NORTHERN IRELAND AMBULANCE SERVICE

A Meeting of Trust Board to be held on Thursday, 15 November 2012 at 2.00pm, Trust Headquarters, Knockbracken Healthcare Park, Saintfield Road, Belfast. BT8 8SG

A G E N D A

		Paper Enclosed
Welcome, Introduction and Format of Meeting		
1.0	**Apologies**	
2.0	**Procedure:** Declaration of potential Conflict of Interest: Quorum:	
3.0	**Minutes of the previous meeting of the Trust Board held 20 September 2012** (for approval and signature)	TB/1/15/11/12
4.0	**Matters Arising**	
4.1	Quality 2020: A 10 Year Strategy to Protect & Improve Quality in Health & Social Care in Northern Ireland	TB/2/15/11/12
4.2	Trend Analysis on Recruitment	
4.3	Corporate Workshop	
4.4	Agenda For Change Communication	TB/3/15/11/12
5.0	**Chairman's Business**	
5.1	Visit to Ardoyne Ambulance Station	
5.2	Chairman's Update	
5.3	Appointment of Non Executive Directors	
6.0	**Chief Executive's Business**	
6.1	Chief Executive's Update	
7.0	**Assurance Framework as at 30 September 2012**	TB/4/15/11/12
8.0	**Items for Approval**	
8.1	Management of Aggression Policy	TB/5/15/11/12
8.2	Policy for Safe Management of Water Systems (including Legionella and Pseudomonas)	TB/6/15/11/12
9.0	**Items for Noting**	
9.1	GP Out of Hours – Response to Consultation	TB/7/15/11/12
9.2	Minutes of Audit Committee held 11 October 2012	TB/8/15/11/12
9.3	Minutes of Assurance Committee held 11 October 2012	TB/9/15/11/12
9.4	The Safety of Services Provided by Health & Social Care Trusts	
9.5	Long Service Medal Ceremony – 18 January 2013	

10.0 Application of Trust Seal

11.0 Forum for Questions

12.0 Any Other Business

Next meeting of Trust Board will be held on Thursday, 24 January 2013. 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

Meeting to be held on Thursday, 15 November 2012 at NIAS Headquarters, Knockbracken Healthcare Park, Belfast. BT8 8SG

TB/1/15/11/12

NORTHERN IRELAND AMBULANCE SERVICE

Minutes of a Meeting of Trust Board/AGM held on Thursday, 20 September 2012 at 1.30pm at the Northern Ireland Ambulance Service Headquarters, Knockbracken Healthcare Park, Saintfield Road, Belfast. BT8 8SG

Present:

Mr P Archer	Chairman
Mr L McIvor	Chief Executive
Mr N McKinley	Non-Executive Director
Ms A Paisley	Non-Executive Director
Prof M Hanratty	Non-Executive Director
Mrs S McCue	Director of Finance & ICT
Dr D McManus	Medical Director
Mr B McNeill	Director of Operations
Ms R O'Hara	Director of Human Resources & Corporate Services

In Attendance:

Mrs M Crawford	Executive Administrator
Miss K Baxter	Senior Secretary

Welcome and Format of the Meeting

The Chairman opened the meeting by welcoming members of the public and Trust Board and advised that the Annual General Meeting would be incorporated within the public Board meeting as before. He advised of the sad passing of Mr Shields, Non Executive Director on 4 August 2012 and added that his valuable contribution to the Board would be missed and asked everyone to stand for a minute's silence. He had also written a letter of condolence to Mrs Shields.

1.0 Apologies

None.

2.0 Procedure: Declaration of potential Conflict of Interest
Quorum

No potential conflicts of interest were declared and the Board was confirmed as Quorate.

Suspension of Standing Orders

The Chairman suspended Standing Orders to allow the Annual General Meeting to take place.

ANNUAL GENERAL MEETING

3.0

i. Presentation of Annual Accounts 2011/12

The Finance Director presented the Annual Accounts by giving a presentation which summed up the financial performance for the past year.

ii. Presentation of Annual Report 2011/12

The Chief Executive presented the Annual Report outlining the activity for the past year and the challenges for the years ahead.

iii. Question & Answer Session

A member of staff who attended raised the question of Agenda for Change advising that it was difficult to obtain information about any progress and expressed his frustration at the length of time it is taking. The Chief Executive responded by saying that it was important to hear from staff and shared his frustration at the length of time it is taking to conclude the process. He added that ongoing communication will be maintained and requested the Director of HR to arrange this.

Action: Director of HR to arrange for issue of communications update to staff.

The member of staff also requested information in relation to the recent leak to the media regarding a new role of Paramedic Assistant and whether this will impact on the role of the Emergency Medical Technician. He added that he really enjoyed his job and hoped that he would have a future within the ambulance service. The Chief Executive responded by saying that the Trust was required to make significant savings and proposals were being developed. The Chief Executive highlighted that while roles may change and at this time no approval has been received from HSCB for this development the ambulance service continues to invest in the development of its personnel and would continue to seek to maximise the contribution of ambulance staff to deliver care to patients.

The Non Executive Directors advised that they appreciate the site visits to the various stations before Board meetings throughout the year as it gives an opportunity to talk directly to frontline staff. The enthusiasm of staff is always evident

The Chairman congratulated the Chief Executive and his team for an excellent year's result under very difficult and challenging circumstances and requested that his thanks be passed on to all staff for their work and dedication.

ANNUAL GENERAL MEETING CONCLUDED

Reinstate Standing Orders

The Chairman advised that the business of the public meeting would now continue.

4.0 Minutes of the Previous Meeting of the Trust Board held on 19 July 2012

Members accepted the minutes as a true reflection of discussions held on the proposal of Prof Hanratty seconded by Ms Paisley.

5.0 Matters Arising

5.1 Quality 2020: A 10 Year Strategy to Protect & Improve Quality in Health & Social Care in Northern Ireland

It was advised that this item was withdrawn again from the agenda due to the non-availability of the DHSSPS representative. It was advised that the official launch is due to take place in October 2012. The Board were disappointed that they have not had the opportunity to hear the presentation.

Action: Chairman to write to DHSSPS in relation to this matter.

5.2 Recent Media Stories

The Chief Executive advised that he reviewed the article in question and advised that it was factually correct and he could not therefore challenge this story. In relation to the second article, it was considered that there was a genuine factual mistake by the press which had been retracted in later bulletins. The Trust does not wish to pursue the matter as it may cause further upset to the family concerned.

The Board were advised of a recent article in the Irish News in relation to the Trust's use of St John Ambulance and the Chief Executive has written to the Editor in this regard. He added that the Trust continues to review papers to seek out positive news stories and will defend the Trust's position where appropriate.

5.3 Trend Analysis on Recruitment

The Director of HR presented the paper which was requested by the Board at the June 2012 meeting. This follows a request from a Non Executive Director for increased monitoring and analysis of potential barriers to appointment for the gender and religious affiliation groups which appear to be under represented in the appointment made. She added that all policies and procedures meet the legislation and all selection panels are mixed in respect of gender and religion.

The following point was raised by the Board.

- As there appeared to be a consistent trend over the last six years has HR looked at why some groups are more successful than others?
- The Board were advised that the Trust submits a detailed report to the Equality Commission every three years and up to now no action has been requested by them. It was suggested that the information could be broken down further if required.

Action: Further analysis to be presented to Board.

6.0 Chairman's Business

6.1 Chairman's Update

The Chairman gave a brief outline of his diary commitments since the last Board meeting. He advised that he is expecting to know the outcome of the recent competition for two Non Executive Directors in the near future.

7.0 Chief Executive's Business

7.1 Chief Executive's Update

The Chief Executive gave a brief outline of some of his activities since the last Board meeting:

- Attended a demonstration by 'Connecting for Health' in relation to Directory of Services which underpins '111' system. The value and importance of this system was clearly demonstrated and NIAS has the technology to support this development.
- Met with the NHS Pay Review Body who spent the day at NIAS HQ meeting with various staff groups. They fed back comments to the Senior Team highlighting the delay in AFC and asked if there were any steps they could take to expedite the matter. This is their first visit to Northern Ireland.
- Met with Trade Unions regarding Transforming your Care (TYC) and the Trust Delivery Plan. The Joint Negotiating Forum is to consider the issue further.
- Attended a workshop on Transforming your Care where it was highlighted that NIAS is the only regional Trust.
- Attended Connected for Health Eco System Event where it was demonstrated how developments could be used by NIAS and how we can improve. This will be shared with Mr Compton, HSCB. It was clearly shown that through Health Care numbers we can access information on patients which will support staff to provide the appropriate care.

The following questions/issues were raised:

- Is there a commitment by the Department to introduce the '111' service and what is the process?
- This is recommendation '93' of TYC and each recommendation required a response. NIAS has responded and the comments have been taken on board. Policy direction will be required for each recommendation.
- Are there still seven Out of Hours providers?
  - Yes. NIAS has recently responded to a consultation on GP Out of Hours where a number of concerns were identified ie reduction in the number of centres will impact on ambulance services. The Trust has highlighted that NIAS is a regional service with the technical support available.
- Has the work on the Directory of Services begun?
  - The work has not started and no such request has been made.

8.0 Assurance Framework as at 31 July 2012

Medical

The Medical Director presented his report in some detail advising that it is in a different format from that presented previously and will be developed further. It is linked to the Strategic Aims and Corporate Plan and is presented in this way to provide assurance to the Board. The following comments/issues were raised.

- o Do all staff coming through the RATC get updated on the protocols for appropriate non transportation of diabetic patients?
- ➢ Substantial training is not required and the memo and guidance clarifies the position for staff.
- o The 'treat and leave' protocols for the management of falls were raised?
- ➢ A pilot is being introduced in the Southern Trust and it is hoped that this will reduce morbidity and mortality in the elderly and will ultimately reduce the number of patients being transported to hospital.

Operations

The Director of Operations updated members on his report and advised that there is a current recruitment for paramedics which will hopefully reduce the Trust's reliance on overtime. The following comments/issues were raised:

- o How widely will the Trust advertise the position of paramedics?
- ➢ The advert will go out nationally, however the Trust has 'Paramedics in Training' who are about to complete their two year course who will hopefully fill some of the current vacancies.
- o The issue of the Erne site was raised.
- ➢ Some positive meetings have been held which will hopefully push the business case through. Moving to the proposed new site is still the best option for NIAS.
- o Has there been improvement in the delays at A&E departments?
  Monitoring is ongoing with some improvement noted at the Ulster Hospital. The Trust is awaiting the definition of turnaround times.

Finance

The Director of Finance updated members on her report advising that work has been carried out with the Chief Executive to develop each Director's report with links to the Strategic Aims from the Corporate Plan. The finance report is primarily about Strategic Aim 2: *To Achieve Best Outcomes for Patients using all Resources while Ensuring High Quality Corporate Governance, Risk Management and Probity.* She added that it would be remiss of her not to mention the contribution which the Finance and ICT department make to Strategic Aim 1 which is helping to evidence that we are '*delivering a safe, high quality service'* by analysing and presenting information. The Information Team within NIAS produce the clinical performance indicators and access the system to provide all performance /activity reports for the Operations directorate. The following comments/issues were raised:

- o Are there still capacity issues within the Finance department, and if so, what remedial action is being taken?

- Staff within the Finance department are contributing to the BSTP programme which has given additional pressure for the departments of both HR and Finance. This issue has been raised as a risk as no further resources are available and it has been noted on the Risk Register. It was added that attempts have been made to modify the programme to accommodate staff and core business.

Human Resources

The Director of Human Resources & Corporate Services updated members on her report advising that there was an error in the absence figures and the correct cumulative figure is 6.74%.

9.0 Proposed Trust Board & Committee Dates 2013

Members were advised that the schedule for Board meetings has been moved to the last Thursday of every other month on the suggestion of Internal Audit to provide the opportunity to report the most up to date financial information.

Prof Hanratty noted the date for January 2013 and advised that she would not be able to attend and asked for the date to be changed. After some discussion it was agreed that the date for January 2013 should be changed to 24 January 2013.

The Board enquired if a workshop for the Board was planned for 2013. The Chief Executive is happy to facilitate and will liaise with the Chairman to progress.

Action: Chief Executive and Chairman to arrange workshop for the Board.

10.0 Items for Approval

10.1 Whistle Blowing Policy

This policy was issued to the Board and some comments were received in relation to the role of the Local Government Comptroller. After some discussion it was agreed that clarification is to be sought from the DHSSPS regarding the role of the Local Government Comptroller. The Board also sought assurance that all staff will be informed about the updated procedure for Whistleblowing. It was advised that the policy will be issued to staff with payslips. The policy was approved on the proposal of Mr McKinley and seconded by Prof Hanratty subject to the clarification of the role of the Local Government Comptroller.

11.0 Items for Noting

11.1 NIAS Annual Report on Equality Schemes

Noted.

11.2 Assurance & Accountability Arrangements for Arms length Bodies – Business Planning for 2013-14

Noted.

12.0 Application of Trust Seal

The Trust Seal has not been used since the last Trust Board meeting.

13.0 FORUM FOR QUESTIONS

No questions received from the floor.

14.0 Any Other Business

14.1 Media Attention

The Board were advised that there has been some anxiety around the ambulance response to a recent stabbing incident. The Trust is happy to engage with the family but will not be doing so through the media.

Date, Time and Venue of Next Meeting

The next meeting of the Trust Board will be held on Thursday, 15 November 2012 in the Eastern Division. Venue to be confirmed.

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

Signed: _____

Date: _____

Chairman

TB/2/15/11/12

Quality 2020

-

A 10-Year Quality Strategy for Health and Social Care

Why a Quality Strategy now?

- To build on success and achieve even more
- To give added focus, direction and motivation
- To better involve people in quality improvement
- To deal with the challenges and opportunities ahead
- To protect and improve quality

Strategic Relevance

Q2020

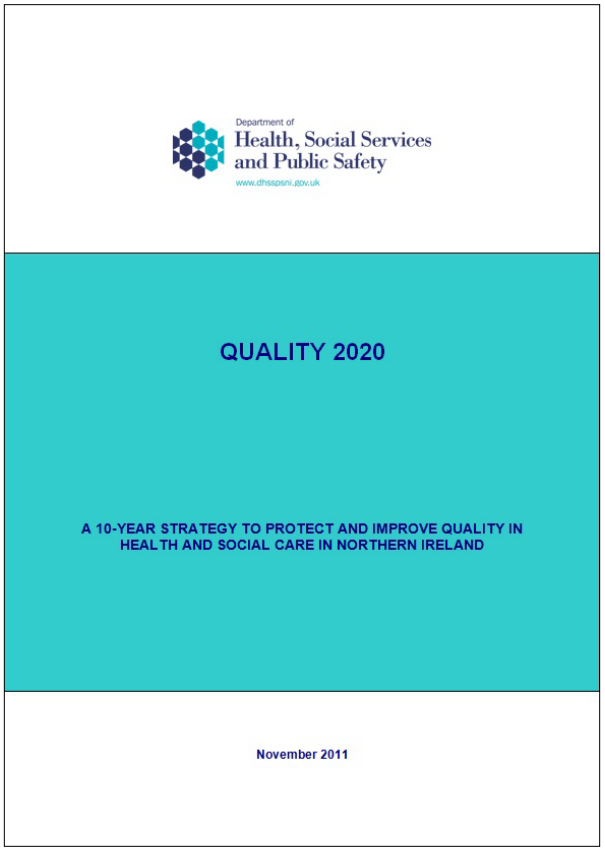
The 3 Key Elements of Quality

Quality

Obstacles to Quality Improvement

- Resources – not enough or poorly used
- Behaviours - arrogance, ‘club mentality’, rivalry
- Human factors - ergonomics, poor design
- Inadequate information and measurement
- Lack of knowledge and skills
- Public expectations
- The health ‘archipelago’

Quality 2020 launched by Minister Edwin Poots on 17 November 2011



Design Principles

- Deliver services that are holistic in nature
- Focus on needs of individuals, carers and families
- Be accessible, responsive, integrated, and innovative
- Be unconstrained by boundaries and flexible
- Protect the vulnerable and help people help themselves
- Use the best available evidence for design and practice
- Listen to the views and experiences of service users

Values

- Empowerment
- Equity
- Involvement
- Respect
- Partnership
- Excellence
- Community
- Continuity
- Value for Money

The Quality 2020 Vision

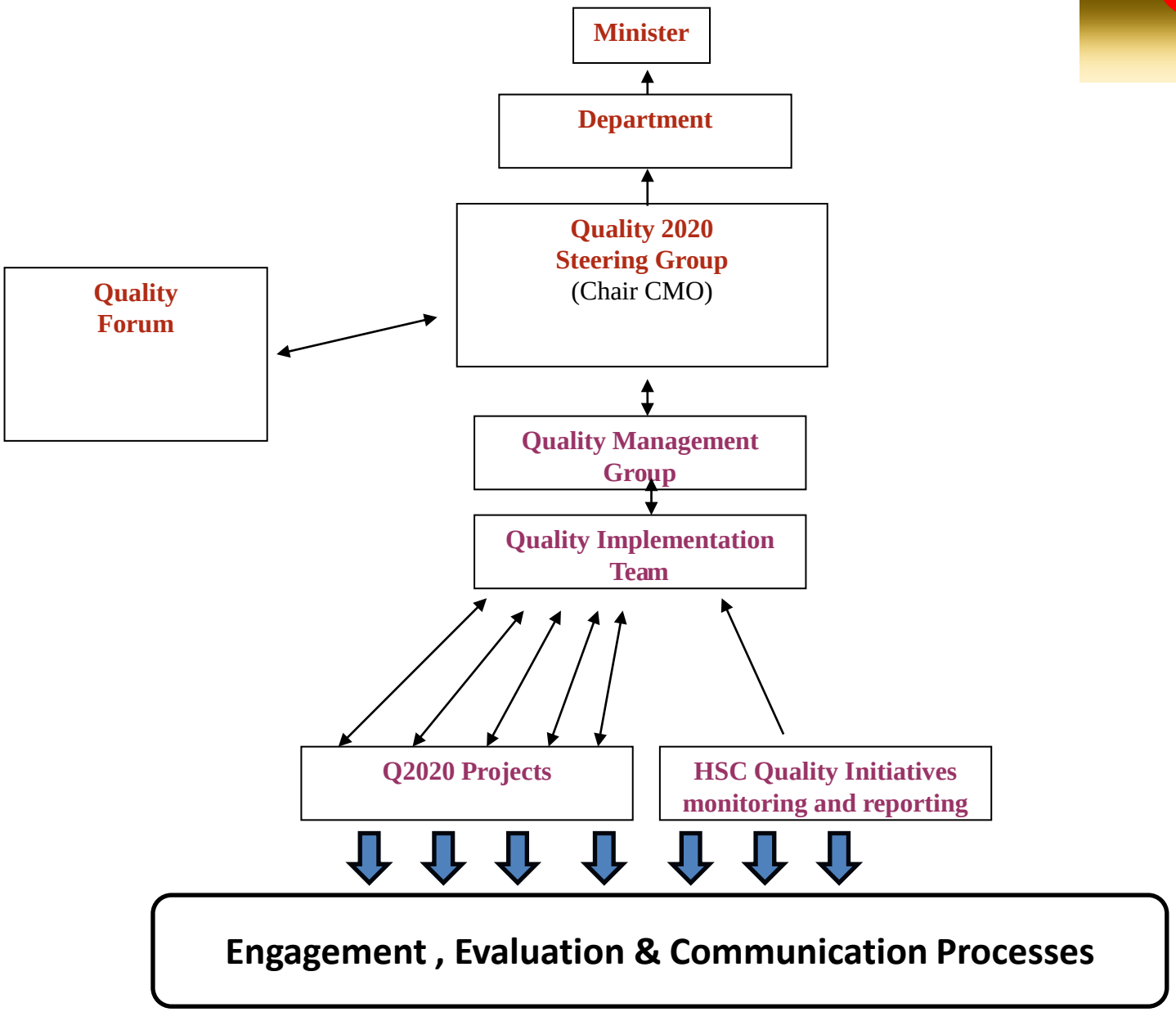
"To be recognised internationally, but especially by the people of Northern Ireland, as a leader for excellence in health and social care"

The Strategic Goals

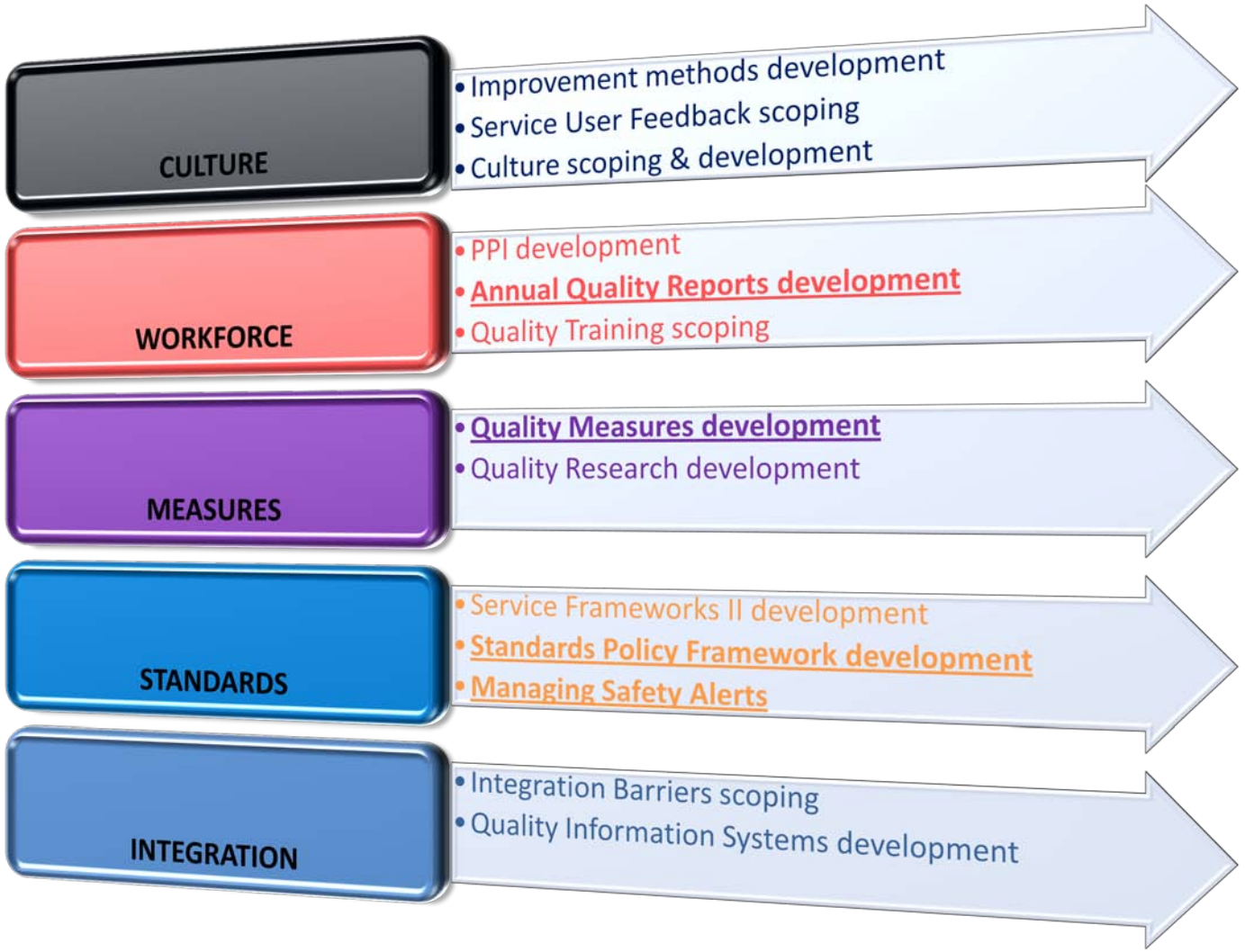
Q2020

- **Transforming the Culture** - A dynamic HSC culture focused on continuous quality improvement that values learning and inspires trust
- **Strengthening the workforce** - A workforce that is confident, skilled and quality-inspired
- **Raising the standards** - A more robust set of service standards effectively applied
- **Measuring the improvement** - An effective set of quality measures and improvement techniques
- **Integrating the care** - More effective integration of services and interfaces

Governance and Delivery of Quality 2020



Implementation (Years 1-3)



Key Messages

- Quality 2020
  - to protect and improve quality
  - not just for clinicians; for everyone
  - a reference point for all we do
  - must be dynamic and relevant
  - all 3 Quality dimensions matter
  - an improvement Agenda **and** Context

Progress to date

- Steering Group, Management Group and Implementation Team meetings already taken place

- Seven projects established and will all be finalised by September 2013

  - Managing Safety Alerts
  - Annual Quality Reports
  - Standards Policy Framework
  - Professional Leadership Development Programme
  - E-learning platform
  - Ward Level Review of Patient Experience & Quality of Clinical Care
  - Literature Review on Changing Cultures in HSC

Next Steps

- First report from 7 projects - February 2013
- Stakeholders / Professions Fora - Spring 2013
- Completion of 7 projects - September 2013
- 1st Triennial Review - January 2014

TB/3/15/11/12

Northern Ireland Ambulance Service
Health and Social Care Trust

Job Evaluation Communique 16
25th October 2012

UPDATE ON JOB EVALUATION OF RRV PARAMEDIC, PARAMEDIC AND EMERGENCY MEDICAL TECHNICIAN JOBS

The Trust's Job Evaluation (JE) Leads continue to manage the national job evaluation process for RRV Paramedic, Paramedic and Emergency Medical Technician jobs.

The relevant parties engaged in the full job evaluation process for the above three jobs, despite making considerable effort, were unable to conclude an outcome for any of the three jobs.

The JE Leads, having discussed the matter in detail, were unable to reach an agreed position as to how to move the process forward from this point. Management were of a view that steps should be taken to move to the next stage of the process, i.e. to the Blocked Protocol as specified in Section 15 of the NHS Job Evaluation Handbook, whilst Trade Union side were of a view that further advice should be sought before considering this stage.

The Trust, in line with Paragraph 1, Section 15 of the NHS Job Evaluation Handbook (which states that either of the parties may make an approach for assistance under this protocol), wrote to the Joint Chairs of the Regional Joint Negotiating Forum (JNF) to request the three related job evaluations move into the next stage of the process, i.e. to the Blocked Protocol. In response, the Trade Union JE Lead wrote to the Trade Union Joint Secretaries to outline her position in this regard.

Following consideration, the JNF Joint Secretaries have advised the Trust that the matter should be referred to the Regional Quality Assurance (RQA) Team for their opinion. The JE Leads, in partnership, have agreed to this approach.

Northern Ireland Ambulance Service
Health and Social Care Trust

A further Communique will be issued when the Trust receives confirmation from the RQA Team as to the next steps to be taken to progress the job evaluations.

We trust the above information clarifies the current position.

Gillian Humphreys
Trade Union JE Lead

Linda Rafferty
Management JE Lead

TB/4/15/11/12

Northern Ireland Ambulance Service
Health and Social Care Trust

ASSURANCE FRAMEWORK

(as at 30 September 2012)

NORTHERN IRELAND AMBULANCE SERVICE

ASSURANCE FRAMEWORK

2012-2013

MISSION

"THE NORTHERN IRELAND AMBULANCE SERVICE WILL PROVIDE SAFE, EFFECTIVE, HIGH-QUALITY, PATIENT-FOCUSSED CARE AND SERVICES TO IMPROVE HEALTH AND WELL BEING BY PRESERVING LIFE, PREVENTING DETERIORATION AND PROMOTING RECOVERY"

INTRODUCTION

This assurance report is the means by which NIAS presents an account to Trust Board and the public which outlines the actions taken to deliver a safe, high-quality ambulance service within available resources, and the principal risks to continued provision of these services on that basis. All personnel in NIAS contribute to the delivery of safe, high-quality services, and all have a duty and responsibility to ensure those services are patient-focussed and represent value for money. The detailed reports which follow enable each directorate area to present and highlight their contribution to service delivery and provide necessary assurance to the Trust Board and the public in respect of the ongoing provision of safe, high-quality services, focussed on the patient and consistent with effective and efficient use of all financial and non-financial resources.

MINISTERIAL PRIORITIES

Minister for Health, Mr Edwin Poots has named eight key priorities;

- driving up the quality of services and outcomes;
- increasing productivity;
- greater collaboration with frontline professionals;
- more powerful local commissioning;
- champion preventative and early intervention measures;
- multi-faceted approach to limit unnecessary hospital care;
- encourage charity and voluntary sector assistance to find solutions; and
- explore means of enhancing the overall patient experience.

"The next five years will bring an ever greater pace of change and difficult dilemmas on where to focus our health and social care resources. The temptation is to "keep our heads down" and avoid making the decisions that are required of us, but that will not be good enough. Rather than wait passively for the tough choices to emerge, let us look ahead now, let us act now, and grab hold of the future."

DELIVERING SAFE, HIGH-QUALITY CARE – NIAS STRATEGIC AIMS & OBJECTIVES

Having considered the health priorities and key challenges within the context of the ambulance services' purpose, mission, vision, principles and values, NIAS has developed a set of strategic aims and objectives to shape the delivery of ambulance services over the coming years. These aims and objectives seek to align delivery of health priorities for the whole healthcare system with the specific priorities, challenges and opportunities presenting to the ambulance service.
Each of the strategic aims has been reviewed by Trust Board and a series of key strategic objectives identified which support and enable progress in delivery of the strategic aim. In order to deliver the strategic aims, to secure the future of the organisation and delivery of healthcare consistent with our purpose, mission and values, specific objectives will be developed and taken forward by the responsible managers.

The Strategic Aims are as follows:

TO DELIVER A SAFE, HIGH-QUALITY AMBULANCE SERVICE PROVIDING EMERGENCY AND NON-EMERGENCY CLINICAL CARE AND TRANSPORTATION WHICH IS APPROPRIATE, ACCESSIBLE, TIMELY AND EFFECTIVE

TO ACHIEVE BEST OUTCOMES FOR PATIENTS USING ALL RESOURCES WHILE ENSURING HIGH QUALITY CORPORATE GOVERNANCE, RISK MANAGEMENT AND PROBITY

TO ENGAGE WITH LOCAL COMMUNITIES AND THEIR REPRESENTATIVES IN ADDRESSING ISSUES WHICH AFFECT THEIR HEALTH, AND PARTICIPATE FULLY IN THE DEVELOPMENT AND DELIVERY OF RESPONSIVE INTEGRATED SERVICES

The Key Objectives are as follows:

1. Establish and develop agreed outcome-based, clinical and non-clinical, quality indicators for patients.
2. Develop a service delivery model for scheduled and unscheduled care and transportation which addresses rural issues.
3. Build and maintain a high-performing, appropriately skilled and educated workforce, suitably equipped and fit for the purpose of delivering safe, high-quality ambulance services.
4. Review and develop operational systems and processes to support the service delivery model which provide necessary assurances of appropriateness, accessibility, timeliness and effectiveness.
5. Promote and develop an open, transparent and just culture focussed on patients and patient safety.
6. Review existing resources and ensure those resources are aligned with delivery of agreed outcome-based quality indicators for patients.
7. Review resource utilisation and ensure those resources are aligned with delivery of high quality corporate governance, risk management and probity.
8. Identify opportunities to improve outcomes for patients and pursue the resources and processes necessary to deliver better outcomes.
9. Establish processes, built around our Patient and Public Involvement strategy, to enable effective communication and engagement with all our communities and their representatives.
10. Use those processes to clarify the ambulance role, function and resource with the community and test this against their perceived needs and expectations.
11. Use those processes to clarify the ambulance role, function and resource with those agencies responsible for setting policy and commissioning ambulance services and test against their assessments of community needs and expectations.
12. Establish processes to enable and support full participation of the ambulance service in the development and delivery of responsive integrated health services.
13. Work with all stakeholders, in particular regional and local commissioners and providers of services, to develop and deliver responsive integrated services.

NIAS PERFORMANCE MANAGEMENT PROCESS

The Board of Directors of the Northern Ireland Ambulance Service Health and Social Care Trust is responsible for ensuring that the care and treatment provided by its staff is of the highest quality.

Executive and Non Executive Directors of the Board provide leadership of the organisation. Guided by the Minister and DHSSPS priorities, they set the strategic direction in promoting the health and well-being of the citizens and communities of

Northern Ireland who use the Trust's services. They set the values and standards and ensure that the necessary financial and human resources are in place for the organisation to meet its objectives.

The Board defines strategic, corporate objectives and risks and monitors the achievement of these in the public interest. It has established a framework of prudent and effective controls to manage these risks, underpinned by core controls assurance standards. Decisions are taken by the Board within a framework of good governance to ensure a successful organisation, which is always striving to achieve excellence. The Chief Executive is accountable to the Trust Board, which consists of professional Executive Directors and lay Non-Executive Directors. The Chief Executive is the Accountable Officer to the DHSSPS for the performance of the organisation. The Executive Team is the major source of advice and policy guidance to the Board of Directors.

The Corporate Plan sets the strategic direction for the Trust in line with the stated purpose, mission and vision of the organisation, aligned to the relevant principles and values, which direct action consistent with Ministerial priorities. Key strategic aims are identified through this process which leads to the development of strategic objectives which contribute to delivery of those aims.

The Corporate Plan is supported by an annual Trust Delivery Plan which is developed to take account of available resources and outline Trust priorities for the period of the plan This Assurance Framework outlines the key actions which NIAS has identified as being necessary to deliver strategic objectives, and identifies principal risks to delivery of objectives. Where possible objective measures of performance against objectives are presented in support of an internal self-assessment of performance against objectives and key actions.
The objectives set by the Trust Board are cascaded through the Chief Executive, the Executive Directors, and through senior managers and embedded within service delivery models for all aspects of the organisation. This process seeks to align activity with objectives reflecting Ministerial priorities, which correspond to the delivery of safe, high-quality care within available resources.

A performance management framework is in place whereby the chief executive meets weekly with executive directors to review activity and performance issues by exception and where necessary provide direction and intervention to achieve goals. In addition, the chief executive meets monthly with each director on an individual basis to consider and address specific issues relevant to their area. Executive directors similarly meet with their senior managers and teams on a regular basis to review performance against objectives, identify issues and address.

Progress against objectives and risks to delivery of objectives are presented to the Trust Board through the Assurance Framework to report ongoing performance against delivery of objectives and highlight, by exception, risks to delivery of objectives. Trust Board committees have been established to provide necessary assurance as to the existence and effectiveness of control systems and processes within the organisation, as outlined in the terms of reference of each committee.

ASSURANCE REPORT: MEDICAL DIRECTORATE

1. STRATEGIC AIM: TO DELIVER A SAFE, HIGH-QUALITY AMBULANCE SERVICE PROVIDING EMERGENCY AND NON-EMERGENCY CLINICAL CARE AND TRANSPORTATION WHICH IS APPROPRIATE, ACCESSIBLE, TIMELY AND EFFECTIVE

STRATEGIC OBJECTIVES

Establish and develop agreed outcome-based, clinical and non-clinical, quality indicators for patients to identify opportunities to improve outcomes for patients and pursue the resources and processes necessary to deliver better outcomes.

Work with all stakeholders, in particular regional and local commissioners and providers of services, to establish processes to enable and support full participation of the ambulance service in the development and delivery of responsive integrated health services.

1.1 TREAT AND LEAVE PROTOCOL FOR PATIENTS PRESENTING WITH ACUTE HYPOGLYCAEMIA

Following presentation at Assurance Committee in October, the first “treat and leave” protocol, relating to acute hypoglycaemia, has been issued to the Regional Ambulance Training Centre (RATC) for cascading to operational staff regionally, and is expected to be fully operational by the end of November 2012. A&E vehicles including RRVs will be supplied with the final checklists which include instructions for their use on the cover. Based on experience in other UK ambulance services, the management of patients who have been successfully treated for acute hypoglycaemia was deemed to be the simplest protocol to introduce, offering the greatest benefit in terms of patients remaining at home, while also having the fewest adverse incidents, but the process will be closely monitored and audited with the results forwarded to operational staff and used to refine the process. The protocol as issued by NIAS is intended as a safety checklist for crews to advise which patients may be safely left at home following treatment, and rather than being a simple directive of non-transport of such patients, takes into account the patient’s consent, their understanding of their illness and their risk of developing further similar episodes. Further documentation is left with the patient for forwarding to their GP in order to inform decisions about longer term management.

Northern Ireland Ambulance Service
Health and Social Care Trust

INTERNAL MEMO

From: Dr David McManus
Medical Director

To: RATC
For attention of all paramedic staff

Date: 06/11/2012

Ref: AD/MD/59(5)/NR/JMcS

GUIDANCE ON NON-TRANSPORT OF DIABETIC PATIENTS RECOVERED FROM AN EPISODE OF ACUTE HYPOGLYCAEMIA

There are a number of specific clinical conditions which can be clearly defined and in which it may not be necessary to transport a patient to hospital and more appropriate to leave them at home. These conditions, such as acute hypoglycaemia in a diabetic patient, involve measureable clinical parameters to inform such decisions and often patients have either recovered prior to arrival of the responding crew or have fully recovered as a result of their clinical interventions. Following recovery, many of the patients are not keen and indeed refuse to be taken to hospital.

While it is accepted that a number of such patients are already not being transported to hospital, this is often based on the patient's or carers' refusal which in fact may not be clinically appropriate, while other patients for whom it may be entirely appropriate to remain at home continue to be transported to hospital unnecessarily

The introduction of this guideline is to assist and support ambulance staff to safely decide when a diabetic patient does not need to be transported to hospital following an episode of acute hypoglycaemia in order to reduce the risk of adverse patient events and inappropriate decisions being made. The guidance and associated checklist also ensures that patients who are not conveyed to hospital are offered appropriate care and advice based upon their clinical needs, safeguarding the interests of both patients and staff

This guideline has been developed by the Medical Directorate and Regional Ambulance Training Centre, is evidence-based, and consistent with the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) UK Ambulance Service Clinical Practice Guidelines and also the National Institute for Clinical Effectiveness (NICE). The application of this guideline will minimise the risk to both patients and to NIAS staff, and ensure that the patient receives the most appropriate care.

This first NIAS non-transport guideline relates to the management of diabetic patients who in many cases may safely remain at home with treatment and advice on ongoing care.

This includes diabetic patients who are fully recovered after being treated and have a blood glucose of at least 5.0 mmol/l, and are in the care of a responsible adult, but several other factors must be considered in order to make a safe and informed decision as to whether a

patient is suitable to remain at home. As always, patient consent is an important factor and we will continue to transport those who insist on hospital attendance or those patients who give cause for concern on other clinical or social grounds. In summary, the checklist should be viewed as guidance, or a safety-netting procedure to follow in order to reduce the risk of a patient coming to harm following a “treat and leave” decision.

Following satisfactory treatment and reassessment of such a patient, the ambulance crew can recommend to the patient and carers etc. that it is safe and appropriate for them to remain at home. Follow-up advice as indicated on the checklist must be provided to the patient, and a non-transport form (i.e. the current “refusal to travel” form) must be completed detailing the patient’s glucose readings before and after treatment and the nature of any treatment given, with the patient being advised to pass this form to their GP who can determine whether any longer term changes to a patient’s treatment are required.

The checklist must be returned along with the patient PRF and a copy of the non-transport form for audit purposes. We would intend to publish the findings of the audit of this information to provide feedback at the earliest opportunity.

As this is the first such guideline to be issued by NIAS, we are anxious to minimse any potential risk to either patients or staff. In order to do so, a number of supporting documents are required to be completed as part of this process. It is hoped that, as experience in the application of this guideline grows, and if no significant problems are identified, that the documentation can be significantly reduced an ultimately incorporated into the PRF. It is also anticipated that a number of similar guidelines for a range of conditions can be introduced in the near future to assist, support, and protect staff in their clinical decision-making for the benefit of the patient.

Should you have any concerns or queries regarding the above, please contact a member of your divisional training team in the normal manner.

Dr David McManus
MEDICAL DIRECTOR

THE FOLLOWING POINTS MUST BE ASSESSED BEFORE CONSIDERING NON-TRANSPORT OF A PATIENT RECOVERED FROM HYPOGLYCAEMIA:

- Is the patient alert (GCS 15) and fully orientated with the capacity for consent?
- Is there a responsible adult with the patient?
- Are there any other complicating factors? (see below)
- Is their blood sugar back up to 5 mmol/l or greater?
- Do they have access to the long acting carbohydrates (e.g. bread, potatoes or bananas) in order to help maintain blood glucose levels?
- Is the episode in the late evening or at night? If it is then transport recommended?
- Do they understand the signs and symptoms of hypoglycaemia and what to do if they re-occur?
- Does the patient consent to remaining at home?

BEFORE LEAVING A DIABETIC PATIENT AT HOME AFTER RECOVERING FROM AN ACUTE HYPOGLYCAEMIC EPISODE:

- Advise patient / carer to call for help if symptoms of hypoglycaemia recur.
- Advise patient / carer to re-check their blood sugar again in 2-3 hours or if they feel unwell
- Advise patient to eat long-acting carbohydrate (as detailed above) after the hypoglycaemic episode to help maintain blood glucose levels unless the patient is on an insulin pump, when only quick-acting carbohydrate should be given.
- Remove cannula and give wound care advice (if applicable)
- Check that the patient had warning symptoms prior to the hypoglycaemic episode
- A RTF form should be completed for the purpose of leaving clinical information for the benefit of the patient's own GP and as a means of recording consent to remain at home
- Document all the above on PRF / checklist and return the checklist together with the PRF and RTF

IN THE FOLLOWING CIRCUMSTANCES, PATIENTS MUST BE ENCOURAGED TO ATTEND HOSPITAL:

- If there is no responsible adult present to continue care / observation.
- If they are taking oral hypoglycaemic agents, as hypoglycaemia may recur.
- If they have no history of diabetes and have suffered their first hypoglycaemic episode.
- If they still have a blood glucose less than 5.0 mmol/l after treatment.
- If they have not returned to normal mental status within 10 minutes of IV glucose.
- If they been treated with glucagon and do not have suitable supervision or food available.
- If they currently have any additional disorders or other complicating factors e.g. renal dialysis, chest pain, cardiac arrhythmias, alcohol consumption, dyspnoea, seizures or focal neurological signs/symptoms.
- If they have a high temperature or other signs of infection (urinary tract infection, upper respiratory tract infections) and/or unwell (flu-like symptoms).

NIAS Safety checklist for non-transport of patients recovered from an episode of acute hypoglycaemia.

PATIENT NAME: **ADDRESS:**			
NIAS Incident Number:		**NIAS PRF Number:**	
Date:	**Time:**		

		Y	N
1.	Is the patient alert (GCS 15) and fully orientated with capacity to consent?	☐	☐
2.	Is there a responsible adult with the patient?	☐	☐
3.	Are they currently free from any additional disorders or other complicating factors? e.g. renal dialysis, chest pain, cardiac arrhythmias, alcohol consumption, dyspnoea, seizures or focal neurological signs/symptoms.	☐	☐
4.	Are they free from a high temperature or other signs of infection (urinary tract infection, upper respiratory tract infections) and/or unwell (flu-like symptoms)?	☐	☐
5.	Is their blood sugar back up to 5.0 mmol/l or greater? (Record on PRF and RTF forms)	☐	☐
6.	Do they have access to the long acting carbohydrates (e.g. bread, potatoes or bananas) in order to help maintain blood glucose levels?	☐	☐
7.	Has this episode occurred during the daytime / early evening?	☐	☐
8.	Do they understand the signs and symptoms of hypoglycaemia and what to do if they re-occur?	☐	☐
9.	Does the patient consent to remaining at home?	☐	☐
10.	Advise patient / carer to call 999 for help if symptoms of hypoglycaemia recur.	☐	☐
11.	Advise patient / carer to re-check blood sugar again in 2-3 hours or if they feel unwell.	☐	☐
12.	Advise patient to eat long-acting carbohydrate (as detailed above) after the hypoglycaemic episode to help maintain blood glucose levels unless the patient is on an insulin pump, when only quick-acting carbohydrate should be given.	☐	☐
13.	Remove cannula and give wound care advice (if applicable).	☐	☐
14.	Check that the patient had warning symptoms prior to the hypoglycaemic episode.	☐	☐
15.	Checklist and PRF and RTF form complete (return this checklist with the PRF and RTF).	☐	☐

NIAS ATTENDANT:	**SIGNATURE:**	**PIN:**

If the answer to any of the above factors is NO then the patient must be advised to travel to hospital due to the risk of further hypoglycaemic episodes.

Northern Ireland Ambulance Service
Health and Social Care Trust

20121106HypoglycaemiaChecklistV1

1.2 Treat and Refer Protocol for Management of Patients who present with a Fall at Home

Working in conjunction with the Southern Trust, NIAS is now in a position to pilot a treat and leave protocol relating to falls occurring in the elderly population. The joint protocol, which has been agreed between NIAS and the Southern HSC Trust, and previously presented in the Trust's Assurance Framework, is now being distributed to the regional training team in advance of cascading to operational staff. They will be provided with referral forms which allow for identification of suitable patients and safety-netting in terms of ensuring suitability for the "treat and leave" process. The process allows for careful joint audit of the referral and follow-up process through joint working between the Southern Trust and NIAS' own information team. Much effort has gone into preserving confidentiality of patient's information in the first process of its kind in NIAS, with changes to the Southern Trust's processes having been made on the basis of NIAS recommendations. Throughout the UK, falls are the single commonest reason for emergency calls to the ambulance service. In the older population, falls are frequently secondary to other health and social issues including the effect of often multiple medications, intercurrent illness, balance and mobility issues and living circumstances. Although a patient may suffer no direct injury from a fall, there is evidence that addressing the causes of a fall can reduce not just the risk of subsequent falls, but also reduce significantly the rate of further calls to the ambulance service and even the mortality within this group. In a joint pilot with the Southern Trust, NIAS crews will have the ability to refer patients over the age of 75 who have suffered a fall but no significant injury for follow-up by the hospital-based Falls Assessment Team. Those patients who do require transport to hospital for assessment and treatment of injuries will be referred internally by the Emergency Department as required.

1.3 Clinical Audit

The presentation of the Patient Report Form Audit was included in the Assurance Framework submitted to the previous Trust Board and Assurance Committee meetings. This showed a marked increase in Patient Report Form completion with a significant increase in workload and productivity within the Clinical Audit function. Following this Audit, an extensive data cleaning and quality assurance exercise to ensure the extraction of accurate clinical performance data for a number of clinical conditions is now being undertaken. This will allow the publication of reports of clinical performance in relation to a full range of clinical conditions and ultimately for them to be benchmarked with similar Clinical Performance Indicators (CPIs) in other UK ambulance services. Further cross-referencing of the clinical data with the information from the Command and Control system, which uses AMPDS software to clinically triage emergency calls, will also be undertaken. This is a manually labour intensive exercise to undertake initially but progress is being made.

Due to the processes outlined above, and to ensure the accuracy of this information, no specific CPI has been presented on this occasion.

2. STRATEGIC AIM: TO ACHIEVE BEST OUTCOMES FOR PATIENTS USING ALL RESOURCES WHILE ENSURING HIGH QUALITY CORPORATE GOVERNANCE, RISK MANAGEMENT AND PROBITY

STRATEGIC OBJECTIVES

Review and develop operational systems and processes to support the service delivery model and provide necessary assurances of appropriateness, accessibility, timeliness and effectiveness.

Review existing resources and ensure resource utilisation is aligned with delivery of agreed outcome-based quality indicators for patients and high quality corporate governance, risk management and probity.

2.1 EMERGENCY PLANNING REPORT FOR SEPTEMBER TO OCTOBER 2012

KPI No		Total from April
2	**NO OF POTENTIAL MAJOR INCIDENTS**	**10**
	No of Declared Major Incidents	**1**
	NO OF AIRPORT ALERTS	
	Belfast International Airport	
	Belfast City Airport	**1**
	City of Derry Airport	
	St Angelo Airport	
	Newtownards Airfield	**1**
	Other airfields	**1**
	BUSINESS CONTINUITY	**7**
	HAZARDOUS MATERIAL INCIDENTS (HART CALLS)	**20**
	HART PRE-PLANNED DEPLOYMENTS	**8**
4	**TRAINING SESSIONS**	
	EMERGENCY PLANNING	**24**
	HART	**43**
	BUSINESS CONTINUITY	**2**
5	**EXERCISES**	
	Live	**4**
	Tabletop	**7**
	Observer	**1**
6	**Updates or amendments to MIP**	

Potential Major Incident

On 3 September 2012 at 11.30 NIAS received a call from the Her Majesty's Prison Service (HMP) with regards a fire in the dining hall, unknown if anyone was injured. NIAS activated a potential major incident, tasked to the scene 3 A&E crews, 1 RRV, 1 HART, 4 Oscar call signs and the Mobile Control Vehicle (MCV), in addition an officer was tasked to the Lagan Valley Hospital to act as liaison officer. On arrival at the security gate to the main prison, the first vehicle on scene informed by Prison Service security staff that all prisoners had been removed from the dining hall and had been accounted for.

In addition, they were informed that all staff had also been removed from the dining hall and had been accounted for. The incident was stood down at 12.00.

Major Incidents

There were no declared Major Incidents.

Airport Alerts

On 10 September 2012 at 15.19 NIAS received an alert to the George Best Belfast City Airport for a report of smoke coming into the cab of a plane with 68 persons on board. Tasked to the scene 5 A&E crews, 2 Intermediate Care Vehicle (ICV) crews, 2 RRV, 2 HART vehicles, 7 Oscar Call signs, 1 Delta call sign, Emergency Equipment Vehicle (EEV) and MCV. In addition 3 Officers were tasked to hospitals and Hospital Liaison Officers (HLO). All passengers disembarked the plane but the crew were medically assessed by a NIAS doctor and paramedics before being discharged at scene.

HAZMAT / Hazardous Area Response Team (HART) deployments

01.09.12	Mourne Mountain Rescue Team (MMRT)	Female fallen near Upper Bridge
03.09.12	NIFRS	Fire in cell Maghaberry
06.09.12	NIFRS Search & Rescue Team (SRT) / PSNI Search & Rescue (SAR)	Knee injury Cavehill
11.09.12	NIFRS	Ankle injury on Riverside
21.09.12	PSNI	Explosion of Council lorry
24.09.12	PSNI NIFRS	RTC involving 2 lorries (entrapment in confined space)
26.09.12	NIFRS	Fumes from house
01.10.12		Call activated HART pager but stood down by HART advisor
17.10.12	NIFRS PSNI	Chemical incident/attempted suicide
17.10.12	NIFRS	House fire smoke inhalation
18.10.12	PSNI	Male collapsed in shed
19.10.12	PSNI	White powder incident
22.10.12	NIFRS	Carbon Monoxide poisoning from car into property
22.10.12	PSNI/ NIFRS	Attempted suicide using gas

William Newton
EMERGENCY PLANNING OFFICER

A HART response will be embedded into mountain and cave rescue teams based in NI. To enable this, appropriate PPE will be purchased; some of this will be multi-purpose and can be utilised across a number of specialities. The training has been arranged with the Mourne Outdoor Activity Centre.

Ballistic training in conjunction with PSNI will be introduced in order to meet the threat of 'Responding to a Marauding Terrorist Fire Arms Attack' (Home Office doc. version 1.3 October 2011). This National Concept of Operations Document will necessitate the purchase of ballistic PPE and the provision of associated training. A "staff measuring" exercise has begun and orders will be in place by end of October 2012.

It is proposed that the number of HART staff trained in Quick Don Personal Protection Equipment (QDPPE) will be doubled to 24. As the requirement for this speciality is limited, it is proposed to limit trained operatives to 24. To enable this increase in the number of QDPPE responders, additional PPE has been purchased.

Initial training activity will continue with partner agencies (external agency capability permitting) to further develop the skill base within the existing team.

Proposed initial training programme:

EXTERNAL TRAINING

- Urban Search and Rescue – one course
- Breathing Apparatus – one course
- Rope Technician – one course (Completed)
- Quick Don Personal Protective Equipment – one course (Completed)
- Firearms awareness (ballistics) – two courses
- Mountain Rescue Training – two courses

INTERNAL TRAINING

- Major Incident Medical Management and Support
- Pre-Hospital Emergency Care Course
- Safe Operation of tail-lift (completed)

RECURRENT ACTIVITY

The continuation training programme will continue to utilise a significant portion of the resources available:

- Urban Search and Rescue – two days per annum for each trained operative
- Breathing Apparatus – two days per annum for each trained operative
- Rope Technician – one day per annum for each trained operative
- Quick Don Personal Protective Equipment – one day per annum for each trained operative

HART EQUIPMENT

MAIN ITEMS OF SPEND

PERSONAL PROTECTIVE EQUIPMENT

Power Respirator Protective Suit (Training) £1,750
Gas Tight Suits (training) £1,996
Gas Tight Suits £2,392
Quick Don Personal Protective suits (Training) £11,921

PROJECTED ITEMS OF SPEND

Ballistic personal protective equipment £30,000
Mountain rescue personal protective equipment £21,824
Quick Don Personal Protective suits £10,181

ESSENTIAL EQUIPMENT

HYDKB Hydrant key £179
Fire FHB45231a 45mm £295.65
Upgrade of storage capacity £1992.19

MAINTENANCE SPEND

For example:
Service of generators £582
MOT preparation of vehicles £432
Servicing of vehicles and repairs £490
Service level agreement for radiation equipment £1502
Repairs to training suits £486

PROJECTED MAINTENANCE SPEND

Service vehicles £2300
Repairs to vehicles £2000
Service of decontamination tent and essential equipment £2000

A programme to maintain / service HART equipment will continue with increased demand as the level of equipment procured increases.

Please find detailed below a summary of the above costs:

FINANCES FOR 2012/2013

HART CAPABILITY COSTS 2012/13

Description	Expenditure to August	Estimated Expenditure Sept-March	Total
	£	£	£
External Training	15,524	36,980	52,504
Internal Training	25,768	40,252	66,020
Equipment & PPE	15,910	62,005	77,915
Maintenance & Servicing	19,138	10,156	29,294
HART Managers	26,836	52,500	79,336
HART Support	16,151	20,000	36,151
Miscellaneous	8,633	2,435	11,068
	127,959	224,328	352,287

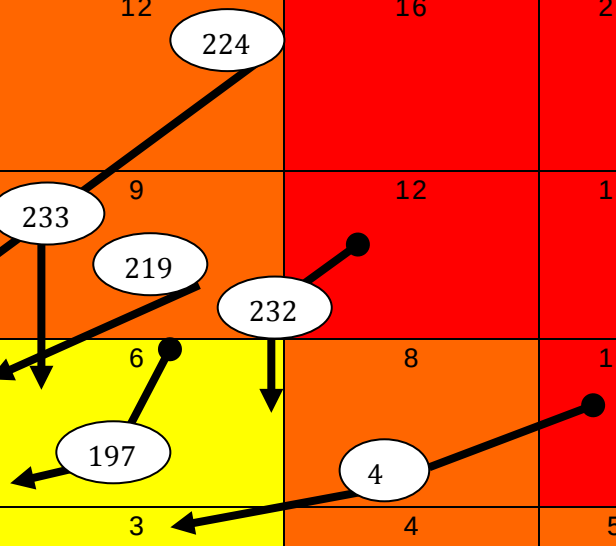
2.2 Risk Register

Please refer to Risk Register submitted as a separate document.

2.3 Risk Map

Risk Map as at 30/09/12 Identifying Current Risk Level

Likelihood of Recurrence	Most likely consequences				
	Insig-nificant	Minor	Moderate	Major	Cata-strophic
Almost Certain 90%-100% of chance of occurrence	5	10	15	20	25
Likely 60%-90% of chance of occurrence	4	8	12	16	20
Possible 30%-60% of chance of occurrence	3	6	9	12	15
Unlikely 10%-30% of chance of occurrence	2	4	6	8	10
Rare 0%-10% of chance of occurrence	1	2	3	4	5

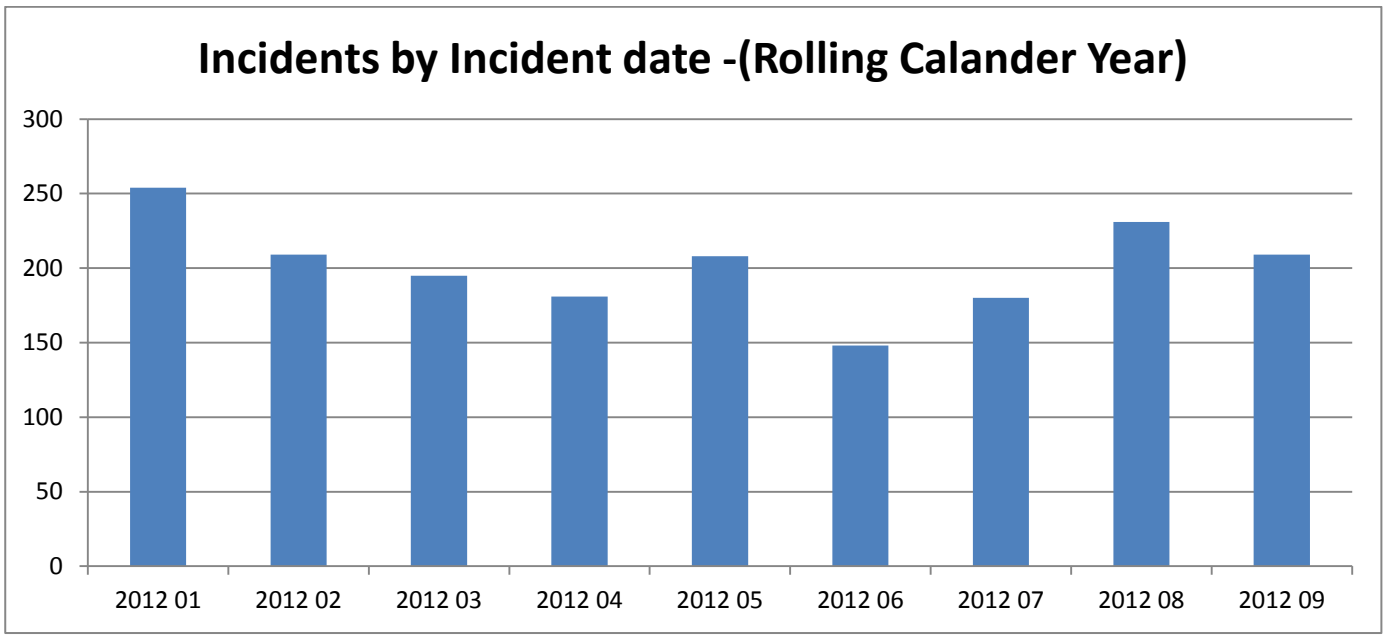


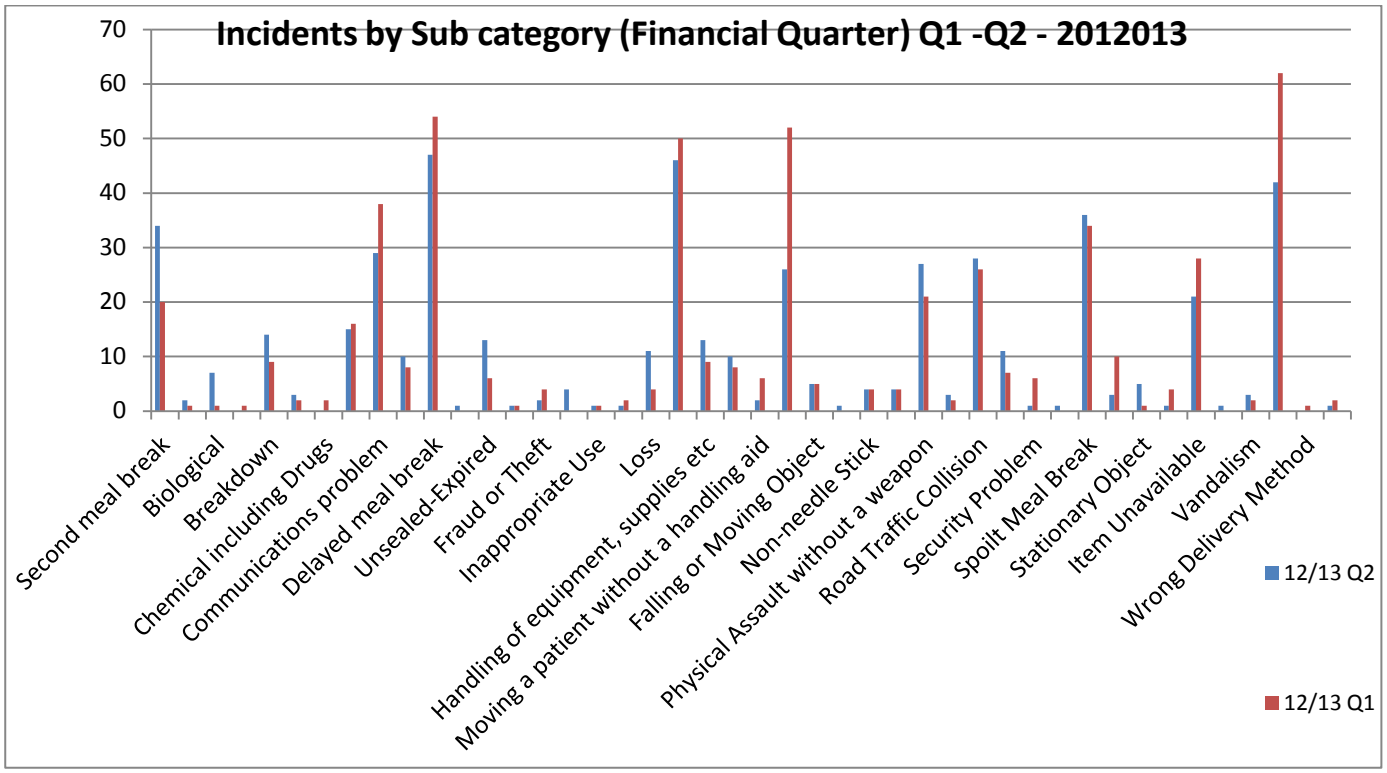
Risk No.	Risk Description	Current Score
224	Senior Executive Directors Retention & Succession Planning	12
232	Business Services Transformation Programme (BSTP)	12
4	Business Continuity P.FA 1.2.	10
197	Vehicle Cleaning	9
219	Assuring Optimal Clinical experience in Patient Care	9
233	Achieving Financial Balance 2012/13	9

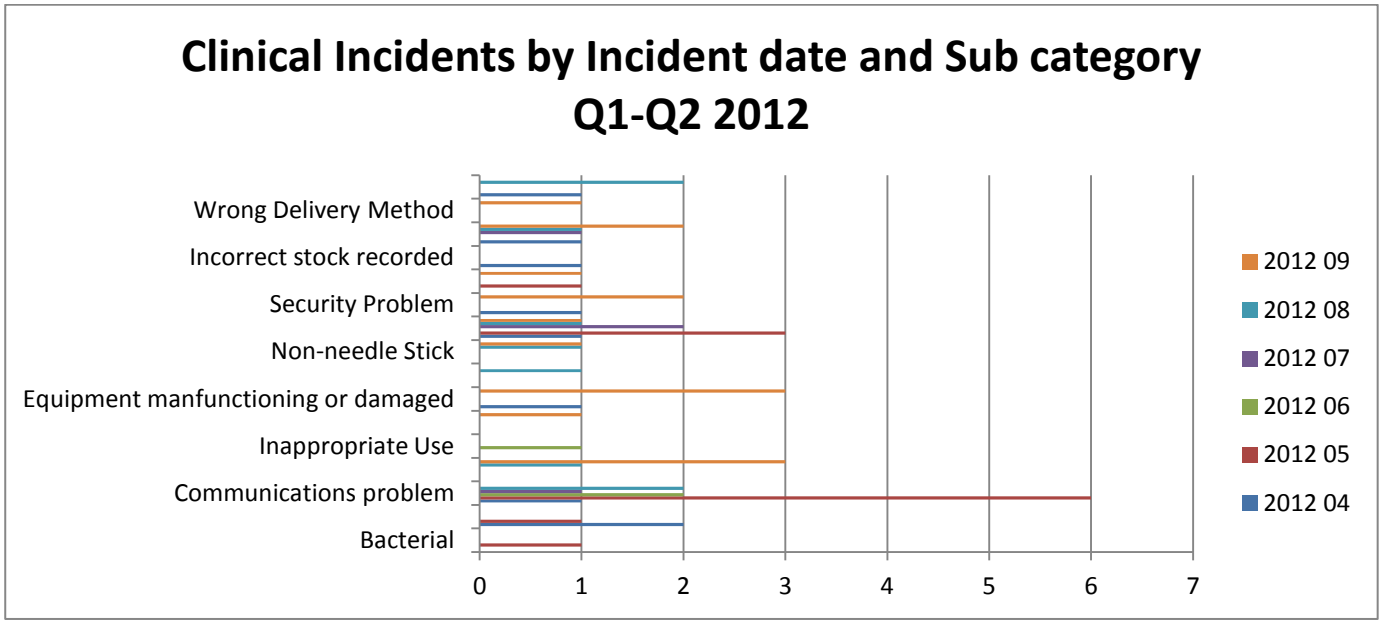
2.4 Incident Reports

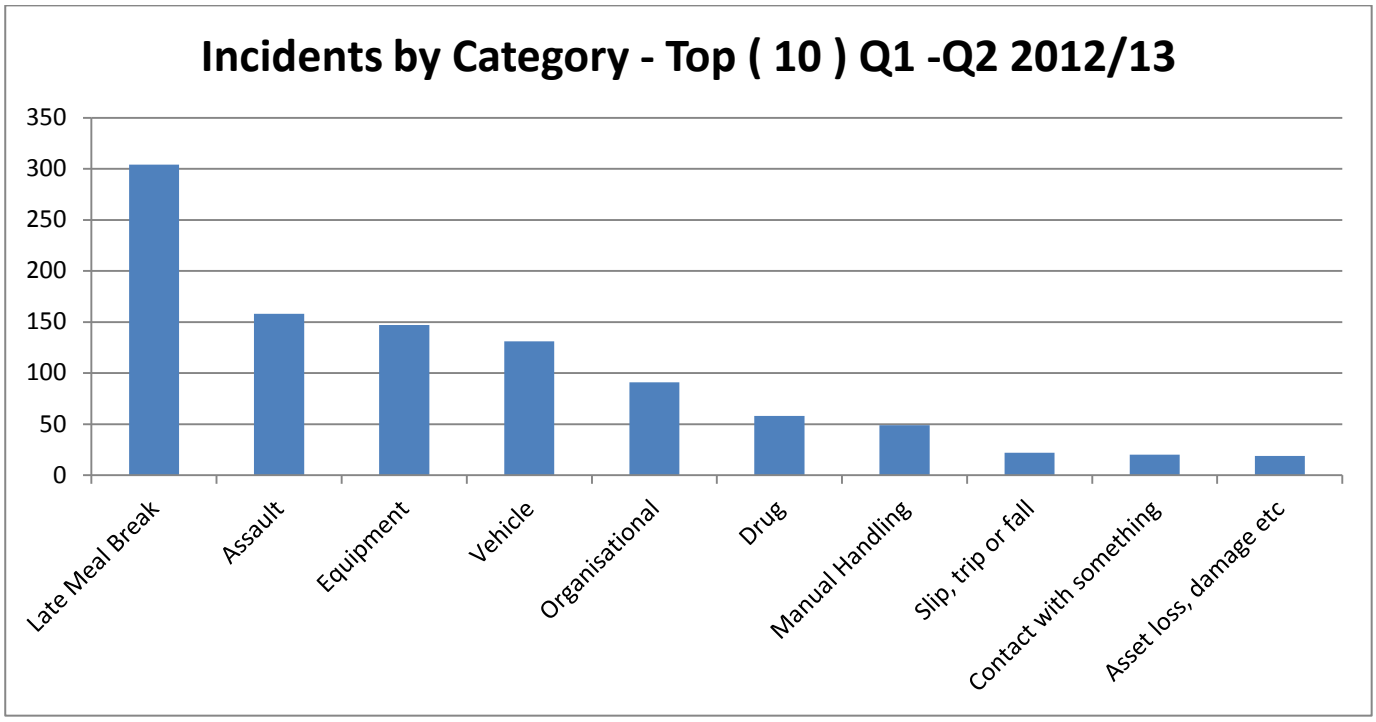
Significant Untoward Incident Reports

No Untoward Incident Reports of significance (moderate and above) received during this reporting period.






Clinical Incidents by Incident date and Sub category
Q1-Q2 2012
Wrong Delivery Method
Incorrect stock recorded
Security Problem
Non-needle Stick
Equipment manfunctioning or damaged
Inappropriate Use
Communications problem
Bacterial
0
1
2
3
4
5
6
7
2012 09
2012 08
2012 07
2012 06
2012 05
2012 04


Incidents by Category - Top (10) Q1 -Q2 2012/13
350
300
250
200
150
100
50
0
Late Meal Break
Assault
Equipment
Vehicle
Organisational
Drug
Manual Handling
Slip, trip or fall
Contact with something
Asset loss, damage etc

SERIOUS ADVERSE INCIDENTS REPORTS AS AT 30 OCTOBER 2012

Ref	Status	Subject	Speciality	Description	Location
SAI 679W / UIR18267	*Joint Investigation underway by NIAS and WHSCT* **This SAI was closed on 16 December 2011.** A Joint Working Group has been set up with the Western Trust in order to develop an Inter Hospital Transfer Policy. This group met on 23 February'12 **A number of actions have already been taken up by the Group and a further meeting is planned. Draft guidelines for Inter Hospital Transfers have been circulated to CCaNNI and the Western Trust. Draft risk assessment has been completed and shared with CCaNNI awaiting response.**	Serious injury to staff member	Accident & Emergency	A member of staff was seriously injured during an inter hospital emergency transfer	Western Area
SAI A1059/ UIR 22371	Reported to HSCB on 27 April 2012 following a front page story in the Irish News in April 2012. The report highlighted that although NIAS had provided a Paramedic Response within 03:07 minutes to the scene . The media reported that there was a delay in providing an A&E Crew to back up the RRV Paramedic. **Report is in the final stage.**	Serious incident of public interest or concern	Accident and Emergency	Patient suffered Cardiac Arrest and did not survive	Belfast Area
SAI A1087/ UIR 19337	Reported to HSCB 0n 3 May 2012 and related to an incident on 23 January 2012 regarding the delay in the provision of treatment and transport to a cardiac patient following a request from the Ulster Cardiac Team. **Report is in the final stage.**	Serious injury to, or the unexpected death of a service user	Accident and Emergency	Patient suffered Cardiac Arrest and did not survive	South Eastern Area
SAI A1262/ UIR 7517	Reported to the HSCB on 22 June 2012 in relation to an elderly patient who had attended OPD at BCH and was subsequently discharged without treatment as he was too ill to receive treatment. Patient was found unresponsive in the PSC sitting case vehicle. Full resuscitation carried out however patient did not survive. **Currently under investigation and the report is due for submission on 26 September 2012, delayed awaiting information from Belfast Trust.**	Serious injury to, or the unexpected death of a service user	Patient Care Service		Northern Area

2.5 CONTROLS ASSURANCE STANDARDS REPORT – SCORES 2012

NO	Standard	Lead		Criterion																																	2012
				1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	T	I/A
1	Buildings	B McNeill	Self	90	90	86	N/A	88	85	82	92	92	N/A	N/A	87	75	87	88	1042																80%	
2	n		Not Assessed as per Departmental Guideline HSS(PPM) 1/2005																																		
3	Emergency Planning	D McManus	Self	95	95	95	95	90	95	90	85	95	90	925																					93%	
4	Environmental Cleanliness		Not Assessed as per Departmental Guideline HSS(PPM) 1/2005																																		
5	Environmental Management	B McNeill	Self	90	82	84	86	86	92	88	92	86	90	876																					88%	
6	Financial Management	S McCue	I/A	95	95	95	95	90	90	85	95	95	95	95	90	1115																			93%	92%
7	Fire Safety	B McNeill	I/A	93	90	95	91	92	N/A	92	95	94	90	94	92	92	92	88	92	93	1475														92%	93%
8	Fleet	B McNeill	I/A	86	84	82	78	78	80	88	80	82	86	90	90	76	82	90	1252																83%	
9	Governance	S McCue / D	I/A	90	83	83	80	90	90	85	601																								86%	84%
10	Health and Safety	R O'Hara	Self	99	99	99	80	90	90	90	95	75	40	95	85	90	80	85	85	75	60	85	90	85	60	75	85	1992							80%	
11	Human Resources	R O'Hara	Self	85	85	50	90	80	85	85	80	75	80	80	70	80	80	80	80	90	80	1435													80%	
12	Infection Control	D McManus	Self	95	85	80	75	75	95	85	75	N/A	90	90	95	85	80	90	90	1285															86%	
13	ICT	S McCue	Self	93	90	90	75	80	76	76	75	75	77	80	75	95	75	75	70	72	75	72	1496												79%	
14	Purchasing & Supply	S McCue	Self	85	60	60	75	85	85	85	85	70	80	80	75	75	80	1080																	77%	
15	Medical Devices	B McNeill	Self	85	80	88	80	N/A	85	88	N/A	85	85	90	90	86	90	N/A	90	80	N/A	95	95	90	90	95	95	95	90	90	80	84	84	2285	88%	
16	Medicines Management	D McManus	Self	90	90	90	N/A	85	95	95	95	N/A	95	N/A	95	95	95	95	95	95	1305														93%	
17	Records Management	S McCue	I/A	90	85	80	85	85	80	505																									84%	84%
18	Risk Management	D McManus	I/A	95	90	90	90	90	90	80	90	90	805																						89%	86%
19	Waste Management	B McNeill	Self	85	76	90	90	92	90	90	90	N/A	90	89	90	90	82	88	90	1322															88%	
20	Security	B McNeill	I/A	92	87	87	85	92	92	92	92	75	89	91	90	1064																			89%	85%
21	Food Hygiene		Not Assessed as per Departmental Guideline HSS(PPM) 1/2005																																		
22	Research Governance		Not Assessed as per Departmental Guideline HSS(PPM) 1/2005																																		
	KEY=	pre Standard				Not Assessed			Self Audit									I/A= Internal Audit																V1final2 2012		

3. STRATEGIC AIM: TO ENGAGE WITH LOCAL COMMUNITIES AND THEIR REPRESENTATIVES IN ADDRESSING ISSUES WHICH AFFECT THEIR HEALTH AND PARTICIPATE FULLY IN THE DEVELOPMENT AND DELIVERY OF RESPONSIVE INTEGRATED SERVICES

STRATEGIC OBJECTIVES

Establish processes, built around our Patient and Public Involvement (PPI) strategy, to enable effective communication and engagement with all our communities and their representatives.

Use those PPI processes to clarify the ambulance role, function and resource with the community and agencies responsible for setting policy and commissioning ambulance services, and test this against their perceived/assessed needs and expectations.

3.1 PERSONAL AND PUBLIC INVOLVEMENT (PPI)

NIAS is represented on the DHSSPS PPI Review Group which is charged with reviewing PPI guidance for HSC. In addition the Trust participates in the PHA Regional PPI Forum in partnership with other HSC organisations and service users. The Trust is also engaged with PHA in respect of a collaborative approach across HSC to the implementation of PPI.

PATIENT AND CLIENT EXPERIENCE STANDARDS

In line with the HSCB Commissioning Plan, NIAS continues to contribute to the regional working group established to develop and implement methodologies to monitor compliance with the Minister's Patient and Client Experience Standards (Respect, Privacy, Dignity, Behaviour and Communication).

Questions in respect of experience of ambulance services are now included in surveys related to the standards undertaken across HSC Acute Trusts. Results of these surveys provided to NIAS.

ACTIONS FOR 2012/13

- Publication of a PPI Strategy for NIAS.
- Implementation of additional methodologies to monitor compliance with the standards and identification of areas for improvement.
- Continued involvement in regional work streams to influence and ensure a collaborative approach to the PPI and Patient and Client Experience standards agendas within the HSC.
- Participation in PPI initiatives with other statutory and voluntary agencies and development of a NIAS reference panel.

CONSULTATION SCHEME

Trusts were required under the 2009 Reform Act to produce consultation schemes by undertaking a process of involvement, following guidance and engaging with the Patient Client Council. NIAS was required to publish its Consultation Scheme by 31 March 2012. The DHSSPS-approved Scheme was published on the Trust website. DHSSPS subsequently requested on 21 May 2012 that NIAS update their consultation scheme to reflect more relevant timeframes. A revised consultation scheme was

resubmitted to SEMT for approval and subsequently to DHSSPS on 13 June 2012. The updated consultation scheme has been published on the Trust's website.

PROGRESS TO 30 SEPTEMBER 2012

PPI

Following engagement with service users and through regional work streams, NIAS has produced a PPI Strategy for the Trust which has been published for consultation. The Strategy has been developed based on PHA/HSCB strategy and following engagement with service users through writing to Acute Trust PPI lists, and placement on PCC website.

The PPI Strategy was approved by NIAS Trust Board in May 2012. The Strategy was issued for consultation which closed on 5 October 2012 (14 weeks to take account of holiday period). To facilitate consultation an Easy Read version of the Strategy was produced. As part of the consultation process, service users were given the opportunity to meet with NIAS staff to discuss their views on the proposed Strategy. The Trust continues to work to increase the involvement of service users in Trust work streams and policy development.

DHSSPS published a policy circular on 20 September 2012 which provides further guidance to HSC organisations on their roles and responsibilities in implementing PPI. The Trust is working to develop an action plan to implement this guidance.

Regionally NIAS is working alongside DHSSPS, PHA and service users and carers to produce updated guidance on PPI for the HSC and to take forward a programme of work within the Regional PPI Forum including the development of PPI Standards. NIAS is also working with the PSNI, NIFRS and the British Deaf Association on access to emergency services.

A meeting took place with the British Deaf Association on 10 July 2012 in respect of engagement with deaf service users and issues around making complaints and accessing emergency services in order to lead to involvement in producing accessible guidance in this regard for deaf service users. A blind service user and Guide Dogs for the Blind Association have been involved in the development of guidance on the transportation of Assistance Dogs.

The Trust has been involved in the work of Regional PHA Forum and the DHSSPS working group on PPI Guidance. The PHA Forum is developing PPI Standards.

PATIENT AND CLIENT EXPERIENCE STANDARDS

NIAS continues to participate in regional work streams to develop and implement methodologies to monitor the standards in delivery of HSC Services. Involved in regional Patient Experience Working group and Patient Experience Steering group which involved in reviewing these work streams. NIAS continues to work with other Trusts on the roll out of surveys and gathering patient stories which include questions on ambulance experience. Committed to learning from feedback from patients and observations of practice and taking appropriate action. Quarterly reports are provided to SEMT in respect of learning outcomes from Patient Experience and PPI activity.

Within this framework NIAS piloted the use of observations of practice in respect of the standards within the Belfast Area and has now undertaken a review of this pilot in order to inform decisions about further developments in methodologies employed. The Equality and PPI Steering Group have agreed a roll-out programme for observations of practice in each Trust Area. Working to develop a system to roll-out observations of practice in the next trust Area.

The Trust also continues to produce regular reports for submission to HSCB around implementation of this work stream including learning outcomes and action plans where appropriate. In addition this work now informs part of the learning outcome work presented to the Trust Senior Executive Management Team (SEMT) on a quarterly basis.

3.2 PATIENT CLIENT EXPERIENCE STANDARDS MONITORING REPORT (QUARTER ENDING 30 JUNE 2012)

BACKGROUND

In April 2009, the DHSSPS published the 'Improving the Patient & Client Experience' document. The document set out the following five core standards:

- Respect
- Attitude
- Behaviour
- Communication
- Privacy and Dignity

All Trusts adopted these standards during 2009/10 and arrangements were put in place to develop methodologies through a regional working group to allow the standards to be monitored.

Priorities for Action 2010/11 includes the following target:

'Following the adoption of the Patient and Client Experience Standards in 2009, Trusts should extend the clinical care areas monitored and increase the range of monitoring tools, ensure appropriate reporting and follow up consistent with direction from the Public Health Agency.'

DEVELOPMENT OF MONITORING TOOLS AND EXTENSION OF MONITORING TO ADDITIONAL CLINICAL AREAS

The use of patient satisfaction surveys was tested during the third and fourth quarters of 2009/10. The surveys were tested in acute medical wards, non-acute rehabilitation wards and acute mental health inpatient wards. Questionnaires have been revised to reflect the learning from the surveys undertaken.

During 2012/13, the surveys continued to be carried out in other wards within these areas and were also extended to other clinical areas including acute surgical wards and learning disability services.

The Regional Patient Client Experience Working Group has developed a work plan in agreement with the Public Health Agency and HSC Board to further develop the

methodologies for monitoring the compliance against the five core standards. The additional monitoring tools to be developed and tested include the following:

- Patient/Client stories
- Review of compliments and complaints
- Observations of practice
- Staff Feedback
- Audit of organisational arrangements

Trusts will provide a monitoring report to the HSC Board on the activities undertaken each quarter. In the current quarter wards have been surveyed and the results relevant to the Ambulance Service provided to NIAS. A regional methodology was agreed by the Patient Experience Working Group and a reporting template for ambulance results was developed by NIAS and agreed by the regional group. Each Trust agreed to complete this template and submit results to NIAS. NIAS then analysed results from each Trust and aggregated the results to present a regional picture of patient experience in respect of the Ambulance Service for the quarter.

PATIENT SATISFACTION SURVEYS

Trust: Northern Ireland Ambulance Service HSC Trust **Ward:** Accident and Emergency Departments across HSC Trusts.

Quarter Ending: 30 June 2012

Return of Questionnaire:	Two options for return of questionnaires were provided: • Via freepost return envelope to the Safe & Effective Care Department. • Placed in a sealed envelope on the ward on day of discharge and then forwarded to the Safe & Effective Care Department.
Response Rate:	Of the 1281 questionnaires issued across the 5 Trusts in Quarter 1 2012/13, 520 were returned. This equates to a response rate of 40.6% compared with 40.9% in Quarter 4 2011/12. The overall number of questionnaires distributed in Quarter 1 2012/13 (1281) was higher than the number distributed in Quarter 4 2011/12 (563). Of those who responded to the survey, 10.8% (55/511) travelled to hospital by ambulance in Quarter 1 2011/12, compared with 13% in Quarter 4 2011/12.

The following table outlines the level of patient satisfaction against each of the five Patient and Client Standards.

Did you feel the ambulance staff ...

<table>
<tr><td>Respect</td><td>100% (55/55)
treated you as an individual</td><td>98.1% (53/54)
considered and respected your wishes</td><td>100% (55/55)
made you feel safe and secure</td></tr>
<tr><td>Attitude</td><td colspan="3">100% (55/55)
were polite and courteous</td></tr>
<tr><td>Behaviour</td><td colspan="2">were caring and compassionate
100% (55/55)</td><td>behaved in a professional manner
100% (55/55)</td></tr>
<tr><td>Communication</td><td>98.1% (46/47)
Did the ambulance staff introduce themselves?</td><td>100% (55/55)
spoke to you in a way which you could easily understand</td><td>100% (55/55)
Explained what was happening in relation to your care and treatment</td></tr>
<tr><td>Privacy & Dignity</td><td colspan="3">100% (55/55)
maintained your privacy and dignity</td></tr>
</table>

COMMENTS FROM PATIENTS AND CARERS

Patients and Carers, Emergency Department Ulster Hospital

- I think the ambulance staff are very good. Could not say a bad word about them. They've been really good with my mum.
- Smooth journey to hospital.
- The ambulance crew were very kind and very patient with my mother.
- The ambulance staff were very helpful and approachable with a fantastic bedside manner.

Carer, Lagan Valley Hospital Emergency Department

- The ambulance crew again were excellent and as a relative I got all the information I needed.

Patients, Downe Hospital Emergency Department

- Smooth journey to hospital.
- The ambulance staff were very helpful and approachable with a fantastic bedside manner.
- I was transferred to another hospital after waiting two hours for an ambulance that was due to arrive within one hour timescale.

Patients, Antrim Area Hospital Emergency Department

- Ambulance crew were excellent.
- Had excellent attention from the ambulance staff.
- Well pleased with the service.

Patient, Causeway Hospital

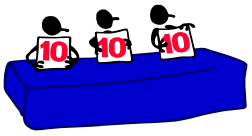
- Brilliant.

ISSUES IDENTIFIED

Issues around accessibility of questionnaires and adjustments needed in order to ensure equality of access and participation were dealt with at the distribution stage of surveys within each of the Trusts.

COMPLIMENTS AND COMPLAINTS

Figures for compliments and complaints have been collected for the quarter and are presented in the table below. A total of 43 compliments and 27 complaints were received by the Trust during the period compared with 36 and 29 respectively in the previous quarter. Compliments and complaints have been mapped from DATIX categories to the five patient experience standards. All compliments are dealt with via the Chief Executive's Office.

COMPLIMENTS and COMPLAINTS FOR PERIOD: 1 Apr – 30 Jun 2012		
Total number of compliments received: 43		
Total number of complaints received: 27		
COMPLIMENTS received at ward / department level (cards, thank you letters)  Recorded over same timespan that questionnaires are being distributed and themed as per Standards	**THEMATIC ANALYSIS** *ILLUSTRATIVE EXTRACTS (UP TO A MAXIMUM OF 5 FOR EACH STANDARD)*	***NUMBER***
	RESPECT All members of staff display a person-centred approach to their care and treatment or in their contact with patients and clients	**N/A**
	ATTITUDE	**N/A**
	BEHAVIOUR	**N/A**
	COMMUNICATION All staff members engage in effective verbal and non verbal communication, leading to clear information being exchanged between staff and patients / clients	**N/A**
	PRIVACY and DIGNITY	**N/A**
COMPLIMENTS received through the Chief Executive's office  Recorded over same timespan that questionnaires are being distributed and themed as per Standards	**RESPECT**	**6**
	ATTITUDE Personal approaches and responses to patients and clients by all members of staff show care and compassion	**24**
	BEHAVIOUR	**7**
	COMMUNICATION	**3**
	PRIVACY and DIGNITY Staff members ensure that all environments where care is provided protect the privacy and dignity of patients and clients	**3**
COMPLAINTS received  Previous 3 months to commencement of PSQ distribution and themed as per Datix categories (refer to Complaints Mapping Proforma)	**RESPECT**	**2**
	ATTITUDE	**1**
	BEHAVIOUR All members of staff involve patients and clients in their care, respecting their wishes and showing professional and appropriate behaviour	**12**
	COMMUNICATION	**12**
	PRIVACY and DIGNITY	**0**

PATIENT STORIES

Patient stories are being gathered by the Hospital Trusts and Ambulance Service related comments are passed on to NIAS. No comments were reported about the Ambulance Service in patient stories during quarter.

OBSERVATION OF PRACTICE

As agreed at the regional working group, NIAS piloted Observations of Practice within the Belfast Area between April and December 2011 following which a review of this methodology was to be undertaken. A collaborative approach to the pilot was used involving Operations and Training staff. During the pilot, observations were undertaken by a Station Officer, Divisional Training Officer and Clinical Support Officer, each carrying out observations one day per month over the 9 month period.

Between January and March 2012 NIAS then undertook a review of this pilot in order to determine the appropriate way to further implement this methodology in the context of an ambulance service. The observation of practice methodology poses particular challenges in an emergency ambulance environment and, if it were to be adopted more widely within NIAS, would have to be adapted to the needs of the service. Issues identified include the time taken to undertake an observation as it requires the observer travelling with a crew to locations and for journey times unknown at the time the observer joins the crew. Patients and service users use the Ambulance Service often for a short period of time, for a single episode and in very traumatic situations. Those accessing our services do so to access facilities and services of other HSC Trusts.

Observations practice was continued in the Belfast area during the quarter April-June. The observations provide further evidence of positive patient experience as well as identifying areas for improvement. Observers have reported that patients are being treated in a way which is in keeping with the patient and client experience standards. Evidence from the observations indicates that patients were treated as individuals, their wishes were respected and taken into consideration and they were made to feel safe and secure. Communication with patients was appropriate and sensitive to their needs.

The observation of practice methodology poses particular challenges in an ambulance environment. These include issues around the time taken to undertake an observation as it requires the observer travelling with a crew to locations and for journey times unknown at the time the observer joins the crew. The Trust will continue to review the results observations and consider comments made by those involved in undertaking the observations. This will include consideration of the role best suited to carry out observations and the time commitment involved.

LEARNING AND TAKING ACTION

The results from implementation of the range of methodologies for this quarter, in terms of experiences of ambulance services, are generally very positive. NIAS is keen to learn from the experiences of all those who use our services. The Trust continues to reaffirm the importance of the standards to staff.

NIAS has established a system to ensure action is taken in respect of issues identified within complaints and patient and client experience work streams.

Regular reports including emerging themes and actions taken to demonstrate learning from this feedback are provided to the Trust's Senior Executive Management Team.

Progress in respect of the standards is also reported to Trust Board. Staff involved with Patient Experience work streams have worked with the Trust's training department to develop a guide around key standards which include addressing the issue of staff introducing themselves which has been a theme in some of the results.

The Trust has developed a 'Work Book' for staff to provide guidance on key areas of responsibility, in support of Trust policies and procedures and ongoing training. This includes a section on Patient and Client Experience Standards.

ASSURANCE REPORT: OPERATIONS DIRECTORATE

TIMELY RESPONSE

The provision of a timely ambulance response to patients is the very core of what we do. There will always be a need for prompt ambulance response and transportation of patients to and from healthcare settings, and we will continue to prioritise and provide rapid response based on clinical need.

The vast majority of patients requiring transportation however, do not require rapid or emergency transportation by highly qualified paramedics. Patients require timely and dependable transportation with dignity and respect in a caring environment by suitably trained and qualified healthcare professionals.

Increasingly the emphasis will be on providing timely dependable transportation on a non-urgent, non-emergency basis to create and maintain emergency ambulance capacity to support sole paramedic response to emergency patients with prompt transportation by emergency ambulance as required.

OBJECTIVES

NIAS will seek to ensure that an average of 72.5% of Category A (life-threatening) calls are responded to within eight minutes, and not less than 65% in any LCG area.

NIAS will seek to ensure that 95% of Category B calls are responded to within 21 minutes and that 95% of Category C calls are responded to in 60 minutes.

NIAS will seek to respond to 95% of Urgent calls within 15 minutes of time specified by the clinician requesting transport.

SUMMARY OF PERFORMANCE

NIAS achieved 70.1% up to September against the 72.5% Regional category A performance target. The 65% target was not achieved in Northern and South Eastern LCG area.

NIAS provided an average of 88.5% of category A patients with a conveying ambulance within 21 minutes of receipt of call. Non conveying ambulances, the majority of which are RRVs contribute 45.5% of Cat A response, regionally.

RISK COMMENTARY

There is a potential risk to achieving the targets if:

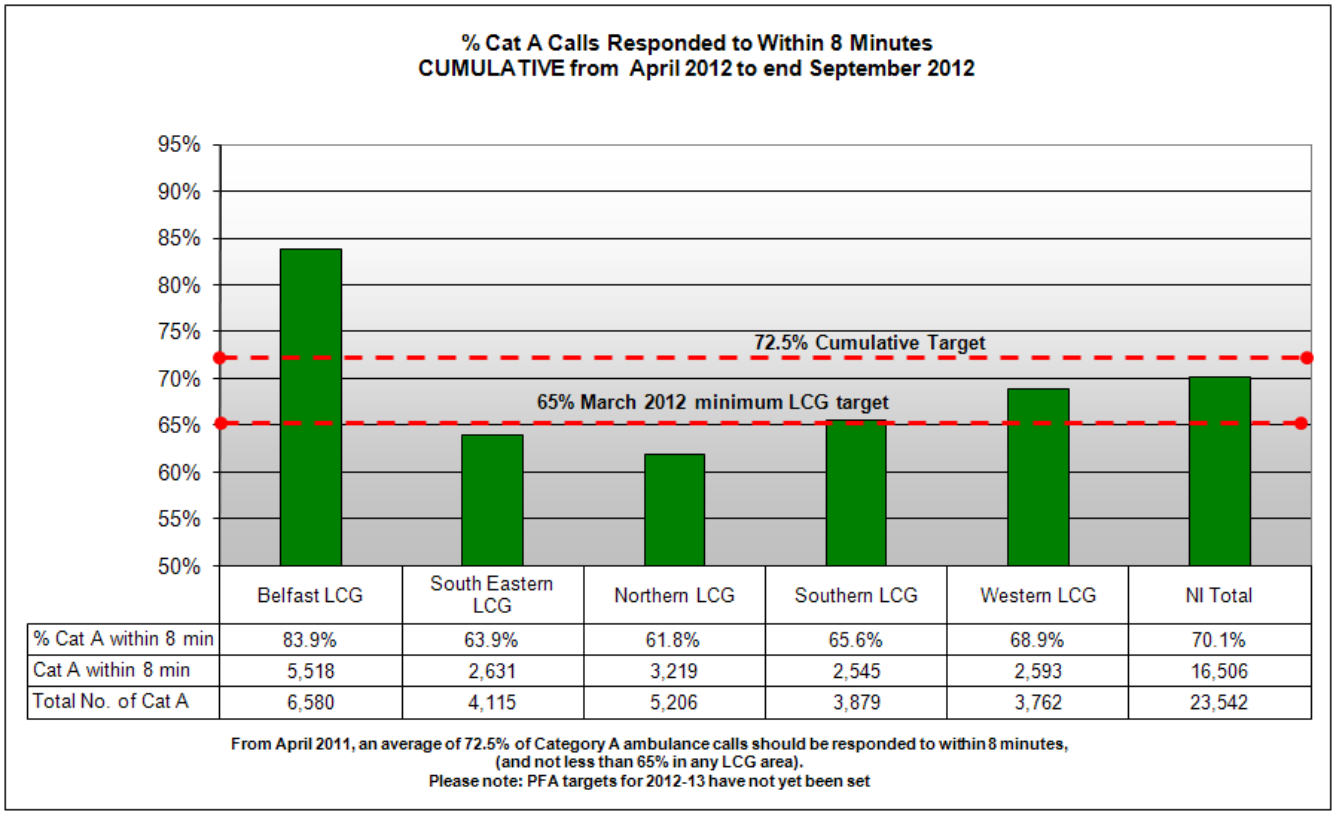
1. NIAS experiences an increase in activity:
2. There are continued delays in emergency departments relating to patient handover.
3. There are continued requests for diverts away from emergency departments resulting in longer journey times and ambulances being out of area.
4. Lack of stakeholder support for proposed service delivery model.
5. Significant changes in the configuration of acute services without assessing the need for or commissioning of additional resources as appropriate.
6. Loss of production hours due to factors beyond the organisation's control e.g. severe weather, pandemic flu, industrial action, response to major incidents.

PERFORMANCE REPORTS

CAT A PERFORMANCE – CUMULATIVE FROM APRIL 2012 TO SEPTEMBER 2012

HSCB 2012/13 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 65% in any LCG area)"

Regional Target: 72.5% LCG target 65%



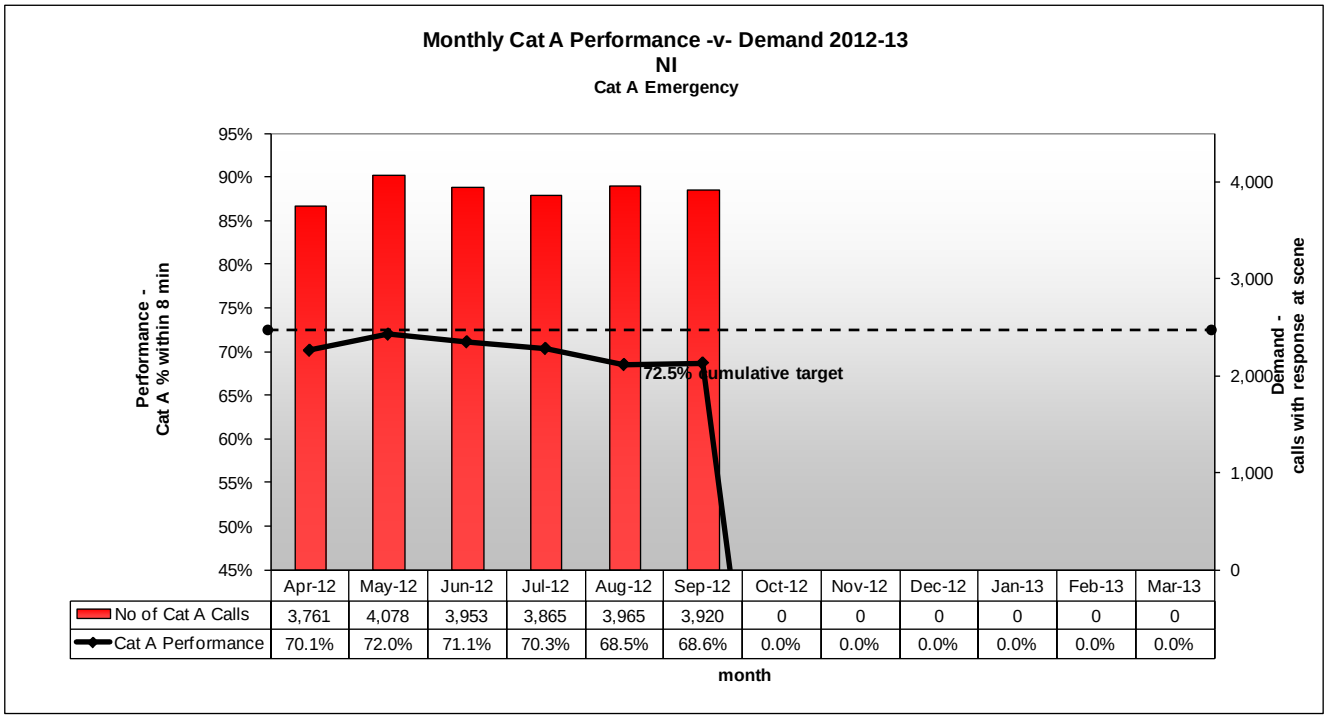
	Belfast LCG	South Eastern LCG	Northern LCG	Southern LCG	Western LCG	NI Total
% Cat A within 8 min	83.9%	63.9%	61.8%	65.6%	68.9%	70.1%
Cat A within 8 min	5,518	2,631	3,219	2,545	2,593	16,506
Total No. of Cat A	6,580	4,115	5,206	3,879	3,762	23,542

From April 2011, an average of 72.5% of Category A ambulance calls should be responded to within 8 minutes, (and not less than 65% in any LCG area).
Please note: PFA targets for 2012-13 have not yet been set

CAT A PERFORMANCE – Monthly Cumulative Position 2012/13 as at September 2012

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Regional	**70.1**	**71.1**	**71.1**	**70.9**	**70.4**	**70.1**							
Belfast	85.7	84.7	84.9	85.0	84.3	83.9							
South East	63.4	64.7	64.6	64.7	64.1	63.9							
North	62.2	63.7	63.6	62.3	61.8	61.8							
South	63.5	64.5	65.3	66.0	66.2	65.6							
West	68.8	71.0	70.0	69.8	69.3	68.9							

CAT A PERFORMANCE – Monthly Regional Position 2012/13 as at September 2012



	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
No of Cat A Calls	3,761	4,078	3,953	3,865	3,965	3,920	0	0	0	0	0	0
Cat A Performance	70.1%	72.0%	71.1%	70.3%	68.5%	68.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

CAT A PERFORMANCE – Monthly LCG Position 2012/13 as at September 2012

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
NI	**70.1**	**72.0**	**71.1**	**70.3**	**68.5**	**68.6**							
Belfast	85.7	83.9	85.4	85.0	81.7	81.7							
South East	63.4	66.1	64.4	64.9	62.1	62.9							
North	62.2	65.0	63.5	58.7	59.8	62.0							
South	63.5	65.4	67.0	68.1	66.8	62.8							
West	68.8	73.1	67.9	69.3	67.3	66.8							

Key:

Target Achieved	
Target Substantially achieved	(within 1% variance)
Target Partially achieved	(within 2.5% variance)
Target Not Achieved	(greater than 2.5% variance)

PERFORMANCE COMMENTARY:

August / September 2012 Trend Analysis v August / September 2011

Activity	Compared with August 2011	Compared with September 2011
Emergency	Up 4.6%	Up to 4.9%
Urgent	Up 6.1%	Up to 5.2%

The 65% target was not achieved in North (62.3% realised). There has been a 5.1% increase in overall activity compared to July 2011, (equivalent to 50 calls extra calls each day) with Belfast LCG increasing by 9.8% (17 extra responses each day), Western LCG increasing by 8.1% (12 extra calls each day) and Northern LCG by 7.8% (22 extra calls each day).

Local context :

- Road works on A2 (Belfast to Bangor dual carriage way down to 1 lane)
- Portrush Air Show (8 and 9 Sep 2012)
- Centenary anniversary of the Covenant Parade (Belfast 29th Sep 2012)
- Introduction of new bus lanes in Belfast City Centre

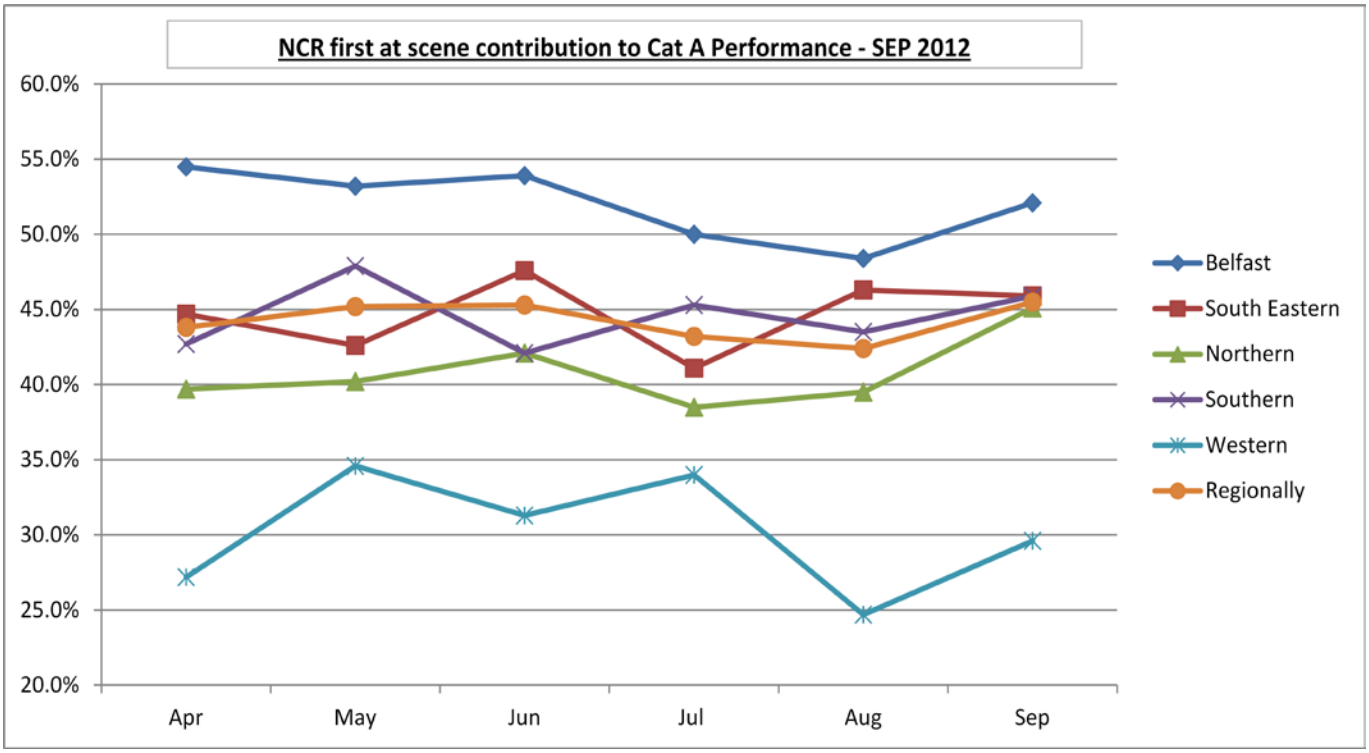
Category A : % Conveyance Resource Response arriving within 21 minutes

Area	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
NI	**89.3**	**89.4**	**90.2**	**90.4**	**89.0**	**88.5**						
Belfast	89.5	90.2	91.6	92.8	93.3	91.4						
South East	84.9	86.7	87.5	88.9	84.1	83.1						
North	90.8	89.8	89.2	89.4	87.0	87.6						
South	90.9	89.6	92.6	89.8	90.4	88.9						
West	90.1	90.3	89.6	90.1	88.9	90.3						

PERFORMANCE COMMENTARY:

NIAS TARGET TO CONVEY 95% OF CAT A CALLS WITHIN 21 MINUTES

Non-Conveying Resource (RRV Etc) - contribution to Cat A



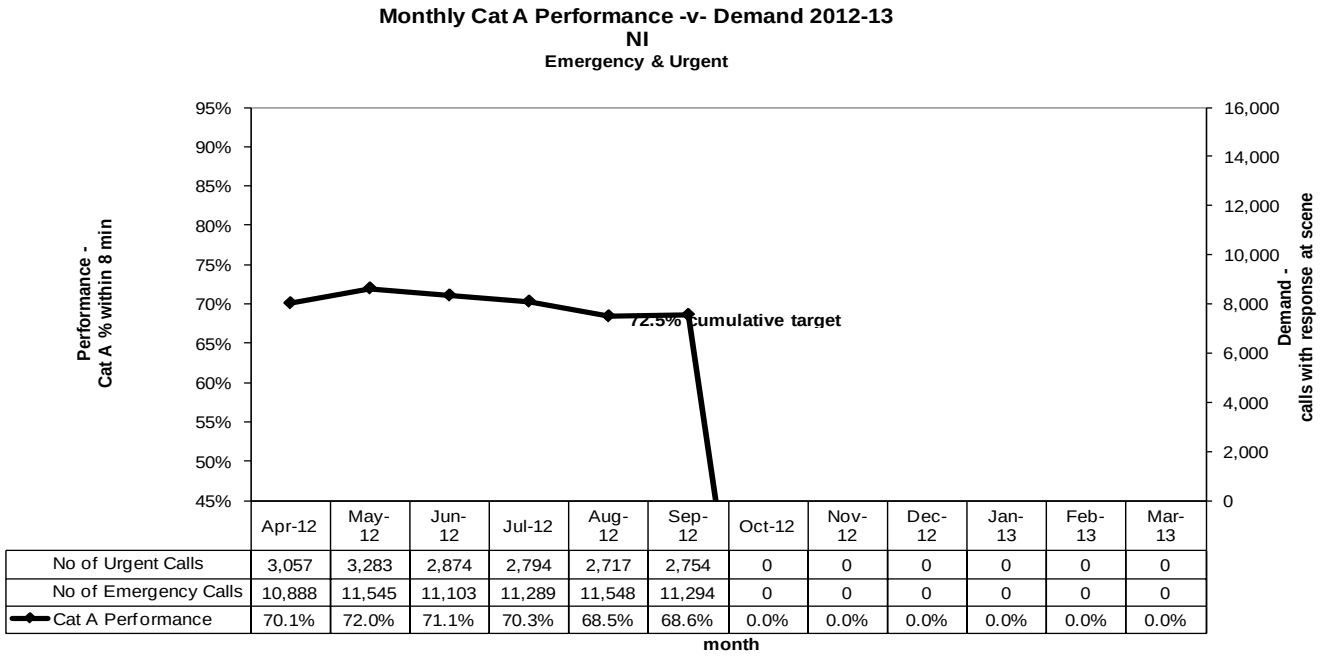
Non-Conveying Resource (RRV etc) - contribution to Cat A data

	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
Belfast	476	520	511	458	430	477						
Belfast (%)	*54.5%*	*53.2%*	*53.9%*	*50.0%*	*48.4%*	*52.1%*						
South East	191	197	211	174	206	198						
South East (%)	*44.7%*	*42.6%*	*47.6%*	*41.1%*	*46.3%*	*45.9%*						
Northern	201	221	228	198	217	251						
Northern (%)	*39.7%*	*40.2%*	*42.1%*	*38.5%*	*39.5%*	*45.1%*						
Southern	166	218	186	199	183	183						
Southern (%)	*42.7%*	*47.9%*	*42.1%*	*45.3%*	*43.5%*	*45.9%*						
Western	120	170	136	145	114	115						
Western (%)	*27.2%*	*34.6%*	*31.3%*	*34.0%*	*27.7%*	*29.6%*						
Regionally	1154	1326	1272	1174	1150	1224						
Regionally (%)	***43.8%***	***45.2%***	***45.3%***	***43.2%***	***42.4%***	***45.5%***						

PERFORMANCE COMMENTARY:

The above table shows show that the number of calls where a non-conveying response is first on scene has increased by 6.4% with the contribution to Cat A performance increasing by 3.1% in comparison with the previous month with the exception of South Eastern where the contribution of NCRs first at scene fell slightly (by 0.4%).

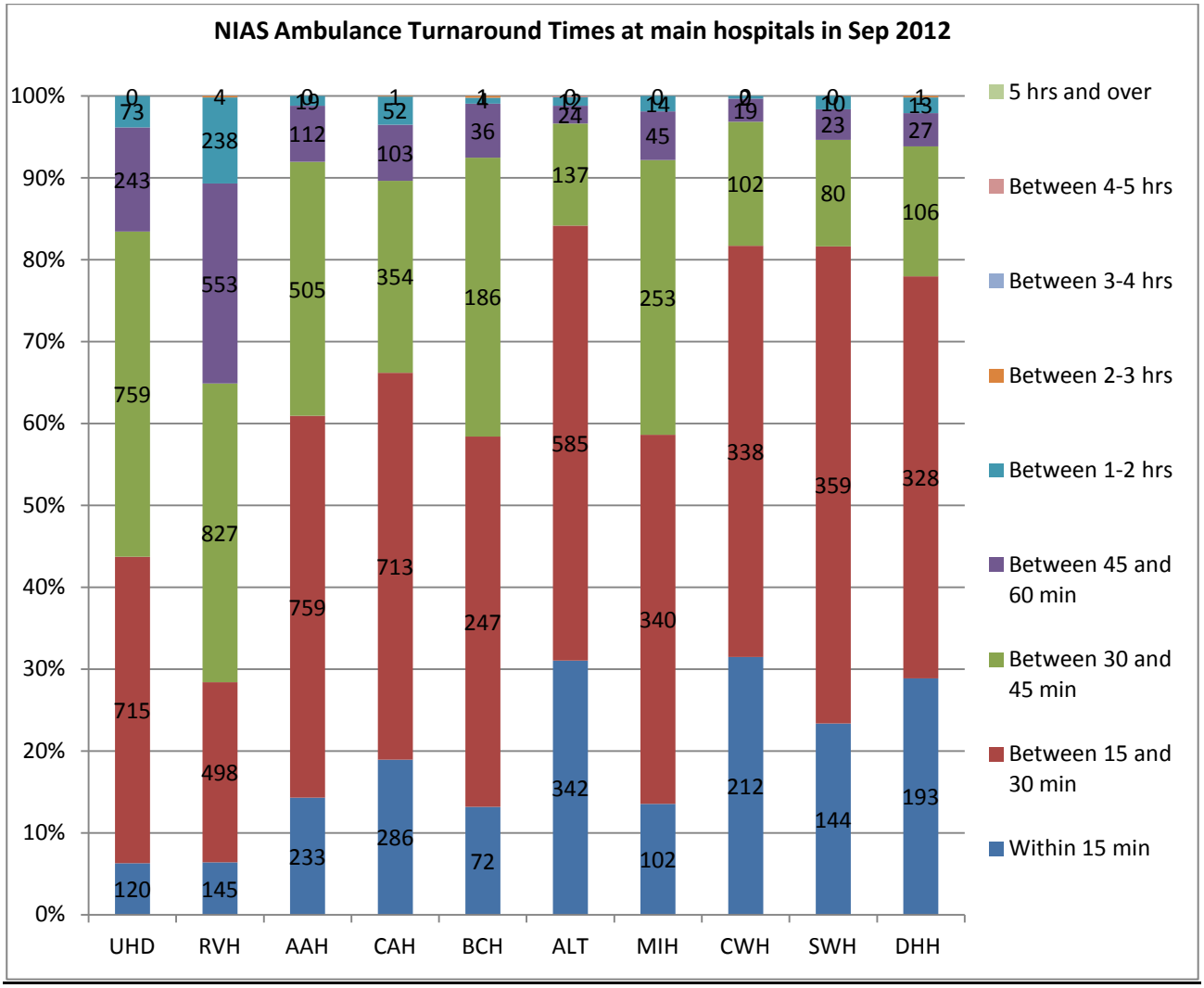
Urgent Calls (non-life-threatening):



	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
No of Urgent Calls	3,057	3,283	2,874	2,794	2,717	2,754	0	0	0	0	0	0
No of Emergency Calls	10,888	11,545	11,103	11,289	11,548	11,294	0	0	0	0	0	0
Cat A Performance	70.1%	72.0%	71.1%	70.3%	68.5%	68.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

PERFORMANCE COMMENTARY: Graph above details the number of Drs Urgent calls responded to for each month. It also shows a profile of 999 calls broken down by category A, B, C. for each month. Black lines shows performance against the regional 72.5% target. 6.9% increase in Urgent activity compared to the same time last year with Belfast LCG up by 8.8% and Western LCG up by 7.4%. However Northern LCG fell by 9.4% (2 urgent calls per month)

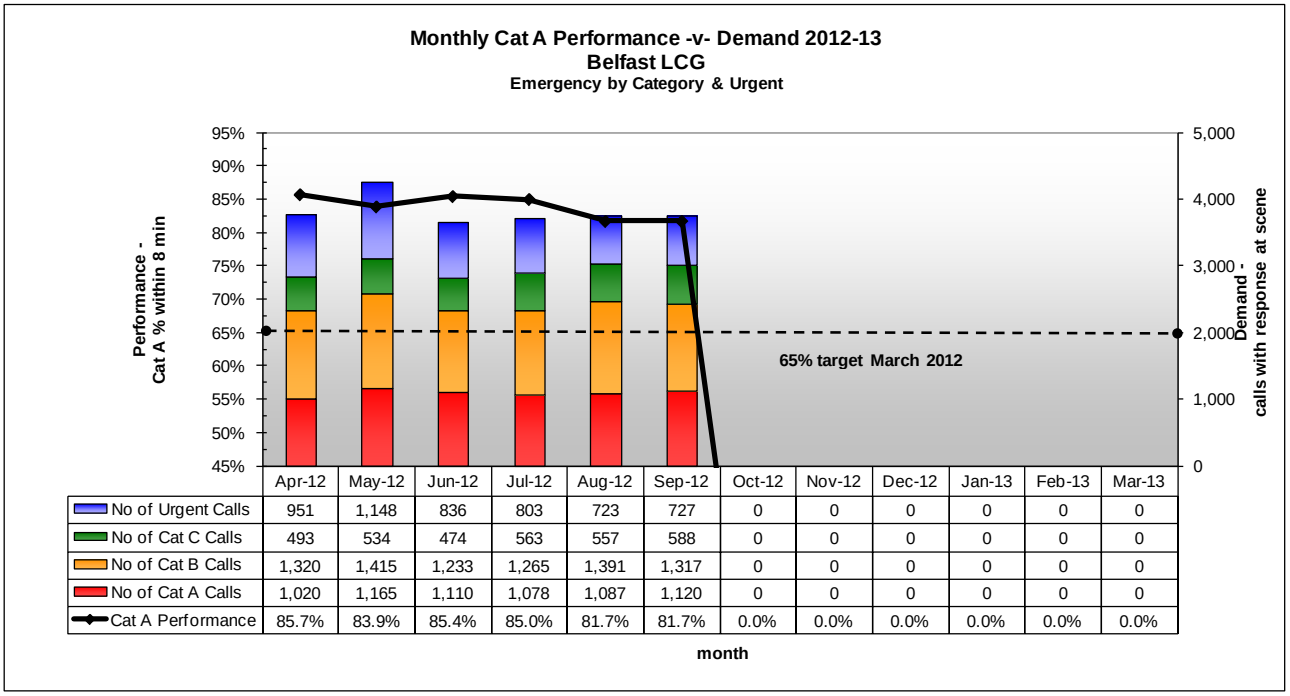
TURNAROUND TIMES AT HOSPITALS



- The total loss of production hours for the top 9 hospitals combined is 3098 hours for the month of September (compared to 2967 in August 2012) and this equates to 4.3 A&E ambulance lost each day.

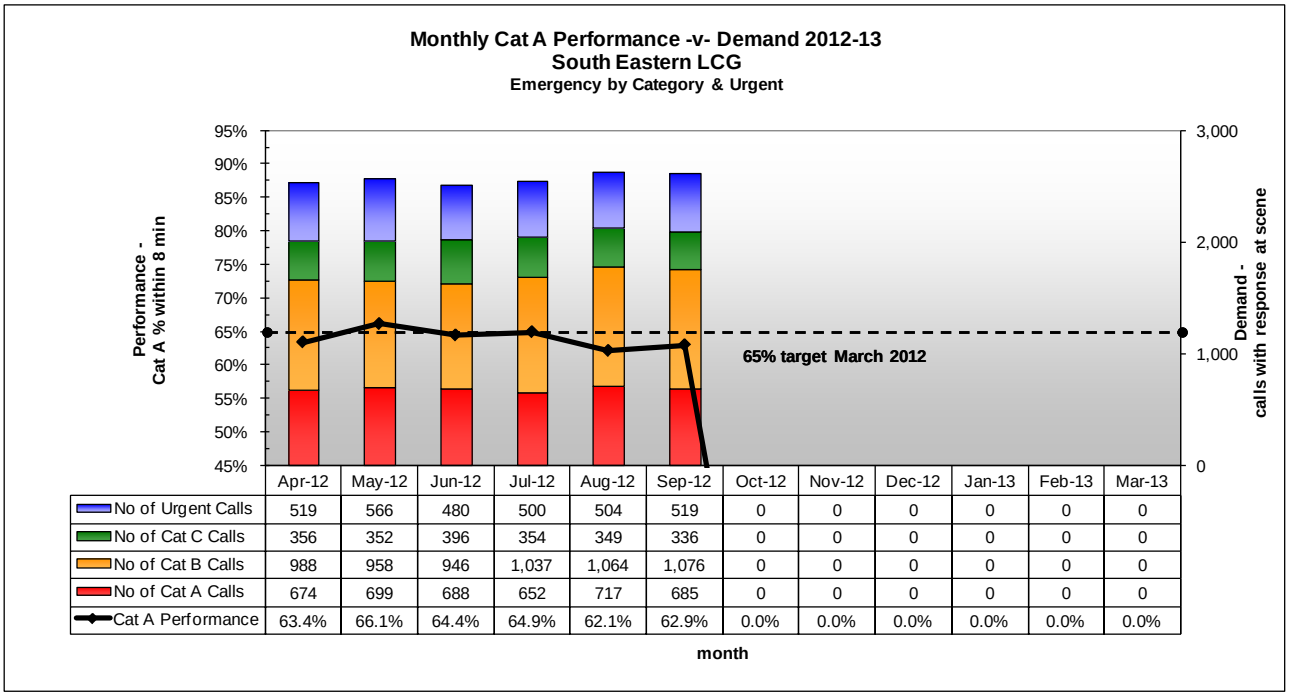
PERFORMANCE REVIEW BY DIVISION

Belfast Division



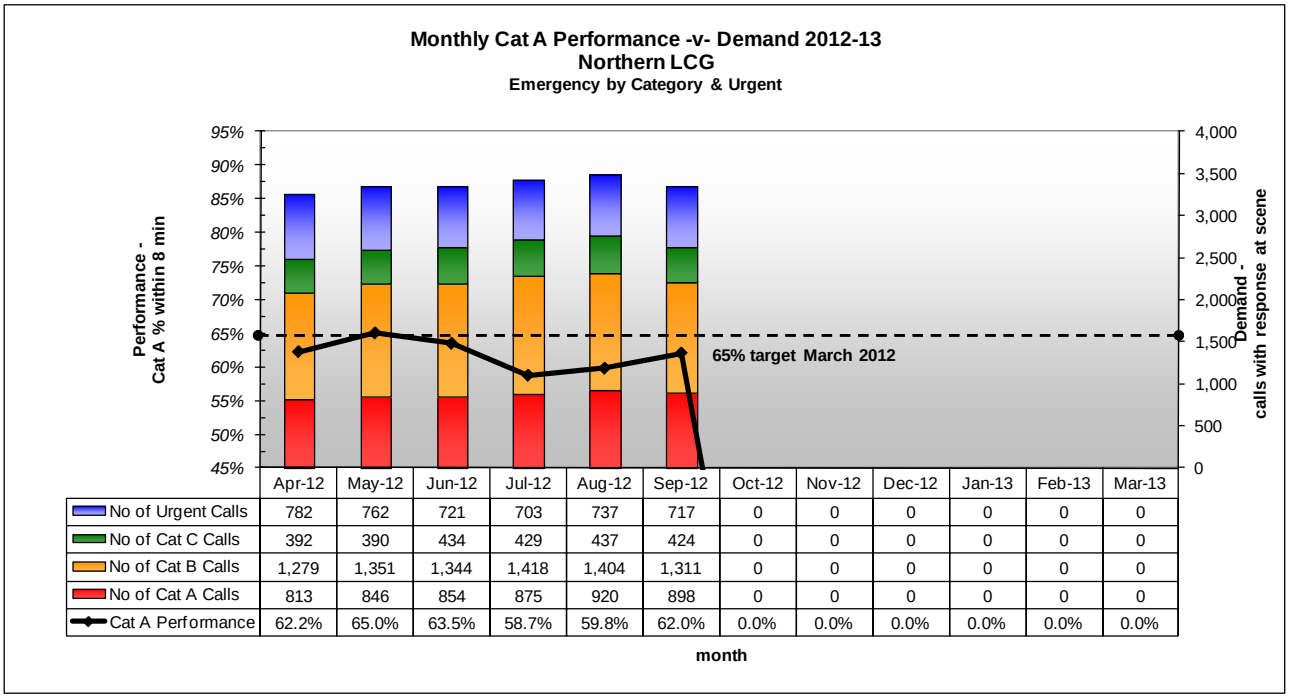
	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
No of Urgent Calls	951	1,148	836	803	723	727	0	0	0	0	0	0
No of Cat C Calls	493	534	474	563	557	588	0	0	0	0	0	0
No of Cat B Calls	1,320	1,415	1,233	1,265	1,391	1,317	0	0	0	0	0	0
No of Cat A Calls	1,020	1,165	1,110	1,078	1,087	1,120	0	0	0	0	0	0
Cat A Performance	85.7%	83.9%	85.4%	85.0%	81.7%	81.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

South Eastern Division



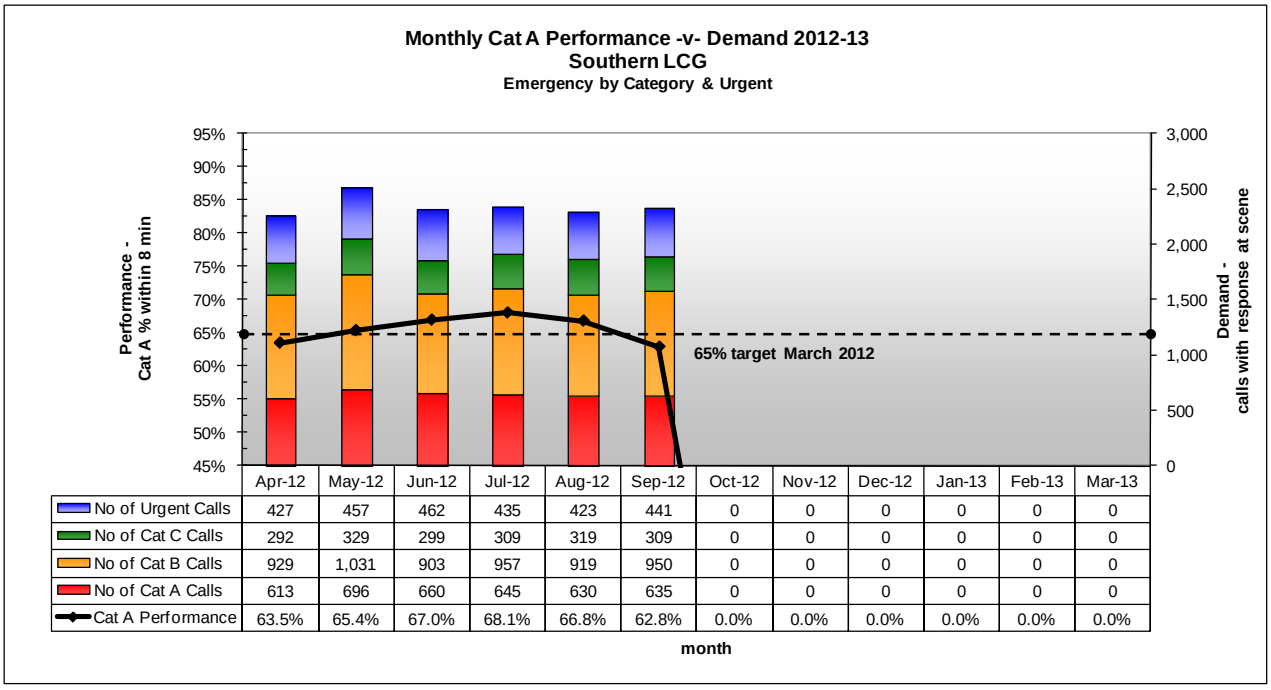
	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
No of Urgent Calls	519	566	480	500	504	519	0	0	0	0	0	0
No of Cat C Calls	356	352	396	354	349	336	0	0	0	0	0	0
No of Cat B Calls	988	958	946	1,037	1,064	1,076	0	0	0	0	0	0
No of Cat A Calls	674	699	688	652	717	685	0	0	0	0	0	0
Cat A Performance	63.4%	66.1%	64.4%	64.9%	62.1%	62.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Northern Division



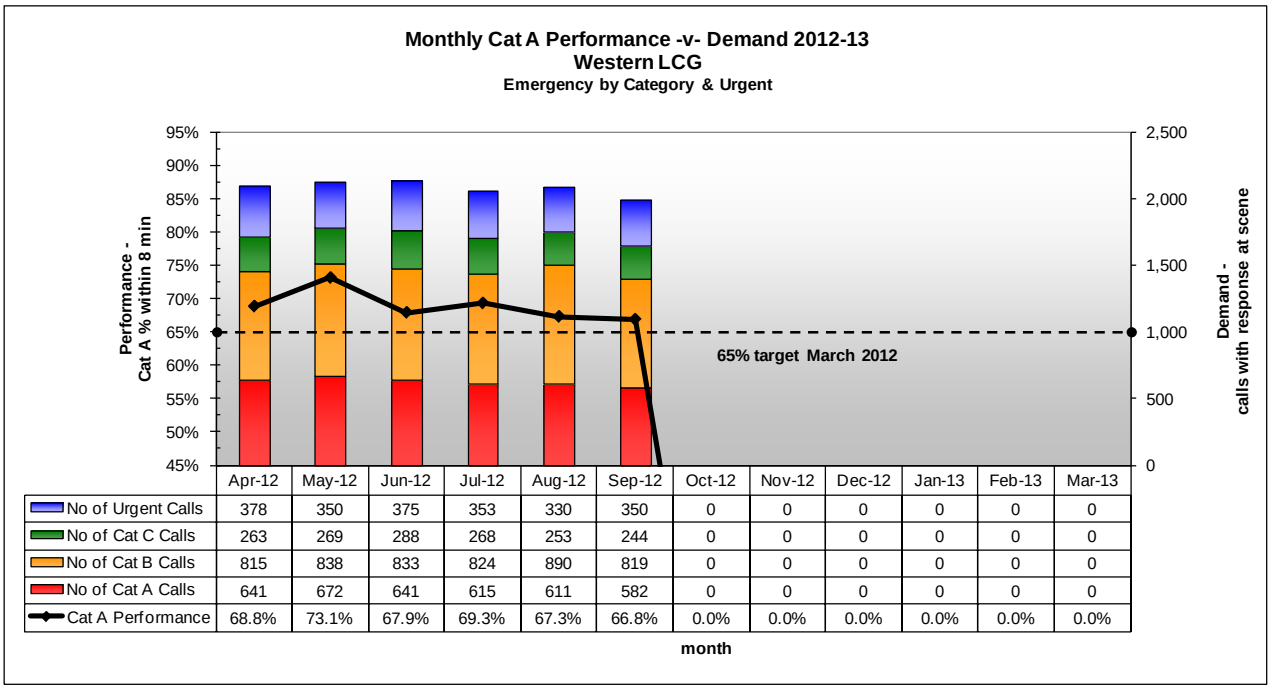
	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
No of Urgent Calls	782	762	721	703	737	717	0	0	0	0	0	0
No of Cat C Calls	392	390	434	429	437	424	0	0	0	0	0	0
No of Cat B Calls	1,279	1,351	1,344	1,418	1,404	1,311	0	0	0	0	0	0
No of Cat A Calls	813	846	854	875	920	898	0	0	0	0	0	0
Cat A Performance	62.2%	65.0%	63.5%	58.7%	59.8%	62.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Southern Division



	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
No of Urgent Calls	427	457	462	435	423	441	0	0	0	0	0	0
No of Cat C Calls	292	329	299	309	319	309	0	0	0	0	0	0
No of Cat B Calls	929	1,031	903	957	919	950	0	0	0	0	0	0
No of Cat A Calls	613	696	660	645	630	635	0	0	0	0	0	0
Cat A Performance	63.5%	65.4%	67.0%	68.1%	66.8%	62.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Western Division



	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
No of Urgent Calls	378	350	375	353	330	350	0	0	0	0	0	0
No of Cat C Calls	263	269	288	268	253	244	0	0	0	0	0	0
No of Cat B Calls	815	838	833	824	890	819	0	0	0	0	0	0
No of Cat A Calls	641	672	641	615	611	582	0	0	0	0	0	0
Cat A Performance	68.8%	73.1%	67.9%	69.3%	67.3%	66.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

month

SECURING THE INFRASTRUCTURE – FLEET ESTATE

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

Work has been continuing on these standards. Compliance should be achievable now that policies have been approved. Estate and Fleet Strategy are being drafted.

	Score in March 2012	RAG Rating	Rating (75% required)	Comment
Buildings & Land	80%		Substantive	2nd quarter review carried out Oct 2012
Environmental Mgt	88%		Substantive	2nd quarter review carried out Oct 2012
Fire Safety	93%		Substantive	2nd quarter review carried out Oct 2012
Fleet & Transport	83%		Substantive	2nd quarter review carried out Oct 2012
Security	85%		Substantive	2nd quarter review carried out Oct 2012
Waste Management	88%		Substantive	2nd quarter review carried out Oct 2012

Fleet

% Fleet Profile (less than 5 years old)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Emergency Ambulances	**64.3**	**64.3**	**65.2**	**68.7**	**73.9**	**73.9**						
Non-Emergency Ambulances	**84.8**	**88.6**	**90.5**	**91.4**	**93.3**	**93.3**						
Rapid Response Vehicles	**78.9**	**78.4**	**78.4**	**81.1**	**81.1**	**81.1**						
Support Vehicles	**55.8**	**48.1**	**48.1**	**46.2**	**50.0**	**50.0**						
PERFORMANCE COMMENTARY:												

IMPROVEMENT PROPOSALS FOR 2011/12

Six vehicles are still allocated towards training but are being commissioned as equipment is available.

IMPROVEMENT PROPOSALS FOR 2012/2013

First vehicle inspections at factories are scheduled for mid-November at WAS & MacNeilly and First vehicle inspection for PCS vehicles at Wilker is also due mid-November.

Replacement cars have yet to be ordered but evaluations are being carried out. New make and model will be included, in limited numbers, within this years' purchase.

ESTATE CAPITAL PROGRAMME

BALLYMENA:

Queries from DHSSPS have been responded to and the Business Case has been forwarded to DFP.

ENNISKILLEN:

Various discussions have been taking place between NIAS, Western Trust, Fermanagh District Council, HEIG and the Programme Management Unit. The long term future for NIAS has not been resolved on the Erne site although the potential has been discussed.

HEIG are currently working through re-evaluation of the options and potential location for NIAS on the western Trust site. Meetings have taken place in October with another meeting scheduled to take place late November to attempt to resolve the options for NIAS. Outline planning permission has been obtained for the proposed site on the Cornegrade Road in Enniskillen.

CRAIGAVON:

No further developments.

ARDS/BANGOR:

Outline planning permission awaited.

BELFAST:

No further sites identified.

RISK COMMENTARY

FLEET

The Business Case for the Replacement Programme 2013 – 2018 is to be prepared.

Continual investment within fleet has enabled the replacement programme to progress. The replacement cycle has remained relatively constant and the benefit is now becoming evident in the age profile for Emergency, Non-Emergency and Rapid Response Vehicles.

With the exception of RRV vehicles all sections of fleet have shown an improvement in the percentage of vehicles within standard.

ENNISKILLEN

The debate continues over viable options within the Erne site. Western Trust are to submit a business case for the demolition of the complete site to include moving NIAS into temporary premises. Moving into temporary premises on the Erne site without an assurance for the final solution for NIAS has the potential to cause further disruption to NIAS in the future if the site changes ownership and longer term plans are not realised.

ASSURANCE REPORT: FINANCE, INFORMATION & ICT DIRECTORATE

FINANCE

The Finance and ICT Directorate has responsibility for the provision of a full range of services to accommodate the provision of a safe and effective Ambulance Service. Financial systems are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. Very broadly, the Trust has a number of financial duties which it is required to achieve each year. These are as follows:

- to break even on its income and expenditure
- to meet the Capital Resource Limit which is the limit placed on net capital expenditure; and
- to meet the performance levels in respect of prompt payment of invoices.

Summary performance in each of these areas is as follows:

Objective Number	Objective Description	Assurance Assessment
1:	**Financial Breakeven**	**Amber – On Target to Achieve**
2:	**Control of Capital Expenditure**	**Amber**
3:	**Prompt Payment Duty**	**Amber**

CROSS-REFERENCE TO MINISTERIAL PRIORITIES AND/OR HSC BOARD COMMISSIONING PLANS

To achieve best outcomes for patients using all resources while ensuring high quality corporate governance, risk management and probity.

ASSESSMENT OF CONTROLS AND ASSURANCE CURRENTLY IN PLACE

A range of controls are in place which include a schedule of matters reserved for Board decisions, a scheme of delegation, standing orders and standing financial instructions. The system of internal financial controls is based on a framework of regular financial information, including comprehensive budgeting systems, regular review and reporting.

For 2011/12, the Trust has achieved substantive compliance in respect of the Financial Management Controls Assurance standard. Internal Audit has provided an opinion that there is a satisfactory system of internal control designed to meet the organisation's objectives. External audit has provided an unqualified financial and regularity opinion on the 2011/12 financial statements.

Ensure that the service lives within available resources	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Submission of Trust Delivery Plan (TDP)	A	G	G	G	G	G						
Approval of TDP by HSC Board	A	A	A	G	G	G						
Ongoing monitoring of expenditure, developments and pressures, through Trust Monitoring Returns, Reports to Trust Board and Budgetary Control.	A	A	A	A	A	A						
Secure confirmation of HSCB and DHSSPS support for developments and pressures, subsequent contract variations both in year and recurrently.	A	A	A	A	A	A						
Ongoing monitoring of capital expenditure and confirmation of HSCB and DHSSPS support for capital developments.	A	A	A	A	A	A						

IMPROVEMENT PROPOSALS FOR 2012/13

Ensure that the service lives within available resources	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Review and develop reporting of financial performance	A	A	A	A	A	A						
Review of Authorisation Frameworks	A	A	A	A	A	A						
Prepare NIAS for Business Service Transformation Programme changes.	A	A	A	A	A	A						
Review and develop procurement practice with Centres of Procurement Expertise (CoPE's) BSO Procurement and Logistics Service (PaLS) and Health Estates Investment Group (HEIG).	A	A	A	A	A	A						

Summary of Performance

Financial Breakeven Assessment (£k)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Staff Costs		7,812	11,775	15,712	19,674	23,601						
Other Expenditure		1,962	2,551	3,423	4,180	5,020						
Expenditure Total		9,774	14,326	19,135	23,854	28,621						
Income		285	465	619	783	924						
Net Expenditure		9,489	13,861	18,516	23,071	27,697						
Net Resource Outturn		9,489	13,861	18,516	23,071	27,697						
Revenue Resource Limit (RRL)		9,489	13,844	18,493	23,049	27,674						
Surplus/(Deficit) against RRL		0	(17)	(23)	(22)	(23)						

The Trust is reporting a small deficit of £23k at the end of September 2012 (Month 6). The Trust continues to forecast a breakeven position at year end, subject to and without prejudice, assumptions in relation to Agenda for Change, efficiency savings and investment. These assumptions are regularly discussed by HSC Board and NIAS and assessed on an ongoing basis to determine any issue which may significantly affect "break-even".

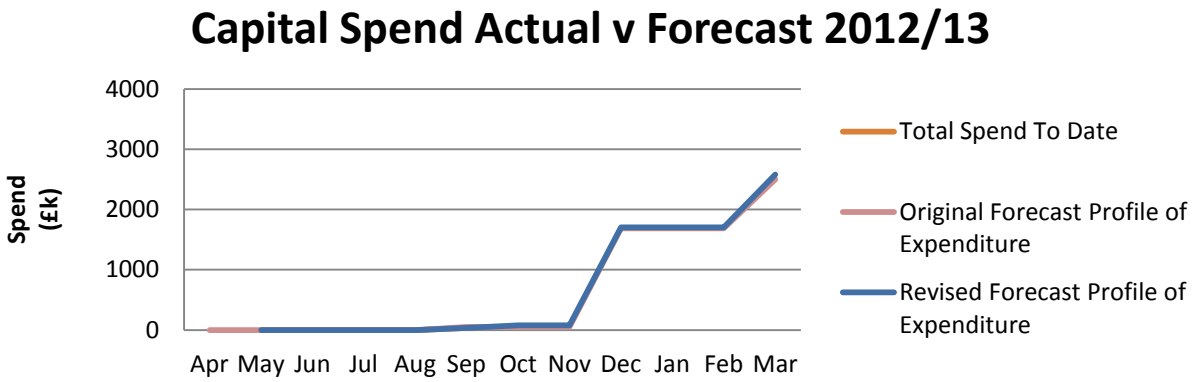
RISK COMMENTARY

There remain uncertainties in the current economic climate that may impact on the ability of the Trust to maintain financial balance.

Given additional pressures on public sector finances, NIAS will respond to any further requests for savings and identify the consequential impact on service delivery. As the final outcome of the Agenda for Change process remains uncertain, there remains a risk to financial breakeven and stability. Discussions with Commissioners to enable NIAS to provide support for changes in the provision of Health Services across Northern Ireland are ongoing.

Capital Spend Priority Areas (£k)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Fleet		0	0	0	0	0						
Estate		0	0	0	0	0						
Medical Equipment		0	0	0	0	0						
IT Equipment		0	0	0	0	0						
General Capital		0	0	0	0	35						
Total		0	0	0	0	35						
Original Forecast Profile of Expenditure		0	0	0	0	50	50	50	1,690	1,690	1,690	2,500
Revised Forecast Profile of Expenditure		0	0	0	0	35	77	77	1,702	1,702	1,702	2,582

Funds are allocated based on priorities identified in Trust plans such as NIAS's Corporate Plan, annual Trust Delivery Plan and supporting Capital Investment Plans. The current approved Capital Resource Limit (CRL) has been increased by £82k in respect of increased Access to Patient Care Data schemes and now stands at £2,582k (split between General capital of £300k, Fleet Replacement for 2012/13 of £2,200k and Improved Access £82k). The profile of spend for Improved Access to Patient Care Data schemes is included in the revised forecast profile of expenditure.



Asset Disposals (£k)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Proposed Disposals	0	0	0	0	47	14						
Actual Disposals	0	0	0	0	47	14						

Invoices paid within 30 days (%)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
In Month	97.1	90.8	92.0	89.4	93.7	95.6						
Cumulative	97.1	93.4	93.0	92.1	92.5	92.9						

Performance in respect of prompt payment of invoices within 30 days or other agreed terms remains a challenge for the Trust. The demands on staff, particularly in respect of the Business Services Transformation Programme continues to impact on performance in this area.

RISK COMMENTARY

Delays in the submission and approval of business cases and the estate planning process may place the capital expenditure programme at risk. Delivery is also subject to supplier capacity. The geography and management infrastructure of NIAS makes achievement of 95% of invoices paid within 30 days or other agreed terms a challenge.

KPI	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Average Processing Time Per Requisition Days (Target 5 Days)	4.37	2.89	2.04	4.05	9.39	4.77						
Percentage of Products Supplied on First Request % (Target 95%)	99.3	100.0	99.3	99.3	94.8	98.2						
Number of Lines Issued (Stock and Non Stock Line)	567	786	757	643	745	663						
Value of Spend £k (Stock and Non Stock)	148	205	87	1,926	579	156						

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. These will be reviewed as part of an enhanced assurance re procurement for Trust Board.

RISK COMMENTARY

The review and implementation of recommendations from a myriad of sources presents a challenge to a small management team.

INFORMATION & COMMUNICATIONS TECHNOLOGY (ICT)

The Finance and ICT Directorate has responsibility for the provision of a Trust wide integrated IT system responsive to business needs. An ICT Strategy was developed and approved by Trust Board in 2009. It is underpinned by six strategic themes.

An implementation plan was developed to identify how these strategic themes would be addressed over the following four years in NIAS. An assessment was carried out at 30 November 2011. Consideration has been given to the Trust's ability to achieve the elements of this implementation plan to be actioned by the end March 2013. The associated assurance against each of these themes is shown below using the legend.

Theme Number	Theme Description	Assurance Assessment
1:	Improving System Integration;	Amber – On Target to Achieve
2:	Enabling Improvement In Performance Management throughout NIAS using ICT	Amber
3:	Embedding an Information Governance Ethos in the Organisation;	Amber
4:	Enhancing ICT Skills and Knowledge across NIAS;	Amber
5:	Building an E-Information Culture; and	Amber
6:	Developing ICT Staff (dealt with at an operational level)	Amber

Themes 1-5 are explored in detail below with associated assurances and performance management framework.

STRATEGIC THEME 1: IMPROVE SYSTEM INTEGRATION

Enable a greater connectivity between the systems both within NIAS and with the wider HSC network.

STRATEGIC OBJECTIVES:

1. Create a single repository for data within the organisation.
2. Improve the availability of corporate information to users.
3. As part of a whole systems approach to the patient experience within the Health Service, NIAS will explore opportunities to integrate its own systems with those of the other HSC organisations.

ASSESSMENT OF CONTROLS AND ASSURANCE CURRENTLY IN PLACE

INTEGRATION – INTERNAL

Information and the systems which provide it are increasingly seen as integral to projects and work programmes across the Trust. As an example the reconfiguration of NIAS's control centres which identify, assign and manage vehicles and staff in response to patients' needs required a full programme of work to be delivered by the Finance and ICT directorate. A robust IT infrastructure has been developed in support of the business of NIAS. Such developments include the following:

Design and implementation of a full suite of NIAS command and control systems for A&E and PCS resources.

Installation, development and support of Geographical Information Systems; Mobile Data and Vehicle Location Systems; Status plan management for predictive analysis; Digital trunk radio; systems to provide on-line clinical advice to emergency callers; electronic patient monitoring etc.

Introduction of management information systems to analyse all aspects of patient interaction, patient movements pre-hospital; performance against operational and clinical indicators.

INTEGRATION – EXTERNAL

NIAS representatives are actively involved in collaborative forums such as:

Director of Finance & ICT member of:	HSC ICT Programme Board
	NIAS BSTP Programme Board
	BSTP Implementation Board
ICT Manager member of:	HSC ICT Leads Group

The Directorate works with HSC colleagues on a number of collaborative projects to integrate and make better use of existing systems. This enables NIAS to provide input to the HSC ICT Programme for procuring, developing and implementing new, integrated ICT infrastructure and systems for all HSC organisations. The Director of Finance and ICT is a member of the group which is responsible for implementing new HR and Finance systems across HSC. She also chairs the NIAS BSTP Programme Board to prepare NIAS for these new systems.

A framework is in place which provides assurances including the following:

CONTROLS ASSURANCE STANDARDS

For 2011/12 Information, Communications and Technology and Records Management standards were assessed and both met DHSSPS expected levels of compliance. For 2012/13 Controls Assurance Standards will be assessed across a range of areas including ICT. These will be reported to Trust Board, following examination by both Audit and Assurance Committees to provide a position for 2012/13 around June 2013.

INTERNAL AUDITS

Fully reviewed by Audit Committee

For 2012/13, as part of the midyear assurance process internal audit will examine any ICT recommendations outstanding from previous audits. These will be fully reviewed by Audit Committee.

IMPROVEMENT PROPOSALS

The ICT Strategy implementation plan identifies improvement proposals as priorities 1, 2 and 3. All improvement proposals set out above within this theme 1 are described as priorities 2 and 3 with priority 2 planned to be delivered in this financial year 2012/13. A summarised update of core work in this area is shown below.

SUMMARY OF PERFORMANCE

CORE WORK

SYSTEM AVAILABILITY

Robust procedures are in place to confirm ongoing availability of Trust systems. Any system failures are reported in this section.

There are no system failures to report in this period

System Security

Security (especially of NIAS's control room systems and associated information) is seen as a priority. Any known breaches are reported in this section.

There are no security breaches to report.

Strategic Theme 2: Enabling Improvement In Performance Management Through ICT

To support managers' access relevant Information for Performance Management purposes.
Strategic Objectives:

1. To enhance our ICT infrastructure to allow the organisation to access information to meet its performance management objectives
2. Enable access to real-time Information to allow proactive decision making
3. Provide relevant Information to external stakeholders

Assessment of Controls and Assurance Currently in Place

All elements of the patient's interaction with NIAS are captured in the information systems used by the staff responsible for patient care (primarily through the manual patient report form and voice recording system) and the control room (primarily through the command and control system). This information enables the Trust to identify by patient, by journey, the interventions made by front line staff.

The information team, led by the Director of Finance and ICT, compiles these statistics to help inform operational management about the deployment and effective use of resources. This is designed to assist with the matching of demand for services with available resources. A suite of reports has been designed to analyse performance against key operational targets on a daily / weekly / monthly basis. With the recent inclusion of clinical audit information there is an opportunity to extend this clinical database to provide more extensive management information.

Improvement Proposals

The ICT Strategy implementation plan identifies improvement proposals as priorities 1, 2 and 3. Only those identified as priority 2 are planned to be delivered in 2012/13 and are listed below after the Priority 1 re data library:

2.1 Create a data library to enable users to navigate to the relevant information
2.2 Enable access to real-time information to allow proactive decision making
2.3 Provide relevant information to external stakeholders

Summary of Performance

Performance is reported below against improvement proposals set out above and core work in this area.

IMPROVEMENT PROPOSALS

The first improvement proposal set out above which had been identified as priority 1 was planned to be delivered in 2011/12. An update on performance against this objective is shown below:

2.1 Create a data library to enable users to navigate to the relevant information

An information audit is currently under way within the Trust to identify software and bespoke systems which manage and capture levels of data. Once this has been completed this will enable the development of a data library. Information Asset Owners within each directorate area have been identified and are undergoing training which will support the process of the data library.

The other two improvement proposals set out above, identified as priority 2 are planned to be delivered in 2012/13. A general update on ongoing work in these areas is provided below.

CORE WORK

The Directorate manages the development, production and delivery of complex statistical and qualitative and quantitative reports on emergency and non-emergency corporate activity for Executive Directors, Senior Managers and external Health and Social Care Organisations. Proactive reporting occurs on a daily, weekly and monthly basis. This provides key information for strategic planning, decision making and statutory reporting requirements. This includes PfA monitoring of operational performance, hospital turnaround times, PCS contract monitoring, monitoring of acute service changes etc.

STRATEGIC THEME 3: EMBEDDING AN INFORMATION GOVERNANCE ETHOS IN THE ORGANISATION

Holding, obtaining, recording, using and sharing information – securely, lawfully and appropriately. Information Governance encompasses Data Protection, Freedom of Information, Environmental Information Regulations, Records Management and Information Security

Strategic Objectives

1. Promote a culture of corporate openness and transparency
2. Ensure the protection and use of personal identifiable information in compliance with legislation and guidance
3. Ensure that the organisation's information assets and resources are managed securely.
4. Improve systems and processes for the effective management of records.

ASSESSMENT OF CONTROLS AND ASSURANCE CURRENTLY IN PLACE

INTERNAL AUDITS

For 2012/13 as part of the midyear assurance process internal audit will examine any ICT recommendations outstanding from previous audits. These will be fully reviewed by Audit Committee.

Governance Structures

Assurance is also provided through a DHSSPS-wide framework of information governance roles and responsibilities as follows.

The Chief Executive as Accounting Officer has delegated the role of Senior Information Risk Officer (SIRO) to the Director of Finance and ICT. The SIRO acts as the champion for information risks to the Board and leads the information governance risk assessment and management processes within the Trust. This role has been supported by the appointment of Information Asset Owners (IAOs) across Directorate areas. IAOs role is to understand what information is held, what is added and what is removed, how information is moved, and who has access and why. As a result they are able to understand and address risks to the information, and ensure that information is fully used within the law for the public good, and provide written input to the SIRO annually on the security and use of information as a key corporate asset.

The Trust's Caldicott Guardian has been identified as the Medical Director who has responsibility for person identifiable patient information and transfers of that information to other bodies.

Any information governance risks, which may arise, will be recorded and actioned as part of the Trust's risk management process. Actions by the SIRO have been developed to minimise the occurrence of such information risks.

All contracts of employment clearly highlight responsibilities for staff in relation to information governance issues. Policies and procedures have been developed and disseminated to staff across the Trust.

Awareness sessions have informed staff of their roles and responsibilities in the area of processing, use, storage, dissemination and retention of all records in particular those which contain personal and sensitive ie staff and patient information. Such policies, procedures and information bulletins are available on the Trust's intranet, internet and form part of the induction process for new recruits or training programme for existing staff.

IMPROVEMENT PROPOSALS

The ICT Strategy implementation plan identifies improvement proposals as priorities 1, 2 and 3. Only those identified as priority 2 are planned to be delivered in 2012/13 and are listed below.

3.1.1 Develop and increase non-confidential information made available to the public
3.1.2 Establish and maintain policies, procedures and processes in compliance with current legislation and guidance.
3.4.1 Implement and review the corporate records management strategy
3.4.2 Ensure ongoing compliance with best practice standards
3.4.3 Establish and initiate a project to implement an Electronic Patient Report Form System.

SUMMARY OF PERFORMANCE

3.1.1 Work has been ongoing to develop provision of non-confidential information through both the Trust's website and the use of social media such as Facebook and Twitter.

Work continues to identify relevant information of public interest and the best means of disseminating such information.

STRATEGIC THEME 4: ENHANCING ICT SKILLS AND KNOWLEDGE

Promoting staff development and learning to improve the understanding of corporate policies and procedures in the use and access to information as well as ICT systems and applications
Strategic Objectives

1. Improve staff awareness of corporate policies and procedures in relation to access and use of information
2. Enhance staff skills and knowledge in the use of ICT systems and applications based on identified need

ASSESSMENT OF CONTROLS AND ASSURANCE CURRENTLY IN PLACE

As part of the implementation of core systems training and development needs in terms of ICT skills are considered.

A sample of staff is currently being reviewed to ascertain ICT skills in support of the introduction of the new HR and Finance systems.

IMPROVEMENT PROPOSALS

The ICT Strategy implementation plan identifies improvement proposals as priorities 1, 2 and 3. Only those identified as priority 2 are planned to be delivered in 2012/13. All improvement proposals set out above within this theme 4 are described as priorities 2 and 3.

SUMMARY OF PERFORMANCE

CORE WORK

New systems and upgrades of current systems are evaluated on the basis of business needs. Whilst the IT department implements and introduces new technologies, training needs are identified by Project Leads and end users in conjunction with the training department. Funds have been identified for ICT resources within the BSTP project for the implementation of these new systems and these positions were filled in August 2012. ICT Manager and newly appointed ICT Project Manager continue to fully participate in BSTP work programme.

STRATEGIC THEME 5: BUILDING AN E-INFORMATION CULTURE

Promotion and exploitation of web-based technologies to increase accessibility to systems, information and knowledge.

STRATEGIC OBJECTIVES

1. Maximise access to corporate and service information for the Trust's key stakeholders, and the public.

2. Improve and promote communication and minimise the distribution of paper based information for the organisation.

ASSESSMENT OF CONTROLS AND ASSURANCE CURRENTLY IN PLACE

The Trust has developed a range of policies and procedures to support the effective management of electronic records in line with legislation. This is assessed as part of the Controls Assurance Records Management Framework.

There are a number of browser based applications, which have recently been introduced by the Trust to replace paper-based systems. These are discussed elsewhere in this report and include the PCS web booking system.

The Information Audit in currently under way and will further explore the effective use of electronic and paper-based systems.

IMPROVEMENT PROPOSALS

The ICT Strategy implementation plan identifies improvement proposals as priorities 1, 2 and 3. Only those identified as priority 2 are planned to be delivered in 2012/13 and are listed below.

5.1 Develop a range of browser based applications for internal and external stakeholders

SUMMARY OF PERFORMANCE

IMPROVEMENT PROPOSALS

Those improvement proposals set out above which have been identified as priority 2 are planned to be delivered in 2012/13. They are detailed below where applicable.

5.1 Develop a range of browser based applications for internal and external stakeholders

The new BSTP systems are browser based applications hosted by the BSO. NIAS ICT network infrastructure will support the implementation and rollout of these systems to core staff initially (HQ) and to a management tier at station level for self service. The rollout of self service Trust wide will require an upgrade to the Trust's network infrastructure and increased desktop access at station level.

A review of the NIAS corporate internet site is currently being undertaken by the Trust's Communication Officer. In addition the Trust is currently using social networking tools, such as Twitter and Facebook to facilitate timely communication.

CORE WORK

Those improvement proposals set out below which have been identified as priority 2 are planned to be delivered in 2012/13. An update on performance against these objectives is shown below:

The IT Department has coordinated the development and implementation of a range of web-based applications for key stakeholders. These include the following:

- Non-Emergency Web Booking System – browser based system which allows Trusts to more effectively book non-emergency patient transport
- Hospital Arrivals System – browser based system which provides acute hospitals with information on impending arrivals to their A&E Departments.

NIAS continues to facilitate a browser based system to monitor service pressures, which allows the information to be shared internally and externally. This captures information provided by acute hospitals across N I in relation to emergency medical and surgical admissions, medical outliners, trolley waits, ICU/HDU/PICU beds.

The Trust has centralized information requests through the Director of Finance & ICT to ensure effective and timely management of same. All requests are processed in line with legislative requirements including the Freedom of Information Act 2000, Data Protection 1998, Access to Health Records (NI) Order 1993. This includes the processing of Freedom of Information Requests, Assembly Questions, DPA Subject Access Requests, PSNI enquiries, Coroner, Social Worker enquiries etc. There follows a summary of performance covering aspects of these requests.

Data Protection (Subject Access)	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Number of Requests Received	2	1	2	0	1	0						
Completed Requests processed within 40 days or less	0	1	1	0	1	0						
Completed Requests exceeding 40 days	2*	N/A	1*	N/A	N/A	N/A						

* Requests were not processed further as awaiting documentation to confirm identity.

Freedom of information	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Number of Requests Received	2	9*	4	6	7	7						
Completed Requests processed within 20 days or less	2	7	4	5	6	7						
Completed Requests exceeding 20 days	0	1	0	1	1	0						
Number of Records Fully Disclosed	2	6	3	4	6	7						
Vexatious Requests	0	0	0	0	0	0						
Number of Records for which records not held	0	3	1	1	1	0						
Requests where exemptions wholly/partially applied	0	2	0	1	0	0						
Referrals for Independent Review	0	0	0	0	0	0						
Appeals to the Information Commissioner	0	0	0	0	0	0						

DHSSPS/AQ's/CORs/TOF's/INV's	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Assembly Questions (Oral)	0	2	0	0	0	0						
Assembly Questions (Written)	7	8	7	0	0	7						
CORs Received	0	1	0	1	2	0						
TOFs Received	0	0	0	0	0	0						
INVs Received	0	0	0	0	0	1						

*Please note that Stormont was in summer recess during the period July/August 2012

ASSURANCE REPORT: HUMAN RESOURCES AND CORPORATE SERVICES DIRECTORATE

EXECUTIVE SUMMARY

The Trust continues to work to ensure Complaints, Disciplinary, Grievance and Harassment issues are managed within Trust Policies & Procedures and the legislative frameworks surrounding these. During this reporting period, work also remained ongoing on reviewing practice and procedures regarding the management of litigation and claims.

The Trust has developed a Health & Wellbeing and Attendance Management Action Plan (2012/13) to support implementation of the Trust's Health & Wellbeing Strategy (2010-2015). This Strategy and Action Plan outlines the Trust's commitment to promoting the health and wellbeing of its staff.

The Trust remains committed to prioritising the management of sickness absence in line with the Regional Framework for Management of Sickness Absence, DHSSPS Circulars and best practice principles. Stringent performance management mechanisms are in place throughout the organisation to assist ongoing efforts to reduce absence to meet the NIAS Absence Management improvement target together with robust Trust Policies & Procedures. The Trust continues to monitor the cost of sickness absence and to benchmark absence levels with other HSC employers, NHS Ambulance Trusts and comparable Occupational Groups.

Industrial Relations during this reporting period continue to represent a challenge and work remains ongoing to finalise the review of the Trust's Trade Union Recognition Agreement, and the review of structures for engagement with Trade Unions.

Work continues on BTSP, with NIAS participation in regional structures to support its introduction. Work will continue throughout the reporting year on the implementation of BSTP within NIAS. The implementation of BSTP systems within NIAS will present significant challenges, particularly in terms of the significant resource implications on the HR & CS Directorate.

The Trust currently has 3 jobs (Paramedics, RRV Paramedics and Emergency Medical Technicians) paid on account without prejudice on Agenda for Change pay bands, while awaiting the outcome of the full Job Evaluation (JE) process.

Trust Board have requested an indicative timeline to complete the JE process for the 3 jobs. The Trust's JE Leads have advised that the NHS Job Evaluation Handbook remains silent with regard to timescales for completion of each element of the process, up to final agreed outcome and post-holder's notified of outcome, and are therefore of the opinion that it is not within their gift to stipulate an anticipated target date for completion. Following a request for an opinion from the DHSSPSNI in this regard, the DHSSPSNI have stated "The Department takes the view that Agenda for Change should be implemented as quickly as practicable. However, it also recognises that the partnership approach has the impact of slowing processes and hinders target setting and achievements of those targets".

In addition, it should be noted that the Regional Joint Negotiating Forum (JNF) Agenda for Change Sub-Group, at their request, receive regular updates on the progression of these particular job evaluations.

The JE panel appointed to carry out the evaluation of all 3 jobs have met over a period of 16 days between November 2010 and August 2012. The panel were unable to conclude the process and get to an agreed outcome. The NIAS JE leads sought Regional advice in an attempt to move the process forward, however, they also were unable to agree a way forward.

Accordingly, the Director of Human Resources and Corporate Services wrote to the Regional Joint Chairs of the Joint Negotiating Committee to request that they move the 3 related NIAS posts to the next stage of the process, ie, to the Blocked Protocol as specified in Section 15 of the Job Evaluation Handbook. In response to advice received from the Joint Chairs, the Trust has referred the matter to the Regional Quality Assurance (RQA) Team for their opinion. The Trust awaits the outcome of the RQA Team's considerations in order to move the process forward.

The Regional Ambulance Training Centre's 2012-2013 Education, Learning and Development Plan (ELDP) has been developed following engagement with key stakeholders at monthly Training Performance, Progress and Accountability meetings and has been ratified by SEMT. The ELDP sets out and facilitates the priority clinical and non-clinical education, learning and development requirements of the Trust staff within the RATC's remit for the training year 2012-2013. The ELDP does not include the education, learning and development requirements of Emergency and Non-Emergency Ambulance Control, Emergency Planning and Hazardous Area Response Teams (HART) as they fall within the remit of the Operations and Medical Directorates respectively.

ENGAGING WITH THE PUBLIC TO APPRECIATE, LEARN FROM AND IMPROVE THE PATIENT EXPERIENCE

The Trust continues to work to mainstream compliance with statutory duties under Section 75 of the Northern Ireland Act, Personal and Public Involvement within the HSC Reform Act and the Human Rights Act. In particular the Trust continues to engage with key stakeholders in the delivery of this agenda.

Having secured Equality Commission of Northern Ireland approval for its revised Equality Scheme, NIAS is now working to implement the Scheme and associated action plan alongside implementing its Disability Action Plan.

In respect of Communication the Trust has produced a Communications Strategy Action Plan in order to ensure implementation of the commitments set out within its Communications Strategy.

WORKFORCE

Continually developing and delivering a regional ambulance service for the people of Northern Ireland requires significant effort and presents unique challenges and opportunities for HR management in delivering safe patient care through the provision of committed, professional and dedicated staff working for the benefit of service users.

The strategic aims in relation to the workforce are outlined below (points 1-6) and are reflected in the NIAS HR Strategy 2011-16, which takes account of Ministerial priorities, HSC Commissioning Plans and NIAS Corporate Plan.

The HR Strategy will be operating during a period of key challenges that include reduced finances; increasing public expectation regarding service delivery; structural reform and service modernisation; reduced job security in public sector organisations, maintaining skills and motivation during a period of public sector workforce reduction; the need for leadership in reorganisation and change; developing and maintaining high quality employment practice; supporting employees and maintaining NIAS as an employer of choice.

The HR vision is to develop NIAS as an organisation that is more adaptive and more able to embrace change with a real focus on patient care and safety, service modernisation and reform, clinical excellence and fair and ethical employment practices. It will enhance the Trust's leadership and management capacity and capability to support, empower, and lead staff in the achievement of NIAS strategic aims, and will ensure NIAS influences and shapes professional HR management practice in the wider healthcare environment.

ASSESSMENT OF CONTROLS AND ASSURANCE CURRENTLY IN PLACE

Robust performance management and assurance structures are in place. These include regular performance and accountability meetings to review progress and risks. HR Controls Assurance standards achieved substantive compliance. Health and Safety Controls Assurance achieved substantive compliance. External validation is also provided through:

STATUTORY RETURNS

Fair Employment Commission (FEC) Annual Return (employment practices)

Article 55 3-year review (employment practices)

Section 75 Annual Report (Equality Scheme – service delivery, patient care and staff focus)

Disability Discrimination Order Annual Report (implementation of Disability Duties)

Revised Equality Scheme Annual Report (service delivery, patient care and staff focus)

HEALTH AND CARE PROFESSIONS COUNCIL (HCPC) ANNUAL RE-APPROVAL

Annual external verification (HCPC approved Paramedic in Training Programme)

EDEXCEL

Annual quality review (Training School practice, policies and procedures)

Annual external verification (clinical education and ambulance driver training and assessment)

RQIA REPORT

IMPROVEMENT PROPOSALS FOR 2012/13

The strategic aims are outlined in points 1-6 and are reflected in NIAS HR Strategy 2011-16, which takes account of Ministerial priorities, HSC Commissioning Plans and NIAS Corporate Plan (2011-14). A performance commentary is outlined under each Strategic Aim with a corresponding assessment of performance.

1. SUPPORTING TRUST PRIORITIES (AS REFLECTED IN THE CORPORATE PLAN 2011-14):

- *to deliver high-quality services to users and carers which are timely, accessible, appropriate and cost effective;*
- *to provide safe services to users and carers which prevent or reduce the risk of harm to staff, and create an appropriate care environment;*
- *to secure and deploy resources to achieve best outcomes;*
- *to ensure high quality corporate governance, probity and assurance;*
- *to build and maintain a high-performing and appropriately skilled and educated workforce;*
- *to work in partnership with other agencies and local communities to support them in influencing the shape of services and responses to issues that affect their health*

PERFORMANCE COMMENTARY

The HR & Corporate Services Directorate continues to support Trust Priorities (detailed above) as reflected in the Corporate Plan (2011-14). In delivering against its statutory requirements the HR & Corporate Services Directorate contributes to the delivery of high quality, safe, clinical services to users and carers (to include working in partnership with other agencies and local communities to support them in influencing the shape of services) and providing a safe working environment for staff (to include working with recognised Trade Unions within the Trust's Industrial Relations Structures).

Legend for Performance Reporting: *Green(G) = Fully Achieved: Green-Amber(GA) = Substantially Achieved: Amber(A)= On Target to Achieve; Amber-Red(AR)Under-Achieving - Monitoring Required : Red(R) Failing to Achieve – Action Required*

	Ensure Statutory Compliance												
1.1	***MEES and TYC/QICR***												
EXCEPTION REPORT:													
		Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
1.1.1	Support Trust in adhering to statutory duty in relation to Equality Screening	G	G	G	G	G	G						
1.1.2	Support Trust in adhering to statutory duty in relation to EQIA and public consultation	G	G	G	G	G	G						
1.1.3	Support Trust in adhering to statutory duty in relation to Section 75 monitoring	G	G	G	G	G	G						
1.1.4	Support Trust in adhering to statutory duty in relation to management of industrial relations/employee relations	G	G	G	G	G	G						
1.1.5	Implement and monitor NIAS Equality Scheme Action Plan	G	G	G	G	G	G						
1.1.6	Support NIAS PPI Lead and related workstreams in ensuring Trust compliance with statutory requirements under PPI agenda	G	G	G	G	G	G						

1.1.7	Complete & Submit Fair Employment & Treatment Order Statutory Annual Report	G	G	G	G	G	G						
1.1.8	Implement and monitor Disability Action Plan	G	G	G	G	G	G						
1.1.9	Complete & Submit Section 75 and Disability Duties Annual Progress Report	G	G	G	G	G	G						
1.1.10	Health and Safety	G	G	G	G	G	G						

1.2 Ensure HR and CS practice supports NIAS 2012-2013 QICR Plan, *TYC/QICR*

EXCEPTION REPORT (1.2.1 - 1.2.6): DRAFT TRUST DELIVERY PLAN SUBMITTED TO HSC BOARD FOR APPROVAL.

		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
1.2.1	Contribute to the development of an Action Plan	--	--	--	--	--	--						
1.2.2	Support the Trust in the public consultation and related work streams	--	--	--	--	--	--						
1.2.3	Support the Trust in managing the organisational change and any resultant industrial/employee relations elements	--	--	--	--	--	--						
1.2.4	Develop and implement Recruitment & Selection Plan to support the reform programme	--	--	--	--	--	--						
1.2.5	Develop and implement Education Learning & Development Plan to support the reform programme	--	--	--	--	--	--						
1.2.6	Develop and implement appropriate communication and media management plans	--	--	--	--	--	--						

1.3 To develop, agree, implement and/or finalise priority action plans for the Trust for 2012/2013 *MEES*

EXCEPTION REPORT (1.3.5): ON TARGET FOR ACHIEVEMENT. PLANS IN PLACE TO FINALISE WORK AND SUBMIT TO SEMT FOR APPROVAL IN OCT 2012

		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
1.3.1	Finalise and implement KSF Action Plan	GA	GA	GA	GA	G	G						
1.3.2	Develop and implement Communication Strategy Action Plan	G	G	G	G	G	G						
1.3.3	Develop and implement Corporate Social Responsibility Action Plan	GA	GA	GA	GA	GA	GA						
1.3.4	Develop and implement Community Education Action Plan	GA	GA	GA	GA	GA	GA						
1.3.5	Develop and implement an action plan around Claims Management to include production of recommendations for improvement and learning	A	A	A	A	A	A						

1.3.6	Develop and implement an action plan around Complaints Management to include production of recommendations for improvement and learning.	GA	GA	GA	GA	GA	GA						

2. MODERNISATION AND REFORM

- *to deliver high-quality services to users and carers which are timely, accessible, appropriate and cost effective;*
- *to provide safe services to users and carers which prevent or reduce the risk of harm to staff, and create an appropriate care environment;*
- *to secure and deploy resources to achieve best outcomes;*
- *to ensure high quality corporate governance, probity and assurance;*
- *to build and maintain a high-performing and appropriately skilled and educated workforce;*
- *to work in partnership with other agencies and local communities to support them in influencing the shape of services and responses to issues that affect their health*

PERFORMANCE COMMENTARY

The HR & Corporate Services Directorate continues to support Trust Priorities (detailed above) as reflected in the Corporate Plan (2011-14) by delivering against its modernisation & reform agenda. Work continues on BSTP, with NIAS participation in regional structures to support its introduction. Work will continue throughout the reporting year on the implementation of BSTP within NIAS. The implementation of BSTP systems within NIAS will present significant challenges, particularly in terms of the significant resource implications on the HR Department and the significantly ambitious timeframe of the Project.

2.1	**Manage implementation of BSTP as it relates to NIAS** ***MEES***												
EXCEPTION REPORT: RESOURCE IMPLICATIONS OF BSTP ON THE HUMAN RESOURCES DEPARTMENT REMAIN SIGNIFICANT. RISK TO MAINTAINING CORE BUSINESS HAS BEEN REFLECTED IN THE TRUST'S CORPORATE RISK REGISTER AND HUMAN RESOURCES & CORPORATE SERVICES DIRECTORATE LOCAL RISK REGISTER													
		Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
2.1.1	Participate on Regional BSTP Structures e.g. Regional BSTP Implementation Board, Regional Shared Services Implementation Board, Regional Forum for Engagement with Trade Unions and related regional work streams.	G	G	G	G	G	G						
2.1.2	Identify NIAS specific issues and highlight to regional structures as appropriate	G	G	G	G	G	G						
2.1.3	Agree and implement related action plans for implementation of BSTP Shared Services within NIAS	G	G	G	G	G	G						

2.1.4	Agree and implement related action plans for implementation of BSTP HRPTS Systems within NIAS	G	G	G	G	G	G						

3. SHAPING AND DEVELOPING THE FUTURE WORKFORCE

- *to build and maintain a high-performing and appropriately skilled and educated workforce;*

PERFORMANCE COMMENTARY

The HR & Corporate Services Directorate continue to support the Trust Priority of building and maintaining a high performing skilled and educated workforce as reflected in the Corporate Plan (2011-14) by delivering Workforce Strategies/Action Plans and in the delivery of Education, Learning and Development Plans. In addition work continues at a national and regional level to ensure education and learning developments meet NIAS requirements.

3.1	**To develop and implement effective workforce strategies and plans to provide safe patient care *MEES and TYC/QICR***												
EXCEPTION REPORT: -													
		Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
3.1.1	Agree priority workforce strategies and plans for 2012-2013	G	G	G	G	G	G						
3.1.2	Ensure workforce planning and strategy monitors and predicts workforce dynamics that match supply of labour to the Service demand and priorities	G	G	G	G	G	G						
3.1.3	Ensure workforce information is accurate and timely to aid strategic decision making	G	G	G	G	G	G						
3.1.4	Support the Trust in implementing the agreed strategies and plans in relation to the HR&CS elements	G	G	G	G	G	G						

3.2	**To scope and shape the educational environment for NIAS staff, *MEES***												
EXCEPTION REPORT:													
		Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
3.2.1	Engage at National level in relation to ambulance education and ensure related developments meet NIAS requirements	G	G	G	G	G	G						
3.2.2	Engage nationally and regionally in relation to all other aspects of education, learning and development for NIAS staff and ensure related developments meet NIAS requirements	G	G	G	G	G	G						

4. SUPPORTING STAFF TO ACHIEVE HIGH QUALITY PERFORMANCE

- *to deliver high-quality services to users and carers which are timely, accessible, appropriate and cost effective;*
- *to provide safe services to users and carers which prevent or reduce the risk of harm to staff, and create an appropriate care environment;*
- *to secure and deploy resources to achieve best outcomes;*
- *to ensure high quality corporate governance, probity and assurance;*
- *to build and maintain a high-performing and appropriately skilled and educated workforce;*
- *to work in partnership with other agencies and local communities to support them in influencing the shape of services and responses to issues that affect their health*

PERFORMANCE COMMENTARY

The HR & Corporate Services Directorate continues to support Trust Priorities (detailed above) as reflected in the Corporate Plan (2011-14). In supporting the delivery of the Trust's Strategic aims, and in the absence of a PFA target, NIAS has identified its own Absence Management Performance Indicator. The target set for NIAS is an absence level of 6.7%. The development and implementation of a Health & Wellbeing and Attendance Management Action Plan 2012/13 will support the delivery of the absence target and the Trust's Health & Wellbeing Strategy (2010-15).

4.1	**Develop, agree and report on a Health and Well Being and Attendance Management Action Plan for 2012-13** ***MEES***												
EXCEPTION REPORT:													
		Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
4.1.1	Review performance improvement plans and bench mark good practice for inclusion in action plan	GA	GA	GA	G	G	G						
4.1.2	Agree action plan at SEMT	GA	GA	GA	G	G	G						
4.1.3	Ratify Action Plan at Trust Board	GA	GA	GA	G	G	G						

4.2	Develop, prioritise, agree and implement 2012-13 NIAS Education Learning and Development (ELD) Plan ***MEES***												
EXCEPTION REPORT: -													
		Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
4.2.1	Engage with key stakeholders in relation to the priority ELD requirements in the plan.	G	G	G	G	G	G						
4.2.2	Agree Plan at SEMT	G	G	G	G	G	G						
4.2.3	Present Plan to Assurance Committee and report compliance	N/A	G	G	G	G	G						
4.2.4	Implement ELD Plan	G	G	G	G	G	G						

5. EQUALITY AND HUMAN RIGHTS

- *to deliver high-quality services to users and carers which are timely, accessible, appropriate and cost effective;*
- *to provide safe services to users and carers which prevent or reduce the risk of harm to staff, and create an appropriate care environment;*
- *to secure and deploy resources to achieve best outcomes;*
- *to ensure high quality corporate governance, probity and assurance;*
- *to build and maintain a high-performing and appropriately skilled and educated workforce;*
- *to work in partnership with other agencies and local communities to support them in influencing the shape of services and responses to issues that affect their health*

PERFORMANCE COMMENTARY

The HR & Corporate Services Directorate continues to support Trust Priorities (detailed above) as reflected in the Corporate Plan (2011-14). The Trust continues to contribute to regional workstreams and the development of a Regional HSC Equality Action Plan. In addition work continues in the mainstreaming of Equality and Human Rights mechanisms in policy development and decision making with training for managers remaining a priority.

5.1	**Support the Trust in the mainstreaming of Equality and Human Rights Agenda *MEES***												
EXCEPTION REPORT: -													
		Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
5.1.1	Review and update research and data to inform Audit of Inequalities	G	G	G	G	G	G						
5.1.2	Implement and monitor NIAS Equality Scheme Action Plan	G	G	G	G	G	G						
5.1.3	Engage in regional work streams and contribute to the implementation and monitoring of HSC Regional Equality Action Plan	G	G	G	G	G	G						
5.1.4	Support the Trust in mainstreaming Equality and Human Rights mechanisms in policy development and decision making	G	G	G	G	G	G						

6.0 PARTNERSHIP AND EMPLOYEE ENGAGEMENT

- *to deliver high-quality services to users and carers which are timely, accessible, appropriate and cost effective;*
- *to provide safe services to users and carers which prevent or reduce the risk of harm to staff, and create an appropriate care environment;*
- *to secure and deploy resources to achieve best outcomes;*
- *to ensure high quality corporate governance, probity and assurance;*
- *to build and maintain a high-performing and appropriately skilled and educated workforce;*

PERFORMANCE COMMENTARY

The HR & Corporate Services Directorate continues to support Trust Priorities (detailed above) as reflected in the Corporate Plan (2011-14) by ensuring effective industrial relations structures are in place. Industrial Relations within the Trust continue to present a challenge.

6.1	**Ensure appropriate Industrial Relations systems and mechanisms are in place for engagement with managers, staff and trade unions to assist in the delivery of Trust priorities *MEES and TYC/QICR***												
EXCEPTION REPORT (6.1.1): ON TARGET FOR ACHIEVEMENT. WORK CONTINUES WITH TRADE UNIONS VIA THE TRUST'S JOINT CONSULTATIVE AND NEGOTIATING COMMITTEE (JCNC) TO FINALISE THE REVIEW OF CURRENT INDUSTRIAL RELATIONS STRUCTURES													
		Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
6.1.1	Engage with trade unions to review existing structures and make recommendations for improvements	A	A	GA	GA	GA	GA						
6.1.2	Engage in regional HSC Industrial Relations structures and contribute to delivering the priority workstreams	G	G	G	G	G	G						

NIAS RESPONSES TO CONSULTATIONS

Date of Response	Consultation Title & Summary	Summary of NIAS Response	Link to Consultation
25 Sept 12	HSC Board – Strategic Framework for the provision of GP Out of Hours Services	NIAS supports measures to simplify access to healthcare and improve alignment with other healthcare services. Strategic Framework needs to recognise the Transforming Your Care context and ensure consistency with the implementation of TYC.	http://www.hscboard.hscni.net/consult/25-06-2012%20-%20Strategic%20Framework%20for%20GP%20Out-of-Hours%20-%20PDF%20456KB.pdf

PERFORMANCE INFORMATION STATISTICAL ANNEX

ATTENDANCE MANAGEMENT ABSENCE STATISTICS

TOTAL YEAR TO DATE ABSENCE 2012/13 = 6.58 % ABSENCE TARGET 2012/13 = 6.7%							2011/12 ABSENCE = 7.18%					
Attendance Management	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
OPERATIONS DIRECTORATE % ABSENTEEISM				**HEADCOUNT: 1035**								
Target absenteeism 2012/13	6.7	6.7	6.7	6.7	6.7	6.7	6.7	6.7	6.7	6.7	6.7	6.7
Monthly absence (%)	7.32	7.06	7.55	6.79	7.28	6.90						
Cumulative absence (%)	7.32	7.12	7.19	7.09	7.20	7.15						
No. of employees on half pay	9	13	12	11	7	7						
No. of employees on no pay	2	2	2	4	4	6						
MEDICAL DIRECTORATE % ABSENTEEISM				**HEADCOUNT: 7**								
Target absenteeism 2012/13	6.7	6.7	6.7	6.7	6.7	6.7	6.7	6.7	6.7	6.7	6.7	6.7
Monthly absence (%)	14.97	14.29	4.76	0	0	0						
Cumulative absence (%)	14.97	14.45	11.21	8.08	6.32	5.21						
No. of employees on half pay	0	0	0	0	0	0						
No. of employees on no pay	0	0	0	0	0	0						
FINANCE & ICT DIRECTORATE % ABSENTEEISM				**HEADCOUNT: 27**								
Target absenteeism 2012/13	6.7	6.7	6.7	6.7	6.7	6.7	6.7	6.7	6.7	6.7	6.7	6.7
Monthly absence (%)	0.18	0	0.07	0.16	0.17	0.00						
Cumulative absence (%)	0.18	0.09	0.08	0.10	0.11	0.10						
No. of employees on half pay	0	0	0	0	0	0						
No. of employees on no pay	0	0	0	0	0	0						
HUMAN RESOURCES AND CORPORATE SERVICES DIRECTORATE % ABSENTEEISM				**HEADCOUNT: 70**								
Target absenteeism 2012/13	6.7	6.7	6.7	6.7	6.7	6.7	6.7	6.7	6.7	6.7	6.7	6.7
Monthly absence (%)	3.31	2.89	0.82	0.72	0.41	4.05						
Cumulative absence (%)	3.31	3.06	2.29	1.89	1.59	1.99						
No. of employees on half pay	0	0	0	0	0	0						
No. of employees on no pay	0	0	0	0	0	0						

NIAS % ABSENTEEISM	HEADCOUNT: 1139											
Absence Target 12/13 (6.7%)	**6.7**	**6.7**	**6.7**	**6.7**	**6.7**	**6.7**	**6.7**	**6.7**	**6.7**	**6.7**	**6.7**	**6.7**
% short term absence	3.13	2.86	3.03	3.32	2.77	1.82						
% long term absence	3.69	3.83	3.78	2.79	3.84	3.48						
No. of employees on half pay	9	13	12	11	7	7						
No. of employees on no pay	2	2	2	4	4	6						
Monthly absence (%) 12/13	6.82	6.69	6.81	6.11	6.61	6.24						
Cumulative absence (%) 12/13	6.82	6.74	6.74	6.58	6.73	6.58						
Performance Assessment	A	A	A	G	A	G						
Estimated Cumulative Cost of absence* (£'000)	262.3	519.9	793.7	1,033.9	1,325	1,553						
% absence 11/12 (monthly)	5.84	6.21	6.03	6.64	5.89	6.69	7.02	7.33	8.60	8.22	7.82	7.78
% absence 11/12 (cumulative)	5.84	6.12	5.97	6.22	6.14	6.31	6.42	6.53	6.85	7.02	7.11	7.18

*Absence costs have been estimated by expressing the % absence figure as a % of the total staff costs within the Trust. As such, this figure is a broad approximation of the cost of absence.

Commentary:

ABSENCE COMPARISON WITH NHS AMBULANCE TRUSTS
(Comparison of Absence Statistics (%)* Across English Ambulance Services and NIAS Apr 11 – Mar 12)

NHS TRUST	Apr 11	May 11	Jun 11	Jul 11	Aug 11	Sep 11	Oct 11	Nov 11	Dec 11	Jan 12	Feb 12	Mar 12
North East Ambulance Service	5.07	4.92	4.89	5.60	5.54	5.56	5.98	6.51	6.35	6.88	6.63	6.33
North West Ambulance Service	5.17	5.43	5.59	5.51	6.11	5.79	5.99	6.17	6.25	5.53	6.02	5.24
Yorkshire Ambulance Service	5.38	5.01	4.99	5.56	5.50	5.46	5.64	6.60	6.74	6.24	6.39	6.44
East Midlands Ambulance Service	6.65	6.17	6.69	6.89	7.08	7.11	7.32	6.70	6.69	6.51	6.56	6.35
West Midlands Ambulance Service	4.16	3.94	4.17	4.74	5.10	5.71	5.84	5.77	5.86	5.90	5.54	4.95
East of England Ambulance Service	6.42	5.96	5.75	5.59	6.06	6.14	6.28	6.72	7.41	7.34	7.45	6.63
London Ambulance Service	5.23	5.09	5.07	5.35	5.10	4.93	5.14	5.07	6.00	6.02	5.70	5.18
South East Coast Ambulance Service	5.23	5.74	5.72	5.75	5.72	5.26	6.21	6.46	6.23	5.82	5.49	5.72
South Central Ambulance Service	5.40	5.30	5.51	4.99	5.49	5.69	5.87	6.48	7.56	6.80	6.23	5.86
Great Western Ambulance Service	5.40	4.24	4.75	4.73	4.31	4.94	5.81	5.57	6.45	5.73	5.28	4.55
South Western Ambulance Service	4.92	4.87	5.33	5.69	5.85	5.20	5.11	4.92	5.56	5.70	5.18	4.63
NI Ambulance Service Trust	**6.87**	**6.12**	**5.97**	**6.22**	**6.14**	**6.31**	**6.42**	**6.53**	**6.85**	**7.02**	**7.11**	**7.18**

*Source - The Information Centre for Health and Social Care

Commentary:

COMPARATIVE ANALYSIS OF % ABSENCE REDUCTIONS

BETWEEN NIAS AND REGIONAL HSC TRUSTS

REPORTING PERIOD	2009/10		2010/11		2011/12		2012/13
ABSENCE TARGET	DHSSPS PFA Target 5.5%		DHSSPS PFA Target 5.2%		NIAS Target 6.85%		NIAS Target 6.7%
	% Absence (2009/10)	% Variance (2008/09)	% Absence (2010/11)	% Variance (2009/10)	% Absence (2011/12)	% Variance (2010/11)	% Absence (to date)
REGIONAL HSC TRUSTS	5.49%	**-2.8%**	5.46%	**-0.55%**	N/A*	TBC	N/A*
NI AMBULANCE SERVICE TRUST	6.72%	**-3.9%**	6.87%	**+2.23%**	7.18%	**+4.5%**	**6.58%**

- Source : HSCT Monitoring of Human Resource Activity

** Figures unavailable from the DHSSPSNI (as at 31 October 2012)*

Commentary:

COMPARATIVE ANALYSIS OF % ABSENCE BETWEEN NIAS AND REGIONAL HSC STAFF GROUPS

Staff Group	No. of staff in group as at Q1 (01/04/12)	Staff Group as % of Workforce as at Q1							
Regulated				2009-10 Q3&4	2010-11 Q1&2	2010-11 Q3&4	2011-12 Q1&2	2011-12 Q3&4	2012-13 Q1&2
Station Supervisors & Clinical Support Officers	67	5.86	**NIAS**	6.36	5.93	4.67	7.98	8.32	8.41
Paramedics	418	36.54	**NIAS**	8.23	6.87	6.76	5.18	7.94	6.46
Nursing & Midwifery (formerly TC5)	N/A*	N/A*	**HSC**	6.25	5.97	6.26	5.90	N/A*	N/A*
Social Services (formerly TC6)	N/A*	N/A*	**HSC**	6.57	5.98	6.42	5.89	N/A*	N/A
Non-Regulated									
Admin & Clerical	122	10.67	**NIAS**	4.88	3.48	2.67	3.78	5.23	3.57
	N/A*	N/A	**HSC**	4.83	4.16	4.26	3.91	N/A*	N/A*
Works & Maintenance	3	0.25	**NIAS**	50.0	50.0	9.57	1.28	0.00	0.00
	N/A*	N/A	**HSC**	5.06	4.89	6.25	3.78	N/A*	N/A*
ACA's	239	20.89	**NIAS**	6.09	5.10	6.57	6.83	7.94	6.39
EMT's	191	16.70	**NIAS**	11.16	8.44	8.91	8.84	8.74	6.76
Control Staff	104	9.09	**NIAS**	8.48	10.27	13.81	7.74	9.52	10.21
Support Services (formerly TC4)	N/A	N/A	**HSC**	7.78	6.99	7.16	6.09	N/A*	N/A*

- Source : HSCT Monitoring of Human Resource Activity

** Figures unavailable from the DHSSPSNI (as at 31 October 2012)*

Commentary:

PERFORMANCE INFORMATION STATISTICAL ANNEX

EMPLOYEE RELATIONS

Grievance Standards	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	TOTAL
No. of Grievances received	3	0	0	1	2	2							**8**
Grievances acknowledged within 2 days	2	0	0	0	2	2							**6**
Grievances at Informal Stage	0	0	0	0	0	2							**2**
Grievances resolved informally / withdrawn	2	0	0	1	2	0							**5**
Stage 1 hearing arranged within 15 working days	0	0	0	0	0	0							**0**
Stage 1 outcome conveyed within 7 working days of hearing	-	0	0	0	0	0							**0**
Stage II hearing arranged within 15 working days of notification	0	0	0	0	0	0							**0**
Stage II outcome conveyed within 7 working days of hearing	0	0	0	0	0	0							**0**
Grievance Cases Closed	2	0	0	1	2	0							**3**
Number of active Grievance Cases (2012/13)													**3**
Total number of active Grievance Cases													**16**

Discipline Standards	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	TOTAL
Number of disciplinary cases	2	4	1	5	2	1							**15**
Number of HPC referrals	2	3	0	4	1	0							**10**
Number of suspensions	0	0	0	0	0	0							**0**
Decision to suspend reviewed every 4 weeks	N/A	N/A	N/A	N/A	N/A	N/A							**N/A**
Formal investigations ongoing	1	2	1	5	2	1							**12**
Formal investigations completed as soon as is reasonable	1	2	Ongoing										**3**
Document disclosure exchanged 5 working days prior to disciplinary hearing	0	0	0	0	0	0							**0**
Decision of Stage I Panel conveyed within 7 working days of date of hearing	0	0	0	0	0	0							**0**
Employee will be given 7 working days notice of appeal hearing	0	0	0	0	0	0							**0**
Decision of Stage II Appeal panel conveyed within 7 working days of date of hearing	0	0	0	0	0	0							**0**
Disciplinary Cases Closed	1	2	0	0	0	0							**3**
Number of active suspensions	**0**	**0**	**0**	**0**	**0**	**0**							**0**
Number of active Disciplinary Cases (2012/13)													**12**
Total number of active Disciplinary Cases													**22**

Harassment Standards	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	TOTAL
Number of harassment cases	1	4	1	0	1	0							**7**
Number of informal cases	0	3	1	0	0	0							**4**
Number of formal cases	1	0	0	0	0	0							**1**
Recipient of the complaint meets complainant within 5 working days of receipt of complaint	1	2	0	0	0	0							**3**
Cases withdrawn	0	1	0	0	1	0							**2**
Investigation complete within 30 working days of receipt of complaint	0	0	0	0	0	0							**0**
Harassment Cases Closed	1	3	0	0	1	0							**5**
Number of active harassment cases (2012/13)													**2**
Total Number of Active Harassment cases													**8**

Industrial Tribunal Standards	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	TOTAL
No. of lT Applications received	0	0	0	1	0	0							**1**
Response to IT Applications within 28 days	0	0	0	-*	0	0							**0**
IT cases Closed	0	0	0	0	0	0							**0**
Number of active IT cases (2012/13)													**1**
Total number of active IT cases													**2**

*Extension to timeframe agreed with I.T. Office and complied with.

Commentary:

PERFORMANCE INFORMATION STATISTICAL ANNEX

EDUCATION, LEARNING AND DEVELOPMENT

Accredited Clinical Training Programmes												
Key Actions	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Paramedic-In-Training Programmes	G	G	G	G	G	G						
Ambulance Care Assistant Programmes	N/A	N/A	N/A	N/A	N/A	N/A						
Mandatory Training & Assessment Programmes												
Key Actions	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Annual Learning & Development Workbook	N/A	N/A	N/A	N/A	N/A	N/A						
Annual Assessment/Structured CPD Paramedic & Emergency Medical Technician	N/A	N/A	N/A	N/A	N/A	A						
Annual Assessment/Structured CPD Ambulance Care Assistant	N/A	N/A	N/A	N/A	N/A	A						
Care & Responsibility Refresher (1 day)	N/A	N/A	N/A	N/A	N/A	N/A						
Care & Responsibility (2 day)	N/A	N/A	G	G	G	G						
First Aid at Work Refresher – Control Staff	G	G	G	G	G	G						
High Speed Competency Assessments	N/A	N/A	N/A	N/A	N/A	N/A						
Continuous Professional Development (CPD)												
Key Actions	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Knowledge & Skills Framework Reviewer	N/A	N/A	G	G	G	G						
Knowledge & Skills Framework Reviewee	N/A	N/A	G	G	G	G						
CSO - Supervision of Clinical Practice	N/A	G	G	G	G	G						

Service Developments												
Key Actions	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Care & Responsibility Instructor Training	G	G	G	G	G	G						
CSO – High Speed Assessor Training	G	G	G	G	G	G						
IHCD Driving Instructors – ADI Training	N/A	N/A	N/A	N/A	N/A	N/A						
CSO – IHCD Instructor Training	N/A	N/A	N/A	N/A	N/A	G						
Management Training												
Key Actions	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
In-house Management Training Programme	N/A	N/A	N/A	N/A	N/A	N/A						
HSC Leadership Programme	N/A	N/A	N/A	N/A	N/A	N/A						
CIPFA	G	G	G	G	G	G						
Clinical Support Officer Work streams												
Key Actions	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Paramedic-in-Training – Practice Placement Educator and Mentoring	G	G	G	G	G	G						
Ambulance Care Assistant – Post-Training Support	N/A	N/A	N/A	N/A	N/A	N/A						
Clinical Supervision of Post-Qualified Staff	G	G	G	G	G	G						
Pandemic Preparedness - FIT Testing	G	G	G	G	G	G						
Clinical Audit	N/A	N/A	G	G	G	G						
Alternative Care Pathways – New Guidelines	N/A	N/A	N/A	N/A	N/A	N/A						
Clinical Performance Indicators (CPIs)	G	G	G	G	G	G						
High Speed Driving Competency Assessments	N/A	N/A	N/A	N/A	N/A	N/A						
Patient/Client Experience Audit	G	G	G	G	G	G						
CPD Events	G	G	G	G	G	G						

PERFORMANCE INFORMATION STATISTICAL ANNEX

AGENDA FOR CHANGE

1. Knowledge & Skills Framework

The Trust's partnership KSF Leads have completed the preparation for the roll-out of KSF, including an agreed Action Plan, development of PDR/PDP documentation and roll-out of Reviewer and Reviewee training.

SEMT were notified of a "go-live" date on 03/10/12 and Directors and Assistant Directors were supplied with the relevant KSF documentation via email on 05/10/12.

Individual Directorates now have responsibility to roll-out PDRs to staff within area of responsibility. The Trust will continue to manage gateways in accordance with the HSC regional approach. At this point in time gateways remain open across the HSC.

Key Actions	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Finalise and implement Knowledge & Skills Framework Action Plan as agreed in Partnership	G	G	G	G	G	G						
Implement Northern Ireland position on gateway progression	G	G	G	G	G	G						

2. Job Evaluation for Paramedics, RRV Paramedics & Emergency Medical Technicians

The relevant parties, engaged in the job evaluation process for these jobs, have to date, despite making considerable effort, been unable to conclude an outcome for any of the three jobs. The Trust has therefore, under advisement from the Joint Chairs of the Regional Joint Negotiating Forum, referred the matter to the Regional Quality Assurance (RQA) Team for their opinion. The Trust awaits the outcome of the RQA's considerations in order to move the process forward.

Manage Job Evaluation (JE) for all 3 jobs	G	G	G	G	G	G						
JE Panel meetings (10 between Nov 2010-Mar 2011)	-	2	2	2	N/A	N/A						
Paramedic Job												
Outcome from JE Panel	N/A	N/A	N/A	N/A	N/A	N/A						
Refer to RQA Team for their opinion	N/A	N/A	N/A	N/A	N/A	N/A						
Consistency Check JE Outcome	N/A	N/A	N/A	N/A	N/A	N/A						
Notify post-holders of JE Outcome	N/A	N/A	N/A	N/A	N/A	N/A						
Notify Payroll of JE Outcome	N/A	N/A	N/A	N/A	N/A	N/A						
RRV Paramedic Job												
Outcome from JE Panel	N/A	N/A	N/A	N/A	N/A	N/A						
Refer to RQA Team for their opinion	N/A	N/A	N/A	N/A	N/A	N/A						
Consistency Check JE Outcome	N/A	N/A	N/A	N/A	N/A	N/A						
Notify post-holders of JE Outcome	N/A	N/A	N/A	N/A	N/A	N/A						
Notify Payroll of JE Outcome	N/A	N/A	N/A	N/A	N/A	N/A						
EMT Job												
Outcome from JE Panel	N/A	N/A	N/A	N/A	N/A/	N/A						
Refer to RQA Team for their opinion	N/A	N/A	N/A	N/A	N/A	N/A						
Consistency Check JE Outcome	N/A	N/A	N/A	N/A	N/A	N/A						
Notify post-holders of JE Outcome	N/A	N/A	N/A	N/A	N/A	N/A						
Notify Payroll of JE Outcome	N/A	N/A	N/A	N/A	N/A	N/A						

CLAIMS MANAGEMENT

Claim Type	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Employers Liability													
Cases Received	2	3	1	1	0	0							**7**
Cases Settled	0	0	1	0	1	0							**2**
Cases Ongoing													**22**
Clinical Negligence													
Cases Received	0	1	0	0	0	0							**1**
Cases Settled	0	0	0	1	0	0							**1**
Cases Ongoing													**10**
Public Liability													
Cases Received	0	1	0	0	0	0							**1**
Cases Settled	0	0	0	0	0	0							**0**
Cases Ongoing													**5**

PERFORMANCE INFORMATION STATISTICAL ANNEX

COMPLAINTS MANAGEMENT

COMPLAINTS & COMPLIMENTS

	2012-13	2011-12
COMPLAINTS RECEIVED	Total (to date)	Total
Total complaints received at 30/09/2012	**58**	**98**

HANDLING TIMES OF COMPLAINTS

	Apr	May	Jun	Jul	Aug	Sep	2012-13 (to date)	%	2011-12	
Total Complaints received	13	6	8	10	8	13	**58**	*100%*	**98**	**100%**
Acknowledged within 2 working days	13	6	8	10	8	13	**58**	*100%*	95	97%
Acknowledged after 2 working days	0	0	0	0	0	0	**0**	*0%*	3	3%
Response within 20 working days	9	2	2	4	4	6	**27**	*47%*	34	35%
Response after 20 working days	4	4	4	4	2	0	**18**	*31%*	64	65%
Complaints Investigations ongoing	0	0	2	2	2	7	**13**	*22%*	0	0%
Average Response time (Working days)							***24***		***31***	
Cases referred to NI Ombudsman (cases ongoing)	0	0	0	1	0	0	**1 (1)**	*2%*	4	4%

SERVICE AREA OF COMPLAINTS										
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**2012-13 (to date)**	***%***	**2011-12**	
Accident & Emergency	6	5	4	4	3	7	**29**	*50%*	42	43%
Patient Care Service	1	1	2	5	3	0	**12**	*21%*	19	19%
Control & Communications	5	0	2	1	2	5	**15**	*26%*	34	35%
Other	1	0	0	0	0	1	**2**	*3%*	0	0%
Voluntary Car Service	0	0	0	0	0	0	**0**	*0%*	3	3%
TOTAL	**13**	**6**	**8**	**10**	**8**	**13**	**58**		**98**	

NATURE OF COMPLAINTS RECEIVED										
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**2012-13 (to date)**	***%***	**2011-12**	
Staff Attitude	2	3	3	4	2	3	**17**	*29%*	37	38%
Ambulance Late/No Arrival	7	2	3	4	3	8	**27**	*47%*	39	40%
Clinical Incident	2	1	1	0	1	1	**6**	*11%*	17	17%
Suitability of Equipment/Vehicle	0	0	0	1	1	0	**2**	*3%*	0	0%
Other	2	0	1	0	0	1	**4**	*7%*	4	4%
Patient Property	0	0	0	1	1	0	**2**	*3%*	1	1%
TOTAL	**13**	**6**	**8**	**10**	**8**	**13**	**58**		**98**	
COMPLIMENTS RECEIVED										
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**2012-13 (to date)**	**2011-12**		
COMPLIMENTS RECEIVED	10	19	14	11	15	8	**77**	**145**		
SERVICE AREA OF COMPLIMENTS RECEIVED										
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**2012-13 (to date)**	***%***	**2011-12**	
Accident & Emergency	8	17	13	10	14	7	**69**	*88%*	128	88%
Control & Communications	2	1	1	1	1	1	**7**	*9%*	10	7%
Patient Care Service	0	1	0	0	0	0	**1**	*3%*	7	5%
Voluntary Car Service	0	0	0	0	0	0	**0**	*0%*	0	0%
Other	0	0	0	0	0	0	**0**	*0%*	0	0%
TOTAL	**10**	**19**	**14**	**11**	**15**	**8**	**77**		**145**	

Performance Information Statistical Annex

SECTION 75

Section 75 Policy Screening	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Completed Policy S75 Screenings	0	0	0	0	0	1						

PERFORMANCE INFORMATION STATISTICAL ANNEX

MEDIA MANAGEMENT

Media Responses	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	TOTAL
Daily Media - Response within same day													
Number of enquiries received	18	26	25	20	31	38							**158**
Number of responses issued on day of receipt	18	26	25	20	31	38							**158**
Weekly Media - Response within three days													
Number of enquiries received	3	5	3	5	9	4							**29**
Number of responses issued within three days of receipt	3	5	3	5	9	4							**29**
Number of responses resulting in Media Coverage	20	31	27	25	36	42							**181**

PERFORMANCE INFORMATION STATISTICAL ANNEX

COMMUNITY EDUCATION

Community Education	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	TOTAL
Number of visits delivered	4	16	27	7	14	5							**73**

Appendix 1

DHSSPS GUIDANCE ON ASSURANCE FRAMEWORKS

Guidance provided by DHSSPS on introduction and use of Assurance Frameworks is intended to help the boards of HSC organisations and other arm's length bodies of The Department of Health Social Services & Public Safety (DHSSPS) improve the effectiveness of their systems of internal control. It does this by showing how the evidence for adequate control can be marshalled tested and strengthened within an Assurance Framework.

The Assurance Framework is a pivotal mechanism through which boards exert control over their organisations. As was stated when the guidance first appeared the essential point of a robust Assurance Framework is that it provides a stronger basis for effective challenge and better-informed decision-making in the boardroom. It will also be of direct relevance to senior executives risk and governance managers and clinical and social care professionals – to all those in fact with responsibility for good governance.
The board of each Health and Social Care (HSC) organisation and of each of the Department's NDPBs has therefore a duty on behalf of its service users carers staff and local communities to ensure that the organisation is carrying out its responsibilities within a system of effective control and in line with the objectives set by Ministers. Their organisations must also demonstrate value for money maximizing resources to support the highest standards of service.

The Framework supplies boards with an instrument for making fuller use of the existing governance capacity:

- in terms of how the various aspects of governance relate to organisational responsibilities accountability and to each other;
- in relation to the information they need to discharge their responsibilities and accountability;
- to know how the different facets of governance are working; and
- to ensure the effective management of risk.
-

Trusts have a duty to protect service users carers staff and others in the planning and delivery of services. Reducing risk is not just about financial or management probity. It is also – indeed it is primarily– concerned with improving the safety quality and user experience of services. This means that equal priority needs to be given to the obligations of governance across all aspects of the business whether financial organisational or in clinical and social care together with a need for governance to suffuse each organisation's culture. Good governance depends on having clear objectives sound practices a clear understanding of the risks associated with the organisation's business and effective monitoring arrangements – in other words a sound system of organisation-wide risk management.

The six core principles of good governance as set out in the Good Governance Standard for Public Service are:

- Focusing on the organisation's purpose and on outcomes for citizens and service users
- Performing effectively in clearly defined functions and roles

- Promoting values for the whole organisation and demonstrating the values of good governance through behaviour
- Taking informed transparent decisions and managing risk
- Developing the capacity and capability of the governing body to be effective
- Engaging stakeholders and making accountability real

Appendix 2

Reporting Template

TITLE:

CROSS-REFERENCE TO MINISTERIAL PRIORITIES AND/OR HSC BOARD COMMISSIONING PLANS

ASSESSMENT OF CONTROLS AND ASSURANCE CURRENTLY IN PLACE

IMPROVEMENT PROPOSALS FOR 2011/12

SUMMARY OF PERFORMANCE

RISK COMMENTARY

ID	224
Principal Aim,Objective.Value	To Achieve the best outcomes for patients whilst Ensuring High Quality Corporate Governace, Risk Management and probity
Risk Type	CORP
Title	Senior Executive Directors Retention & Succession Planning
Description	There is a risk to the Trust that the current terms and conditions of service available to senior executives may not be sufficiently attractive to support retention of existing staff or recruitment of suitably qualified and experienced applicants
Risk level (initial)	MOD
Risk level (Target)	VLOW
Risk level (current)	MOD
Lead Director	CHAIR
Initial Action Taken to Control/ Mitigate Risk	Existing remuneration, terms and conditions are consistent with DHSSPS guidance. □ Permanent Secretary has been appraised of concerns by CX NIAS. □ Issue has been discussed at NIAS Trust Board level by non-executive directors and at Remuneration committee. □ NIAS has engaged fully in all senior job evaluation processes to address issue - SSRB, HAYS. □ Chairman has requested re-evaluation of jobs through DHSSPS. □ Application has been made to secure re-evaluation through SSRB and HAYS.□ Directors have been appraised of developments by CX and Chair.□ Relevant directors have been, and will be, fully engaged in the process and appraised of developments□
Opened	28/09/2011
Review Date	10/08/2012
Action Plan to Address /Mitigate Risk	1. Chair to write to DHSSPS to seek re-evaluation of jobs and regrading to address anomalies and pay differentials. □ 1.1 DHSSPS response received after numerous requests on 30/5/2012 advising of outcomes of process.□ □ 2. Issue to be raised with Permanent Secretary DHSSPS in Accountability Review meeting (July 2012) to highlight risk to NIAS and identify any other actions available to NAIS to address risk. □ 2.1 Issue Raised at Meeting on 3/7/2012. NIAS has been advised by Permanent Secretary at accountability meeting on 3/7/2012 that the risk identified by the Trust is acknowledged but the process has been applied and the results are as notified. the risk is therefore recognised but no further steps have been identified which are available to the Trust to reduce or mitigate the risk further. □ □ 3. Chair to write to DHSSPS at request of Remuneration Committee to appeal result of regrading and request further evaluation of the posts which had no change in outcome. □ 3.1 Chair wrote to DHSSPS on 26/7/2012 requesting this.□ □ 4. Chair to review risk position taking account of most recent developments.□ 4.1 On the basis of information received as at 10/8/2012, it is recommended that the target risk level be changed to moderate, and the current level of risk accepted by NIAS. It is further proposed that the risk remain as live and active on the Corporate Risk Register to maintain focus and attention on this issue.
Closed	

ID	232
Principal Aim,Objective.Value	Build and maintain a high performing, appropriately skilled and educated workforce, suitability equipped and fit for purpose
Risk Type	CORP
Title	Business Services Transformation Programme (BSTP)
Description	"There are three distinct projects within BSTP that represent various risks to NIAS: Finance, Procurement, Logistics (FPL) Human Resources, Payroll, Travel and Subsistence (HRPTS) Shared Services (SS). Each of these projects present risks across three broad areas - Business as Usual: The ability to maintain core business requirements prior to and during implementation of BSTP Implementation: Lack of human and physical resources to undertake work required leading to non delivery/delay in completion of elements of BSTP Benefits Realisation: The project is unable to realise anticipated benefits (financial and non financial)"
Risk level (initial)	HIGH
Risk level (Target)	LOW
Risk level (current)	MOD
Lead Director	FINDIR
Initial Action Taken to Control/ Mitigate Risk	"Representation on HRPTS, FPL, and SS Boards and Groups regionally and locally. Establishment of Project Management Infrastructure and Project Team. Recruitment of Project Manager, Implementation Managers and Functional Specialists with backfill as appropriate. Targeting of capacity to core business and critical issues as appropriate. Participation in Change Impact Assessment Workshops. Engagement and communication with stakeholders. Pilot IT infrastructure audit and engagement with Regional ICT leads. Inventory of existing system contracts. "
Opened	01/04/2012
Review Date	
Action Plan to Address /Mitigate Risk	Recruitment to vacant posts and backfill as appropriate. Continue prioritisation of core business requirements. Continue to review priorities, engaging with other HSC Trusts Bid for additional resources as appropriate/available. Continue to work with BSTP Central Team and suppliers as appropriate within existing resources. Focus on resolution of critical issues, for example rostering interfaces, multiple employment, Collaborative Planning, IT Infrastructure. Further development of business continuity, recovery and contingency measures Continued engagement in Change Impact Assessment Workshops. Development of Deployment and Training Strategy Ongoing review of key financial controls Further development of NIAS Change Network and Change Action Plan. Refresh ICT audit in line with Business Readiness/Project Plan. Ongoing engagement with Trade Unions at regional and local level.
Closed	

ID	4
Principal Aim,Objective.Value	To deliver a Safe,High Quality Ambulance Service providing emergency and non emergency care and trasportation which is appropriate, accessable, timely and effective
Risk Type	CORP
Title	Business Continuity pFa 1.2.
Description	There is a risk to the Trust from the failure to review, update and test the internal disaster management plans.
Risk level (initial)	HIGH
Risk level (Target)	LOW
Risk level (current)	MOD
Lead Director	MEDDIR
Initial Action Taken to Control/ Mitigate Risk	- There are a number of Business Continuity Plans in place requiring review.□ - Amended plans have been presented to the SEMT for comment in Q4 2010□ - AEPO has been appointed to develop Business Continuity Strategy, Policy and Action Plans to review existing plans.□ - A number of local BCP were implemented due to civil disturbances and adverse weather.□ - EAC evacuation plan was tested in September 2010□ - All existing plans captured and identified whether in draft, tested or implemented.□ - Four 'Critical' activities identified□ Call Taking□ Information Processing□ Ambulance Despatch□ Medical Care□ -Existing plans reviewed to ensure that the areas which directly influence these 'critical' activities have been tested, activated and reviewed or debriefed: REMDC, Operational Divisions, REMDC - specific ICT Infrastructure.□
Opened	30/12/2010
Review Date	30/09/2012
Action Plan to Address /Mitigate Risk	1. Draft Strategic Business Continuity Strategy/ Policy completed for submission to SEMT ratified during Q2 2011/12□ 1.1 Completed - Presented to Trust Board 17th Novemeber 2011□ □ 2. Action plan for review of Directorate and local BCP agreed and presented to SEMT Q1 2011/12□ 2.1Completed - Approved by SEMT and Trust Board 17th November 2011□ □ 3. EAC evacuation plan to be amended and retested based on learning outcomes for evacuation exercise in September 2010□ 3.1 Completed ICT tested - Date August 2012 further test scheduled 9/9/12 during schedule fire drill.□ □ 4. All other areas will be captured during the next phase of the programme which is under the control of the Emergency Planning Officer.□ 4.1 Established EP and BCP group in June 2012□ 4.2 Terms of Reference and Schedule of Meetings will be submitted to the Assurance Committee Oct 2012□ $.3 Completed.October 2012. 5. EP Team engaging with all directorates to undertake a systematic review of existing contingency plans by year end□ 5.1 Identified directorate BC leads - Completed June 2012 5.2 Identified and agreed with RATC training programme for BC leads, HSCB staff will also attend this programme.□ Lead AEPO attended National training course in advance of roll out. 6. Programme of 'testing' plans will be developed. For completion by end of 2013/14 as per Departmental Guidance. 6.1 This will be within the remit of the EP and BCP group. (4.1)□ 7.Learning identified following this exercise will be incorporated into plans□ 7.1 Learning will be incorporated into future plans and exercises and reported to Trust Assurance Committee.
Closed	

ID	197
Principal Aim,Objective.Value	Establish and develop agreed outcome-based clinical and non-clinical quality indicators for patients to improve outcomes for patients
Risk Type	CORP
Title	Vehicle Cleaning
Description	There is a risk to the Trust from the lack of a robust reporting system for cleaning to ensure compliance with Infection Prevention and Control Policy and procedures
Risk level (initial)	MOD
Risk level (Target)	VLOW
Risk level (current)	LOW
Lead Director	MEDDIR
Initial Action Taken to Control/ Mitigate Risk	- Vehicle cleaning considers as a 'standing item' on the Trust's IPC Group. Activity is reported to the Trusts Assurance Committee□ -Vehicle cleaning schedule has been introduced□ -Vehicle cleaning products have been reviewed, streamlined and are now consistent across the Trust□ -Web based reporting system developed□ -Compliance with the reporting of cleaning is improving□ - System reviewed and improvements made□ -EAC will record the cleaning on data base□ - Significant improvement in reports□ □
Opened	05/02/2010
Review Date	30/09/2012
Action Plan to Address /Mitigate Risk	1. Vehicle Cleaning Sub group of the IPC Group established with individual representatives from across the Trust to review current reporting procedure during Q1 2011/12□ 1.2 Completed□ □ 2. Workshop for 'newly appointed Station Officer planned for Q1 2011/12□ 2.1 Completed□ □ 3. Audit of station cleanliness ongoing from Q3 2010/11□ 3.1 In Progress- This is an ongoing schedule part of the Health and Safety Audit carried out on a rolling basis annual. Exception reports are submitted to IPC Group □ 4. When new reporting system implemented compliance with vehicle cleaning will be subject to audit to identify any gaps in compliance□ 4.1 Reviewed at each meeting of the IPC Group □ □ 5. Vehicle cleaning has been agreed as a KPI for the IPC Group.□ 5.1 IPC Group to review compliance with this programme, Station Officers will record vehicle cleaning at a local level and provide feedback to staff and control□ 5.2 Ast. Director OPs (Command and Control) has reviewed the procedure and agreed that Control Staff will record the data on the vehicle cleaning spreadsheet. (This will be reviewed by the IPC Group at the meeting in Oct 2012 this meeting was postphoned)
Closed	

ID	219
Principal Aim,Objective.Value	Establish and develop agreed outcome-based clinical and non-clinical quality indicators for patients to improve outcomes for patients
Risk Type	CORP
Title	Assuring Optimal Clinical experience in Patient Care
Description	There is a risk to patients in the care of NIAS that their care and treatment could be compromised by the attendant at an incident having a lower level of clinical expertise than the driver of the vehicle. The risk arises because ambulance crews currently have discretion in relation to which member of the crew operates as attendant at incidents.
Risk level (initial)	MOD
Risk level (Target)	VLOW
Risk level (current)	MOD
Lead Director	DIROPS
Initial Action Taken to Control/ Mitigate Risk	NIAS seeks to ensure that each ambulance is crewed by at least one paramedic. All NIAS RRV are operated by paramedics and can be assigned to enhance level of clinical expertise at the incident ir en route to hospital. Paramedic have a professional responsibility and duty of care to the patient which applies whether they are designated as driver or attendant at the incident. Communication between crew members is facilitated at all times by a range of technical and non-technical solutions (radios;intercoms;bulkhead doors).
Opened	10/06/2011
Review Date	31/03/2012
Action Plan to Address /Mitigate Risk	Instruction / guidance will be issued to ambulance personnel to clarify roles and responsibilities to remove ambiguity and ensure the members of staff with the highest degree of clinical expertise always attend to the patient while they are in the care of the ambulance service. Monitoring mechanisms will be developed to provide and maintain assurance in this regard
Closed	

ID	233
Principal Aim,Objective.Value	To Achieve the best outcomes for patients whilst Ensuring High Quality Corporate Governace, Risk Management and probity
Risk Type	CORP
Title	Achieving Financial Balance 2012/13
Description	There is a risk to the Trust that it will fail to meet its statutory duty to achieve financial balance. There remain uncertainties in respect of the outcome of Agenda for Change and the extent or timing of any outcome cannot be determined at this stage. The Trust continues with the assumption that the HSC Board will fund the full legitimate costs of Agenda for Change in NIAS. The Trust assumes all pay and non pay pressures will be funded by the HSCB and that in year developments to support acute service changes will be fully supported. The delivery of required savings plans both in year and recurrently represents a significant challenge. Breakeven is dependent upon the achievement of these savings and the assumes no further efficiency savings in 2012/13 beyond the £1.176m already required.
Risk level (initial)	MOD
Risk level (Target)	LOW
Risk level (current)	MOD
Lead Director	FINDIR
Initial Action Taken to Control/ Mitigate Risk	Ongoing monitoring, review and engagement with stakeholders as appropriate to include: Approval of DTP by HSCB Trust Board - assurance framework at each Board meeting Submission of TDP in response to Ministerial Targets and Commissioning Plan HSC Board - Monthly NIAS Trust Performance Meeting; Financial Stability Programmed Board DHSSPS - Monthly Trust Monitoring Returns Internal Budgetary Control Processes led by Director of Finance reporting to Chief Executive as Accounting Officer"
Opened	01/04/2012
Review Date	30/06/2012
Action Plan to Address /Mitigate Risk	Continue to advise stakeholders as outlined above - Monthly reports provided and regular meetings held monthly - Dir Fin Ongoing monitoring of expenditure, developments, pressures and delivery of saving plans through Trust Monitoring Returns, reports to Trust Board and Budgetary Control cycle. Monthly Dir Fin. NIAS is seeking to proactively conclude the Agenda for Change job evaluation process within agreed framework. Formal Review Q4 2012/13 Dir Fin DO to continue to reflect the financial implications of any agreed outcomes to stakeholders. Formal Review Q4 2012/13 Dir Fin Completion of final accounts and external audit expected 2013/14 Dir Fin
Closed	

TB/5/15/11/12

NORTHERN IRELAND AMBULANCE SERVICE

TRUST BOARD MEETING

15 November 2012

Title:	Management of Aggression Policy
Purpose:	To set out NIAS policy on the Management of Aggression.
Content:	To promote safe practice, and protect and support staff.
Recommendation:	For approval
Previous Forum:	Health & Safety Committee and SEMT
Prepared by:	Mr John Wright, Area Manager Mrs Christine Wilkinson, Clinical Training Manager
Presented by:	Ms Roisin O'Hara, Director of Human Resources and Corporate Services

Northern Ireland Ambulance Service
Health and Social Care Trust

NORTHERN IRELAND AMBULANCE SERVICE

MANAGEMENT OF AGGRESSION POLICY

June 2012

Version 1.0

Title:	**Management of Aggression Policy**		
Purpose of Policy:	To set out NIAS policy on the Management of Aggression. To promote safe practice, and protect and support staff.		
Directorate Responsible for Policy:	The Human Resources Directorate		
Name and Title of Authors:	John Wright, Area Manager Christine Wilkinson, Clinical Training Manager		
Staff Side Consultation	Distributed to the Zero Tolerance Group and the H & S Committee for consultation in November 2011		
Equality Screened:	2011		
Date Presented to:	H & S Committee	2011	
	SEMT	2012	
	Assurance Comm.		
	Trust Board		
Publication Date:	2012	Review date: November 2013	Review completed:
Version:	**Version 1.0**		
(01)			
(02)			

Circulation List:

This Policy was circulated to the following groups for consultation.

- Staffside
- Executive Directors and Senior Managers

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

- All Trust Staff
- Trust Internet Site/ Intranet Site

CONTENTS

1.0 Introduction

1.1 This policy sets out the Northern Ireland Ambulance Service Trust's (hereafter referred to as 'The Trust') plan for the management of aggression.

1.2 This policy identifies the Trust's commitment to the management of aggression in all its activities.

1.3 The Policy gives guidance on minimising risk, investigating incidents and promoting a culture of continuous improvement.

1.4 The Policy should be read in conjunction with the Trust's procedural arrangements for management of aggression.

1.5 This Policy has been developed in consultation with internal stakeholders.

2.0 Policy Statement

2.1 The Trust promotes a pro-active approach to the management of aggression.

2.2 The Trust will minimise risks to patients, staff, clients, visitors, contractors and others through the effective management of aggression.

2.3 The management of aggression policy is a declaration of the NIAS's overall aims and principles with respect to minimising aggression in the workplace. It includes a commitment to promote a safe working environment and acknowledges that there is always a risk of actual and potential aggression for staff.

3.0 Definitions

3.1 Aggression is defined as; “any incidents where persons are abused, threatened or assaulted in circumstances relating to their work, involving an implicit or explicit challenge to their safety, wellbeing or health.”
European commission DG-V1997

3.2 Additionally the Trust will adopt the following explicit definitions of physical and non-physical abuse as defined by the Security Management Agency.

Physical abuse – the intentional application of force against the person of another, without lawful justification, resulting in physical injury or personal discomfort.

Non-physical abuse – the use of inappropriate words or behaviour causing distress and/or constituting harassment.

4.0 Scope of the Policy

4.1 This policy applies to all sites across the Trust.

4.2 This policy provides guidance on how the Trust will deal with circumstances where staff may be at risk of aggression from patients, members of the public or from other persons or animals. It outlines the preventative measures which can be taken to assist staff to reduce potentially aggressive situations and what should happen if they occur.

4.3 This policy should be read in conjunction with the procedure for managing aggression.

4.4 This Policy must be adhered to by all Trust employees. It will also apply to those who carry out work for the Trust such as contractors and agency staff. It includes a commitment to the continual improvement of managing aggression and to compliance with health and safety, legal and other requirements.

5.0 Policy Objectives

5.1 The Trust will ensure that it has in place suitable and robust governance arrangements to support the management of aggression.

5.2 The Zero Tolerance group will review, monitor and report on management of aggression issues and to fulfil the requirements of this Policy.

5.3 To reduce the risks associated with aggression incidents, particularly the risks from physical abuse.

5.4 To encourage staff, in line with the Trusts Policy for reporting incidents, to report incidents which have resulted in or which may give rise to an aggressive incident, to enable monitoring and to ensure procedures in place are functioning effectively. The Trust will support staff in providing information to the Police Service Northern Ireland (PSNI) when required.

5.5 To establish the reporting of managing aggressive incidents annually to the Board.

5.6 The Trust will seek independent assurance that an appropriate and effective system of managing aggressive risks is in place and that the necessary level of controls and monitoring are being implemented.

6.0 Roles and Responsibilities

6.1 The Chief Executive has overall responsibility for ensuring the objectives of this policy are met and resources are made available to implement the policy.

The Chief Executive will delegate responsibility for establishing and monitoring the implementation of this policy to the Director of Human Resources.

The Chief Executive will report to the Trust Board on a regular basis regarding management of aggression through the Assurance Committee.

6.2 The Director Human Resources is the designated Executive Director with lead responsibility for the management of aggression.

The Director Human Resources will report to the Trust's Assurance Committee and Trust Board on matters relating to management of aggression.

The Director Human Resources will Chair the Trust's Health and Safety committee and through the sub group of Zero Tolerance it will address the requirements of this policy. (Appendix 1 committee structure)

6.3 All Trust Directors, Assistant Directors and Senior Managers have responsibility for management of any aggressive incidents within the areas of their remit and control. They will ensure that procedures are fully implemented and monitored as part of the Trust's governance requirements.

They will ensure that information required in relation to this policy is reported.

They will develop and implement local arrangements and monitor them to ensure that those under their control adhere to the policy.

They will ensure that clients, patients and visitors to NIAS premises are aware of the NIAS policy on management of aggression.

6.4 The Health and Safety Committee is responsible for the surveillance, prevention, investigation, management of aggression across the Trust.

The Committee is responsible for the implementation of the Management of Aggression Policy and ensuring there are supporting procedures, guidelines and arrangements.

The Committee is responsible for advising on appropriate resources to facilitate the implementation of managing aggression issues throughout the Trust.

The Committee is responsible for ensuring periodic review of the Policy and associated procedures.

6.5 All Trust staff have a responsibility to adhere to this Policy and ensure that they operate in accordance with its supporting procedural arrangements. All staff have a responsibility to protect themselves as well as making all reasonable efforts to safeguard the welfare of patients and all other persons encountered in their daily duties.

7.0 Context and detail of Managing Aggression in NIAS

7.1 Introduction

NIAS places the greatest importance on the safety and wellbeing of its staff. The trust recognises that its staff, on a daily basis, faces incidents of actual and potential aggression. The trust as an employer, has a statutory duty under the Health and Safety at Work (NI) Order, 1978, to take all reasonable practicable steps to protect its staff from risks of injury due to violent assault.

In addition, the Trust has a duty under the Management of Health and Safety at Work (Regulations) (NI) 2006, to assess risks of violence and implement arrangements to manage the risks identified in the assessment.

The Trust will, as far as is reasonably practical, ensure that appropriate support is in place to provide the required follow-up to staff in the aftermath of a violent incident. This support is presently available through;

- The Trusts line management structure (including the officer on call system).
- Access to confidential counselling services, currently provided by care call.
- Direct access to Occupational Health services.

The trust is committed to developing and maintaining good relationships with the Police Service Northern Ireland (PSNI) in order to ensure a common understanding of how incidents of violence against staff are processed.

All employees have a duty to attend training delivered by, or on behalf of the trust which will assist in the handling of violent incidents. All employees have a duty to ensure they act in accordance with relevant codes of conduct in order to minimise risks to themselves, colleagues or Trust property.

8.0 **Risk Management**

8.1 All Management of aggression matters within the Trust will be risk assessed in accordance with the Management of Health and Safety at Work (Regulations) Northern Ireland 2006 and Trust Risk Management Strategy.

8.2 Sensitive or high risk issues will be managed by the risk owner and monitored by the Zero Tolerance group.

8.3 Aggression management arrangements and the effectiveness of policies and procedures will be monitored through the Health and Safety Committee which reports to the Assurance Committee.

8.4 The Untoward Incident reporting system (UIR1) will be used to report aggressive incidents. This will allow the Trust to be informed of the risks facing the organisation and to take appropriate action to avoid, minimise or significantly reduce the occurrence or repetition of these incidents.

8.5 The Health and Safety Committee will monitor and review Untoward Incidents. In addition, the Senior Executive Management Team (SEMT) will also review incidents on a 2 weekly basis.

8.6 The Clinical Training Manager will ensure the provision of any necessary information. Instruction training and supervision with regard to this Policy.

8.7 All Managers must ensure that their staff have access to this policy, have reviewed its content, and are aware of its aims and purpose immediately upon its release.

8.8 All Trust staff must comply with this Policy.

9.0 **Equality and Human Rights Considerations**

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

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

9.3 This policy embraces Diversity, Dignity and Inclusion in line with emerging Human Rights guidance. We recognise, acknowledge and value difference across all people and their backgrounds. We will treat everyone with courtesy and consideration and ensure that no-one is belittled, excluded or disadvantaged in any way, shape or form.

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

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

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

10.0 **Policy Review**

10.1 The Trust is committed to ensuring that all policies are kept under review to ensure that they remain compliant with relevant legislation.

10.2 This Policy will be reviewed by the Health and Safety Committee bi-annually, or earlier if changes to legislation, work practices or a significant incident require it. That review will be noted on a subsequent version of this policy, even where there are no substantive changes made or required.

11.0 **Legal**

11.1 Legislative compliance, relevant policies, procedures, statutes, guidance, circulars and other publications relevant to this Policy are listed in the

http://extranet.dhsspsni.gov.uk

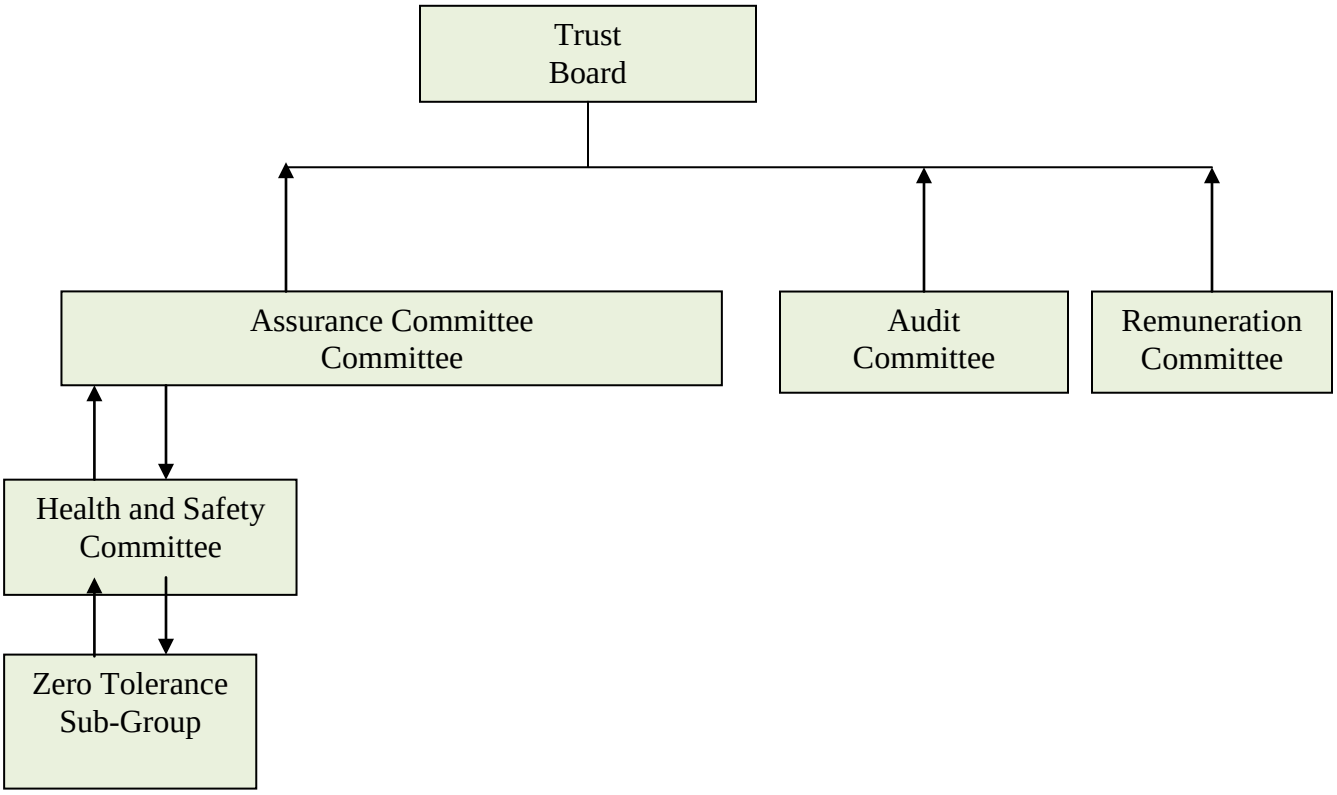
NIAS policies and procedures can be found using the NIAS Intranet link below:-

http://nias-sharepoint:81/policies_procedures/policy.htm

11.2 Other relevant documents, legislation, statute and guidance can be found at Appendix 2

Appendix 1

Committee Structure



Appendix 2

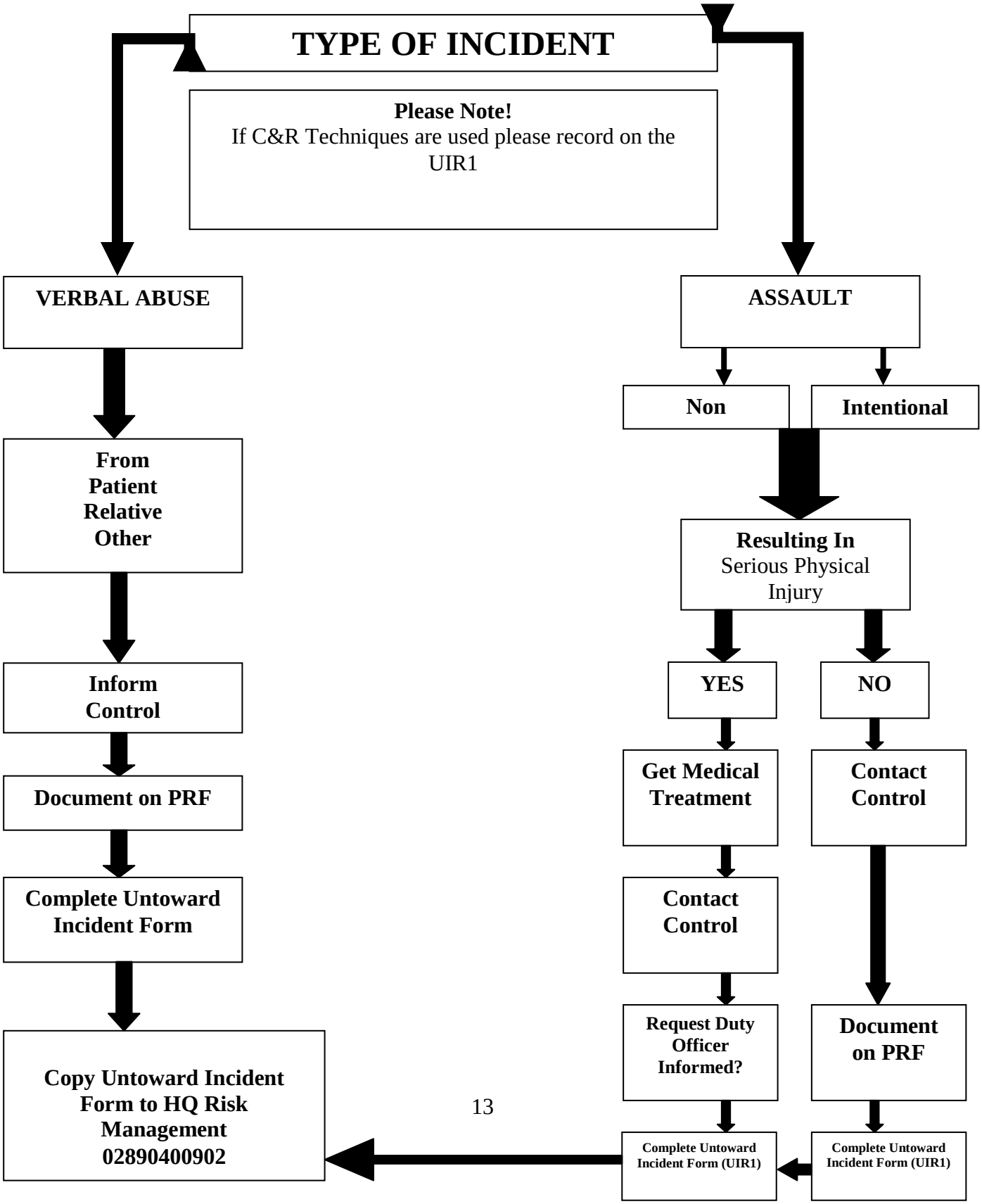
Related documents

- Health and Safety at Work (Regulations) Northern Ireland 2006
- Health and Safety at Work (NI) Order 1978
- Management of Health and Safety at Work Regulations 1992
- Section 75, Schedule 9, of the Northern Ireland Act, 1998
- Human Rights Act, 1998
- http://extranet.dhsspsni.gov.uk

This list is not exhaustive and other documents can be found by following the links supplied above to the DHSSPSNI and NIAS websites and intranet.

Appendix 3

ACTION TO BE TAKEN BY A MEMBER OF STAFF WHO IS THE VICTIM OF VIOLENCE OR AGGRESSION



TB/6/15/11/12

NORTHERN IRELAND AMBULANCE SERVICE

TRUST BOARD MEETING

15 November 2012

Title:	Policy for Safe Management of Water Systems (including Legionella and Pseudomonas
Purpose:	To express strategically how NIAS will meet its obligations in relation to identifying, managing and preventing contamination to the water systems within the buildings owned/managed by NIAS.
Content:	To prevent contamination of the water systems within the buildings owned/managed by NIAS.
Recommendation:	For approval
Previous Forum:	Executive Directors, Senior Managers, SEMT
Prepared by:	Mr Bryan Snoddy, Assistant Director Of Operations Ms Anne Malone, Project Assistant Operations
Presented by:	Mr Brian McNeill, Director of Operations

Northern Ireland Ambulance Service
Health and Social Care Trust

NORTHERN IRELAND AMBULANCE SERVICE

Policy for Safe Management of Water Systems (including Legionella and Pseudomonas)

Version 1.1
October 2012

Northern Ireland Ambulance Service
Health and Social Care Trust

Title	Policy for Safe Management of Water Systems (including Legionella and Pseudomonas)		
Purpose of Document	To express strategically how NIAS will meet its obligations in relation to identifying, managing and preventing contamination to the water systems within the buildings owned/managed by NIAS.		
Directorate responsible for Policy	Operations		
Name and Title of Author(s)	Assistant Director of Operations (Estate & Fleet) Project Assistant - Operations		
Consultation	Area Managers, Frank Rafferty, Tom Quinn		
Equality screened	N/A		
Date presented to:	SEMT	30 October 2012	5 November 2012
	Trust Board	15 November 2012	
Publication Date		Review Date October 2014	Review completed
Version	1		
	1.1 31 October 2012		
	1.2 6 November 2012		

Circulation List:

This document was circulated to the following groups for consultation:

- **Executive Directors, Senior Managers**

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

- **All Trust Staff**

Contents:

Appendices

1. General Statement

This policy outlines NIAS commitment to safe management of water systems to prevent and control the spread of water borne bacteria such as Legionella and Pseudomonas in accordance with current legislative requirements, guidance and good practice within DHSSPS. This document lists NIAS objectives and identifies the procedures it will put in place to provide guidance to staff responsible for implementing its Policy for Safe Management of Water Systems (including Legionella and Pseudomonas)

2. Introduction

NIAS has a general duty of care under the Health and Safety at Work Order (NI) 1978 to safely supply, store, distribute and manage water services under their control to safeguard staff and patients.

2.1 Legionnaires' disease

This is potentially a fatal form of pneumonia, caused by inhalation of contaminated water aerosols containing the bacterium *Legionella pneumophila* or related bacteria. Engineered water systems may become contaminated by such bacteria and hence pose a health risk to susceptible individuals. Factors determining the susceptibility of the individual to this disease includes age, illness, immunosuppression and smoking. Other legionella bacteria can also cause less serious illnesses. The collective term used to cover the group of diseases caused by legionella bacteria is legionellosis or Legionnaires' Disease.

2.2 Pseudomonas

Pseudomonas bacteria are common organisms that can thrive in water systems. Once in a water system, pseudomonas bacteria grow rapidly, quickly forming a bio-film on pipe work if left untreated. Biofilms are a critical area where other bacteria, such as legionella can inhabit and proliferate. Pseudomonas bacteria are extremely difficult to eradicate once they have formed within a system and are therefore ideally tackled pro-actively before the problem occurs.

3. Scope

This policy will be applied and adhered to by all managers, employees, building / engineering services and contractors involved in the design, maintenance and repair of the systems and associated services. The policy covers all NIAS Premises and shared sites.

4. Objectives

With respect to current guidance, the policy objectives are as follows:

- Ensure that procedures are in place to assess the risk of bacterial contamination and ensure that corrective actions identified in risk assessments are implemented, so as to either eliminate or adequately manage and control the inherent risk.

- Ensure that any operational changes, redesign of facilities or buildings, or change in their use, consider associated risk from exposure to bacteria.

- Ensure that effective control procedures (written scheme Appendix 2) are implemented and maintained for each premises under the direct control of NIAS.

- Ensure that clear lines of communication are maintained and that individual responsibilities within the control programme are defined and adequately resourced.

- Ensure that all precautionary measures are regularly monitored to maintain their effectiveness and that a continuing programme of awareness is maintained.

- Ensure that results are recorded and that defects in the written scheme of control (defect/action process) are acted upon.

- Ensure that appropriate action is taken in the event of an outbreak of Legionellosis or Pseudomonas.

5. Roles and Responsibilities

Persons designated to any staff functions below shall possess sufficient skills, knowledge and experience to be able to perform the designated tasks safely. These skills may be defined as ‘competence’.

NIAS commits to training individuals within their defined roles to assist meeting the criteria set out above.

NIAS will identify by title/grade and provide contact details, the individuals nominated as contributing to the Policy for Safe Management of Water Systems (including Legionella and Pseudomonas). NIAS will maintain and update records of individuals nominated and their responsibilities. NIAS will also communicate with representatives of the workforce their actions in respect to this policy.

5.1 Chief Executive

The Chief Executive has overall responsibility for the safe management of the water systems within NIAS premises and shared sites.

The Chief Executive delegates the day to day responsibility for establishing and monitoring the implementation of this policy to the Medical Director.

The Chief Executive is responsible for ensuring periodic review of the Policy.

5.2 Director of Operations

The Director of Operations is the designated Executive Director with lead responsibility for the safe management of the water systems with NIAS premises and shared sites and will advise in infection control and water quality. He will report to the Infection Prevention and Control Group on related matters.

The Infection Prevention and Control Group which reports to the Assurance Committee shall agree any amendments to NIAS policy on the control of legionella and pseudomonas.

5.3 Responsible Person

Due to the nature of NIAS service we do not have a chartered engineer, however, we will appoint suitably qualified professionals as necessary. The Responsible Person shall be a manager or director, or have similar status and sufficient authority to ensure that all operational procedures are carried out in an effective and timely manner. The Responsible Person will be required to liaise closely with other professionals in various disciplines

NIAS recognises that the Responsible Person cannot be an expert on all matters and must be supported by specialists in specific subjects as water treatment and microbiology, but he/she must undertake responsibility for calling upon and coordinating the activities of such specialists.

5.4 Contractor

A contractor is the person or organisation designated by management to be responsible for the supply, installation, validation and verification of hot and cold water services, and for the conduct of the installation checks and tests. NIAS will ensure that potential contractors have suitable qualifications (for example companies/individuals who are members of the Legionella Control Association).

5.5 Senior Managers & Staff

Senior Managers, Area Managers, Station Officers are responsible for developing and implementing local arrangements to facilitate the effective management of water systems. They also have responsibility to ensure that information required in relation to this policy is provided in an accurate and timely manner. In the event of discovering an infrequently used water outlet, this shall be reported to the Responsible Person and added to the area's water outlet flushing list. (Appendix 5).

All staff is responsible for co-operating with the operational requirements and procedures of this policy. NIAS Directors will ensure that this policy document is available to all staff. (Appendix 1)

6. Risk Assessment

The Responsible Person will ensure that a suitably qualified person (BS 7592:2008) carries out an adequate risk assessment in accordance with BS8580 that will:

- Identify each water system, its extent and purpose
- Have available an updated schematic of each water system (schematics shall be available for the assessment process and as part of the written scheme)
- Document the conditions and performance of the system
- Identify any risks which the system presents in terms of Legionella or Pseudomonas contamination
- Identify the measures necessary to remove or adequately control any identified risks
- Regularly review the risk assessment
- If risk identified, have action plan to eliminate, remove or control

The risk of healthcare associated legionellosis depends on a number of factors such as:

- The presence of Legionella in sufficient numbers
- Whether conditions suitable for multiplication of the organisms exist
- A source of nutrients
- A means of creating and disseminating respirable droplets (eg from showers or cooling towers)

- The presence of susceptibility populations of people who may be vulnerable to Legionnaires disease

If the above factors are controlled this will prevent the proliferation of other opportunistic water pathogens such as recommended in Annex A (2) of the DHSSPS Circular HSS (MD) 16/2012.

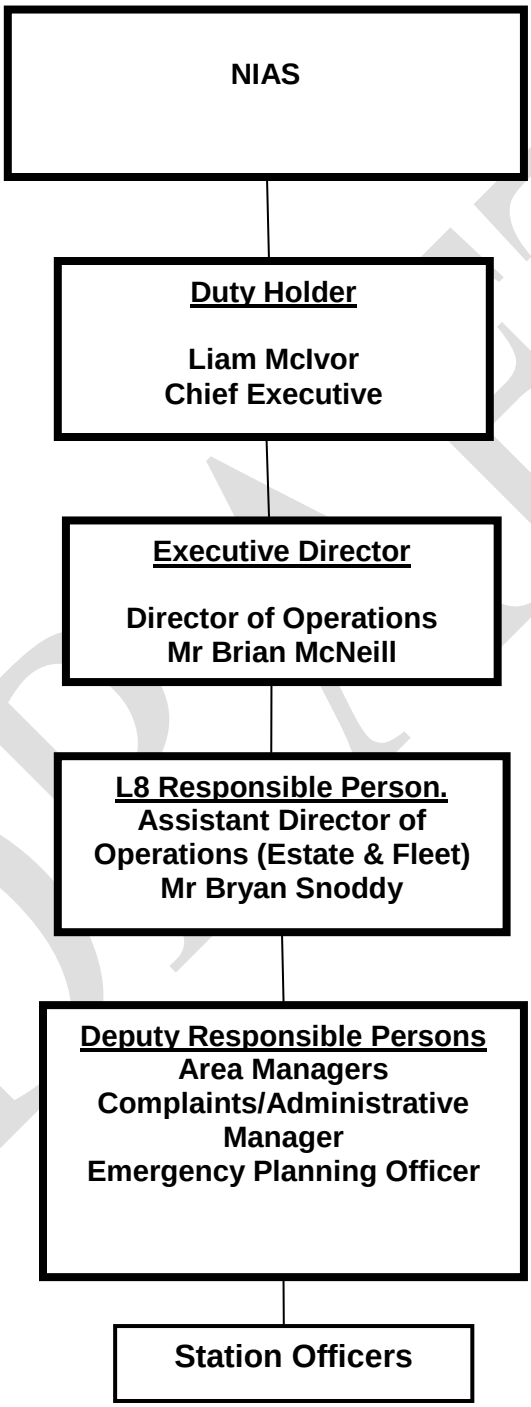
The risk assessment will form the basis of the risk management plan which will be known as the “Written Scheme” (Appendix 2).

All relevant documentation, ie risk assessments will be held at NIAS Headquarters, Site 30 Knockbracken Healthcare Park, Saintfield Road Belfast BT8 8SG and the Responsible Person will schedule any corrective actions identified.

The risk assessment shall be reviewed every two years or when there is any relevant or significant change to the water system or its use, when testing indicates that the control programme is no longer effective or when a case of Legionellosis is associated with the system. The risk assessment shall also be reviewed when new or revised information relating to risk or control measures becomes available.

Appendix 1

Management Details



Appendix 2

WRITTEN SCHEME FOR CONTROLLING THE RISK OF EXPOSURE TO CONTAMINATION IN WATER SYSTEMS (PARTICULARLY LEGIONELLA AND PSEUDOMONAS BACTERIA) IN NIAS PREMISES

The following written scheme is issued in accordance with NIAS Approved Code of Practice L8, and contains a summary of the requirements of the NIAS Policy for Safe Management of Water Systems (including Legionella and Pseudomonas)

(a) Schematic Diagram

The schematic diagram for the particular premises will be held at NIAS Headquarters, Site 30 Knockbracken Healthcare Park, Saintfield Road, Belfast BT8 8SG. This will be managed by Bryan Snoddy who can be contacted on 02890 400999. A copy may be held locally for each station/deployment point, however, the master copy **must** be consulted in the event on an incident.

(b) Description of correct and safe operation of systems

The water systems at the premises operate under the following conditions of temperature:

Cold water storage cisterns: below 20°C
Hot water storage: 60–65°C
Hot water distribution: 60–65°C
Hot water service return: 50°C or above
Hot water to be heated to 60–65°C before first draw-off takes place
All outlets to be flushed weekly unless used more frequently
Hot water outlets with blending valves set to 41-46°C as appropriate

(c) Precautions to be taken

Design and construction of new systems and alterations to be in accordance with HSC ACOP L8, BS 8558: 2011

Hot water outlets which pose a scalding risk to be fitted with thermostatic mixing valves within 2 metres of point of draw-off or mechanical mixing valves with high temperature limit stops, depending on the risk assessment for the particular outlet and persons at risk.

Showers and outlets shall be flushed in a manner that removes the possibility of creating an aerosol. Flexible hoses have been removed from NIAS premises to avoid contamination.

(d) Checks to be carried out to ensure efficacy of scheme

Checks, their frequency and the persons responsible for carrying them out are in accordance with Table 1 of this document**.**

(e) Remedial actions to be taken

The expected results of the checks set out in Table 1, and the actions to be taken in the event of non-compliance, are listed below under the reference number for each check.

(1) No reporting appropriate.

(2) Temperature at blended outlets should be nominally 41-43°C for showers and washbasins. **Record** discrepancies and report to Responsible Person.

(3) Temperatures at sentinel[1] taps should be within range and times stated in Table 1. **Record** discrepancies and report to Responsible Person.

(4) Temperatures at calorifiers[2] should be within range stated in Table 1. **Record** discrepancies and report to Responsible Person.

(5) Representative outlets should be tested annually, approximately 20% and tested on a rotational basis.

(6) If shower roses and hoses cannot be cleaned or descaled effectively, call in a Maintenance Contractor and request replacement with the permission of the Responsible Person.

(7) Temperatures at incoming main and storage tanks should be below 20°C in all cases. **Record** discrepancies and report to Responsible Person.

(8) Cold water temperature rise should be less than 2-3°C under constant flow conditions. **Record** discrepancies and report to Responsible Person.

(9) Water from calorifier drains should be clean and free from visible debris. **Record** discrepancies and report to Responsible Person.

(10) Calorifiers should be clean internally and free from sludge or heavy scaling. **Record** discrepancies and report to Responsible Person.

[1] Sentinel outlets are normally those that- on a hot water service – are the first and last outlets on a recirculating system. On cold water systems (or non-recirculating hot water systems), they are the closet and furthermost from the storage tank (or water heater). The choice of sentinel taps shall include other outlets that are considered to represent a particular risk, eg those identified in the risk assessment and temperature mapping exercise as having the least satisfactory temperature performance.

[2] Calorifier is an industrial-size version of the indirect domestic hot water cylinder found in houses

(11) Compare temperature of water from taps checked with original values measured at Risk Assessment. If any differ by more than 5 degrees or fall outside the control parameters in Table 1 (3) above, **record** discrepancies and report to Responsible Person

(12) Cold water storage cisterns should be serviced in accordance with requirements. **Record** work done and if any discrepancies, report to Responsible Person.

(13) Report and **record** any discrepancies between the schematic drawing and the physical arrangements of water services found on site to Responsible Person.

Table 1

Frequency	Action	Responsibility
1. Weekly	Flush little-used outlets to drain without release of aerosols. Record.	Occupier
2. Weekly	Check and record blended water temperatures from thermostatic mixing valves where fitted. Confirm that stable temperature is attained within one minute.	Occupier (2)
3. Monthly	Check water temperatures at sentinel taps. Hot water >50^{o}C after 1 minute, cold water <20^{o}C after 2 minutes. Record.	Occupier (2)
4. Monthly	Check calorifier temperatures. Flow 60^{o}C, return >50^{o}C. Record.	Occupier (3)
5. Quarterly or as necessary	Dismantle, clean and descale shower heads and hoses. Record.	Occupier (1)
6. Six monthly	Measure incoming water temperature to cold water cisterns and water temperature remote from float valve. Record.	Maintenance Contractor
7. Six monthly (January and July)	Measure cold water temperature rise between incoming main and most distant outlet. Should be less than 2-3°C. Record.	Occupier (4)
8. Annually	Take sample and record condition of water from HWS calorifier drains.	Maintenance Contractor
9. Annually	Open and inspect internal surfaces of HWS calorifiers for scale and sludge and clean or descale as necessary. Record.	Maintenance Contractor
10. Annually	Check and record temperatures at a representative number of taps throughout the system, on a rotational basis	Occupier (2)
11. Annually	Inspect cold water cisterns and carry out remedial work as necessary. Record work done and report outstanding defects.	Maintenance Contractor
12. Annually	Physically inspect the hot and cold water systems and check accuracy of schematic drawings. Note changes. Check for under-used fittings and report recommendations.	Scientific Services and/or Specialist Contractors

Notes

1) May be undertaken by competent Caretaker or maintenance operative using proprietary domestic kettle descaler (COSHH Regulations apply to use of chemicals at work), or by Maintenance Contractor. However, the person responsible must be clearly defined by the Occupier

2) Shall be done using a simple digital thermometer with immersion probe.

3) Readings to be taken from fitted temperature gauges.

4) Should be done using digital thermometer as in (2). Sample points can be the nearest tap to the incoming main, and the most distant tap. These points should be labelled permanently to identify them.

5) Water samples for analysis, where appropriate, are to be taken at the same time as the visual survey is undertaken. In addition samples will be taken at a greater frequency, to be agreed with surveyor, where the water supply is obtained from a private source.

Tests for Temperature performance (ref L8 and HTM 04-01)

Frequency	Check	Cold water	Hot water
Monthly	†Sentinel outlets	The water temperature should equilibrate below 20°C after draw-off for 2 minutes	The water temperature should equilibrate to at least 50°C after draw-off for 1 minute
Monthly	Inlets to sentinel TMVs	Temperatures as above	Temperatures as above
Monthly	Water leaving and returning to calorifier		Outgoing water should be at least 60°C, return at least >50°C
6-monthly	In-coming cold water at inlet to building – in the winter and in the summer	The water should be below 20°C	
Annually	‡Representative outlets	The water temperature should equilibrate below 20°C after draw-off for 2 minutes	The water temperature should equilibrate to at least 50°C after draw-off for 1 minute

Summary checklist for hot and cold water services (ref L8 and HTM 04-01)

Service	Task*	Frequency
Hot water services	Arrange for samples to be taken from hot water calorifiers/water heaters in order to note condition of drain water	Annually
	Check temperatures in flow and return at calorifiers/water heater	Monthly
	Check water temperature after draw-off from outlets for 1 minute to ensure that 50°C has been achieved in sentinel outlets	Monthly
	Visually check internal surfaces of calorifiers/water heaters for scale and sludge. Check representative taps for temperature as above on a rotational basis	Annually
	Manual check to confirm secondary hot water recirculation pumps are operating effectively	Monthly
Cold water services	Check tank water temperature remote from in-coming ball valve and mains temperatures. Note maximum temperatures recorded by fixed max/min thermometers, where fitted	6-monthly
	Check temperature in sentinel outlets after draw-off for 2 minutes to establish that it is below 20°C	Monthly
	Visually inspect cold water storage tanks and carry out remedial work where necessary. Check representative taps for temperature, as above, on a rotational basis	Annually
Mixed-temperature outlets	Check delivery temperature in accordance with D08	6-monthly
Showerheads	Dismantle, clean and descale showerheads and hoses	Quarterly, or as necessary
Sporadically-used outlets	Flush through and purge to drain, or purge to drain immediately before use without release of aerosols	At least twice weekly

Action following *Legionella* Sampling in Hot and Cold Water Systems (ref L8 and HTM 04-01)

Legionella bacteria (cfu/L)	**Action required**
>100 but <1000	Either: If only one or two samples are positive, system shall be resampled. If a similar count is found again, a review of the control measures and risk assessment shall be carried out to identify any remedial action to be taken. Or: If the majority of the samples are positive, the system may be colonised with *Legionella*. Disinfection of the system shall be considered, but an immediate review of control measures and risk assessment shall be carried out to identify any other remedial action required.
>1000	The system shall be resampled and an immediate review of the control measures and risk assessment shall be carried out to identify any remedial action, including disinfection of the system. Retesting shall take place a few days after disinfection and at frequent intervals thereafter until a satisfactory level of control has been achieved.

Appendix 3

Schematic Drawings to be inserted.

Appendix 4

Action Plan in the Event of an incident

An outbreak is defined by the Public Health Agency as two or more confirmed cases of legionellosis occurring in the same locality within a six month period.

In the event of a single case of legionellosis being confirmed on NIAS premises then an emergency meeting will be called by the Responsible Person and a group set up comprising**:**

1 Executive Director – Mr Brian McNeill
2 The Responsible Person
3 The Infection Prevention & Control Lead – Medical Director
4 Health Protection Agency
5 Communications Officer

The group shall meet as necessary, with others as appropriate to co-ordinate an investigation of the problem and progress any necessary action. Minutes will be kept and a log of actions taken. Results of tests and inspections will be recorded and a photographic record to be kept where possible.

Legionnaires Disease is a notifiable disease and should be reported to the Public Health Agency (PHA) by the diagnosing physician. If a member of staff has contracted the disease it may be notifiable by the Risk Manager under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR). Once alerted the Health & Safety Executive may be involved in further investigation of outbreaks under the Health and Safety at Work (NI) Order 1978

<u>The Group shall keep the following informed:</u>

1 The Chief Executive
2 Director of Human Resources
3 Environmental Health Officers
4 Public Health Agency
5 DHSSPS
6 Health & Safety Executive

<u>Immediate action may include:</u>

1 Consideration of sending staff home
2 Sampling of water
3 Testing hot and cold temperatures at all outlets
4 Elevation of temperatures to 55^{o}-60^{0} C at outlets and placing warning notices of raised temperatures
5 Isolation of showers or suspected equipment

Further Action may be necessary:

1 Examination of ductwork of ventilation plant and sampling of drain water from cooling coils
2 Sampling of water from calorifiers serving the building
3 Infection of maintenance records for legionellosis preventive work
4 Disinfection of water services in accordance with BS8558:2011

Appendix 5

Showers

- **Flush through all showers for 5 minutes every week at maximum temperatures.**
- **Avoid the release of water droplets / aerosols, for example by either securing a plastic bag over the shower head with a corner cut off to allow water to escape or by removing the shower head and placing the shower hose directly over the drain outlet.**
- **Flushing should take place after the facility has been cleaned;**
- **Doors/curtains of shower facilities should remain closed during the flushing period and should display a notice indicating that cleaning is in progress and the facility is out of use;**
- **Weekly flushing to be recorded and signed overleaf .**

Taps

- **Flush through the taps, as you would the showers above (avoid splashing to minimise the release of water droplets / aerosols)**
- **Taps, both hot and cold are to be run at a "trickle" for 10 minutes**
- **Weekly flushing to be recorded and signed overleaf .**

Toilets & Urinals

- **Each week flush all toilets (the lid should be closed to avoid contact with any water droplets / aerosol).**
- **In the case of urinals, ensure the continuous flushing systems are working correctly.**
- **Weekly flushing to be recorded and signed overleaf .**

NB **If the above protocol is not followed, the Responsible Person (Legionella) must be informed and the water outlet cannot be used.**

Report any irregularities/maintenance issues to Responsible Person. (insert name & contact no)

Flushing Record

Week commencing : _____ Station:_____

Location	Room No	Shower		Sink Hot Cold	Date	Duration	Signature	Print Name

Checked by Responsible Person : Signed: _____ Print Name :_____ Date: _____

Audited by : Signed: _____ Print Name :_____Date: _____

Source(s) / Evidence Base

Health & Safety at Work (NI) Order 1978
The Management of Health & Safety at Work Regulations (NI) 2000
Control of Substances Hazardous to Health Regulation (NI) 2003 (COSHH)
Public Health Notifiable Diseases Order (NI) 1989
The Water Supply (Water Quality) Regulations (NI) 2007
The Water Supply (Water Fitting) Regulations (NI) 2009
HTM 04-01 The Control of Legionella, hygiene, "safe" hot water, cold water and drinking water systems.
The Health and Safety Commission's (2000) Approved Code of Practice L8.
HSS(MD)34/2010 Water Sources and Potential Cross Infection Risks From Taps and Basins – Interim Advice
HSS (MD) 6/2012 Water Sources And Potential For Pseudomonas Aeruginosa Infection From Taps And Water Systems
HSS (MD) 16/2012 Water Sources And Potential For Pseudomonas Aeruginosa Infection From Taps And Water Systems
BS 7592:2008 Sampling for Legionella bacteria in water systems
BS8580 : 2010 – Water Supply – Risk Assessment for Legionella – Control of Practice
WRAS – Water Supply (Water Fittings) Regulations (NI) 2009
BS EN 12780: 2002 Water Quality – Detection and enumeration of Pseudomonas aeruginosa
BS 8558: 2011 Water Supply - Design, Installation, Testing and Maintenance of services
TM 13:1991 CIBSE Technical Memorandum – Minimising the Risk of Legionnaires Disease

TB/7/15/11/12

NORTHERN IRELAND AMBULANCE SERVICE

TRUST BOARD MEETING

15 November 2012

Title:	NIAS Response to Consultation on the Strategic Framework for GP Out-of-Hours services
Purpose:	Trust response to HSC Board consultation on GP Out-of-Hours services. The Strategic Framework aims to simplify access to GP Out-of-Hours services, improve efficiency and align GP Out-of-Hours provision with other healthcare services
Content:	Completed questionnaire containing NIAS response to the consultation
Recommendation:	For Noting
Previous Forum:	Senior Executive Management Team
Prepared by:	Mr John Gow, Equality & PPI Officer
Presented by:	Ms Roisin O'Hara, Director of Human Resources and Corporate Services

Health and Social Care Board

GP Out-of-Hours

Consultation Response Questionnaire

June 2012

Contents

1 Submitting a response

You can respond to this consultation by e-mail or letter.

Before you submit your response, please read Appendix 1 about the effect of the Freedom of Information Act 2000 on the confidentiality of responses to public consultation exercises.

If you require the documents in another format or language please use the contact details below. Public meetings will also be held.

Responses should be sent to:

E-mail: OOH.consultation@hscni.net

Written: Dr Sloan Harper (GP Out-of-Hours Consultation)
Health and Social Care Board Headquarters
12 – 22 Linenhall Street
Belfast
BT2 8BS

Telephone: (028) 9032 1313

Textphone: 18001 028 9032 1313

Fax: (028) 9055 3622

Responses must be received no later than 4.30pm on Friday 28th September 2012.

2 Background

An independent review of the GP Out-of-Hours services was carried out in late 2007 and early 2008. Following this review the Health & Social Care Board (HSCB) has developed a Strategic Framework outlining proposals for the future development of GP Out-of-Hours. The aims of the proposals are to:

- Simplify access to GP Out-of-Hours
- Improve operational efficiency
- Improve alignment with other healthcare services

These proposals are explained fully in the Strategic Framework.

For reference, further details on current GP Out-of-Hours services and our standards of service are available at www.gpoutofhours.hscni.net

This questionnaire seeks your views on the Strategic Framework for GP Out-of-Hours, and should be read in conjunction with this document.

The questionnaire can be completed by an individual health professional, stakeholder or member of the public; or it can be completed on behalf of a group or organisation.

3 Your views - The Consultation Response Questionnaire

Please tell us if you are responding on your own behalf or for an organisation by placing a tick in the appropriate box:

I am responding: as an individual ☐

on behalf of an organisation √

(please tick a box)

Name:	Roisin O'Hara
Job Title:	Director of Human Resources and Corporate Services
Organisation:	Northern Ireland Ambulance Service
Address:	Site 30, Knockbracken Healthcare Park,
	Saintfield Road, Belfast, BT8 8SG
Telephone:	028 9040 0999
Textphone:	028 9040 0871
Fax:	028 9040 0903
E-mail:	roisin.ohara@nias.hscni.net

May we contact you should clarification be required on your response?

Yes √ or No ☐ (please tick a box)

Have you used a GP Out-of-Hours service in the last 12 months?

Yes ☐ or No ☐ (please tick a box)

1. There are three proposals for GP Out-of-Hours. Please indicate whether you agree or disagree with each of the proposals.

Proposal	Agree	Disagree
(i) Simplify access to GP Out-of-Hours.	√	
(ii) Improve operational efficiency.	√	
(iii) Improve alignment with other healthcare services.	√	

2. Do you have any comments on the above three proposals contained in the Strategic Framework or other suggestions? If you disagree with any of the detailed actions associated with the proposals, then please give the reason why you disagree with each action and if you have alternative suggestions, please give details.

Comments:

(i) <u>Simplify access to GP Out-of-Hours</u>

NIAS strongly supports measures to simplify access to Healthcare. The draft Strategic Implementation Plan for Transforming Your Care (TYC), recently published by DHSSPS signals the implementation of a single number, 111 for urgent care. It outlines a three year commitment for simplified robust 24/7 access to urgent and emergency care via 111/999 with clinical triage and disposition which is regionally consistent and locally sensitive. The implementation of this single number for urgent care clearly signals linkages and interdependencies for GP Out-of-Hours. The finalisation of the Strategic Framework for GP Out-of-Hours needs to recognise the TYC context and ensure consistency with the implementation of TYC. The proposal to reduce the current telephone and text numbers from 7 to 1 will simplify access for people when contacting GP Out-of-Hours and will provide a strong foundation for further development in relation to 111. The implementation of TYC signals closer integration between 999 and 111 telephone access systems for healthcare. Proposals to realign and share call handling workload in GP Out-of-Hours should take due account of existing facilities, processes and technology, in particular those embedded within emergency and non-emergency call handling within the Ambulance Service which already operates on a regional basis for the whole of Northern Ireland. In the context of the telephony required to manage the sharing of call handling workload across Northern Ireland, consideration should be given to maximising the potential of existing telephony installations before procuring new ones at additional cost. Any communications with the public in terms of how best to access and make use of the service should pay due regard to the direction of travel signalled in the implementation of TYC. Given that TYC clearly signals '111' as a public facing contact number for access to unscheduled care, including (we presume) GP Out-of-Hours, any proposal to introduce a single public facing number for GP Out-of-Hours in the interim period runs the risk of confusing the public in a period of change and potentially jeopardises the bigger prize of simplified access to unscheduled care for the whole of Northern Ireland on a 24/7 basis.

NIAS would be concerned that efforts to simplify access to GP Out-of-Hours must be accompanied by a very robust and effective call management system which ensures that those patients most in need are prioritised above less clinically urgent patients. Failure to do this will reinforce the default position for delayed response by GP Out-of-Hours which is to redirect callers to the Ambulance Service. This would create an unnecessary and inappropriate workload for ambulance and emergency departments in hospitals.

ii) Improve Operational Efficiency

The implementation of TYC signals the important developments being made elsewhere in the UK in relation to the introduction of triage systems for unscheduled care, such as NHS Pathways. Due regard should be paid to these developments in the construction of proposals to improve operational efficiency in GP Out-of-Hours in Northern Ireland. The introduction of 111 and NHS Pathways in the UK, albeit on a limited basis at present, has already strengthened the important clinical linkages between ambulance services and Out-of-Hours services. Embedding proposals to enhance GP Out-of-Hours in Northern Ireland within the strategic direction provided by the implementation of TYC should enable us to secure similar results for Northern Ireland. Consideration should be given to integrating any change in GP Out-of-Hours into the overall TYC implementation programme to ensure that benefits are realised and maximised and that consequences such as changes in call volume and onward referral to NIAS are effectively identified, considered and managed.

The document highlights a range of measures to improve operational efficiency on page 15. NIAS has made significant progress in this area and already operates to standard protocols and processes for the whole of Northern Ireland:

- we have in place Northern Ireland wide clinical governance arrangements, including best practice pathways for the common presentations of illnesses;
- we have a standardised triage process with appropriate decision support tools; agreed performance management processes;
- we already operate triage processes which provide alternatives to direct clinical assessment and management of the patient;
- we manage workload across Northern Ireland and take account of workload fluctuations;
- we have invested heavily in technology to support the processes highlighted above and to facilitate home visits including satellite navigation, mobile data and digital radio;
- we engage with HSCB PHA and DHSSPS as well as other healthcare providers to ensure that the service is developed in a way which meets patient needs; and
- we operate and maintain a strong performance management system.

NIAS believes that it is well placed to host the regional GP Out-of-Hours services and would welcome clear direction in this regard and engagement from HSCB. As a minimum any new systems developed must integrate fully with existing systems of relevant care providers such as NIAS and emergency departments.
It has been the experience of NIAS in recent years that the introduction of nurse triage to GP out of hours has increased referrals to NIAS in an unplanned and unresourced manner. Any further plans and proposals to change the operation of GP Out-of-Hours will require consideration from these perspectives to manage the consequence of change particularly the realigning of resource to demand both within GP Out-of-Hours and in those services such as the Ambulance Service impacted by the change.

iii) Improve alignment with other healthcare services

NIAS strongly supports efforts to improve alignment with other healthcare services by GP Out-of-Hours. We have already engaged with one GP Out-of-Hours provider and piloted the triage and passing of appropriate calls (non-urgent/non life threatening) to the GP Out-of-Hours for assessment and management. We have also introduced GPs into ambulance control to provide alternatives for non-emergency and non-urgent callers who require advice and support rather than attendance at an emergency department. Simply 'exploring' better alignment as outlined in Section 4.6 is not enough. It is imperative that action is taken to ensure better alignment and the initiatives taken by NIAS to date and outlined previously highlight both the feasibility of this and the value to patients and the whole healthcare system. We strongly support the retention of the provision by local organisations of home visits to see patients and would welcome measures to improve access to these services to better manage demand for unscheduled care throughout Northern Ireland. We are concerned that co-location for GP Out-of-Hours with Emergency Departments in hospitals could lead to inappropriate use of ambulances to transport patients to Out-of-Hours which would increase demand for ambulance transport. This potential impact must be factored in the considerations for both inward and outward journeys. We are also concerned that co-location of GP Out-of-Hours centres with the Emergency Departments at Hospitals could reduce the number of locations where patients can directly access GP Out-of-Hours with particular impact in rural areas. Our experience has been that such changes result in increased pressure for ambulance services. There is also a risk that changing accessibility in this way discourages patients from seeking advice early and results in an increase in emergency activity as the clinical condition worsens. We believe also that the technology solutions which we have in place will support and facilitate this. In relation to the broadening of service provision, we would point again to the direction of travel signalled in the draft implementation plan for TYC as the most appropriate way of developing a programme which encompasses all aspects of unscheduled care and both simplifies access for the patient and improves management for the whole system. In relation to delivery of the strategic framework for GP Out-of-Hours NIAS welcomes the opportunity to work closely with the HSCB and other relevant providers to maximise opportunities in this area.

Equality implications

Before completing this section, please refer to Appendix 2.

3. This proposal was screened for equality and human rights considerations. A full copy of the screening exercise is included as part of this consultation. A summary of the outcomes is also included in Appendix 2. Please let us know if you are satisfied with the content of the screening exercise and outcomes. If no we would be interested in your reasons for this.

   Yes [√] No [ ]

Comments:

4. If you have any suggestions on how the proposals could better promote equality of opportunity, human rights or good relations please give details.

   Yes [ ] No [√]

Comments:

If you have any additional evidence to support the equality and human rights screening activity give details below.

Yes ☐ No ☑

Comments:

5. Please use the box below to insert any further comments, recommendations or suggestions you would like to make in relation to the Strategic Framework for GP Out-of-Hours.

Comments:

Responses must be received no later than 4.30pm on Friday 28th September 2012. Thank you for your comments.

4 Appendix 1 - Freedom of Information Act 2000 – confidentiality of consultations

The Health and Social Care Board (HSCB) will publish a summary of responses following completion of the consultation process. Your response, and all other responses to the consultation, may be disclosed on request. The HSCB can only refuse to disclose information in exceptional circumstances. Before you submit your response, please read the paragraphs below on the confidentiality of consultations and they will give you guidance on the legal position about any information given by you in response to this consultation.

The Freedom of Information Act gives the public a right of access to any information held by a public authority, namely, the HSCB in this case. This right of access to information includes information provided in response to a consultation. The HSCB cannot automatically consider as confidential information supplied to it in response to a consultation. However, it does have the responsibility to decide whether any information provided by you in response to this consultation, including information about your identity should be made public or be treated as confidential.

This means that information provided by you in response to the consultation is unlikely to be treated as confidential, except in very particular circumstances. The Lord Chancellor's Code of Practice on the Freedom of Information Act provides that:

- the HSCB should only accept information from third parties in confidence if it is necessary to obtain that information in connection with the exercise of any of the HSCB's functions and it would not otherwise be provided;
- the HSCB should not agree to hold information received from third parties "in confidence" which is not confidential in nature;
- acceptance by the HSCB of confidentiality provisions must be for good reasons, capable of being justified to the Information Commissioner.

For further information about confidentiality of responses please contact the Information Commissioner's Office (or see web site at: http://www.informationcommissioner.gov.uk/).

5 Appendix 2 – Equality Implications

Section 75 of the Northern Ireland Act 1998 requires the HSCB to “have due regard” to the need to promote equality of opportunity between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation; between men and women generally; between persons with a disability and persons without; and between persons with dependants and persons without. The HSCB is also required to “have regard” to the desirability of promoting good relations between persons of a different religious belief, political opinion or racial group.

In keeping with the above statuary obligations and in accordance with guidance produced by the Equality Commission for Northern Ireland, the HSCB has carried out a preliminary equality screening exercise to determine if the proposals in the Strategic Framework for GP Out-of-Hours are likely to have a significant impact on equality of opportunity and should therefore be subjected to an Equality Impact Assessment (EQIA). The HSCB has concluded that an EQIA is not appropriate for a number of reasons, for example:

- The introduction of the Strategic Framework is designed to improve the Out-of-Hours service, pathways and communication about the out-of-hours service for everyone.

- It appears that it will improve equality and human rights through greater accessibility and equity of services.

- The introduction of the Strategic Framework is unlikely to impact negatively on any of the equality groups.

TB/8/15/11/12

NORTHERN IRELAND AMBULANCE SERVICE

Minutes of a meeting of the Audit Committee held on Thursday 11 October 2012 at 2.00pm in the Board Room, Ambulance Headquarters, Site 30 Knockbracken Healthcare Park, Saintfield Road, Belfast, BT8 8SG

PRESENT:	Mr N McKinley	Non Executive Director (Chair)
	Prof M Hanratty	Non Executive Director
	Ms A Paisley	Non Executive Director
IN ATTENDANCE:	Mr L McIvor	Chief Executive
	Dr D McManus	Medical Director
	Mrs S McCue	Director of Finance & ICT
	Mr P Nicholson	Assistant Director of Finance
	Mr A Phillips	Financial Accounts Manager
	Ms C O'Hagan	NIAO External Audit
	Mr M Magill	KPMG External Audit
	Mr D Charles	BSO Internal Audit
	Mrs E Hamilton	Personal Assistant

Welcome and Introduction to the Meeting

The Chairman expressed on behalf of the Committee his gratitude for the contribution and sadness at the passing of Mr Seamus Shields, Non Executive Director, since the last meeting of the Audit Committee. This had also already been acknowledged by the Trust Board in the interim.
Prof Hanratty offered her congratulations to Mr McKinley on his reappointment for a further four years as a Non Executive Director.

1.0 Apologies

Mrs C McKeown, Internal Audit.

The Chairman, in offering apologies for the late circulation of papers, acknowledged the hard work of Internal Audit and NIAS staff in preparing papers which would reflect the most up to date position.

2.0 Declaration of Potential Conflict of Interest & Confirmation of Quorum

There were no expressions of potential conflict of interest and the meeting was declared to be quorate.

3.0 Minutes of Previous Meeting of the Audit Committee held on 7 June 2012 (for noting)

Minutes had been previously agreed and presented to Trust Board on 19 July 2012. One further matter arising was an update on the Priority 1 finding as it appeared at Item 6.2 on the minutes.

4.0 Matters Arising

Mr Nicholson gave an update on the Priority 1 finding in Management of Contracts Audit. As the Committee and Trust Board were already aware this matter had been referred to the Counter Fraud and Probity Service (CFPS). Extensive expenditure and invoice details have been provided to the allocated investigator. Sub-Order books have been secured and replacements issued. After around three days of detailed analysis of the information, no evidence of fraud had been discovered to date, however findings similar to those identified by internal audit, for example sub orders consistently not being counter signed, were identified.

The investigator and Mr Nicholson met with the relevant manager, who provided full and comprehensive responses to questions posed. There was no admission, knowledge or evidence of fraud resulting from this meeting. A further, final, day of investigation took place, also finding no evidence of fraud. The final report from the CFPS is awaited and further follow up analysis of individual invoices will be required. Mr Nicholson undertook to continue to report on progress to the Audit Committee. The area of Management of Contracts is also due to be the subject of a full Internal Audit within this year.

Ms Paisley expressed her sense of reassurance that no evidence of fraud had been identified to date and asked what steps had been taken to strengthen controls in the area. Mr Nicholson advised that in order to protect the integrity of the investigation, follow up on some specific audit points, for example reminding managers of the correct procedures to follow, had not yet taken place. Specific actions would be taken following receipt of the final report from CFPS, or earlier if required as the contracts in this specific area are currently being renewed.

Mr McIvor requested confirmation that the Committee were content with this approach in waiting for their investigation to finish before taking any further actions, given the assurance to date of a lack of evidence of fraud. He also welcomed Mr Nicholson's assurance that matters would be brought forward as required in light of the renewal of contracts. The Audit Committee agreed with the approach outlined.

Prof Hanratty enquired as to the position on updating the initial complainant and it was explained the complaint had been received anonymously.

Mr McKinley asked about the timing of the Internal Audit of Management of Contracts audit. He was advised that this audit would take place before the end of the financial year, but had been moved to quarter four to allow time for the CFPS investigation to complete and any required changes to the control environment to be established.

4.1 Invitation to DHSSPS

Mr McKinley informed the Committee that he had, as promised, written to Mr John McKeown at the Department to extend an invitation to attend Audit Committee, to which no reply has been received.

4.2 Audit Committee Self Assessment Checklist

Mr McKinley thanked Prof Hanratty for her help in completing the checklist, which has been duly submitted along with ideas to strengthen induction for new Audit Committee members.

5.0 Chairman's Business

5.1 RQIA Audit Committee

Mr McKinley apologised for not being available to meet with RQIA on their planned visit to NIAS on 25 October. Prof Hanratty undertook to attend on behalf of Audit Committee. Mr McIvor indicated that the invitation had also been extended to have a reciprocal visit of the NIAS Audit Committee to RQIA.

6.0 Internal Audit

6.1 Progress Report

Mr Charles indicated final reports for payroll and the midyear follow up of audit recommendations had been issued. A draft report in respect of workforce planning had been issued and that fieldwork for two further assignments had either commenced or was due to commence imminently. Some audits normally carried out in the first quarter had been deferred to the fourth quarter to allow for the introduction of the new Finance, Procurement and Logistics (FPL) systems.

In respect of the completed payroll audit, Mr Charles advised that there was one Priority 1 finding and two Priority 3 findings and that Internal Audit can provide management with overall satisfactory assurance with regard to the controls surrounding payroll and specific substantial assurance in relation to payroll processing.

There was lengthy discussion around the assurance given and Priority 1 finding assigned to the Payroll Audit. The Non Executive Directors and management felt that, as Agenda for Change was not an issue which Payroll are in a position to progress, the Priority 1 finding should sit elsewhere rather than appear as an unresolved Priority 1 finding in this area. Internal Audit felt that this was the nearest appropriate audit area to record this concern and Mr Charles stated that Mrs McKeown had given the matter consideration and decided that this was the approach consistently taken across all HSC organisations.

While Mrs McCue and Mr McIvor felt this duplicated the External Audit Priority 1 finding on the same issue, both Internal and External Audit felt recording these in both places showed consistency while targeting different audiences.

Mr McIvor advised that the Agenda for Change process is silent on the issue of timescales for completion of the Job Evaluation process and that other HSC bodies have not yet reached this stage of the process therefore there are no comparators to determine timescales. In the absence of further guidance it is not possible to establish what is a "reasonable" timescale for completion of a process where the outcome requires agreement in partnership by both parties. NIAS has placed this issue on the agenda of DHSSPS Accountability meetings to ensure that the matter remains high on the corporate risk agenda of NIAS, DHSSPS & HSCB. This also provides an opportunity to regularly review activity and progress and identify opportunities to secure resolution. Advice to NIAS to date has consistently been that the Trust continues to vigorously pursue resolution within due process.

These efforts were acknowledged by both Ms Paisley and Prof Hanratty, who would have preferred not to see the Priority 1 finding in two places. Mr McIvor further queried how progress would be measured at a future date given the vague wording of the recommendation. Mr Charles assured him that there would be an update in March, which would reflect any change in the situation at that time. It was agreed that there was no dispute over the acceptance of the recommendation or the priority of progressing the matter for the Trust, rather the inclusion of the matter within a payroll audit and the ability of the payroll function to address the matter.

6.2 Follow Up Report

In respect of the follow up on previous Internal Audit recommendations, Mr Charles advised that of the 59 recommendations that should now be implemented, 39 (76%) were fully implemented, 10 (20%) had been partially implemented and 2 (4%) had not been implemented. The recommendations that had not been implemented were in relation to the completion of an Information Asset Register and the finalisation of Information Governance and Risk Policies which currently remain in draft format.

With regard to the Information Governance audit follow up Mr Charles indicated that the outstanding recommendation in relation to compilation of an Information Asset Register is currently a matter for attention in all organisations, not just in NIAS. He drew attention to the revised implementation date of December 2012 for Draft Policy Documentation.

Ms O'Hagan referred back to the Agenda for Change Knowledge Skills Framework and indicated that this is a sector wide issue, not particular to NIAS.

6.3 Mid Year Assurance Report

Mr Charles drew attention to revised implementation dates and stressed the need to progress outstanding items by these dates. Mrs McCue highlighted the 76% completion by mid-year

as a good position to maintain momentum for further progress by year end. Ms Paisley expressed her sense of reassurance whilst emphasising the need to maintain vigilance for the remainder of the year.

7.0 For Approval

7.1 NIAS Mid Year Assurance Statement

The Chief Executive undertook to consider comments from Audit Committee and drew attention to his choice of words in some sections to make Non-Executives aware of his stance on the need to make further progress in those areas. It was agreed to insert a sentence relating to Pseudomonas and the Audit Committee endorsed the statement on the basis of the amendments discussed, recommending that the Chief Executive should sign the statement thereafter.

8.0 External Audit

8.1 RTTCWG for noting

Ms O'Hagan assured the Committee that this is identical to the version already seen by them except that it has removed the remarks referring to BSO which had had no impact on NIAS and were therefore unnecessary.

9.0 For Noting

9.1 – 9.5 Charitable Trust Fund Accounts 2011/12 and associated documents

It was noted that these accounts and associated documents had been considered by the Chair of the Audit Committee under Chairman's action and had subsequently been approved by Trust Board on 20 September 2012.

Mr McKinley asked Ms O'Hagan whether the Audit Office had anything to report on more appropriate use of audit and NIAS resources in producing Charitable Trust Fund Accounts. Ms O'Hagan indicated that Mr Lynn is due to meet with DHSSPS in mid October again with a view to pressing for further progress. Mr McKinley asked that she convey the Committee's thanks to him for undertaking to progress the matter with the Department. Mr Nicholson also informed the Committee that the Clear Line of Sight initiative is likely to have potential for incorporating Charitable funds into the Exchequer Funds in due course. Mr Magill indicated that the certificate should be forthcoming imminently as he has them ready to pass to the Audit Office.

10.0 Any Other Business

10.1 National Fraud Initiative Press Release

NIAS are fully participating in this initiative. The Committee were advised that the data upload was recently authorised by the Chief Executive.

10.2 Fraud Update

Mr Nicholson recapped on the background to issues raised from the last NFI and assured Ms Paisley that the individuals identified are aware of the fact, there is no cash loss to the Trust, and processes are in place to flag any recurrence.

The second issue related to low-value equipment being offered for sale, which have been reported to the PSNI and alerts are in place to assist in the identification of such instances. Assurance was also taken from the fact that individuals had also felt able and aware of how to report such incidents.

10.3 BSTP

Mrs McCue updated the Committee on go-live date changes for the HR & FPL systems, NIAS being scheduled to be in the 3rd tranche for go-live on 17 December, while likely to feel the impact of BSO's go-live in mid October given the use made of their services. HRPTS is currently the subject of a re-planning exercise. Mr Nicholson assured Ms Paisley that NIAS staff is fully engaged in the process.

10.4 Revised Code of Conduct

It was noted that this guidance, issued in July, stated that no member of a Remuneration Committee should also be a member of Audit Committee. Ms Paisley is currently in this situation, which is expected to be resolved shortly with the appointment of two new Non Executive Directors.

10.5 PALS Recovery Plan

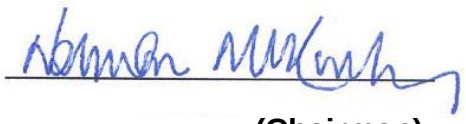
As part of the 2011/12 accounts process an issue with BSO contracts operating beyond their expiry date was raised and indeed led to BSO's accounts being given a qualified opinion. It was clarified that this had had no material impact on NIAS. BSO PaLS had engaged in the development of a recovery plan, progress against which would be reported through the Regional Procurement Board, alerting all Trusts to any impact.

Ms O'Hagan indicated that the Department has set up a working group to assist with resolving this matter as quickly as possible. Mr McIvor expressed concern that an isolated focus on regional BSO contract management could result in delays in processing of local Trust contracts. He highlighted the need for the Regional Procurement Board, of which Mrs McCue is a member, to keep a focus on both regional and local contracts.

This concluded the business of the meeting and the Chairman closed the meeting.

Date, Time and Venue of Next Meeting

The next meeting of the Audit Committee is scheduled for Thursday 6 December 2012 at 2.00pm in the Boardroom, NIAS Headquarters.

Signed 

(Chairman)

Date **6 November 2012**

TB/9/15/11/12

Northern Ireland Ambulance Service
Health and Social Care Trust

Minutes of a Meeting of the Assurance Committee held on Thursday 11 October 2012 at 11.00am, Boardroom, NIAS Headquarters, Site 30, Knockbracken Healthcare Park, Saintfield Road, Belfast, BT8 8SG

PRESENT	Prof M Hanratty	Non-Executive Director (Chair)
	Miss A Paisley	Non-Executive Director
	Mr N McKinley	Non-Executive Director
IN ATTENDANCE	Mr L McIvor	Chief Executive
	Dr D McManus	Medical Director
	Mr B McNeill	Director of Operations
	Mrs S McCue	Director of Finance
	Ms R O'Hara	Director of Human Resources & Corporate Services
	Ms L Rafferty	Assistant Director of Human Resources, Education, Learning & Development
	Dr N Ruddell	Assistant Medical Director
	Mr P Nicholson	Assistant Director of Finance
	Mr T McGarey	Risk Manager
	Mrs J McSwiggan	Senior Secretary

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

Noted. The Committee was reminded 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 7 June 2012

The Minutes were presented for noting by the Assurance Committee. The Minutes had been previously circulated, agreed and signed by Professor Hanratty (Chair) and were presented to Trust Board on 19 July 2012.

4.0 Matters Arising

Matters arising are dealt with as agenda items.

5.0 Chairman's Business

The Committee congratulated N McKinley on his reappointment to the NIAS Board.

5.1 Code of Conduct and Accountability

The Committee had previously agreed to consider the Risk Register at Assurance Committee meetings and report to the Trust Board accordingly. However in line with the new Code of Conduct, the Risk Register will continue to receive due consideration at Assurance Committee meetings, but will now also be presented to Trust Board.

The Committee also noted an aspect of the Code relating to the constitution of Trust Board Committees, which will be considered once the two new Non-Executive Directors are appointed.

6.0 Presentation

6.1 Clinical Supervision and the Role of the CSO

A presentation was given on Clinical Supervision and the role of Clinical Support Officers.

A copy of the presentation will be circulated to Non-Executive Directors following the meeting.

The Committee thanked the Human Resources & Corporate Services Directorate for a comprehensive and useful presentation, and expressed its support for the ongoing role of the CSOs.

The Committee noted that the presentation on 7 December 2012 will be given by the Operations Directorate on performance, including a review of out-of-standard calls.

7.0 Standing Items

7.1 Risk Register as at 30 September 2012

The Risk Register and updated Risk Map were presented to the Committee and discussed.

A strategic planning workshop has been arranged for Executive and Non-Executive Directors to review the Corporate Plan, providing an opportunity to consider potential corporate risks. This was welcomed by the Committee.

7.2 Untoward Incidents Report as at 30 September 2012

The Untoward Incidents Report was presented to the Committee and the new presentation format was welcomed.

The issue of meal breaks was raised, with the shift in reporting from numbers of missed meals to numbers of late meal breaks being noted.

A typographical error on page 1 will be corrected.

Serious Adverse Incidents (SAIs) were defined and the Committee noted that there are three SAIs involving NIAS that are currently being investigated. It was requested that a table of SAIs be presented to the Committee at future meetings.

The regional benchmarking data was welcomed, and the Committee was reassured that it reflected positively on NIAS reporting systems and staff willingness to report incidents. The Trust also hopes to improve feedback to staff who report incidents.

7.3 Controls Assurance Standards

The auditors are currently undertaking an internal audit review of risk management within the Trust and an update will be provided to the Committee in due course.

The Committee noted the letter from the Department advising that compliance with the management of purchasing and supply and the decontamination of medical devices controls assurance standards will be subject to internal audit verification in 2012/13. It was noted that the decontamination standard is not assessed within NIAS, but that the Trust would have the opportunity to consider other standards for verification by internal audit.

It was also noted that the Trust is currently substantively compliant with all controls assurance standards. The issue of contracts management as part of the management of purchasing and supply standards, has been discussed by the Audit Committee.

7.4 Assurance Framework

The Assurance Framework was presented and the Committee confirmed its approval of the document's continuing development towards a greater alignment with the Corporate Plan.

The presentation of Clinical Performance Indicators (CPIs) and the audit of Patient Report Forms (PRFs) were highlighted. The Trust aims to develop a suite of all CPIs and then benchmark these. The significant increase in year on year numbers of PRFs following the introduction of the Clinical Support Officers (CSOs) was noted. The huge amount of work required to quality assure this data means that only individual CPIs are being produced at the moment. The benefits of an electronic PRF system were noted, as was the problem of introducing this within the current financial climate.

A report on the timeliness of the return of PRFs and their processing will be presented to the Committee at its next meeting.

The work of the training teams, CSOs and Assistant Medical Director was acknowledged in the production of the safety checklist for the treat and leave protocol for hypoglycaemia.

The work on falls assessment was also commended.

7.5 RQIA Action Plan

A progress update on outstanding recommendations was provided to the Committee.

A typographical error in recommendation 12 ("HSC Trust" to be changed to "HSC Board") will be corrected.

A typographical error within recommendations 13/14 was raised again and will be corrected.

7.6 Medical Device Alerts

The Trust continues to review all Medical Device Alerts and none are currently of relevance to NIAS.

7.7 Coroner's Rule 43

The Coroner's Rule 43 report was presented to the Committee and progress was noted.

The Committee agreed that those items which have been actioned can now be removed from the list.

With regards laryngoscope handles, a progress report will be provided to the Committee on the move to single use disposable handles and blades at the next Committee meeting.

As part of the report, the Committee was informed of a Safety Quality Learning Alert issued by the Public Health Agency (PHA) at the request of the Senior Coroner for Northern Ireland relating to a rare case of fatal scalp haemorrhage. Although NIAS were involved in the incident that gave rise to the alert, the Trust has been unable to identify the specific call. However the recommendations in the alert have been noted and will be circulated to all operational staff through RATC.

7.8 Reports from Groups and Committees

7.8.1 Health & Safety Committee – Minutes of Meeting 25 April 2012

Noted. No items for Assurance Committee.

7.8.2 Health & Safety Committee – Management Summary 25 August 2012

Noted. No items for Assurance Committee. The issue of "non-NIAS employees" attending the meeting was clarified.

7.8.3 Fire Compliance Sub Committee – no further meetings since last meeting

No further meetings had taken place since the last Assurance Committee meeting.

7.8.4 Infection Prevention & Control Group – Notes of Meeting 18 July 2012

Noted. The Committee noted that the issue with gloves has been resolved.

7.8.5 Medical Equipment Group – Notes of Meeting 1 August 2012

Noted.

7.8.6 Emergency Planning & Business Continuity Group – Notes of Meeting 15 June 2012

Noted. This was the first meeting of this Group, arising from recommendations by the auditors with regards business continuity. The Terms of Reference for the Group were noted.

8.0 Pharmacy and Medicines Management Update

Thirty stations have now been inspected by the DHSSPS Pharmacy Inspection Team and there have been no major issues identified to date. Any minor issues arising continue to be swiftly resolved. The Committee noted an inspection report relating to the loss of a Med05 record within a filing cabinet, with action already underway to resolve this issue with the supplier of the cabinets.

The Committee noted that the inspection reports had been very positive, and highly commended the high standard and professional NIAS practices in relation to the management of controlled drugs, which are a credit to all staff.

9.0 Outbreak Management

A draft NIAS Outbreak Contingency Plan had been developed with input from the Infection Prevention & Control lead in Public Health Agency (PHA). The plan has now been amended to reflect Departmental advice on support for staff, and the amended draft plan will be presented to the Infection Prevention & Control Group, with a final draft being provided to the Assurance Committee on 6 December 2012.

10.0 Any Other Business

The schedule for flu vaccination for staff was highlighted.

Date, Time and Venue of Next Meeting

The next meeting will take place on **Thursday 6 December 2012 at 11.00am** at NIAS HQ.

Signed: _____ **Date:** 6 November 2012

(Professor Hanratty, Chairman)