Northern Ireland Ambulance Service Health and Social Care Trust

Minutes of NIAS Trust Board held on Thursday 16 December 2021 at 9.30am via Zoom (due to Covid-19)

Present:	Mrs N Lappin	Chair
	Mr W Abraham	Non Executive Director
	Mr D Ashford	Non Executive Director
	Mr J Dennison	Non Executive Director (left the meeting at 12.15pm and rejoined at 12.30pm)
	Mr T Haslett	Non Executive Director
	Mr M Bloomfield	Chief Executive
	Ms R Byrne	Director of Operations
	Ms M Lemon	Interim Director of HR
	Mr P Nicholson	Interim Director of Finance
	Dr N Ruddell	Medical Director
In Attendance:	Ms L Charlton	Director of Quality, Safety & Improvement (left the meeting at 12.15pm)
	Mr B McNeill	Programme Director - Clinical Response Model (CRM)
	Ms R O'Hara	Programme Director – Strategic Workforce Planning
	Ms M Paterson	Director of Performance, Planning & Corporate Services
	Mrs C Mooney	Board Secretary
	Mr C Carlin	Boardroom Apprentice
	Ms C Greene	Communications Officer (for agenda item 4 only)
	Ms T Avery	Head of Informatics (for agenda item 6 only)
	Ms H Orr	Senior Data Analys (for agenda item 6 only)
	Mr D Flannagan	Head of Safeguarding (for agenda item 7 only)
	Mr N Walker	Head of Performance (for agenda item 9 only)

Ms M Johnston	REACH Project Manager (for agenda item 9 only)
Ms R Smyth	Graduate Intern

1 Welcome, Introduction & Apologies

The Chair noted no apologies had been received and reminded those present that they should declare any conflicts of interest at the outset or as the meeting progressed.

The meeting was declared as quorate.

The Chair welcomed Ms Rebecca Smyth, Graduate Intern, who would observe today's meeting.

2 Previous Minutes (TB16/12/2021/01)

The minutes of the previous meeting held on 21 October 2021 were **APPROVED** on a proposal from the Chair and seconded by Mr Ashford.

3 Matters Arising (TB16/12/2021/02)

Members **NOTED** the update against the Matters Arising.

4 Chair's Update

The Chair advised the meeting that all HSC Chairs and the Chair of the NI Fire and Rescue Service (NIFRS) had issued correspondence the previous day to all MLAs around the increase in assaults on staff across health and social care. She said she was pleased to see that the issue had received some media attention and MLAs had indicated their support. The Chair added that consideration was being given to what actions could be taken at Trust Board level to demonstrate to staff that members were very aware of the challenges they faced on a daily basis.

Continuing, the Chair referred to correspondence recently received from the Permanent Secretary extending the pause on sponsorship and governance activities until the end of the financial year 2021/22. She asked Mrs Mooney to circulate the correspondence to members for their information.

The Chair thanked those who had attended the Audit Committee on 2 December and extended her thanks in particular to Mr Abraham, Audit Committee Chair, who had been instrumental in leading the meeting. She commented that, as well as receiving assurance about the progress which had been made, those attending also had the opportunity to have constructive discussion with IA colleagues which would prove beneficial over the coming weeks.

The Chair thanked members for facilitating approval of the consultation on the introduction of Body Worn Video by e-mail and said she looked forward to seeing the results of the consultation when they became available.

Continuing, the Chair encouraged Non-Executive Director colleagues to visit stations in the approach to Christmas and asked them to speak to Mrs Mooney should they require any information around Covid-19 protocols.

The Chair commented that she would like to arrange 1:1 meetings with Board members and Director colleagues in the New Year. She said that members would be aware that it had been her hope that the December Trust Board would be held on a face-to-face basis. However, with the current uncertainty over the Omicron variant, it had been considered prudent to revert to holding the meeting virtually. The Chair said that it remained her hope that the Trust Board would be able to meet face-to-face in March but that the situation would be kept under review.

Concluding her report, the Chair explained that she would like to take some time to share with members a presentation celebrating NIAS achievements over the last number of years. She reminded the meeting that, as well as frontline staff delivering care, there were corporate support functions who were critical to the Trust's work. The Chair thanked Mr McPoland and Ms Greene for their work in developing the presentation and said that it provided her, as Trust Chair, with an opportunity to convey her deep appreciation to all staff across the Trust and to show what had been achieved, particularly during the pandemic.

Following the presentation, the Chair suggested that it would be useful to consider how the presentation might be shared with a wider audience.

She indicated that members would receive an update on the roll-out of the REACH project later in the meeting and acknowledged that, while there had been a delay in the roll-out, the fact that it had been undertaken at all during the pandemic was to be recognised and would prove beneficial to both patients and staff.

Members **NOTED** the Chair's update.

5 **Chief Executive's Update**

Mr Bloomfield reported that the Trust continued to operate at REAP 4 level and said this was mainly due to ambulance response times and delayed handover times at EDs. He advised that a high level of staff, ie approximately 20%, were unavailable for work and said that this was due to 'normal' sick leave and those unavailable for Covid-19 reasons. Mr Bloomfield said that, despite this, operational cover remained good for the week. He indicated that such a high level of staff abstractions reinforced the Trust's reliance on staff overtime to provide the level of cover and reminded the meeting that much of the overtime rates was being paid at the enhanced Covid-19 rate.

Continuing Mr Bloomfield said the impact on patient care and staff was clear and added that this would be the main focus of his Chief Executive's report.

Mr Bloomfield indicated that patient care was being compromised by the current pressures despite staff doing their best for patients. He indicated that patients were experiencing unacceptable waits for an ambulance response and as a result were having poorer outcomes. Mr Bloomfield explained that the rationale for response time standards was to ensure patients had the best chance of a positive outcome. He said that currently the response time for Category 1 calls was 20 minutes while, on occasions, responses to Category 2 calls, including heart attacks and strokes, were over one hour with responses to Category 3 calls, including responses to elderly patients who had fallen, being over five hours. Mr Bloomfield said that Trust staff were finding such response times very difficult to cope with.

He noted, however, that the Trust continued to receive many compliments about the compassion and kindness shown by staff to patients in such challenging circumstances.

Mr Bloomfield indicated that the Association of Ambulance Chief Executives (AACE) had recently published a report on the impact and harm caused to patients waiting in ambulances and patients in the community waiting as a result of a delayed response. He pointed out that Northern Ireland was not included in the clinical study used in the report. He acknowledged the deep frustration felt by staff to spend significant periods of time outside EDs. Mr Bloomfield referred to late or missed rest periods and said that late finishes, by as much as six hours, had become the norm, resulting in shifts of up to 18 hours.

Continuing, Mr Bloomfield said that the Trust's Senior Management Team had decided that late finishes were not sustainable for staff and represented a risk to patient safety as well as impacting on the health and wellbeing of staff. He added that late finishes increased the risk of errors and the likelihood of staff being absent from work for extended periods of time.

Mr Bloomfield said that staff in other professions usually finished their shifts on time and he believed that this should also apply to NIAS staff. He indicated that pilots were being trialled in the South East and Belfast Divisions to try to ensure staff finished their shifts on time. Mr Bloomfield said that, given the overall pressures, any further reduction in staffing through increased absences, staff being unwilling to work overtime or longer handover times at EDs, had the potential to result in ambulances not being available to respond to calls.

Mr Bloomfield referred to the uncertainty currently surrounding the new variant, Omicron, and said that infections were forecasted to peak in mid-January. This could, he said, have further potential to reduce staffing levels.

Mr Bloomfield said that the Trust had recently moved from NIAS Silver Command to surge planning to ensure the Trust was taking every step to maintain service delivery over the winter months. He indicated that this would undoubtedly involve difficult decisions around actions which previously would have been considered unconceivable but which could now become necessary.

Mr Bloomfield advised that it had become necessary to pause business as usual and transformation projects such as the

Operational Structure Management Review had been paused. He said that the position would be reviewed in the New Year.

Mr Bloomfield commented that most of the significant meetings he would normally reflect upon in his report to the Board had focussed on the current pressures, including recent meetings with elected representatives from across NI.

Mr Bloomfield reported that he, Ms Byrne and Ms Paterson had met with the Health Committee on 2 December to brief Committee members on the current service pressures. He said that the support expressed by the Committee for NIAS was very much welcomed.

Continuing, Mr Bloomfield advised that he, Ms Charlton, Dr Ruddell and Ms Byrne had had a positive meeting with the Chief Officer of the NI Fire and Rescue Service (NIFRS) and his colleagues to explore how NIFRS might be able to work with the Trust in responding to calls. He indicated that engagement and collaboration over recent years had mostly related to areas of fleet and estate while the focus of recent discussions had been on the ability to co-respond to calls on behalf of NIAS. Mr Bloomfield said that he was greatly encouraged by the willingness of the NIFRS to progress discussions around this and he hoped to be able to report on progress in the coming months. He noted that there had also been increasing interest from elected representatives on this collaboration.

Mr Bloomfield reported that he and Dr Ruddell had attended a summit engagement convened by the Minister and involving all health bodies with the aim of identifying further actions which might be taken to address system pressures over the next three months. He said that, while issues and priorities had been identified, it had proved more difficult to identify the potential actions to be taken and he believed that this reflected the challenges being faced by the health and social care system. Mr Bloomfield said that Dr Ruddell had taken the opportunity to highlight the impact that delayed handovers were having on patients and staff and had also referred to the need for alternative pathways to conveying patients to EDs which would have a positive impact on the HSC system and on outcomes for patients.

Mr Bloomfield advised that Dr Ruddell had recently done a media interview in relation to an incident where there had been a delay in

ambulance response. He said that he was unable to give any further details but said that Dr Ruddell had explained the reason for delayed ambulance response times. Mr Bloomfield said that it was very likely over the coming months that such explanations would be rehearsed many times given the pressures facing the service. He said it was clear from the complaints received by the Trust that delayed response accounted for many complaints. Mr Bloomfield assured the Board that the Trust was taking all possible actions to provide the safest care it could in the circumstances and ensure greater focus on supporting staff to remain at work to provide that care over the period that lies ahead.

Mr Ashford described the Chief Executive's report as 'sobering' and said that, whilst concerning, he very much appreciated hearing further about the challenges facing the service. He said he was sure he was speaking on behalf of other Non-Executive Directors when he offered whatever support they could provide. Mr Ashford welcomed the collaboration with the NIFRS and said he looked forward to hearing about progress. He sought clarification on whether the Trust had any further detail on the peak expected in mid-January and how it might compare to previous peaks.

Responding, Mr Bloomfield explained that the current modelling used by the DoH only looked at a four-week forecast and said the Trust expected further detail around Christmas time of what the peak might look like. He reminded the meeting that Northern Ireland was approximately two weeks behind England and Scotland and pointed out that England had recently had the biggest single number of daily infections since the start of the pandemic. Mr Bloomfield said that it would be a few weeks until it was clear how these infections translated to pressures in hospitals, ICU admissions and deaths.

Mr Bloomfield pointed out that, even if the new variant, Omicron, did not lead to individuals becoming very sick or an increase in hospital admissions, the biggest impact on NIAS would be the abstraction of staff through having to self-isolate.

Mr Haslett thanked Mr Bloomfield for his honest and frank report and said it was clear that the Trust was doing everything possible to improve what was ultimately an impossible situation. He conveyed his appreciation to all involved.

Mr Abraham emphasised the need for a resolution to be found to the issue of delayed handovers and praised all staff for their sterling work.

Mr Bloomfield thanked members for their comments and said that Trust officers were examining on a daily basis what changes could be made to make a difference to patient care but he acknowledged there was a limit to what was possible. He said the reality was that the entire health and social care system was under extreme pressure and it was becoming increasingly difficult to maintain service delivery.

Members **NOTED** the Chief Executive's report.

6 **Self Service Business Intelligence (BI) Reporting Model – presentation (TB16/12/2021/03)**

The Chair welcomed Ms Tracy Avery, Head of Informatics, and Ms Hannah Orr, Senior Data Analyst, to the meeting and asked Ms Paterson to introduce this agenda item.

Ms Paterson conveyed her pride in the team and alluded to the significant support they provided across the organisation.

Ms Avery said that, earlier in the year, she and Ms Orr had presented to the Board on the sample dashboards and had highlighted the benefits of the Trust transferring to a Self-Service Analytics Business Model. She said that, since then, Ms Orr had been leading the team in proving the concept should the Trust adopt this new model.

Ms Avery advised that the team had engaged with internal stakeholders to design and develop the dashboards and had also explored their suitability for each Directorate across the organisation. She added that, through this engagement and trialling of the dashboards, the team had been able to allow users to access the business intelligence for the use of:

- Operational Management
- Planning, Performance and Quality Improvement
- Enabling decision-makers to interrogate data from a range of NIAS systems, including:

- Control and Demand System
- Global Rostering System
- Electronic Patient Record

Following presentation of the business intelligence reporting model by Ms Orr, Ms Avery commended Ms Orr on leading this valuable piece of work at a pace which was unprecedented in the HSC. She pointed out that, only a year previously, decision-makers had only been able to access limited information on a retrospective basis. Ms Avery commented that to be in a position to look at up-to-date information and to extend that further in terms of being able to provide real-time information represented a significant achievement in the HSC.

Ms Avery explained that the benefits to the organisation and to the patients who availed of the Trust's services had been clearly demonstrated in Ms Orr's presentation. She was of the view that the concept for the adoption of a self-service analytics business model had been proven and the team would seek to move into formal development and implementation at scale.

Mr Abraham commended the team on their work and described it as 'impressive'.

Ms Orr said she hoped she had showcased the potential of the BI dashboard and believed it complemented the strategic direction of the Informatics Department.

The Chair welcomed the further development of the dashboard and was of the view that it very much supported evidence-based decision making. She said that she recognised the invaluable nature of this work and she commended those involved.

Dr Ruddell commented that he was currently taking forward some work with the Informatics Team which would assist in clinical models. He referred to the real-time aspect of the information being provided and said he hoped to highlight some of this work at the February Trust Board meeting.

Mr Ashford referred to the sophistication of the information available through the dashboard and asked whether it was shared with hospitals, for example, delayed handovers and the associated lost hours.

In response, Ms Paterson explained that all Trusts used a common set of indicators to assess their respective positions in relation to long waits and performance. She acknowledged the invaluable nature of such data to all those working across the region with their counterparts and agreed that it would be useful to share the data. Ms Paterson pointed out that the data was not yet available to the public and was only for internal use by managers who used it to aid them in planning and performance decisions.

The Chair referred to the range of information within the dashboard, for example information relating to overtime, and suggested that Directors may wish to consider how this could be brought to the attention of the relevant Trust Committees.

Mr Haslett echoed the comments made and said the development of the BI dashboard could ultimately act as a 'game changer' in how information could potentially help shape service provision.

Ms Byrne pointed out that access to the data provided by the BI dashboards was invaluable both for discussions within NIAS but also with acute Trusts and HSCB colleagues as well as informing decision making and operational planning. She conveyed her thanks to the team.

Ms Charlton referred to the work being taken forward around falls and learning from deaths and said that the dashboard helped reinforce where the Trust sat in relation to national quality indicators. She added that the information available would help revolutionise the work being taken forward within the Quality, Safety and Improvement Directorate.

Ms Avery commended Ms Orr who had led the development of the dashboard and said that to be able to develop the volume of and real-time data was a testament to her significant contribution and that of her team. She said that the benefits of having such data available would become evident over time. Ms Avery added that the concept had now been proven and the Informatics Team would seek to move forward to formally roll-out the implementation of the toolkit to everyone.

Following the Board's noting of the presentation, the Chair thanked Ms Avery and Ms Orr for their attendance and they withdrew from the meeting.

7 **Safeguarding – role of Trust Board (TB16/12/2021/04)**

The Chair welcomed Mr Des Flannagan, Head of Safeguarding, to the meeting. She reminded members that Mr Abraham had agreed to assume the role of NED Safeguarding Lead and explained that, following a meeting with Ms Charlton and Mr Flannagan, Mr Abraham had suggested a presentation should be given to the Board on the roles and responsibilities of members in this important area.

Mr Flannagan gave a detailed presentation which covered areas such as - what safeguarding encompasses in NIAS; Board level accountability; legislation & statutory requirements; partnerships; governance; NIAS safeguarding; achievements and current risks.

Mr Flannagan highlighted that safeguarding leadership was critical and alluded to the fact that it was everyone's responsibility. He suggested that Board members should also complete the safeguarding training available online.

Mr Flannagan indicated that safeguarding should be embedded in every aspect of the Trust's work and was an integral part of patient care. He referred to the Muckamore Report and in particular the finding that there was an 'absence of curiosity' on the part of the Board.

The Chair thanked Mr Flannagan for his presentation and invited members to comment.

Mr Bloomfield agreed that safeguarding was a hugely important area of work. He said that members would recall that, at an early stage, he had identified the absence of a dedicated and expert safeguarding role as a key gap and the decision was taken to include this role in the new Safety and Quality Directorate. Mr Bloomfield acknowledged that the area of safeguarding had been a significant risk to NIAS, staff and most importantly vulnerable patients as has tragically been evidenced in recent media. He said that, while much work remained, he hoped the Board was assured that Mr Flannagan's appointment had contributed significantly to

addressing this risk. Mr Bloomfield thanked him for his support for staff and Ms Charlton for her leadership in this important area.

Mr Dennison suggested that there would be a significant workload associated with this area of work and asked if additional resources might be required.

The Chair said that, while she was aware of the learning emanating from the Muckamore Report, she was interested in how they applied to NIAS and how NIAS could learn. She added that she had been struck by Mr Flannagan's reference to an 'absence of curiosity' and acknowledged the work to be taken forward in the coming year. The Chair also alluded to the safeguarding examples shared by Mr Flannagan and experienced by NIAS staff.

Ms Charlton commended Mr Flannagan on his support to and engagement with staff on the ground. She added that staff were now contacting him directly for advice. Ms Charlton alluded to Mr Dennison's earlier reference to the significant workload associated with safeguarding. She said it would be important that Mr Flannagan did not feel vulnerable in the organisation and consideration would be given to a structure for safeguarding.

Mr Bloomfield said that Mr Flannagan's appointment was positive for the Trust in that it needed to have dedicated expertise in post. However, he added that he was mindful of the need to consider what additional resources might be required. Mr Bloomfield said that, while harrowing, he welcomed Mr Flannagan sharing the safeguarding examples with members as they clearly demonstrated the challenges facing staff on a daily basis.

Ms Lemon advised that she and Mr Flannagan intended to develop a domestic abuse policy within the Trust which they hoped would be of some assistance to staff in the course of their duties and she emphasised the importance of ensuring the appropriate support frameworks were in place for staff.

Mr Abraham thanked Mr Flannagan for his detailed presentation and for his work to date.

Concluding the discussion, the Chair said the support shown by members for this work was clear and she conveyed her thanks and

those of Board members to Mr Flannagan for his attendance. He withdrew from the meeting.

8 **NIAS Fleet Strategy – Preparing for our Future (TB16/12/2021/05)**

Introducing this agenda item, Mr McNeill said that, following a request from the Board, the Strategy had been recirculated to staff with a list of questions with pre-empted responses to specific areas. He advised that, while three responses had been received, none of these would materially change the content of the Strategy. However he said that the responses would certainly be useful when the Trust came to design the vehicles at procurement stage.

Mr McNeill said that the reason for recirculating the Strategy had been to generate comments on the carbon footprint and the impact on the environment and he confirmed that no comments had been received in relation to this aspect of the Strategy.

Mr McNeill said that the Trust was taking every opportunity to address these aspects where possible and had recently procured a further seven electric cars. He indicated that the Trust's network of electric chargers had also been expanded at all facilities and said that no vehicle would be more than 30 miles from an electric charger at a NIAS property. However, Mr McNeill pointed out that the issue of sustainability would be better addressed through the development of a NIAS Sustainability Strategy and added that consideration would be given to its development in the next quarter.

Acknowledging that Mr McNeill had actioned the Board's request to recirculate the Strategy, the Chair expressed her disappointment at the low response rate from staff.

Ms Charlton said that Mr McNeill and she had discussed how best to involve service users in the design and comfort measures in the back of the fleet. She added that asking service users to comment on aspects of the Fleet Strategy would provide the opportunity for more pragmatic ways of involving them at a later stage.

The Chair acknowledged that this would probably prove more helpful to staff as they would be using the vehicles procured.

The 'NIAS Fleet Strategy – Preparing for our Future' was **APPROVED** on a proposal from Mr Bloomfield and seconded by Mr Haslett.

The Chair extended her thanks to Mr McNeill and all involved in the development of the Strategy.

9 **Update on the implementation of the NIAS Strategic Plan (TB16/12/2021/06)**

The Chair welcomed Mr Neil Walker, Head of Performance, Planning & Corporate Services, and Ms Marianne Johnston, REACH Project Development & Implementation Manager, to the meeting. She conveyed Mr Thompson's apologies.

Mr Walker explained that the purpose of the report was to provide a summary of progress to date to the Board on how well the organisation was delivering the key deliverables identified within the annual Corporate Plan 2021/22. He reminded the meeting that the deliverables were linked to the Strategy: Caring Today, Planning for Tomorrow: Our Strategy to Transform 2020-2026.

Mr Walker indicated that the Corporate Plan was a critical component for the Trust to monitor and measure progress against corporate and operational objectives set for financial year 2021/22. He said that this year had seen the Trust implement processes to review and scrutinise the delivery of the Corporate Plan at the Directorate level.

Continuing, Mr Walker advised that, for 2021/22, the Trust had broken down the Corporate Plan objectives that were applicable to each Directorate and created Directorate Plans. He explained that it was at this level that the Trust assessed and scrutinised its delivery of the Corporate Plan. He referred to the collaborative approach that had been adopted and said that meetings were held on a quarterly basis with Directorates to review the position.

Ms Paterson highlighted that the update before members was at October and she referred to the significant pressures which had impacted on progress since then. She added it was intended that the Board would receive updates on a quarterly basis. Ms Paterson advised that the standard portfolio style report had been used to indicate progress and transformation and said that the report would

be enhanced over time with a view to becoming more robust across the programme portfolio. However, she said she would welcome feedback from members as to how this reporting format could be further enhanced. Ms Paterson indicated that the Operational Management Structure Review did not align with the dashboard and said there was insufficient data to report through this mechanism.

Mr Abraham said that he had been impressed with the professional approach and work of the team and commended them.

Mr Haslett commented that, as a NED, he looked forward to seeing the detail of the progress made in relation to the Trust's Corporate and Strategic Plans. He commended everyone involved and said that, given the recent Covid-19 pressures, the RAG progress to the end of October was impressive. He added that he looked forward to the quarterly updates. Mr Haslett said it would be important for the Board to monitor the progress being made and said that one should not underestimate the challenges facing all levels of the service and which could impact on the progress being made. He said that members appreciated the fact that progress may not be as expected.

Ms Paterson referred to the risks which had been articulated and said it was the responsibility of risk owners to put in place the necessary mitigation. She said that consideration would be given to pressures and the decision had already been taken to pause certain digital and IT work.

At the Chair's invitation, Ms Johnston provided a detailed update on the implementation of the REACH project.

Mr Bloomfield commented that REACH was very much a success story to be celebrated. He acknowledged that health and social care had a mixed record on the introduction of digital transformation and he very much welcomed the successful implementation of REACH within budget. He pointed out that feedback from staff had been very positive and said that much of the credit of the implementation success had been due to Ms Johnston's leadership.

Ms Charlton commented that the achievement of the REACH implementation was even more impressive given the considerable flexibility and resilience that had been required to continually change plans to be able to deliver in the current context.

The Chair welcomed the progress which had been made and said that it was an excellent development which would support staff and benefit patients.

Mr Ashford also welcomed the progress made and said it was positive to see technology exploited and used in this way. He referred to the fact that there were Wi-Fi hubs in all vehicles as well as Wi-Fi roaming availability at EDs and asked what Wi-Fi connectivity was like when travelling in vehicles.

Ms Johnston acknowledged that there would always be occasions when staff experienced blackspots on the network. However, she said, the Electronic Patient Care Record (EPCR) would work offline and would resynchronise when it connected again. She added that work was being taken forward to explore other options.

Responding to a question from Mr Haslett as to the roll-out, Ms Johnston advised the Ulster Hospital was to be the first hospital to go live with the REACH system. However, the Trust had asked NIAS to defer implementation at the Ulster until the new critical care building became operational.

Ms Johnston said that, after Christmas, it was intended to pause the implementation with a view to undertaking some quality assurance on the roll-out to date. She said the pause would also allow additional support to be provided to those staff not using the system as much as others. Ms Johnston said that work would then be taken forward to implement the roll-out in the South and South Eastern Divisions.

Ms Paterson referred to the earlier presentation by Ms Orr around the BI dashboard and noted the potential through the EPCR.

Dr Ruddell commented that the integration of REACH with the BI dashboard work viewed earlier meant that one would be able to see contemporaneous information on clinical care. He noted that previously it would have taken many people months to compile the data and then transfer it into usable information.

Ms Byrne alluded to the added support and governance this key work would bring to patient care and safety was really important and commendable and supported clinical care standards.

Ms Byrne also referred to the challenges in being able to address potential risks to deliver the REACH programme. She noted that the service had to be very agile in its planning and ability to deliver and support the roll-out of the programme for staff. Ms Byrne pointed out that the exception list within the programme protected against time-critical diagnoses such as acute stroke or heart attack.

The Chair indicated that, once the roll-outs had been completed, the Board would be interested in learning of the impacts both on patients and staff. She reminded members that feedback on the report would be welcomed and Ms Paterson said she would follow up with individual members.

The progress report was **NOTED** by members.

The Chair thanked Mr Walker and Ms Johnston for their attendance and they withdrew from the meeting.

10 **Performance Report & Covid-19 Update (TB16/12/2021/07)**

Ms Paterson referred to the established format of the Trust's Performance Report and explained that the data concept would allow progression to the next phase of an Integrated Quality and Performance Report. She provided members with a high level overview of the report and drew the Board's attention in particular to page 155 which set out the actions taken to address current pressures and support staff.

Mr Ashford referred to the re-introduction of 'receivers' at hospitals and asked whether any progress had been made in this regard.

Responding, Ms Byrne acknowledged that progress had been slow in terms of reintroducing receivers. However she advised that the Chief Executive had been in contact with the HSCB Chief Executive and the Trust had been asked to participate in combined visits with HSCB colleagues to look at the dedicated ambulance handover zones which was a key action of the No More Silos work.

Ms Byrne acknowledged that progress in establishing the dedicated zones had been at a slower pace than envisaged and advised that individual Trusts had submitted progress reports to the HSCB for consideration. She explained that the visits would be used to

explore potential options for a dedicated handover zone or an area to cohort patients. Ms Byrne indicated that, while the Trust had identified a number of staff on light duties who would support the receiver concept, it was necessary to identify physical space.

Ms Lemon referred members to page 151 of the papers which provided data in respect of absences and abstractions. She advised that, by way of assurance, the report highlighted the specific and direct actions being taken and, as well as the health and wellbeing measures, the Board had heard earlier re the work being taken forward in relation to late finishes. Ms Lemon indicated that a specific piece of work was also being taken forward in relation to additional management intervention and examining instances where there had been multiple absences associated with Covid-19. She added that, where appropriate, meetings would be held with staff to discuss in more detail.

The Chair thanked everyone for their input to the discussion and the Performance Report & Covid-19 Update was **NOTED** by members.

11 **Finance Report (Month 7) (TB16/12/2021/08)**

Commencing his report, Mr Nicholson advised that the new format Finance Report started at page 161 and was the position at the end of October 2021, providing an update of revenue, capital and prompt payment.

Mr Nicholson reported that the Trust continued to report a breakeven position at Month 7 as well as at the year end. He said he was pleased to report that significant progress had been made in the formal confirmation of funding with over £20 million of funding being confirmed since his last report to October Trust Board. He added that a number of outstanding allocations remained and said these largely related to the pay award which had recently been announced with plans being developed to make payments to staff including arrears in the new calendar year.

Mr Nicholson advised that, since the October Board meeting, the Trust received a request from the DoH to cease all discretionary spend in areas that would not have an impact on service delivery. This, he said, would suggest there were significant pressures across the HSC. Mr Nicholson acknowledged that opportunities in this area were limited, particularly this year when

every area of effort and expenditure had been targeted at the response to Covid.

Continuing, Mr Nicholson said that, since the last Board meeting and as part of this review, plans had crystallised in relation to the requirement to deliver £2.6m savings in 2021/22. He advised that it was no longer expected that the Trust would be required to deliver any further savings in-year.

Mr Nicholson drew members' attention to the fact that this had been achieved on a non-recurrent basis and the issue would roll into next year.

Mr Nicholson said that, in addition to the pay award, another significant issue yet to be resolved related to the funding for the final NIAS grown Cohort 4 of Paramedics. He advised that the Trust continued to discuss this matter with HSCB/DoH colleagues to identify the costing implications in-year and the significant revenue tail in the next financial year.

Mr Nicholson reported that there had been a slight increase on VAS/PAS expenditure compared to the same time last year, reflecting levels of pressure.

He advised that overtime expenditure had increased marginally over the last few months, though the graph as presented may suggest otherwise. Mr Nicholson reminded members that a range of schemes had been introduced across the HSC to pay enhanced rates for Covid Rapid Response Shifts, offering double time at the top of the scale for specific shifts. Mr Nicholson explained that all NIAS systems had been designed and built in line with the standard terms and conditions and, when initiatives such as this were introduced, it was necessary to develop and implement workarounds in order to make payments.

Mr Nicholson indicated that an unintended consequence of this was that such payments were not currently included in the graphical representation presented at today's meeting. He said that he would consider how this could be developed in future to assist in the presentation of figures and provide reasonable comparisons between years. He pointed out that, in addition to the figures shown, there was an additional £600,000 of Covid-19 Rapid Response Shift payments to be taken into account.

Mr Nicholson acknowledged that, while there were multiple factors impacting on the success of these initiatives, there were financial consequences. He added that the success of the schemes had undoubtedly improved cover and had been welcomed by staff. He pointed out that plans to deliver payments, and potentially utilise further enhancements, over Christmas were in train but would be challenging and would be impacted by the implementation of the pay award.

Moving to capital resources, Mr Nicholson reported that there had been a slight increase in the Capital Resource Limit (CRL) with recent confirmation that the Trust's bid for £470,000 had been successful. He indicated that there were a number of risks to the full delivery of schemes by 31 March 2022, but the Trust continued to plan and take steps to mitigate against these risks.

He advised that the Trust had been asked to confirm if any further schemes could be delivered. He acknowledged that this would add to the challenges faced by the Trust and transfer the risk to the Trust in terms of delivery of schemes by the year-end.

Concluding his report, Mr Nicholson reported that the prompt payment performance remained strong and said such performance was important, not only from a statutory perspective, but to support suppliers during these difficult times.

The Chair thanked Mr Nicholson for his report and said she had noted the continuation of the prompt payment performance. She acknowledged the contribution made by Finance in the current environment.

Mr Haslett welcomed the new format of the report. He referred to the capital funding and expressed his nervousness in relation to end of year expenditure, taking account of EU Exit and the difficulties associated with the global movement of goods. Mr Haslett referred to the £470,000 capital allocation from the DoH and sought clarification around the Trust's ability to spend this by the year-end. He said that, as was evidenced in the earlier presentation around the BI dashboards, there were interdependencies, for example, the increase in the use of VAS/PAS linked to the fact that approximately 20% of staff were unavailable for work.

The Chair said she noted from the papers the intention to recalibrate the capital spend in-year. She believed this would be helpful as Directorates developed their budgets and could potentially avail of funding as it became available. However, she acknowledged the current difficulties doing this as the focus was on ensuring service delivery.

The Chair reiterated her thanks to Mr Nicholson for the new format of the Finance Report which was **NOTED** by members.

12 **Clinical Response Model (CRM) – verbal update**

Mr McNeill said he was pleased to advise the Board that, following discussion at Senior Management Team, the CRM Outline Business Case (OBC) had been submitted to the DoH the previous day. He explained that this represented the start of the process with the DoH Project Management Unit and DoH economists. He pointed out that the OBC was available for Board members' review and said that there would be opportunities to adapt its content over the coming months.

Mr McNeill said that the OBC put forward the case for an additional 565 staff – 350 frontline staff with the remainder being clinical/non-clinical support; 105 vehicles; an estate solution which was a mixture of temporary solutions and the introduction of an Estates Capital Plan. He reminded the meeting that there was reference within the Trust's Strategic Plan to the Estates Capital Plan and the Trust's intention to move forward with a hub and spoke model.

With this in mind, Mr McNeill said it would be important to engage further with Board members and provide further detail around this development. He stressed that, at this stage, the model was a proposal and was sufficiently flexible to change should it not be accepted by the Board or service users. Mr McNeill indicated that the DoH had specifically requested that the Trust include this element within the OBC.

Continuing, Mr McNeill acknowledged that a key issue for the Trust was that of affordability and had asked the Trust to include two potential options, namely a five-year investment plan which sought the 365 frontline staff and 215 support staff plus capital while the second option was to present a three-year of the five-year plan. Mr McNeill explained that, in the case of the three-year plan, the plan

was to review performance after three years with a view to considering investment for years four and five.

Mr McNeill acknowledged that the Trust's preferred option would be to receive the total funding for the five-year plan.

He advised that the OBC detailed the benefits of the investment as well as detailed benchmarking with other organisations across the UK, both in terms of their structure and introduction of the CRM.

Responding to a question from Mr Haslett, Mr McNeill advised that there was no clarity as yet around the availability of funding and said that DoH colleagues would be aware of the CRM's funding requirements but had advised that there was currently no available funding. He added that the HSCB were in a similar position in that they had no available funding.

Mr Bloomfield said that, while the recent announcement of funding was to be welcomed, the amounts provided fell short of what was needed to meet all pressures identified. He said that, as had been alluded to by Mr McNeill, the OBC would be considered for funding along with other projects.

Mr Nicholson explained that the Trust had already received £2.5 million towards training and said that, while this allocation had been made on a non-recurrent basis, the Trust had been advised to assume that it would be a recurrent allocation.

Mr McNeill reminded the meeting that there would be further opportunity for the Board to contribute to the process before the business case was considered by Trust Board for approval and he undertook to arrange a workshop in the New Year.

The Chair expressed her appreciation to Mr McNeill for leading on the development of the CRM OBC and said that she looked forward to updates on its progress.

This update was **NOTED** by members.

13 **'Being Open' Policy (TB16/12/2021/09)**

Mr Ashford explained that this important Policy would affect all aspects of the Trust's work and it was for this reason he was

bringing it to the attention of Trust Board. He explained that the policy had originated from the Inquiry into the Hyponatraemia Related Deaths (IHRD).

Mr Ashford advised that the policy had been considered by the Safety Committee at its meeting on 25 November and Committee members had requested a number of amendments to be made. He added that, following approval by e-mail, he had asked for the policy to be brought to the attention of today's Trust Board.

The Chair agreed the importance of the policy and said she understood from discussions with Ms Charlton that further work was required before full implementation.

Dr Ruddell indicated that the IHRD had brought the importance of being open to the fore and alluded to the development of the Duty of Candour which had also originated from the IHRD. He was of the view that this policy needed to be led from the top of the organisation in order to demonstrate clearly what was expected from staff.

Agreeing with the points made by Dr Ruddell, the Chair acknowledged the importance of the Trust Board in terms of leading on the policy. She referred members in particular to Section 3.1 which set out the roles and responsibilities of Trust Board. The Chair suggested that the Safety Committee would wish to revisit the policy to consider at how it was being implemented and whether improvements were evident as the focus of the policy was to learn from experiences and incidents that had taken place to ensure they did not recur.

Following this discussion, Mr Ashford proposed and the Chair seconded that the Board adopt the 'Being Open' Policy.

14 **Committee Business:**

- **Audit Committee**
  - **minutes of 7 October 2021**
- **Safety, Quality, Patient Experience and Performance Committee**
  - **report of meeting on 25 November 2021**
- **People, Finance & Organisational Development Committee**
  - **minutes of 30 September 2021 (TB16/12/2021/10)**

The Chair asked the respective Committee Chairs to highlight any salient points.

Mr Abraham referred to the additional Audit Committee held on 2 December to discuss progress in addressing the outstanding IA recommendations. He complimented the team for their work and contributions on the day and was of the view that the steady progress being made would hopefully result in the limited finding being removed.

Mr Ashford drew members' attention to the discussion at Safety Committee in relation turnaround times which in turn impacted upon performance. He said that the discussion highlighted the benefits of having Mr Sowney attend meetings in his capacity as Clinical Adviser.

With regard to the People Committee, Mr Haslett welcomed the new format of financial reporting and believed that, once the reporting format was finalised, it would hopefully reduce the Finance workload. Mr Haslett referred to the earlier BI dashboard presentation and felt that this work could potentially overlap between Committees.

He indicated that the People Committee on 9 December had focussed on HR issue and he commended the papers which had been presented at both the September and December meetings.

Members **NOTED** the Committee reports and minutes.

15 **Date of Next Meeting**

The next Trust Board meeting will take place on Thursday 10 February 2022 at 10am. Arrangements to be confirmed.

16 **Any Other Business**

(i) Format of Board/Committee meetings

The Chair explained that it had been her intention to hold face-to-face meetings where possible. However, with the recent increase in infection rates, she said it was unlikely that a face-to-face meeting would be held before March. She undertook to keep the position under review.

(ii) Update on Computer Aided Dispatch (CAD) Business Case

Ms Paterson advised that she was seeking Trust Board approval to submit the business case to the Digital Health and Care Northern Ireland (DHCNI) Portfolio Board for consideration. She explained the current Computer Aided Dispatch (CAD) systems for EAC and NEAC were to be replaced with a new CAD system for both.

She explained that the function of CAD was central to NIAS operations in managing emergency response and resources to meet the timely needs of service users who requested A&E 999 services and Patient Care Services.

Ms Paterson advised that CAD systems were at the core of having a single real time view of the organisation, including measuring capacity and demand, to enable a clinical response to appropriate calls and their prioritisation.

She indicated that a draft business case which sought to replace the NIAS' CAD systems was currently in progress within the Digital Health and Care Northern Ireland (DHCNI) Portfolio Board. She drew members' attention to the projected costs for the Preferred Option from the Business Case.

Ms Paterson pointed out that, in parallel with the CAD Replacement project, strategies had been put in place to ensure a continuation of CAD services post 30 December 2021. She advised that, from 1 January 2022 to 30 September 2023, the current services would continue in operation under a temporary Direct Award Contract (DAC) with the current service provider and added that the intention was that the new service would be operational by that end date. Ms Paterson confirmed that the DAC had already been approved by PaLS and a Business Case in support of the DAC was awaiting a final approval from DHCNI. She explained that the reason for this was that the costs for the DAC were above NIAS delegated limits and therefore required DHCNI approval.

Ms Paterson indicated that, should the DHCNI approve the business case, it would be brought back to the Trust Board for consideration.

The Chair explained that the opportunity to raise this under AOB today had arisen after the December Board papers had been issued, hence Ms Paterson's subsequent e-mail briefing.

The Trust Board **APPROVED** the submission of the business case to the DHCNI on a proposal from the Chair. This proposal was seconded by Mr Ashford.

(iii) Update on work relating to late finishes

Ms Paterson provided a detailed update on the work being undertaken around late finishes said that references had been made throughout today's meeting to late finishes and the resultant impacts on staff and patient safety. She said it was critical that the Trust examined this and put the necessary mitigations in place.

She explained that two pilots had been put in place – one in the Southern Division to release crews who had been waiting overnight while the second pilot in the Belfast Division examined what arrangements could be put in place to ensure staff finished on time in the evenings. Ms Paterson said that, through the pilots, it had been possible to identify the barriers which prevented staff from finishing on time and allowed the Trust to put in place practical and structural arrangements to release crews. She added that Operations staff continued to look at potential solutions and implement these as elements within business as usual.

Mr Bloomfield clarified that late finishes had not come about as a result of Covid-19 and highlighted the importance of the pilots as well as the importance of crews finishing on time. He believed that ensuring crews finished on time would reduce the likelihood of mistakes. Mr Bloomfield explained that should a crew member make a serious clinical error, the crew member would remain responsible to their registering body and that the fact that he/she had been required to work late would not be taken into account. He said that, as Chief

Executive, he was comfortable in explaining the need to ensure crews finished on time.

The Chair agreed with Mr Bloomfield's comments and said that the challenges faced by crews should not be underestimated and it was essential they were able to finish their shift on time.

She said she was sure other members would agree with the endorsement of the pilots with a view to rolling this out across the region.

Mr Haslett commended the high standard of papers for Board and Committee meetings at such a challenging time and said the commitment shown by all involved was clear.

THIS BEING ALL THE BUSINESS, THE CHAIR CLOSED THE PUBLIC MEETING AT 1.00PM.

SIGNED: 

(electronically signed due to Covid-19)

DATE: 10 February 2022

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD – 16 DECEMBER 2021

		INDIVIDUAL ACTIONING	UPDATE
	PUBLIC		
1	DoH letter re Further Extension of Pause on Sponsorship and Governance Activities - Financial Year 2021/22: - to be shared with members	CM	E-mailed to members on 16/12/21.
2	Presentation re achievements – consider how this might be shared with a wider audience	JMcP	Consideration being given as to how this might best be done.
3	BI dashboard: - share with Trust Board the work being taken forward by the Medical Directorate in conjunction with the Informatics Team; - consideration to be given to how information within the dashboard could be brought to the attention of the relevant Trust Committees	NR DIRS	Work being taken forward with a view to presenting this at the relevant Committee in the first instance. Ongoing consideration being given to this.
4	CRM OBC: - share final copy of CRM OBC with members; - arrange Board member workshop in New Year;	BMcN/CM BMcN/CM	E-mailed to members 4/1/22. A short workshop on the Estates Strategy will be organised for March/early April.
5	Programme Portfolio report: - provide feedback on how report might be enhanced; - members to be advised of impact on patients and staff of REACH implementation	NEDs MJOHNSTON	Ongoing. b/f for June to confirm position