commercial vehicles and are a chassis cab with a modular body. They incorporate sophisticated control systems to safeguard vehicle reliability, patient monitoring and communications. They provide a mobile treatment centre for the practice of life saving paramedic interventions at the point of need.

Rapid Response Vehicles

RRVs are deployed to life-threatening calls as a first response and are crewed by an individual paramedic. They are intended to quickly deliver enhanced clinical care and patient outcomes through early arrival, assessment, intervention, treatment and care. The RRV fleet comprises of 42 estate cars and off road 4x4 capability to aid access in difficult conditions.

Currently the planned mix between rapid response vehicles (RRV) and A&E ambulances is 34-35 to 58-60 or approximately 1:2 at peak of day. Growth in recent years in rapid response has been principally to ensure a faster response to life threatening calls with a paramedic in attendance.

Patient Care Service (PCS) Vehicles

The non emergency PCS ambulance provides transport and care for patients travelling to hospital for pre planned appointments, patients travelling between hospitals and thereafter for discharge to home. Increasingly it is also used to carry out transport and transfer of patients who require more than basic care.

Intermediate Care Ambulances (ICS) are an extension of the service and are used to transport patients with mobility difficulties or who require some clinical intervention such as oxygen therapy but not a paramedical level of care. These vehicles are adapted to accommodate wheelchairs, stretcher and bariatric patients. PCS ambulances are based on a light commercial panel van design. Two specialist vehicles are used for neonatal transfers.

Support Vehicles

The support vehicles are a mixture of vehicle types and uses that do not form part of the above categories. NIAS Officers use cars to the same specification as RRV as they can respond to any call and more serious or major incidents. These vehicles are shown in the chart above assigned for Divisional use.

Major incident specialist vehicles are commercial vehicles providing communications and equipment at the scene of major incidents or mass casualty events. Hazardous Area Response Team (HART) vehicles are also a mix of vehicle types that provide

further equipment for specialist hazardous operations e.g. rescue from height, chemical incidents, mountain or difficult terrain and confined space rescue.

Maintenance and logistics vehicles provide mobile service, drug, stores and equipment delivery in light commercial vehicles.

Fleet Age Profile

The age profile of the fleet is largely a function of its replacement cycle. A proportion of the fleet needs replaced annually and this spreads the need for capital funding evenly over the programme of replacement and allows it to be planned and managed effectively. More importantly it minimises the risk to service operations as there is never a particularly "old" fleet, which happens when there are peaks and troughs in the replacement programme. The current age profile is a result of steady state replacement. Regular replacement also reduces the risk to service provision if the fleet were to suffer a generic fault.

The replacement cycle has been 5 years for A&E, RRV and PCS. The support fleet varies according to vehicle type and its use, the minimum replacement cycle is 5 years but it ranges to 10 or more years for more specialized vehicles.

In all categories mechanical condition and mileage of vehicles is taken into consideration prior to disposal. Vehicle costs and reliability are considered as part of the disposal process. Vehicles may be disposed of earlier or retained longer after this assessment.

The current capital spend for fleet replacement is £3.3m pa this is to replace:

- 22 A&E
- 21 PCS
- 7 RRV
- 4 Support, and £70k for specialist vehicles

Mileage

Mileage is an important factor in fleet management, not just for servicing schedules but also as an indicator of vehicle utilization. It highlights different utilization as a factor of its location and supports fleet rotation decisions to maximize use while evening out the impact on individual vehicles and divisional fleets.

Total mileage for the A&E, PCS, RRV and Support fleet:

@ 31/3/14	Vehicles	Mileage	Average pa
A&E	116	4,128,462	35,590
PCS	106	2,489,343	23,265
RRV	42	731,308	17,412
Support	49	253,778	5,180
		7,602,891	

The Appendix shows the fleet mileage by type over the last seven years.

A&E ambulances operate 24/7 and currently average about 36,000 miles per year. Older vehicles will tend to do less than the average miles while newer vehicles will do higher mileage than the average in the first few years.

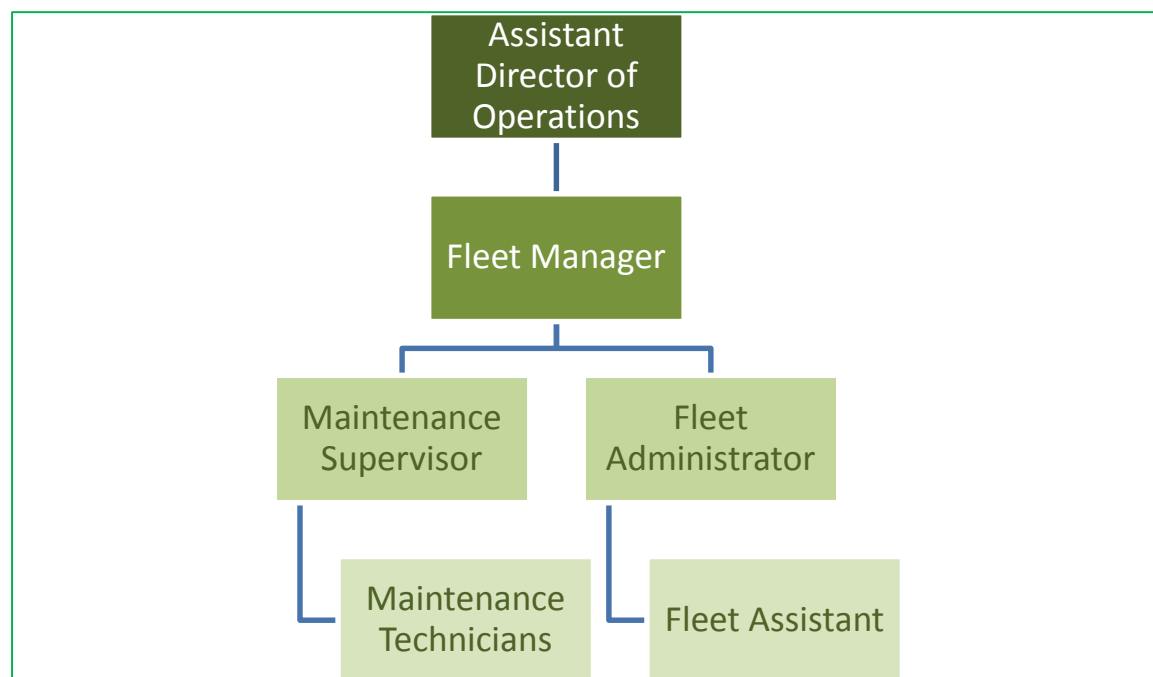
RRVs are being used increasingly as a first response in key areas where there is a high demand for ambulance services and high population density. At present RRVs don't operate a night shift unlike A&E and their average miles are 17,500 per vehicle.

PCS average mileage is approx. 23,300 per vehicle per annum although they would carry more patients.

The support fleet is made up of diverse vehicles and an average across this sector of the fleet is meaningless.

Management

The fleet management structure is shown below. The fleet department responsibilities are in the specification, procurement, disposal and management of fleet contracts. The day to day management of the asset is the responsibility of the user ie the relevant Area Manager. A small maintenance workshop is also managed by the fleet Department and this provides ongoing maintenance and inspection services.



The maintenance department commission and decommission vehicles into and out of service and maintain the fleet in Belfast and South Eastern divisions primarily but support the fleet in other areas as required. A maintenance call out system is provided in Belfast and South Eastern areas.

The Fleet Administrator and Fleet Assistant manage statutory compliance with vehicle licensing and testing, monitor contractor performance and handle vehicle related legal claims, accident reporting and downtime.

The Fleet Manager oversees the work of the department and contributes to vehicle specification and procurement/disposal, gives approval for work over set limits and tenders and manages fleet contracts.

The Assistant Director of Operations (fleet) develops strategy and investment proposals for fleet replacements, sits on national fleet ambulance groups and is responsible for the assurance and governance of fleet issues.

Maintenance

Most of the vehicle maintenance is provided by contractors local to the division to minimise travel distances and downtime. Local contractors are used for this on a divisional basis. The contracts are based on the geographic area for maintenance and recovery ensuring a local service and resilience in the event of peaks in demand in specific areas. Routine servicing in the Belfast and South Eastern divisions is provided at the Belfast Workshops which operate 8-5 Mon-Fri.

Costs

Fleet costs over the last 4 years have increased marginally by 6.1% and thus have remained fairly static with the rise mainly due to fuel price rises.

£'000	10/11	11/12	12/13	13/14
Repairs	1,566	1,444	1,558	1,517
Fuel	1,877	2,000	2,192	2,192
Insurance/Tax	182	189	158	140
Total	3,625	3,633	3,908	3,848

4 Strategic Context

This section discusses the strategic changes within health and social care in Northern Ireland as they may impact on NIAS fleet in particular. More detail of the impact on fleet and how the fleet needs to change is explored in section 5 Fleet Strategy: Future Model.

Acute Services Reconfiguration

The main changes proposed in the Acute review was the reduction of Hospital Emergency Departments to maintain standards of care at 6 to 9 key locations and the development of regional centres of excellence where appropriately skilled clinicians could offer the best available service to the population.

Those changes to the configuration of acute services generally means that ambulances have to travel further to take patients to an emergency department and quite often this would lead to a secondary transfer to a regional specialty. The net effect is that ambulances are travelling further to hospital and are therefore less available for calls in their home area. To some degree the decrease in availability is

off set by the use of RRVs to respond to calls but the problem is then shifted to a delay in waiting for an ambulance to become available to transport the patient. The corollary was that the ambulances from a wide area now tended to converge on fewer hospital locations and therefore were displaced from the ideal locations to give a timely response while, at least on a temporary basis, the main hospitals are overstocked with ambulances waiting to admit patients. NIAS developed the role of Hospital Liaison Officer to help improve turnaround times at hospital to alleviate this problem.

The increased utilization of vehicles within a shift pattern can be viewed as an efficient use of resources, as the ambulances are occupied for more of the time. Within limits this is true, however if the increased utilization leads to a reduction in availability when it is needed then performance will degrade indicating that capacity limits have been reached. Additional hours of cover would require more personnel and potentially more vehicles to be available depending on shifts and location of the additional resources.

Some additional resources have been added to the system as a result of specific changes, namely an extra A&E vehicle was funded because of the acute change at Magherfelt and an additional Neonatal unit was purchased for the neonatal/pediatric retrieval service. The increases brought A&E and PCS to 116 and 106 vehicles respectively.

Transforming Your Care

The changes to acute provision were followed by the reform of the health and social care system as a whole with emphasis not on in-hospital treatment but on more locally delivered services wherever possible. Hospitals and specialised treatments would be available at fewer centres but clinical and quality standards could be ensured at the appropriate level required for safe practice.

The acute reconfiguration impacted primarily on the emergency ambulance services and the changes from Transforming Your Care are impacting primarily on non emergency ambulance work. The continuing development of Community Care and Treatment Centres and Primary Community Care Initiatives provide more services locally and therefore provide more destinations for patients to travel to and from in smaller numbers.

Changes arising from Transforming Your Care are still working through the system and as they develop NIAS will be better able to assess the actual impact on our service and fleet. Any additional requirement as a result of the changes would likely be at a local level and proposals will be developed as necessary. Schemes under consideration as known to NIAS at September 2014 are noted below.

Trust	Project	Impact on NIAS
BHSCT	Frail Elderly Assessment Unit at BCHU	Potential for increased transfers from RVH ED, additional resource may be required
	Frail Elderly Acute Care at Home	TBC

	Respiratory Community Team	TBC
SEHSCT	Frail Elderly Care at Home	Potential pressure on PCS
	Falls Rapid Assessment Service	None at present
	Minor Injuries Unit, Bangor*, Ards	None
NHSCT	Minor Injuries Unit, Whiteabbey*, Mid Ulster	None
SHSCT	Frail Elderly Rapid Response	TBC
	Minor Injuries Unit, Armagh*, Dungannon	None at present
WHSCT	Enhanced District Nursing Service	None
	* = Temporary closure announced (Oct 2014)	Potential displacement of patients to ED, longer journeys, increased waiting.

At present none of the above are giving rise to a quantifiable change in fleet and this is to be expected at this stage. However as services develop they may have a cumulative effect on the NIAS workload and require a change in resources due to the changing pattern of transport.

Demand

Accident and Emergency

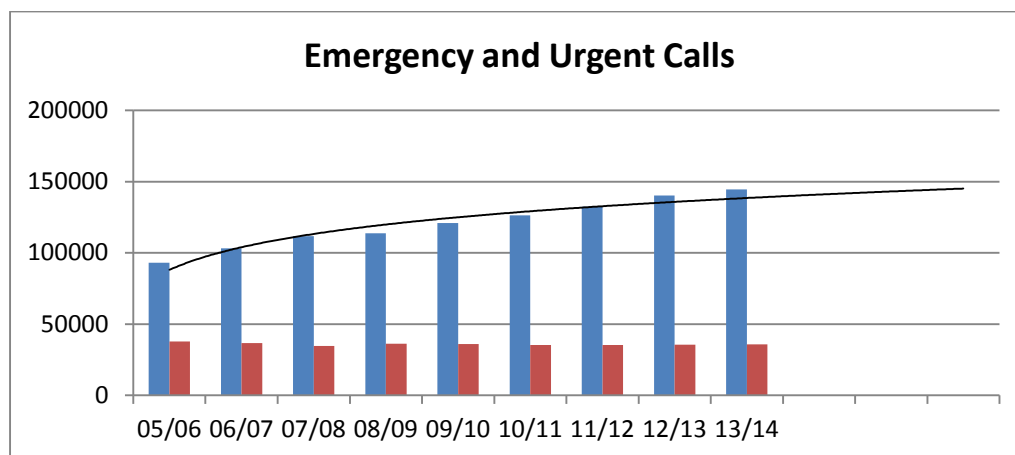
The general trend is of rising demand in A&E Emergency Calls, while urgent calls have remained relatively stable. The Strategic Review (2000) stated that A&E calls had increased by 26% on the previous 5 years. Demand over the following 5 years rose by 28.5%. While in the five years between 2005 and 2010 demand rose by 38.5%. Demand is projected to increase in the future and performance targets will likely also increase across Northern Ireland. 'Transforming Your Care' (The Compton review) is anticipating a 4% increase per year in demand by 2015. This can be summarised as follows:-

A&E Demand	Emergency Calls	Percentage increase
1995 - 2000	54,365 to 68,500	26.0%
2000 - 2005	68,500 to 87,374	28.5%
2005 - 2010	87,374 to 121,020	38.5%
2010 - 2014*	121,020 to 144,657	19.5%
	Overall	166% increase

*N.B. Last increase is for four years only

Overall demand for the A&E service has grown significantly over the last 20 years (approx. 170%) In order to preserve response targets, the number of deployment locations was also increased and RRVs were introduced. Currently there are 42 RRVs in the fleet.

The total demand is a strong indicator of the workload but in meeting that demand the profile of resources is a key factor for fleet size. In general the busiest areas will need more resources and that is also true of the busiest times, as demand is not evenly distributed through the days, weeks or months. Therefore fleet must be matched to the peak demand typically Monday to Friday through the day.

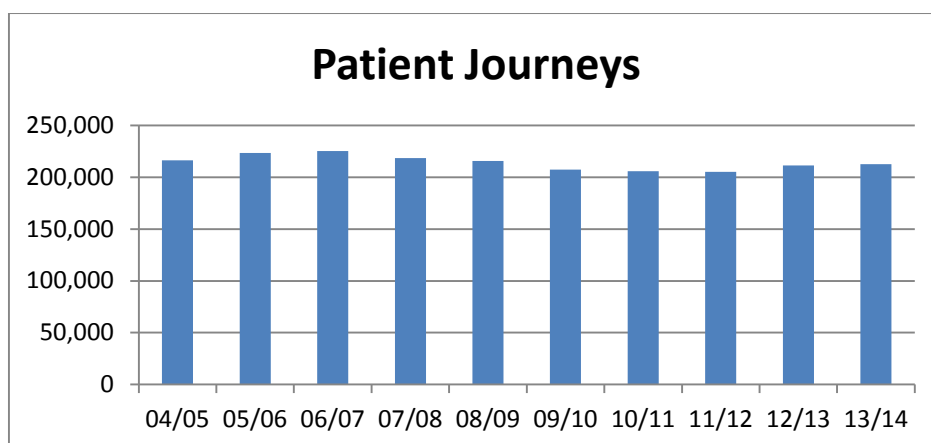


Urgent calls, shown in red above, have not grown significantly and have varied slightly around 36,000 calls. A&E work has risen significantly and continues to rise. The Appendix shows the call demand and patient journeys over the last seven years.

PCS

PCS activity has dropped from its height in 2007/8 to a low in 2011/12. It has increased in the last two years but not to the level of the previous high. However this change has been offset by the miles travelled by the service. This will be in part due to the rationalisation of acute and hospital services. PCS vehicles have to travel further between wider spread resources. PCS have also picked up some of the work previously carried out using A&E vehicles involving the use of Intermediate Care Vehicles.

PCS Demand	Patient Journeys	Percentage change
2007/08	218,469	-
2008/09	215,652	-1.3
2009/10	207,189	-3.9
2010/11	205,721	-0.7
2011/12	205,269	-0.3
2012/13	211,164	2.8
2013/14	212,592	0.1
	Overall	-2.7%



Routine or non-emergency calls are all other types of calls which are usually pre-planned and primarily responded to by PCS. The transport and care requirements for patients are increasing. NIAS is committed to working with other health sector partners on the non-emergency access strategy and continues to review A&E workload and use appropriate alternative solutions within PCS.

Performance Targets

Typically ambulance service performance has been measured by the timed speed of response to different categories of calls. These targets have been incorporated into the Public Service Agreement associated with the NI Executive's Programme for Government. For the year 2014/15 the targets that will apply to NIAS are:

Category A - responded to within 8 minutes (and not less than 65% in any LCG area)" By March 2015, 72.5% of Category A (life threatening) calls responded to within eight minutes, 67.5% in each LCG area.

Category B - patients, ie those with serious but not life-threatening conditions should receive a response within 21 minutes of the request for transport being made in 95% of cases.

Category C – calls are considered non-life threatening or serious. For these calls the response time standards are not set nationally but are determined locally. In Northern Ireland, the performance standard is that presenting Cat C conditions require a vehicle to attend within 1 hour of the request being made, in 95% of cases.

Urgent Calls: NIAS is required to take patients to hospital where the need is identified by a doctor as urgent. These patients should arrive at hospital within 15 minutes of the time specified by the doctor in 95% of cases.

The drive for increased performance led to a wider deployment of ambulance resources from 30 stations, 10 years ago, to the present with over 60 stations and deployment points. It also consolidated the use of rapid response Paramedics to deliver an effective intervention more quickly than was possible before. This was at a time when demand was also increasing at significant rates.

It is unlikely that more improvements in performance could be obtained without increasing ambulance resources, A&E or RRV. An increase in deployment points would be ineffective without additional resources to deploy from them. Additional

hours of cover would require more personnel and potentially more vehicles to be available depending on shifts and location of the additional resources.

Cat A Performance	Northern Ireland
2005-06	51%
2006-07	55%
2007-08	62%
2008-09	68%
2009-10	72%
2010-11	70%
2011-12	73%
2012-13	68%
2013-14	68%

The achievement of performance targets is directly related to the number of ambulance resources and their location in relation to calls. The locations that ambulances can deploy from have increased to 62 stations or deployment points. Ambulances are dynamic and can receive a call to a patient whenever they are available ie not already carrying or committed to a patient and this can occur as the ambulance returns to its base or when it is clear at a hospital, for example.

Environmental Issues

Operating a large fleet has obvious environmental impacts. Much has been achieved through technological advances in the motor industry to mitigate this impact and wherever practicable NIAS will explore the opportunity to adopt good environmental practices particularly in relation to carbon emissions.

There are targets set locally, nationally and by the EU to reduce Greenhouse gas (GHG) emissions over the next number of years. The following is a summary of the various targets set:-

EU target to reduce GHG emissions by 20% below 1990 levels by 2020

PfG target to reduce GHG emissions by 25% below 1990 levels by 2025

UK target to reduce GHG emissions by 80% below 1990 levels by 2050

These targets can only be met by ensuring that sustainability is considered at all levels in the procurement, management and disposal of fleet assets.

Safety: Patient, Staff, Road

European standards for ambulances set the benchmark for patient safety and all patient transport ambulances will comply with the relevant standard EN1789:2007 for vehicles modified to carry stretcher patients. The standard is currently under revision.

European Whole type approval now applies to ambulances manufactured since April 2012 and further improves the safety features in vehicles and stipulates the testing/certification regime that must be complied with. Driver and road safety legislation has increased in order to improve general road safety and includes drivers hours, working time directives, medical fitness to drive and drivers Certificate of professional Competence, all of which increases the pressures on vehicle and work pattern design to minimise adverse consequences on safety.

Management of road risk is a significant consideration in assessing insurance risk and for a service that daily operates in difficult circumstances the safeguarding of staff and road users is at the forefront of NIAS fleet management. New uses for the existing technologies are now available in mobile platforms to enhance safety eg vehicle mounted CCTV and vehicle status monitoring and recording via telemetry.

5 Fleet Strategy: Future Model

The factors discussed in section 4 Strategic Context, will now be related to the NIAS fleet. In many scenarios the potential effect on fleet cannot be fully defined at this stage but the likely impact will be flagged up and specific business cases for service developments will be produced as required. The purpose here is to highlight the likely implications for the future of the fleet and make recommendations for future action.

Operational Model

NIAS operates a service of continuous improvement to provide ambulance services to the population of Northern Ireland. A necessary part of that is to ensure that an appropriate resource is able to respond to the point of need within given time parameters, specific to the nature of the call (see Performance Standards above). The service is delivered from the existing estate infrastructure and as the ambulance service is essentially a mobile service the distribution of resources is constantly changing. The nature of health services and therefore the requirements on the ambulance service are also changing following the two major reforms in the last years. The fleet size and distribution is influenced by the estate configuration and the changes in demand profiles. The fleet can and must be flexible to meet the demands and constraints on its operation and to meet the needs of the population.

A&E Fleet

The A&E part of the ambulance service has been impacted by significant changes over last 10 to 20 years. Demand has risen, measured by call volumes, year on year; from 1995 demand has risen by 166% (90,000 extra patients pa), over two and a half times what it once was.

In terms of the A&E fleet, mileage has increased as the fleet size has reduced resulting in increased miles per vehicle. The mileage travelled by the fleet has increased by 26% in the last six years. The size of the A&E fleet has reduced from its peak of 140 in 2005 to the current level of 116 a reduction of 17.2%. Although the fleet was smaller in size it was also younger in age and more evenly profiled across the age range. In other words regular fleet replacement in the past was

successful in enabling a reduction in fleet size and improved utilisation of fleet while also increasing its reliability.

NIAS Cat A standard has become progressively more challenging over the years and peaked at 73% in 2011/12 and has fallen below standard to 68% in the last two years. There are a multitude of factors that influence performance but currently fleet size is not a factor, there is sufficient fleet to support the current pattern of ambulance cover.

The fleet is distributed across the region on a per-station basis and this gives the benefit of a local contingency at the cost of additional capital assets. Station spare capacity is factored in for A&E ambulances to ensure continuity of service in the event of vehicle failures or maintenance and to cover shift changes when vehicles may not have returned to station in time for the new shift starting. Should it be necessary to put on additional ambulance cover the impact on fleet numbers will have to be reviewed.

- Review local provision to identify further efficiencies
- Include impact on A&E fleet in any proposal for new services
- Include impact on A&E fleet when matching cover to demand

RRV Fleet

The RRV concept was developed to deliver paramedic skills to life threatening calls within the 8 minute target. They would deliver care and transfer the patient to an ambulance for the onward journey to hospital. RRV were successful at both directly contributing to the achievement of the target and releasing ambulances from attending if not required.

Following their introduction there were 8 RRV in 2005 and the number quickly rose to the present 42. Mileage travelled by the RRV fleet has risen as the number of vehicles have increased. The service is provided in early and late shifts with an overlap in the middle of the day. The fleet is well utilised with 35 vehicles on at the peak periods leaving just seven spare vehicles distributed across Northern Ireland. Similar to PCS spares may need transported to offset vehicle downtime but because of the nature of RRV work more flexibility is possible with start locations and operation. Given the current configuration of services there is no requirement to change RRV fleet size.

- Include impact on RRV fleet in any proposal for new services
- Include impact on RRV fleet when matching cover to demand

PCS Fleet

PCS vehicles were averaging about 22,000 miles per year for 06/07 and this has changed only slightly in 2013/14 to 23,480. Over the long term there have not been significant changes to PCS activity in relation to patients or miles. The PCS and specifically ICS have acted in support of A&E service where patient condition allows and help to make the A&E resource more available.

Transforming Your Care has the potential to increase the activity of PCS through the general thrust of a more elderly population accessing more care locally. PCS fleet is more fully utilised than A&E and continuity of service, while still important, is less critical than for A&E. Spares for PCS are not based at every station so when faults or servicing is required vehicles must be transported between stations. Spare capacity in PCS is minimal.

PCS fleet was increased following the introduction of the 24/7 neonatal/paediatric service but did not have a funded uplift following ED changes in Belfast which has left them without any spare vehicles, which in turn will lead to service disruption for routine maintenance requirement and breakdowns. PCS fleet needs to be increased slightly to provide for the high utilisation and lack of spare capacity in certain areas.

- Increase PCS fleet size to 110 to cover scheduled maintenance and contingency capacity
- Include impact on PCS fleet in any proposal for new services

Support Fleet

The support fleet comprises of a range of vehicles as previously described. The most recent changes have included specialist vehicles in support of the HART programme. Changes in the support fleet are on a as and when required basis and will be the subject of specific proposals. There is no identified need for changes in this portion of the fleet at present.

- Develop specific proposals for support fleet as required

Size

The Size of the fleet and the mix of vehicles have changed significantly over the last number of years. This has been as a result of a change in the method of delivery of the Ambulance Service. It has also been influenced by the reconfiguration of hospitals and the changing methods of provision of healthcare services in Northern Ireland. Ambulance response and transport is such that investment in dynamic fleet management and replacement will be key to continuing effective service delivery for both ambulance and wider healthcare.

Fleet Size	2001	2005	2008	2011	2014
A&E	137	140	132	120	116
PCS	87	103	105	105	106
RRV	0	8	24	40	42
Support	35	50	53	51	49

Fleet size was increased through funded changes following the Omagh and Magherfelt reconfigurations. The original fleet size was also reduced as part of NIAS efficiencies and the resulting A&E fleet size has absorbed pressures from Belfast and Lisburn ED changes without an increase in resources.

Changes to the fleet size are dependent on how the assets are utilized and this is directly linked to the shift pattern. Until the shift pattern changes there is no need

to consider fleet changes but this must be done in conjunction with a development and the impact assessed at as early a stage as possible. A change in the fleet may not always be necessary but should always be considered. As discussed above the fleet size for A&E, RRV and Support are all considered adequate in the present circumstances. PCS fleet size would need to increase to 110 to support changes in Belfast, and maintain the contingency levels for servicing and maintenance.

The distribution of the fleet across Northern Ireland gives rise to logistical issues in ensuring that resources are placed to meet the requirements of the shift cover and that contingency capacity is available in the event of accident, incidents and routine servicing. With a network of just over 30 stations spread across the region it is vital to have spare contingency available at a local level for the emergency fleet.

The 62 locations provide an adequate base from which to achieve the targets providing that a resource is available. Fleet can be managed more effectively if it is not distributed so widely (33 stations). Fewer but larger stations would enable the reduction of spare vehicles in relation to active vehicles and thereby reduce the total size of the fleet. Reconfiguring the estate will be a long term objective that would yield a reduction in A&E fleet numbers.

- Maintain Current fleet size for A&E, RRV, Support
- Increase fleet size for PCS
- Identify spare capacity required to cover downtime and map to existing locations
- Develop larger hubs for more efficient management of fleet

Fleet Age Profile

A reliable fleet is a function of age and use. Mechanical systems are prone to wear and tear and the effects of age. An ambulance fleet and particularly the emergency response vehicles operate in a harsh environment for significant portions of their life. Regular maintenance can keep vehicles in a roadworthy condition but the cost of doing so increases with age of the vehicle and increasing mileage.

NIAS have had regular investment in the fleet over the last 6 years and this has benefited the service. Now the fleet is evenly distributed across the age range with no peaks and troughs in the age profile. Troughs in investment mean that older, less reliable vehicles must be retained. Peaks in investment provide a bonus of young vehicles in the early years and a corresponding slump when those vehicles get older and skew the average age. For illustration the A&E Age profile in 2009 is compared to 2014 in the appendix. It highlights the irregular funding and skewed age profile in 2009 and shows a flat profile, evenly distributed and a reduced maximum age in 2014 following regular investment.

- Maintained a flat age profile ie regular investment in fleet.

Replacement

Fleet size and replacement cycle when considered together determine the annual number of vehicles that need to be purchased. It is important to note that annual

fleet replacement numbers have remained constant over the last 6 years as part of the NIAS infrastructure programme. The regular annual investment has been of significant benefit to the service and ultimately to the users and public confidence. Regular investment has sustained the service through a period of significant growth in demand and major changes to health services in Northern Ireland. Where local pressures have been identified they have either been funded by development proposals or absorbed by NIAS. Some additionality has been funded by NIAS, the RRV development was a combination of new development and NIAS funding. The replacement programme has had additional funding where specific needs have been established but the base level of replacement has been adequate over the last 6-7 years.

- Review replacement cycle with changes in fleet size

Environmental Issues

The Trust seeks to act in a socially responsible manner and takes its commitment to minimize and reduce its impact on the environment seriously. The impact on the environment is directly proportional to the size and mileage of the fleet because the fuel usage is the main factor. Manufacturing and disposal at the end of life are largely outside of NIAS control but also contribute to the overall sustainability of fleet operations.

Vehicle manufacturers must comply with European emission standards and are increasing the use of recycled materials in vehicle production and ensuring that more of the vehicle can be recycled at the end of its life. NIAS must continue to include sustainability issues in the procurement processes to support the environmental sustainability of the fleet.

Alternative energy sources for vehicles are not fully mainstreamed; electric vehicles do not have the range and performance for ambulance work, yet. Hybrid vehicles, a cross between conventional fuel and electric power are becoming more readily available and offer a reasonable alternative in some roles although they would currently be cost prohibitive for ambulance work. In 2014 NIAS equipped two RRV vehicles with solar panels to offset the use of mains vehicle charging, reduce the drain on vehicle batteries and reduce excessive engine idling. The RRVs are rarely garaged during their duty as they are mobile between calls and deployment locations and would maximize their exposure to solar energy.

- Comply with NIAS environmental policy to support good environmental practices.
- Ensure sustainability factors continue to be considered during procurement.
- Roll out solar panel fitment after the pilot is evaluated.
- Raise staff awareness, cycle to work scheme, surveys and newssheet.

Safety: Patient, Staff, Road

Road risk encompasses all the risks associated with driving, the operation of motor fleets and personal cars used for business purposes (grey fleet). NIAS are in the final stages of producing a Driving Policy and Driving Procedures for all staff driving

on behalf of NIAS. The risk for operational staff driving as part of their duty and transporting patients are obviously greater than business car users and when those duties involve emergency driving responsibilities as well, then the trust must do as much as practicable to safeguard staff patients and other road users.

Vehicle telemetry has been introduced to emergency vehicles in 2014 to assist with monitoring and encouraging safer driving. The system will be able to assist accident investigation and to provide feedback to drivers to promote safer driving. Safer driving and in particular the reduction of speed where it is not necessary will also have a major impact on fuel consumption and therefore fleet costs and environmental impact.

- Issue NIAS Driving Policy and Procedures
- Roll out telemetry to the whole A&E, RRV and PCS fleet.
- Utilise telemetry data to modify driver behavior and improve safety.
- All vehicles to comply, at time of purchase, with relevant safety guidelines eg CEN 1789:2007, Whole Type Approval

Management

NIAS fleet management department is responsible for the procurement, commissioning, decommissioning and disposal of fleet assets. It also manages the contracts for vehicle maintenance and repairs and has oversight on fleet issues. As described earlier infrastructure changes would allow the fleet resource to be concentrated on fewer sites and subsequently enable efficiencies to be made in terms of fleet size. Without those changes, which would be long term objectives, efficiencies could be gained through more effective management of fleet assets. . This could be achieved by centralisation of the vehicle management functions from the current divisional model to a specific centralised model with a core responsibility for fleet.

- Centrally manage spare fleet to achieve greater efficiencies.
- Review fleet function and consider central management of all fleet assets.

Specification

Fleet user groups provide input to the specification for ambulance vehicles and, in conjunction with the fleet department, user and technical specifications are developed and reviewed prior to the annual procurement exercise. Changes to the specification have been relatively minor and over the last replacement programme changes to the specification have been managed within the allotted funds. Looking to the future it is hard to predict any significant change in the A&E specification although the ongoing review of the CEN standard may drive changes in the new standard.

PCS fleet has been designed around a multipurpose stretcher/wheelchair vehicle and this multi role approach is no longer meeting the needs of patients. The increased distances travelled to hospitals, especially regional specialties, and the generally less mobile patients are exceeding the capacity of the current vehicles. The PCS fleet of the future will develop down more specific roles eg separate stretcher and

wheelchair capable vehicles with greater carrying capacity. There is still work to be done in quantifying the specific changes required and applying them to a local level to determine exactly where such vehicles could be used most effectively.

Considered with the potential growth in demand for PCS services this is likely to be the major change in fleet in the near future.

The RRV vehicle specification is based on an estate car preferably with four wheel drive capability. This provides greater safety factor and a degree of contingency for poor weather conditions. In specific areas off road capability with additional ground clearance is required and typically this means that approx. 20% of the RRV fleet should be a jeep type specification. There is currently no requirement to change RRV specification.

There is a variety of vehicle types in the support group ranging from officer cars to highly specialised Incident Communication Vehicles. Specifications for cars are the same as RRV and this provides an element of standardisation and contingency between RRV and officer fleet. Other vehicles have particular roles and will have individual specifications. The life of these vehicles is extended because of the relatively low mileage and high investment in the conversion to bespoke specifications.

The biggest change in recent years has been the introduction of HART with its support vehicles and equipment. HART deals with specialised incidents over and above the “normal” major incident and in particular specialises in difficult rescue and terrorist related incidents such as chemical, biological and radiological causes of casualties. Any significant changes or additions to the support category would likely be through individual investment proposals linked to the need for specific resources.

- Monitor the review of CEN standard and incorporate into A&E specifications.
- Develop PCS specification to match patient transport needs.
- Consider support vehicle specification as required.

Procurement

All ambulance services UK wide require replacement vehicles similar in specification to NIAS and therefore most options are covered by National procurement frameworks. Base vehicles are available from pan government frameworks and specialised ambulance related conversions are covered by relevant frameworks. NIAS is a member of a procurement hub for ambulance related contracts and this generally provides a compliant route to market for vehicle conversion and equipment for ambulances, cars and specialist vehicles.

Contracts for vehicle maintenance, repair, recovery, parts and equipment are managed by the fleet department. The contracts are let in accordance with procurement best practice and under guidance from a procurement Centre of Excellence. NIAS has and continues to procure collaboratively with other UK ambulance services and Northern Ireland emergency services and public bodies to obtain best value.

- Explore opportunities to obtain best value through collaborative procurement.

Maintenance

NIAS outsources the vast majority of vehicle maintenance and repair on framework contracts. The current framework expires in 2018. The small in house facility generally provides maintenance services for the Belfast and South East fleets. Further efficiencies in fleet size could be realised if the infrastructure changed to concentrate fleet in fewer locations. Maintenance, repair, equipment servicing and fleet resourcing could all be managed more effectively if vehicles were not distributed so widely necessitating more travel between locations.

The in-house maintenance function is based in Belfast where there is a concentration of vehicles which makes the workshop viable. If larger hubs are developed then in-house maintenance could be effectively extended into other areas. Where NIAS cannot efficiently provide a maintenance function in-house then collaborative working with other services should be considered.

- Explore collaborative working with other services.

Fuel

Fuel is a significant cost of fleet operations and it also has the most volatile pricing due to the nature of the market. NIAS buys fuel through National contracts and therefore obtains the best price possible through the buying power of the combined UK ambulance services. Fuel is vital to NIAS' operation and is in relatively short supply regionally because of Northern Ireland's reliance on imported fuel. The supply route is vulnerable to disruption as has been evidenced during recent fuel protests. Bunkered fuel at station level offers a small cost saving but more importantly provides a contingency supply in the event of supply failure or localised distribution inadequacies.

- Identify locations for surface storage for bunkered fuel

Disposal

The disposal of vehicles at the end of life must realise the best value for trust assets and comply with security considerations associated with A&E vehicles. NIAS currently offers old vehicles to the voluntary societies prior to decommissioning and public auction. The market for used ambulance vehicles is limited and in many cases the vehicles are not economically viable for work as an ambulance within the European market.

- Utilise national contract to obtain better value for the disposal process.

6 Benefits and Risks of the Fleet Strategy

Benefits

The prime benefit of the strategy is to provide a fleet infrastructure fit to support ambulance service into the future and thereby deliver on the trust's mission. To enable that to happen the strategy must provide the right type of vehicle, in the right quantity and make it available in the right locality.

A healthy fleet will enable a flexible service, responsive to changes and with the ability to absorb service changes in the short term, although developments will need to be funded for significant change.

Improved efficiencies in the management of the fleet resource are possible but rely on the continued steady state capital investment on fleet in the first instance and, in the longer term, investment in estate to support efficiency in fleet.

- Develop KPIs to monitor benefit realisation
 - Maintain 100% statutory compliance of fleet e.g. MOT
 - Monitor vehicle downtime (unavailable hours) and minimise.
 - Use telemetry to measure vehicle utilisation as a percentage of availability
 - Investigate accidents to highlight training needs.

Risk

The benefits derived to date from the steady investment in fleet will be quickly lost if that investment is not maintained. A reliable fleet underpins ambulance service operations and enables continued operation.

A unreliable fleet leaves day to day operation at risk and would be unable to cope with service changes, seasonal pressures events or major incident which all impose demands over and above normal operations.

Funding of the fleet is a prime necessity for the strategy but so to is funding for estate changes to facilitate changes in fleet deployment. Changes to estate and staffing are challenging projects in themselves and delivering them in the current economic environment will not be easy. This strategy proposes a way forward that should be considered in the round and would change the service but also better prepare it for the future.

7 Appendix

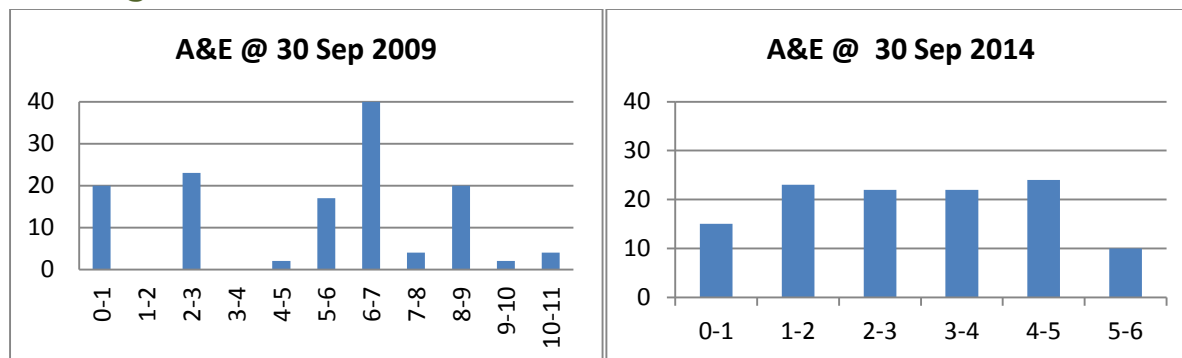
Call Demand - Northern Ireland

	07/08	08/09	09/10	10/11	11/12	12/13	13/14
Emergency Calls	111,663	116,787	121,017	126,446	132,447	140,369	144,657
Urgent Calls	34,608	36,264	36,071	35,320	35,386	35,492	35,736
Totals	146,271	153,051	157,088	161,766	167,833	175,861	180,393
Patient Journeys	218,469	215,652	207,189	205,721	205,269	211,164	212,592

Fleet Mileage

Mileage	07/08	08/09	09/10	10/11	11/12	12/13	13/14
A&E	3272281	3391522	3588350	3627975	3816416	4026944	4128462
PCS	2308945	2366020	2425792	2386824	2444330	2425828	2489343
RRV	363704	473502	554760	667020	751482	745286	731308
Support	194262	160060	143929	180641	220614	239325	253778
TOTAL	6139192	6391104	6712831	6862460	7232842	7437383	7602891

A&E Age Profiles



TB/6 03/12/15



Minutes of a Meeting of the Assurance Committee held on Tuesday 6 October 2015 at 2.00pm, 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 J Wright	Acting Director of 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 Pattison	Senior Secretary (Temp)

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 18 May 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 6 August 2015.

4.0 Matters Arising

Assurance Equality Audit Committee confirmed that they would revert to normal statutory reporting on Equality matters for future reports.

No other matters arising that were not otherwise covered in the Agenda.

5.0 Chairman's Business

Dr Livingstone informed the Committee that it was a pleasure to be appointed as the new Chair. He also commented that he had previously been a member of the Committee for three years.

5.1 Agenda

The Chair proposed that the Agenda for meetings be restructured in order that items were clearly identified for either discussion, consideration or noting, with an indicative timeframe for each item. It was agreed that Standing Agenda Items would normally require discussion.

6.0 Standing Items

6.1 Assurance Framework as at 31 July 2015

Noted. The previous Trust Board workshop regarding the presentation of the Assurance Framework was discussed. It was agreed that as an electronic version was developed for ongoing regular review by SEMT for presentation to the Committee, a hard copy version would continue to be presented in the meantime. It was agreed that both versions should clearly record any changes made to entries on the framework for ease of reference.

6.2 Local Risk Register Review as at 31 July 2015

The local Risk Register for Finance was presented and noted.

In particular Risk 204 (Geographical Location Systems) was discussed in relation to the lead directorate, as Operations, Information and IT were all involved in the management of the risk. It was agreed that a procedure for updating the GPS mapping systems would be presented at the next meeting and this would help inform this decision.

The Committee thanked the Director of Finance & ICT and the Risk Manager for the work involved in preparing this comprehensive local Risk Register for presentation.

6.3 Controls Assurance Standards

The Controls Assurance Standards report was presented. It was noted that compliance with the three core standards and two other standards subject to review by internal audit was found to be substantive. Substantive compliance was noted for all other standards subject to self-assessment with the exception of Information Governance. The Committee was informed of the measures that were already in place to improve compliance with these particular standards.

6.4 Untoward Incidents as at 31 July 2015

Noted. It was agreed that it would be helpful if the presentation of data regarding incident severity could be disaggregated by, for example, incident type to improve clarity and understanding.

Incidents of violence to staff were discussed and it was agreed that it would be helpful, particularly for new members, if a presentation on the measures to management incidents of violence to staff could be made to Trust Board at a future meeting as a lot of work had been undertaken in relation to this.

6.4.1 Clinical Incidents as at 31 July 2015

Noted. The level of self-reporting continues to increase. The increased level of reporting was welcomed, with the Committee encouraged that potential risks are being identified and reported for learning across the Service.

6.5 Serious Adverse Incidents as at 31 July 2015

Noted. The regional multi-agency Place of Safety Protocol developed and agreed in response to a serious adverse incident will be presented to the next meeting.

6.6 Coroner's Reports & Letters

Noted.

6.7 Medical Device Alerts

There were no Medical Device Alerts within this reporting period.

6.8 PHA Safety & Quality Reminder of Best Practice Guidelines

Noted. It was also noted that the Reminder of Best Practice Letter in relation to the prevention of hypotension during the transfer of all pregnant women would be shared with relevant staff.

6.9 Pharmacy & Medicines Management Update

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

6.9.1 Medicines Procedures Review

Noted. The Committee were advised that only minor amendments had been made following the regular review of the Policy and Procedure.

6.10 Reports from Groups and Committees

6.10.1 Fire Compliance Group – Notes of Meeting 28 January 2015

Noted.

6.10.2 Fire Compliance Group – Draft Notes of Meeting 14 May 2015

Noted.

6.10.3 Medical Equipment Group – Notes of Meeting 21 May 2015

Noted.

6.10.4 Infection Prevention & Control Group – Notes of Meeting 31 March 2015

Noted.

6.10.5 Infection Prevention & Control Group – Notes of Meeting 2 June 2015

Noted.

6.10.6 Emergency Preparedness & Business Continuity – Notes of Meeting 25 June 2015

Noted.

Director of HR and CS advised that Health and Safety Committee had not met since last Assurance Committee meeting and there were no items that required to be raised.

It was proposed and accepted that in addition to the Minutes of each Group and Committee being presented, any particular items requiring escalation for consideration by the Assurance Committee be highlighted.

It was agreed that a presentation of the work or agenda issues of each Group or Committee would be made on a rolling basis.

The Chairs of the Assurance and Audit Committees agreed to consider where the Minutes of the Information Governance Steering Group should be reported, either to the Audit Committee, Assurance Committee or possibly both. It was agreed that in the meantime the Minutes would continue to be presented to the Assurance Committee.

7.0 RQIA Infection Prevention / Hygiene Team Governance Assessment Announced Inspection Report

Noted. It was agreed that a progress report against the Action Plan be provided to the Committee on a six-monthly basis.

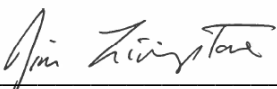
8.0 Any Other Business

None.

Date, Time and Venue of Next Meeting

It was noted that the Assurance Committee meetings should ideally take place more than two weeks before a Trust Board meeting in order that the Minutes be included in Trust Board papers. Despite the next Assurance Committee meeting being scheduled following the next Trust Board meeting, it was agreed that this should remain unchanged on this occasion, but that the schedule of meetings for 2016 should be reviewed. It was also agreed in order to minimise delays in meetings that the dates should be confirmed with members in advance in order that any postponed meeting could take place as close as possible to the original date.

The next meeting will take place on **Thursday 10 December at 1100hrs.**

Signed: 
(Dr Livingstone, Chairman)

Date: 5 November 2015

TB/7 03/12/15

NORTHERN IRELAND AMBULANCE SERVICE

TRUST BOARD MEETING

3 December 2015

Title:	Annual Quality Report 2014-15
Purpose:	For noting
Content:	The Trust, as are all other HSC organisations, is required to publish an annual Quality Report in accordance with a template provided by DHSSPSNI as part of Quality 2020. The report reflects initiatives and progress in improving the quality of care.
Recommendation:	
Previous Forum:	
Prepared by:	John McPoland
Presented by:	Medical Director

Northern Ireland
Ambulance Service
Health and Social
Care Trust



Annual Quality
Report
2014-15





Introduction

In 2011, the Department of Health, Social Services and Public Safety launched “Quality 2020: A 10-year Strategy to Protect and Improve Quality in Health and Social care in Northern Ireland”.

The Strategy defines quality under three main headings:

- Safety - avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.
- Effectiveness - the degree to which each patient and client receives the right care (according to scientific knowledge and evidence-based assessment), at the right time, in the right place with the best outcome.
- Patient and Client Focus - all patients and clients are entitled to be treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

The Strategy has identified five strategic goals to be achieved by 2020 that will turn the vision of being ***“recognised internationally, but especially by the people of Northern Ireland, as a leader for excellence in health and social care”*** into a reality.

The five strategic goals are:

1. Transforming the Culture.
2. Strengthening the Workforce.
3. Measuring the Improvement.
4. Raising the Standards.
5. Integrating the Care.

The Northern Ireland Ambulance Service provides ambulance care, treatment and transportation services to a population of 1.8 million in Northern Ireland. Our staff are

committed to the delivery of safe, high quality care to all who have need of our services, 24 hours a day, 365 days per year.

In our first Quality Report, last year, we provided information to allow an assessment to be made on where we were on our journey to improve quality in all we do. This second report enables you, the reader, to assess how we have built upon progress that had been made and how commitment and dedication of our staff continue to put the patients and clients front and centre of all we do.

The report will demonstrate activity undertaken, and progress made, under the five Strategic Goals listed above.





Chief Executives Foreword

I am delighted to present the second Northern Ireland Ambulance Service HSC Trust Annual Quality Report 2014/15.

The year has been a challenging one for NIAS given the financial and operational constraints within which we function and, particularly, in the context of continued, increasing demand for our services.

Our investments in staff, equipment, vehicles and facilities have created a stable platform to meet the challenges presented as we strive to deliver on our aim of “preserving life, preventing deterioration and promoting recovery”. Our efforts align with the strategic goals of Quality 2020: Transforming the Culture; Strengthening the Workforce; Measuring the Improvement; Raising the Standards and Integrating Care.

Increased numbers of front-line staff have been trained in new clinical skills and interventions enabling them to be fully integrated into the HSC network of care. Our purpose built, state of the art vehicles are equipped with the best clinical and technology systems to improve the care we provide. We have invested in our capacity to take and triage calls to ensure that appropriate care is provided at the right time and place. We are strengthening the workforce by recruiting and training additional frontline personnel.

This platform has enabled us to continue to provide high levels of clinical care at a time when our speed of response to patients has, regrettably, suffered to the extent that we did not meet targets set in respect of providing a sub 8 minute response to 72.5% of Category A calls.

We, more than anyone, understand that speed of response, although only one factor in determining patient outcome, is a key measure of our performance. As a Trust, going forward, and as part of our commitment to providing quality services, we will seek to introduce measures that will ensure that patients will not only be provided with a highly skilled and suitably equipped clinician but that said clinician will respond in a more timely fashion. We accept that we cannot do this as a quick fix and that any measures introduced must be sustainable in the medium and long terms. Driven by our commitment to quality care for the patient, we will work, in partnership with commissioners and other colleagues to deliver a service which meets the expectations of our patients and which, as outlined in the Quality 2020 Vision can be “recognised internationally, but especially by the people of Northern Ireland, as a leader for excellence in health and social care.

Transforming the Culture

NIAS will seek to make achieving high quality the top priority at all levels within the organisation. This emphasis on high quality will improve the experience of all those who use and work in the ambulance service. It will also make our services safer for all.

Key to transforming culture is the willingness of the Senior team to lead from the front in motivating staff to embrace change. A clear strategic direction aimed at delivering a sustainable transformation must be communicated to staff to encourage an acceptance that changes in working practices are designed primarily to deliver higher quality care for patients.

NIAS recognises also that patients and their carers, or representatives, have a voice to be heard in determinations around levels of care to be expected from our service.

In relation to our staff we are keen that that we should afford them opportunities to voice their opinions and concerns; that we should listen to what they have to say and that they should be encouraged to become involved in decision making, problem solving and innovation at all levels.

In 2014/15 we took steps to ensure that all these voices were heard by;

- Conducting a survey among staff on the outcome of the Donaldson Review to feed into our response to the consultation on Donaldson,
- Carrying out a staff survey as part of the regional 10,000 Voices project,
- Working to mainstream service user engagement and involvement in the development and implementation of key policy work. This included service user

workshops on policy areas related to the Trust's non-emergency service. NIAS liaised with Disability Action for this work, who facilitated engagement with their members accessing these services. The workshops provided an opportunity for service-users to meet directly with those responsible for delivery of these services to provide feedback and hear about and input into service development plans.

Being cognisant of the fact that in any process of transformation there is always the opportunity for learning to take place, the Trust is keen that staff, in their personal pursuit of excellence, should be confident that, when things go wrong, each incident will be dealt in a just and fair manner.

In 2014/15 NIAS continued with its commitment to error management via ongoing training and data reporting of cause of error etc. by adhering to the following process of incident management;



- Clinical Incidents brought to attention through the Untoward Incidents reporting procedure,
- Call reviewed by Clinical Training and Support Teams,
- Incident stored on database,
- Any learning or action agreed upon and taken,
- CSOs and CTOs provide supervisions and reviews,
- There has been an increase in number of incidents reported as staff have become more familiar with the process of error reporting – they have learned that issues are resolved through training and learning, which is disseminated to staff, if appropriate,
- A medical device alert was raised following a breakage to an intra-osseous needle. It was reported through an adverse incident report to the manufacturer and training was disseminated to staff.

Throughout 2014/15 the Trust continued to make regular use of communication channels embedded within Trust systems to ensure that staff were kept up to date with information relevant to the performance of their duties. These channels included;

- Staff newsletter,
- Memo's,
- Email,
- Noticeboards,
- Mobile Data Terminals,
- Staff Intranet.

in addition to which we continued to feed our social media sites and public facing website in an attempt to ensure that staff and public were kept informed of developments and emerging issues which may have impacted upon them.

Internally, as part of the Transformation and Modernisation Programme, a number

of focus groups were established , separately, for staff and their representatives to gauge reaction to recently implemented changes in practice and to map out a direction of travel in regard to “Transforming Your Care”.

It is also recognised that key to managing the transformation of the organisation’s culture is a process whereby staff feel supported and informed. To this end, throughout 2014/15, the Trust continued to provide feedback to staff, through Clinical Support Officers, on performance relating to clinical practice and interpersonal skills. Such opportunities afforded the Trust the opportunity to celebrate and profile good performance through Corporate Social Media and external media outlets.



Strengthening the Workforce

NIAS will provide the right education, training and support to deliver high quality service. No matter how good our systems and procedures are, they all rely on staff who are motivated, skilled and trained to deliver them. We must also consider future personal and public involvement in the design and implantation of these systems.

Our staff, in dealing with patients each and every day, are the public face of our organisation and act as ambassadors in all they do and say. The Trust recognises the importance of staff being trained to the highest levels of clinical expertise but also the necessity for staff to be trained in processes relating to error management and service-user interaction.

In 2014/15 NIAS continued with its commitment to support staff in the process of error management by:

- facilitating supervised reflection on performance, with local Clinical Support Officers (CSO's) being given a lead role,
- continuing to audit Patient Report Forms for clinical practice, patient outcomes re ROSC and recording procedures,
- sharing recommendations of any Independent Review with Clinical Training Team and CSOs. This information was then included in induction and annual refresher training and a joint, multi-agency protocol for admissions to a place of safety has been agreed and developed.

Training provided to staff must be of the highest quality if we are to deliver to service-users a level which meets and surpasses their needs. NIAS ensures that training delivered for the benefit of service-users is accredited to ensure quality and as such;

- we have maintained accreditation with the HCPC to remain a centre for paramedic training programmes,
- we respond to SAls through review by senior training officers and identification and implementation of appropriate training,
- Paramedic and nursing professionals have undertaken CPD to enable revalidation and maintenance of their professional registrations,
- 2 members of RATC have completed the HSC Leadership Centre's "Putting People First" training,
- RATC has developed a CPD programme for all frontline operational staff,
- Statutory Mandatory Training is delivered regularly on;
 - a. Manual Handling
 - b. Psychology
 - c. Sociology
 - d. Patient-centred communication skills
 - e. Management of Health and Safety (Including Risk)
 - f. Medicines Management
 - g. Fire safety
 - h. Stress Management

Measuring the improvement

NIAS will improve outcome measurement and report on progress for safety effectiveness and the patient/client experience. High quality service is underpinned by safety, effective treatment and a good experience of the care received. NIAS will continue to compile good baseline data to measure all of the above and we will make this information as accessible as possible.

NIAS recognises the importance of gathering data and statistics as a means to examine performance and identify areas of strength and, perhaps more importantly, to identify areas where improvements can be made.

The Trust gathers this information at all operational levels of the organisation, including administration, and a dedicated team of information analysts produce regular reports for scrutiny by all levels of management, up to, and including Trust Board. These reports indicate levels of performance across the Trust and, through complaints and compliments, the levels of satisfaction, or otherwise of service-users.

The Trust is aware that for the service user, the most important factor in their interaction with us, as a Service, is how we treat them and their relatives. We publish the same information that is available to Trust Board on our website and it is available for all to see, including plans to improve the delivery of service.

Information is shared with Trust Board in a number of fora and on a wide range of issue as detailed below;

- Report to Trust Board through Quality Assurance Committee,
- Trust board papers every 2 months,
- Report activity of number of groups through Assurance Committee
 - Health & Safety
 - Fire Compliance
 - Medical Equipment
 - Infection Prevention & Control
 - Emergency Preparedness
 - Business Continuity
 - Information Governance,
- Recommendations from any reviews or inspections,
- There are a number of standing items, such as Assurance Framework, Controls Assurance Standards and Untoward Incidents.

Through the complaints and compliments process NIAS has a regular opportunity to assess each and improve working practices where appropriate.

NIAS operates the DHSSPS Complaints Policy and Procedure. Through this the Trust works to ensure a robust investigation of complaints received. Learning outcomes are an important element of the investigation of complaints and the Trust is committed to ensuring that learning is fed into quality improvement. Regular reports in respect of complaints are sent to the Trusts Senior Executive Management Team. Officers involved in undertaking complaints investigations have received Investigation Training.

Anonymised details of all complaints received are sent to Trust Board and placed on the Trust website.

The Trust is in the process of reviewing complaints processes to deliver a stronger focus on learning outcomes and related reporting. The Trust similarly records and monitors compliments as it is important to learn from good practice.

In April 2014 NIAS appointed a Transformation and Organisational Programme Manager and established a Transformation and Modernisation Programme. The NIAS Transformation and Modernisation Programme Board meets monthly and is chaired by the Director of HR&CS. In relation to Transforming Your Care (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, ICPs, LCGs and Users on an ongoing basis.



The projects include;

- implementation of a range of Appropriate Care Pathways (previously referred to as Alternative Care Pathways),
- pilot of a Clinical Support Desk in Ambulance Control,
- implementation of a NIAS Directory of Services.

In addition the Transformation and Modernisation Programme includes a User and Staff Engagement and Communication Project, an ICT Enabler project and oversight of the development of the EPRF business case, Performance against key deliverables for NIAS Trust and the benefits realisation with the wider HSC is reported at each Programme Board and Trust Board.



User and Staff Engagement and Communication are a critical element of effective delivery of TYC priorities. This is led through the Equality and Patient Experience function working with the TYC team and is reported on accordingly.

An overview of the change processes have been as follows:

- Activity data relating to the chief complaints was analysed,
- Literature review and use of learning from elsewhere provided a range of potential ACPs,

- These potential ACP pathways were analysed,
- A risk management approach were applied to create a priority list for the 10 new Pathways. These comprise a range of See and Treat, Hear and Treat, and Treat and Leave, depending on the condition and chief complaint,
- It was agreed that the following pathways (ACPs) will form key work-streams for NIAS over the next two years:

Diabetes
 Cardiac
 Frequent Callers
 Clinical Support Desk development
 Minor Injuries
 Blocked Catheter
 Falls
 Epilepsy
 Mental Health
 COPD
 Palliative Care

In relation to CPD training for staff the Trust takes steps to ensure it is appropriate and comprehensive.

We have received support from the Patient Safety Forum to improve our clinical audit programme.

We continue to evaluate our training programmes to review learning outcomes to improve safety and quality.

Raising the standards.

NIAS will establish a framework of clear evidence-based standards and best practice guidance. These standards will be authoritative and concise, aimed at achieving high quality in the most cost effective way.

NIAS is cognisant of the importance of engaging with service-users in a meaningful way to ensure their voice is heard in matters relating to current delivery of services and, perhaps more importantly, in how we plan to deliver our service in the future. We are aware that our view on what is best for the patient may, at times, be from the wrong perspective and while we may believe that we do things in the best interest of the patient, we realise that, in the process of developing any new processes or procedures, the views of those who will be most impacted by any such change should be paramount and incorporated into the process as an integral part.

Stakeholder registration and participation in guidance consultations

We have;

- continued to involve disabled people and their representatives in the development of key work-streams such as the policy on the transportation of assistance dogs, booking procedures for non-emergency ambulance transport and the introduction of revised protocols for the prioritisation of emergency and urgent calls,
- engaged widely on the Trust's Equality Action Based Plan and Disability Action Plan,
- facilitated a formal 12 week Consultation on Equality Action Plan and Disability Action Plan ended in June 2014.

NIAS is aiming to achieve a patient centred culture which identifies learning outcomes from such engagement as well as from complaints, untoward incidents and equality and patient experience work-streams. These learning outcomes are intended to create a focus on quality improvement. Learning outcomes are presented to the Trust's Senior Executive Management Team.

NIAS has a Personal and Public Involvement (PPI) Strategy in place which sets out the key principles under which it seeks to promote its PPI agenda. As indicated previously, the Trust has worked to mainstream PPI within the development and implementation of key policy areas. One key strategic policy area is the Trust's Transformation and Modernisation Programme which incorporates Transforming Your Care. This programme has a strong Communication and Engagement element which ensures that involvement of key stakeholders such as staff, service-users and



representative community and voluntary sector groups is central to service development. Focus groups, feedback forms, dedicated email addresses and news sheets are used to keep people informed of progress and to enable input and suggestions as work moves forward.

We have in place robust arrangements for seeking the views of patients/clients including how the organisation promotes personal involvement and during 2014/15;

- we worked to implement PPI Strategy and Action Plan.
- patient stories have continued to be gathered as part of NIAS' contribution to the regional 10,000 Voices project which asks patients and carers to share their experiences of using our services.
- we undertook pre consultation engagement with service-users in respect of booking processes for non-emergency services which resulted in changes to the proposals and booking procedures.

As NIAS continues to play an important role in the implementation of wider HSC Service Frameworks we continue to;

- engage with a number of service networks e.g. cardiovascular, respiratory, stroke, end of life care etc.,
- develop National Regional Performance Guidelines,
- lead in the Community Resuscitation Strategy which was officially launched in 2014,
- support Community First Responder Schemes, with two more launched in December 2014, and interest noted from a further two,
- map public access AEDs for use in Control, in collaboration with the British Heart Foundation and the University of Ulster,
- engage with the British Red Cross regarding a project to install AEDs in disused telephone kiosks in rural areas such as Fermanagh,
- engage with civic bodies to facilitate Public Access Defibrillator installation in Derry

City,

- engage with colleagues in HSC to develop Appropriate Care Pathways including Palliative Care, Respiratory, Cardiac and Regional Cancer Network.
- constantly review the process by which 999 callers are communicated with to effectively triage their calls

In relation to Command and Control activity, NIAS is represented on the national clinical governance group for AMPDS.

In relation to Pharmacy arrangements within the wider HSC:

- all NIAS stations undergo regular independent inspection by the Medicines Regulatory Group of the DHSSPSNI of their arrangements for the safe and secure management of controlled drugs,
- NIAS regularly reviews the range of drugs made available for frontline emergency staff to treat patients in line with the latest clinical guidelines.

As part of the HSC Clinical Frameworks;

- NIAS meets regularly with the Regional Cardiology Network to review progress of the Regional Primary PCI service whose performance is already exceeding that seen in the long-established services in England and Wales,
- NIAS participates in the Regional Stroke Strategy Implementation Group to improve the management of patients suffering an acute stroke. The service has worked hard to ensure that patients with symptoms of acute stroke are prioritised appropriately and transferred to hospital in a timely fashion in order to maximise their chances of successful thrombolysis therapy,
- NIAS is working with the RQIA to review Infection Prevention and Control Procedures across the service in line with the new measures introduced in hospitals with the aim of further reducing the risk of Healthcare Acquired Infections

- NIAS regularly reviews new medical devices to consider what clinical benefit their acquisition may have for patients e.g. paediatric supraglottic airway devices, chest decompression devices, bougies,
- performance is regularly reviewed in the management of certain clinical situations:
 - Cardiac arrest outcomes
 - Management of diabetic hypoglycaemia
 - Referral of patients to hospital falls services
 - Acute asthmatic exacerbations
 - ST-elevation myocardial infarction
 - Acute stroke
 - Referral to minor injuries services,
- NIAS has participated in a regional review of “Places of Safety” for patients with acute mental health problems, and is participating in a multi-agency audit of formal admissions to mental health facilities,
- NIAS has engaged in a regional strategy on labelling of invasive clinical devices in order to reduce the risk of administration of drugs etc. via inappropriate or unsafe routes,
- NIAS has implemented a process of syringe labelling for emergency drugs to reduce the risk of incorrect drug administration,
- NIAS regularly reviews the level of personal protective equipment available to frontline staff in order to both reduce the risk of healthcare acquired infections and to protect staff, particularly in the light of outbreaks of diseases such as swine flu and ebola,
- a robust process of incident reporting is in place which allows all staff to highlight areas of risk or concern so that they may be addressed regionally with learning passed to partner agencies as appropriate,
- a new PRF allows for clearer communication with hospital colleagues regarding clinical information on patients, and acts as an aide memoire for staff in terms of vital safety criteria,

- NIAS is formalising the process of passing “Standby” messages to hospital emergency departments regarding critical patients as well as the process by which such patients are handed over to the receiving hospital staff to ensure that vital information is not missed.

During 2014/15 NIAS continued to contribute to the development of Guidelines and Audit Implementation Network (GAIN) guidance or regional clinical audits by;

- contributing to regional trauma audit,
- reporting frequently on Clinical Audit Information with out of hours Cardiac Arrest, diabetic hypoglycaemia, STEMI etc.

We also contributed to the enhancement of social care practice through the implementation of Social Care Institute for Excellence (SCIE) guidance by;

- introducing “*assist and safe talk*” training to staff – how to manage and talk to someone feeling suicidal etc.

Knowledge of, and adherence to, NICE guidance is key to ensuring that our staff are equipped appropriately to deal with situations which may present themselves in the course of their duties. To this end, during 2014/15 NIAS:

- introduced assist and safe talk training to staff – how to manage and talk to someone feeling suicidal etc.
- added Activated Charcoal to the drugs we carry in relation to NICE guidelines.

The Trust has a number of examples, during 2014/15, of good practice and innovation in implementing NICE guidance to the NICE Shared Learning database and/or the Quality, Innovation, Productivity and Prevention (QIPP) collection. Such examples include;

- Serious Adverse Incident – Example of Learning
Incident with patient with mental health issues, there was a delay in the ambulance arriving.

Outcome – As a result of a review of this case, NIAS engaged with other Trust's mental health services, social services and PSNI, and participated in joint workshops and an independent review which made a number of recommendations regarding training of staff. We also engaged in prospective audit of all admissions under mental health legislation to examine sources of delay and ensure that all patients are admitted to hospital in a safe and timely manner,

- engagement with the Regional Safety Forum, identifying a number of areas for joint co-operation and development, including:
 - Benchmarking of clinical performance indicators
 - Regional application of falls protocol
 - Nursing home collaborative, specifically ambulance transfers
 - Inclusion of physiological early warning scores in review of Patient Report Form
 - Participation in quality and safety training for Trust Boards
 - Spinal immobilisation protocols
 - Pre-alert and patient handover in EDs
- undertaking, with Scottish Ambulance Service, a study of syringe labelling, the findings of which will be formally introduced into both Trusts. They have been submitted to the Patient Safety Forum for recognition and NASMeD and JRCALC for potential implementation nationally.

Senior Management within the Trust is committed to the delivery of a quality service and ensure this is delivered through regular;

- reporting to Assurance Committee and Trust Board
- participation in networks, safety forum and national initiatives

Integrating the care

NIAS will work with colleagues throughout Health and Social care to develop integrated pathways of care for individuals to facilitate seamless movement across all professional bodies and sectors of care, thereby contributing significantly to the raising of quality of care and outcomes experienced by patients, clients and their families.

NIAS continues to strive for clinical excellence in all we do and as part of the process to achieve this goal it is important that all training undertaken is of the highest standard and takes account of the many providers of excellence both within and outwith the Ambulance Service and Health and Social Care networks.

Always mindful of the needs of service-users, NIAS has sought and will continue to seek opportunities to unearth best practice, from whichever sector, which can be utilised in the most cost effective manner for the benefit of the service user.

During 2014/15;

- RATC has engaged with AHPs from the CEC to bring expertise from other clinical specialities into our training programmes,
- NIAS attended national education groups and has been involved in discrete “task and finish” projects to share good practice between other Ambulance Services,
- through training we support the implementation and evaluation of alternative care pathways in conjunction with external stakeholders.

