Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

A meeting of Trust Board to be held at 10am on
Thursday 16 December 2021 via Zoom *(due to Covid-19)*

Northern Ireland Ambulance Service
Health and Social Care Trust

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

AGENDA

1	Welcome, Apologies & Declarations of Conflict of Interest	***Click on links to navigate:***
2	Minutes of the previous meeting of the Trust Board held on 21 October 2021 **For Approval**	TB16/12/2021/01
3	Matters Arising	TB16/12/2021/02
4	Chair's Update **For Noting**	
5	Chief Executive's Update **For Noting**	
6	Self Service Business Intelligence (BI) Reporting Model - presentation **For Noting**	TB16/12/2021/03
7	Safeguarding – role of Trust Board **For Noting**	TB16/12/2021/04
8	NIAS Fleet Strategy – Preparing for our Future **For Approval**	TB16/12/2021/05
9	Update on implementation of the NIAS Strategic Plan **For Noting**	TB16/12/2021/06
10	Performance Report & Covid-19 Update **For Noting**	TB16/12/2021/07
11	Finance Report (Month 7) **For Noting**	TB16/12/2021/08

12	Clinical Response Model – verbal update **For Noting**	No paper
13	'Being Open' Policy **For Noting**	TB16/12/2021/09
14	Committee Business: - Audit Committee – minutes of 7 October 2021; - Safety Committee – report of meeting on 25 November 2021; - People Committee – minutes of 30 September 2021. **For Noting**	TB16/12/2021/10
15	Date & venue of next meeting: **Thursday 10 February 2022 at 10am.** **Arrangements to be confirmed.**	
16	Any Other Business	

TB/16/12/2021/01

Northern Ireland Ambulance Service Health and Social Care Trust

Minutes of NIAS Trust Board held on Thursday 21 October 2021 at 10am 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
	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
Apologies:	Dr N Ruddell	Medical Director
In Attendance:	Ms L Charlton	Director of Quality, Safety & Improvement
	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
	Mr Sinclair	Assistant Clinical Director (rep Dr Ruddell)
	Mrs C Mooney	Board Secretary
	Mr C Carlin	Boardroom Apprentice
	Mr D Charles	Internal Audit, BSO

1 **Welcome, Introduction & Apologies**

The Chair noted that apologies had been received from Dr Ruddell and reminded those present that they should declare any conflicts of interest at the outset or as the meeting progressed.

The Chair said that she would like to declare a conflict of interest in relation to agenda item 12, as she was currently Chief

Commissioner of the Charity Commission. She also declared the meeting as quorate.

The Chair welcomed Mr Christopher Carlin who had officially taken up his position Boardroom Apprentice on 1 September and extended a welcome to Mr David Charles, Internal Audit, who had asked to observe the Board meeting as part of the Board Effectiveness audit.

2 Previous Minutes (TB21/10/2021/01)

The minutes of the previous meeting held on 19 August 2021 were **APPROVED** on a proposal from Mr Ashford and seconded by Mr Haslett.

3 Matters Arising (TB21/10/2021/02)

The Chair advised that, given the current pressures, it would not be possible to accommodate additional meetings of the People Committee in the current Board/Committee schedule. However she had asked that the 2022-23 schedule take into account the need to increase the frequency from six to eight. She said that it would be for Directors to determine if additional meetings of the People Committee were necessary and added that this would be kept under review.

4 Chair's Update

Commencing her report, the Chair referred to the forthcoming Public Sector Chairs' Forum briefing on 24 November in relation to the report into the circumstances surrounding the resignation of Board members from RQIA. She said that she, and Mr Ashford, had attended an initial briefing session in August and she encouraged members to join the briefing in November. The Chair noted that, when there was capacity to do so, she intended for members to look at the report to determine whether there were any implications for the Trust.

The Chair said that she hoped it would be possible for the December Trust Board meeting to be held face-to-face taking account of social distancing guidelines. She suggested that it would be an opportune time to reschedule the Assurance Workshop to take place following the Board meeting, followed by the scheduled

Remuneration Committee. The Chair said that she had also suggested that the workshop could also touch upon relevant recommendations emanating from the recent independent report surrounding the circumstances of Board member resignations in the RQIA. She said that Board members would be kept informed of arrangements.

The Chair advised that she had been appointed as Chair of the Public Sector Chairs' Forum and would arrange to update her Declaration of Interests accordingly.

The Chair alluded to the recent NICON conference which had been held virtually over two days. She said it was her understanding that those who had been unable to attend would be able to access recordings of the various sessions and she commended these to members.

The Chair reported that she had hosted a meeting of Trust Chairs at NIAS HQ on 21 September and said it was the intention to hold these meetings on a quarterly basis.

She advised that HSC Chairs had met with the Minister on 22 September and had used the opportunity to highlight a number of concerns and challenges.

The Chair thanked Non-Executive Directors for taking the time to meet with her to discuss their appraisals which had now been submitted to the DoH.

The Chair alluded to an event which had been held at Stranmillis and which had been attended by the Ministers for Health and Education to mark the commencement of CPR training to undergraduate teachers in schools. She said that members would be aware that Ms Stephanie Leckey was leading on this work and added that she looked forward to hearing about progress.

The Chair advised the meeting that this week had been designated as International Control Week and said that the Chief Executive and other Director colleagues had visited the Emergency Ambulance Control (EAC) on a number of occasions. She explained that she and the Chief Executive were currently in Altnagelvin Station where they would meet with staff from the Non-Emergency Ambulance Control (NEAC) following the Board meeting.

Concluding her remarks, the Chair advised that Mrs Stacey Beggs had recently taken up post as the Office Manager for the Chair and Chief Executive's Office.

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

5 Chief Executive's Update

Mr Bloomfield thanked the Chair for referencing the NICON conference in her report. He alluded to the excellent programme and said he would commend, in particular, the address given by Professor Sir Michael Marmot on health inequalities and how these had been exacerbated because of the Covid-19 pandemic.

Continuing, Mr Bloomfield reported that the Trust had experienced its most challenging period of the pandemic during July-September in terms of the difficulties involved in ensuring the necessary level of cover was provided. He said that this had resulted in an impact on response times and the continued deterioration in turnaround times. Mr Bloomfield indicated that other ambulance services across the UK were experiencing similar pressures and these pressures had attracted an increasing amount of media attention.

Mr Bloomfield said that the Minister had recently alluded to the extreme pressures being experienced across the NI HSC and had warned of the very significant impact on services during the winter months, including the potential for no ambulances being available to respond to calls. Mr Bloomfield said that this was a very real possibility.

Mr Bloomfield thanked members for their understanding in terms of reducing Board and Committee agendas to a minimum to allow focus on supporting Operational service delivery.

Mr Bloomfield indicated that, given the extent of pressures across the system, the Minister and Permanent Secretary had been undertaking a series of low-key visits to Trusts to meet with staff. He said that their wish had been to meet with frontline staff to hear at first-hand the pressures they were facing. Mr Bloomfield advised that the Permanent Secretary had visited NIAS on 8 October, meeting with staff in the EAC and had discussed with them at length the pressures and their concerns about those patients to whom

ambulances had not been despatched. He added that Mr Duncan, Area Manager Western Division, had then taken the Permanent Secretary around a number of Emergency Departments where he met with those staff impacted by handover delays. Mr Bloomfield welcomed the fact that staff had spoken very openly with the Permanent Secretary and said his visit had been positively received by staff.

Continuing, Mr Bloomfield explained that Ms Byrne and he had had the opportunity to meet with the Permanent Secretary at the start of his visit and said he remained committed to supporting the Trust in terms of investment to ensure the Trust maximised the Paramedic Foundation Degree.

Mr Bloomfield reported that the first Paramedic BSc to take place in Northern Ireland commenced in September at the Ulster University Magee. He indicated that he had attended the Magee campus with Ms Byrne, Dr Ruddell and Mr Sinclair to speak to the students and indicated that there had been over 600 applicants for the 40 places on the course. He said that he had been encouraged by the students' commitment and many of them had had a long interest in joining the ambulance service and becoming a paramedic.

Mr Bloomfield advised that he had met recently with the new Chief Fire Officer, Mr Peter O'Reilly, to discuss areas of collaboration between the two services.

Mr Bloomfield reported that the Regional Electronic Ambulance Communication Hub (REACH) initiative had recently gone live in the Western area in the first instance with a view to rolling it out across the region. He commended all involved particularly as its implementation had taken place during a time when many projects had been stood down because of the pandemic. He said that the initiative had enhanced the level of information collated from calls which would improve patient care and also inform service improvement.

Continuing, Mr Bloomfield said that the Chair had already referred to the event held in Stranmillis and said that the event had followed the recent announcement by the Minister for Education that CPR training would be included on the school curriculum. He said that Ms Leckey had been instrumental in progressing this and added that the Trust would be responsible for providing the training.

Mr Bloomfield alluded to International Control Week and the fact that he and the Chair were both in the Altnagelvin Station to recognise the importance of the work carried out by the NEAC. He acknowledged that, at times, the work of Patient Care Services could be overlooked and stressed the importance of recognising the work carried out. Mr Bloomfield reported that, during the same week, the Trust launched its implementation of the new process for handling Inter-Facility Transfer/Health Care Professional (IFT/HCP) calls. He explained that these calls were mainly received from GPs and acknowledged that, at times of pressures, there was a risk that calls from HCPs not being received on the 999 line were disadvantaged. Mr Bloomfield advised that the new process would ensure that such calls were handled in a consistent manner and would receive an appropriate response.

Mr Bloomfield briefed members on the planned implementation of a new development in relation to a function within the GoodSam app whereby live streaming can be used to allow the Helicopter Emergency Medical Services (HEMS) air desk to use the camera on a caller's phone to see and diagnose a patient at scene. He said that the intention would be, once initial use had been evaluated, to roll this out to the Clinical Support Desks (CSD).

Concluding his remarks, Mr Bloomfield acknowledged that, given the recent extreme pressures and challenges, he wished to take the opportunity to thank all staff for their efforts over the last number of months. He pointed out that it was likely that there would not be any respite for staff as the pressures and challenges would continue over the winter months.

He said that there had been numerous references to staff being 'burnt out' and acknowledged that this was the reality. Mr Bloomfield indicated that, whilst the attention had understandably been on Operational staff, the pressures had also been felt by those staff working in the Trust support functions. He said that he recognised this and thanked all staff.

Mr Bloomfield assured the Trust Board that the Trust continued to make staff welfare and wellbeing a priority and said that the services could only be provided to the public if there was a workforce able to do so.

Alluding to the final point made by the Chief Executive, the Chair believed that it would be timely to note at Trust Board the impact of the additional challenge and pressures which Covid-19 had had on staff. She encouraged those members on social media to post positive messages of support to staff and said this would not go unnoticed.

Mr Abraham said that he would like to echo the comments made by the Chair and Chief Executive in relation to the commitment of staff and said it was incumbent upon the Trust Board to ensure that it moved forward to ensure the necessary changes in staffing were made. Mr Abraham emphasised his support and that of his fellow Non-Executive Directors for the BSc programme and was of the view that this complemented the professionalism within the Trust. He said that he too had been encouraged by the 600 applicants for a 40-place course and believed this to be a testament to the quality of the course.

Mr Ashford thanked the Chief Executive for his report and noted the number of positive initiatives referenced. He too echoed his support for the comments made around the contribution made by staff and the need to ensure the continuation of work around staff welfare and wellbeing.

Referring to the IFT/HCP work, Mr Ashford said that this had been a significant project and he commended that implementation had been completed during a time when pressures had been so great.

Mr Bloomfield acknowledged that this project had been delayed on a number of occasions but it had reached the point where it had been necessary to ensure it was completed and implemented.

Ms Byrne explained that it had become necessary to delay the initial implementation date of August due to a number of reasons. She said that it had proved and would have continued to prove difficult to identify an opportune time to complete this work, hence the decision was taken to proceed.

She said that additional resources had been put into the EAC to ensure calls were taken and monitored and added that the process had worked well to date with the process starting to feel well embedded within the normal Operations.

Mr Ashford said he hoped that the concept in terms of improving efficiency around transfers would reduce pressure within the EAC.

Ms Byrne indicated that the number of responses for requests within one-hour had reduced while the number of four-hour requests had increased. She welcomed the fact that the number of calls deemed suitable for ICP/PCS had increased.

Mr Bloomfield alluded to the BSc programme at Magee, particularly the mock-up facilities to replicate the inside of an ambulance, and suggested that members might find it interesting to visit. He asked Mrs Mooney to look at making the necessary arrangements.

Mr Haslett agreed with the comments made by colleagues and was of the view that more could be done by the NI Executive to support the health and social care sector, for example by introducing a Covid vaccination passport.

The Chair advised that, at the recent meeting with the Minister, HSC Chairs had indicated their willingness to assist with any messaging to the public and said they were awaiting advice from the DoH.

Mr Abraham was of the view that greater discussion was required and he expressed concern about a Covid vaccination passport and also the risks associated with providing the vaccine to younger age groups.

The Chair assured members that should any such discussion require the Trust's input on an official capacity, that discussion would take place at Trust Board level.

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

6 **Patient Stories (TB21/10/2021/03)**

At the Chair's invitation, Ms Charlton referred to the staff experiences during Covid-19 shared by Ms Hallissey and Mr Donnelly at the August Trust Board and believed such experiences were testament to the power of the story being delivered by the individual.

She said that it was a huge privilege being able to share Care Opinion stories in order that members could get a sense of what

patients and staff experience on a day-to-day basis. Ms Charlton acknowledged the contributions made by Ms Demi McKay, Mr Jarlath Kearney and Ms Amanda Sweetlove who had worked on introducing Care Opinion to the Trust.

Ms Charlton advised that Care Opinion was regularly discussed by the Safety Committee and the Senior Management Team and said today's presentation would focus on those patient experiences submitted through Care Opinion.

Continuing, Ms Charlton emphasised the importance of patient experiences in terms of quality and safety in an organisation and the key learning that can be gained.

Through her presentation, Ms Charlton made reference to a number of key enquiries such as the 'Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry'; 'A promise to learn – a commitment to act'; 'The Right Time, the Right Place' (Donaldson Report); 'Systems, Not Structures' (Bengoa Report). She stressed the importance of taking on board the learning from such reports and commended these reports to members.

Referring to the patient experiences submitted through Care Opinion, Ms Charlton clarified that, while some patient stories referred to NIAS, there was also reference to other health and social care services.

She reminded the meeting that the vision of Care Opinion was 'to enable impactful engagement with patients and the public in a fully open and transparent way that supports meaningful engagement and drive sustainable, measureable quality improvements'. Ms Charlton said that the Trust Senior Management Team was committed to visible and compassionate leadership. She acknowledged the challenges in changing the culture of the organisation to try to promote positive messages as well as identifying and understanding where improvements were needed.

Ms Charlton then shared a number of Care Opinion stories with members. She explained that the stories were not always detailed as they were posted on a public website but the stories clearly provided a sense of how valued NIAS staff were by patients and their families. Ms Charlton pointed out that work was undertaken to

try to identify the staff member from the story and the Chief Executive wrote to each staff member to acknowledge their actions.

Ms Charlton alluded to a number of negative stories in relation to NIAS and pointed out that these were mainly in relation to delayed responses as well as staff attitude. She said that members would be aware of the increase in waits for ambulance response and said that this had been discussed at length at the Safety Committee in terms of the increased number of complaints received. Ms Charlton said that the Trust was taking forward work to try to improve the response to patients, particularly those calls where patients have fallen.

The Chair thanked Ms Charlton for her comprehensive presentation and advised that Ms Mooney would share the presentation with members as well as links to the various reports referenced within the presentation.

Ms Lemon referred to the powerful impact of the patient stories and experiences.

Mr Ashford welcomed the fact that Trust Board had heard from patients and staff. He emphasised the importance of taking account of the negative experiences. He referred to the negative experiences word cloud used by Ms Charlton and asked whether the reduced number of words, compared to the positive experiences word cloud, was directly related to the fact that patients' negative experiences had focussed on delayed responses.

Responding, Ms Charlton explained that there had been less negative experiences submitted to Care Opinion and she confirmed that any references to patients' hospital experiences had been removed.

In response to a further question from Mr Ashford around Serious Adverse Incidents, Ms Charlton advised that officers would engage with the individual wishing to post the story to explain that such was the seriousness of the issues raised that it met the criteria of a Serious Adverse Incident and would be investigated as such. She said that this then allowed for much more effective family engagement through the SAI process.

The Chair emphasised the importance of visible and compassionate leadership and was of the view that, focussing on this, would ensure the Trust delivered services to meet the needs of patients. She said that for patients to take the time to acknowledge the care they had clearly demonstrated the esteem in which NIAS was held.

The Chair said that she hoped the process of hearing both patient and staff experiences at Trust Board would continue and she looked forward to hearing directly from patients at some stage.

Members **NOTED** the presentation on Patient Stories given by Ms Charlton.

7 **Performance Report & Covid-19 Update (TB21/10/2021/04)**

Ms Paterson introduced the Performance Report and advised members of the appointment of Mr Neil Walker as the Trust Head of Performance. She noted that, as it evolved, the performance report would include an increased contribution from the Quality, Safety & Improvement Directorate in terms of patient outcome data.

Ms Byrne advised that, while the REAP level had recently been de-escalated to REAP 3, the Trust continued to experience significant pressure. She indicated that, over recent weeks, cover had been 95% and said that it had taken significant effort to achieve this. Continuing, Ms Byrne advised that the Trust was using critical shift payments in keeping with other Trusts and said that, for the period 3 September to 8 October the critical shift payments were used for 732 shifts. She added that these were mainly A&E shifts with a few shifts within the EAC.

Continuing, Ms Byrne referred to the increased demand in call handling. She said that reference had been made at the August Trust Board to duplicate calls and the potential for BT to put arrangements in place to reduce duplicate calls. Ms Byrne said that there had been discussion at national level in relation to this and reminded members that the increase in duplicate calls had impacted on delay in call answering which in turn created significant clinical risk for patients. Ms Byrne advised that all English ambulance Trusts had advised of their intention to participate in the proposed process while services in the devolved nations would link directly with BT. She described the new process to members and said that it should reduce the impact of duplicate calls and pressure within

the EAC. Ms Byrne added that it was likely to be introduced in the coming weeks and said that monitoring the process would be critical.

Ms Byrne referred to calls received since the August Trust Board meeting and reported that NIAS had received 65,000 contacts over the three-month period.

Ms Lemon described the progress which had been made around improving absenteeism and attendance management. She acknowledged the challenges which had presented over the summer months and said these were reflective of pressures across the system as well as absence levels across Trusts both regionally and nationally. She said that Ms Byrne had made earlier reference to critical shift payments and explained that these payments had been introduced due to high levels of abstraction and as part of the efforts to increase levels of cover across the region.

Ms Lemon alluded to discussions at a recent People Committee when the Committee had received an update around work being taken forward to improve the Occupational Health Services provided. She reported that there had been significant improvements with the availability to the Trust of a dedicated Lead Nurse, Clinical Psychologist and Physiotherapist.

Continuing, Ms Lemon said that, in addition to the support measures being put in place, it would be important to understand the factors which had contributed to the absence. She indicated that work was being progressed, for example, around ensuring staff finished their shift on time and received rest periods.

In relation to staff testing, Ms Charlton reported that more staff had been tested in the last two-week period than at peaks in the pandemic with the trend of staff being tested reflecting the number of positive cases in NI. She indicated that the majority of staff were being tested because of contacts with positive cases as opposed to displaying Covid-19 symptoms. However the proportion of staff testing positive was low in relation to the number being tested.

Mr Ashford referred to the potential performance challenges and sought clarification around returning staff to work.

Ms Byrne acknowledged that performance had been a particular challenge and had led to the introduction of the critical shift payment in an effort to increase cover.

Ms Charlton indicated that there had been concerns that staff had become complacent in relation to the wearing of PPE and said that these concerns had been shared by other ambulance services. She said she was happy to report that PPE compliance was now improving and added that the Trust would look to ensure increased compliance levels before it would consider returning those staff isolating due to contacts to work. However she pointed out that, while there had been 92 members of staff isolating on 20 October, in line with CMO guidance, only 23 of those staff would be suitable for consideration to return to work.

Referring to the introduction of the critical shift payment, Ms Lemon said that the fact that such a measure had been introduced demonstrated the unprecedented nature of the pandemic and the ability of the service to function without a radical initiative. She pointed out that critical shift payments were only to be used when the Trust had identified a shift and cover levels as critical.

Mr Haslett asked whether there was anything further the Trust could do to improve handover times.

Ms Byrne acknowledged the significant and detrimental impact waiting outside EDs had on the service both in terms of the ability to free up crews to respond to calls as well as the impact on both patients and staff. She described the work ongoing with Trusts to ensure a collaborative and proactive approach to this issue.

In terms of hours lost to the service, Ms Byrne reported that, over a month, the Trust lost 580 12-hour shifts or 20 12-hour shifts per day. She said that these figures were shared with the Permanent Secretary when he visited the Trust on 8 October.

Mr Dennison referred to the learning from SAIs and sought further detail as to how the Trust ensured learning was disseminated and implemented across the Trust.

Ms Charlton indicated that approximately 40% of SAIs related to delayed responses and said it would be important to ensure that the learning incorporated actions which would make a difference, for

example procedures and training. She explained that learning was shared with staff via different modalities. Ms Charlton acknowledged that, while learning was identified and shared, there unfortunately were occasions when it did recur. She said that the challenge of embedding learning was an issue which had been identified by RQIA in its review of regional SAIs.

Mr Dennison thanked Ms Charlton for her response which he believed demonstrated the seriousness of how the Trust approached this area of work. He was of the view that the fact the Trust had attempted to use different methods of communication with staff to ensure learning was disseminated was commendable.

Ms Lemon indicated that, although the Trust was focussing on immediate pressures, work in relation to compassionate leadership and culture continued and she advised that the Trust planned to launch its culture programme in the coming weeks. She added that the Chief Executive was also keen to recommence the staff engagement sessions.

Mr Sinclair referred to the challenges in clinical performance, in particular the fact that the Clinical Support Officers traditionally involved in clinical audit had been realigned to support the frontline. He reported that, as had been referred to earlier by the Chief Executive, the REACH project had gone live in September in the Western Division with a view to rolling out the project to other Divisions.

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

8 **Finance Report (Month 5) (TB21/10/2021/05)**

Commencing his presentation of the Finance Report, Mr Nicholson thanked members for their time and contributions to the development of the report which provided an executive summary of the three statutory financial performance targets across the areas of revenue, capital and prompt payment as well as providing some additional detail in specific areas.

Mr Nicholson reported that, in terms of revenue, the Trust was reporting a breakeven position at the end of August 2021 (Month 5) and was also forecasting a breakeven position at year end. He

explained that there were a number of assumptions underlying this position which had been detailed within the report. Mr Nicholson advised that the areas of CRM and Training had largely been resolved since the last report in that the Trust had received an allocation of £6 million and added that the issue of funding for Cohort 4 of Paramedic training remained under discussion. He indicated that the training which would commence in the current year had significant costs running into 2022-23 which were yet to be formally agreed. However, he referred to the positive discussions and correspondence in relation to securing the funds required.

Continuing, Mr Nicholson indicated that, while he was confident around the detail contained within the assumed income levels, some of them were subject to in-year monitoring rounds for which the results were not yet known and cited the example of the 2021-22 pay award. He said that the Trust had also received positive indications around support for Covid-19 but noted that some of these were only being released to Trusts on a quarterly basis.

Mr Nicholson referred to the respective Directorates financial position and advised that he had included figures of actual expenditure in this report. He acknowledged that the Directorate budget position was particularly complicated this year with levels of absence and expenditure on overtime and VAS/PAS skewing the financial performance in each area. He indicated that the Directorate reports to Trust Board would develop over the coming months and into next year.

Mr Nicholson reported that expenditure on VAS/PAS remained high but was forecast to be slightly below levels of expenditure in 2020-21. He explained that the vast majority of this expenditure was funded from additional non-recurrent Covid-19 allocations.

Continuing, Mr Nicholson advised that overtime expenditure remained significant even as vacancies were filled. He indicated that this was likely to remain the case with the impact of Covid-19 and subsequently additional hours of cover through the introduction of the Clinical Response Model. He pointed out that the vast majority of expenditure was in relation to frontline services and added that there were additional factors in play this year including a premium Covid-19 Rapid Response Shift Payment as well as the payment of overtime to staff in Band 8 and above AfC payscales.

Mr Nicholson reported that capital expenditure remained on track but there were additional risks in the current year in terms of supply.

In relation to Prompt Payment, Mr Nicholson advised that performance remained strong with a slight reduction in July. He indicated that this area remained a focus for the Trust and explained that a delay in the payment of a small number of invoices could impact significantly on cumulative performance and make the achievement of the overall target impossible.

The Chair thanked members for putting forward their suggestions as to the content of the revised Finance Report.

Mr Bloomfield referred to the overall forecasted breakeven position and agreed with Mr Nicholson's highlighting of those areas for which funding had not yet been received and the Trust's expectation in relation to these. He acknowledged that the discussions around finance in which he had been involved had given him a high degree of confidence that expected allocations would be made.

Mr Haslett extended his thanks to Mr Nicholson for turning around the revised Finance Report in the short time since the People Committee. He acknowledged that, while there was likely to be iterations of the report, the revised format before members had provided the information Non-Executive Directors had asked to see around VAS/PAS and overtime expenditure.

Mr Abraham noted the technical accrual accounting issue in the Trust's accounts and cautioned that there could be a similar outturn in the 2021-22 year. He reminded the meeting that the issue had arisen very close to the end of the financial year and he asked to be kept apprised on a regular basis as to the regional discussions.

Responding to the point made by Mr Abraham, Mr Nicholson noted that one of the assumptions within the forecasted breakeven position was the accounting treatments. He advised that the Trust was engaging on a regional basis with DoH colleagues as to how the accounting treatment for a number of elements of expenditure would be treated in the 2021-22 financial year.

Mr Dennison agreed with the comments made by Mr Haslett and described the report as 'clear and concise'.

Mr Ashford commended the format of the revised report. He referred to the fact that the proposal around St Johns' Ambulance providing assistance with hospital handovers had not come to fruition. He also alluded to the increasing reliance on VAS/PAS and asked what the Trust's long-term plan was in this area.

Mr Nicholson advised that there had been a slight reduction in the Trust's reliance on VAS/PAS from previous years. He explained that a significant number of Independent Sector (IS) providers had returned to 'business as normal' in terms of providing support at events which had decreased their ability to meet NIAS' demands and the demand across the rest of the HSC. Mr Nicholson said that it was the Trust's intention to increase its own staffing levels through the Clinical Response Model in order to reduce the reliance on VAS/PAS. He expressed concern in relation to the potential impact on services should the Trust not receive the necessary funding.

The Chair reminded the meeting that there had been discussion at the start of the financial year around Trust Board's expectation that VAS/PAS expenditure would reduce but, due to Operational pressures, this had not been possible. She advised that the People Committee would examine VAS/PAS expenditure in detail.

The Chair thanked Mr Nicholson for his report and acknowledged that there may be further iterations, in particular around the area of Directorate budgets.

The report was **NOTED** by members.

9 **Review of NIAS Standing Orders (TB21/10/2021/06)**

The Chair introduced this agenda item, took the opportunity to pay tribute to the work of Ms Anne Quirk, former Boardroom Apprentice, who had ensured that the Committee Terms of Reference were consistent, and fed into to the Standing Orders.

Ms Paterson referred to the comprehensive review of the Trust's structures and the workshop which had taken place in July 2020. She pointed to the transfer of corporate risk and governance from the Safety Committee to the Audit Committee which it was proposed should be known as the Audit and Risk Assurance Committee.

Mrs Mooney advised that the Trust's Standing Orders were last reviewed in 2019. She drew members' attention to document before them and explained that the majority of changes made provided further clarification to the Standing Orders. She advised that one major change related to the approval of policies and procedures which, if approved, would result in approval of policies now resting with the relevant Committee. The Trust Board would be advised of the policy approval through the regular updates brought forward by the Committee Chairs.

Mrs Mooney explained that the approval of procedures had also been taken into account during the review and advised that procedures relating to policies deemed relevant by a Director would also, where necessary, be presented with its associated policy. However the Senior Management Team would have previously considered the procedures.

She indicated that, in order to provide further assurance, it had been proposed that the Trust Board would be presented with a register on an annual basis detailing the policies, and including such information as review dates and monitoring information, including scrutiny at Committee level. However, in exceptional circumstances, a Committee Chair, which had been included at Mr Ashford's request following discussion at the Audit Committee, or the Trust's Senior Management Team may take a view that the significance of the policy and its impact on the organisation was such that it merited direct consideration by the Trust Board. This would be agreed by the Chief Executive in consultation with the Chair. Mrs Mooney pointed out that there may also be regional policies which the Trust Board would be required to adopt and these would be considered at Trust Board.

Mrs Mooney stressed that the Standing Orders remained a live document and further changes may be necessary as the new Committee structure continued to embed. She extended her thanks to the Chair, Non-Executive Directors and Directors for their assistance in reviewing the Standing Orders and acknowledged that, while a number of areas had been highlighted for further development and consideration, none of these areas would result in material changes to the document before the Board.

Mr Dennison questioned the Trust's statutory duty to breakeven.

The Chair indicated that Trust Directors of Finance worked to the statutory duty to breakeven and acknowledged that there had been difficulty in identifying the NI legislation which required them to do so. She indicated that it was the long-standing position of the NIAS Trust, as well as other Trusts, to adhere to the convention of a statutory duty to breakeven.

The NIAS Standing Orders were **APPROVED** on a proposal from Mr Dennison and seconded by Mr Bloomfield.

10 **Medical Devices Policy (TB21/10/2021/07)**

Mr Sinclair explained that the Medical Devices Policy provided an up-to-date, comprehensive, Trust-wide strategy for the management of Medical Devices, from inception to disposal.

Mr Ashford advised that the policy had been considered in detail by the Safety Committee. He commended the decision taken by the Trust to ensure the Committee was provided with clinical advice and said that Mr Sowney's role as Clinical Adviser to the Committee had been invaluable. Referring to the policy, Mr Ashford acknowledged its importance and complexity and said the Committee had been reassured by those presenting the policy.

Mr Dennison suggested that, when considering policies, it might be helpful to have a cover paper accompanying each policy detailing how the policy had changed from previous versions and why the changes were necessary.

The Chair agreed with the importance of ensuring a house-style for policies. She referred to the earlier discussion on Standing Orders and the intention to bring to Trust Board on an annual basis a policy register detailing information such as review dates and how the policy had been disseminated and monitored. She reiterated the fact that, while policies would now be approved at Committee level, the Committee Chair or the Senior Management Team could deem the policy of such significance or impact on the organisation and seek to bring it to Trust Board.

The Medical Devices Policy was **APPROVED** on a proposal from Mr Ashford and seconded by Mr Haslett.

11 **DoH letter re: Further Pause in Sponsorship and Governance Activities (TB21/10/2021/08)**

Members **NOTED** the most recent correspondence from the DoH advising of a pause in sponsorship and governance activities.

Mr Bloomfield advised that it remained the Trust's intention to produce a Corporate Plan for 2022-23.

The Chair welcomed this and was of the view that the Corporate Plan assisted Non-Executive Directors in focussing on the work to be taken forward by the Trust and to assist in monitoring the delivery of the Strategic Plan.

12 **NIAS Charitable Trust Fund – Trustees' Annual Report & Accounts for the year ended 31 March 2021 (TB21/10/2021/09)**

The Chair advised that, following approval by the Trust's Audit Committee and Trust Board, the Charitable Trust Funds were now being presented in public for the first time. She added that, as there was no intention to discuss these Accounts, she would not absent herself from the meeting.

Mr Nicholson explained that these accounts had previously been approved by Trust Board and subsequently certified by the NIAO. He wished to place on record at Trust Board his appreciation of the kindness and generosity of individuals, groups, organisations and businesses to the Trust during what had been a most difficult year.

Members **NOTED** the NIAS Charitable Trust Fund - Trustees' Annual Report & Accounts for the year ended 31 March 2021.

13 **Committee Business:**

- Safety, Quality, Patient Experience and Performance Committee

- **report & minutes of 16 September 2021**

- **People, Finance & Organisational Development Committee**
  - **minutes of 8 July 2021 & report of 30 September 2021**
- **Audit Committee**
  - **report & minutes of 7 October 2021**

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

Mr Ashford said that the clinical advice provided by Mr Sowney to the Committee had been invaluable and he was of the view that it had improved the quality of the work undertaken. He referred to the September meeting which had considered policies on Medical Devices and the Management of Medicines and said that he had asked for the latter to be revisited when the Trust appointed a pharmacist.

Mr Haslett advised that the report of People Committee on 30 September highlighted the main points of the discussion. He acknowledged the Committee's intention to use alternative meetings to examine issues relating to HR and Finance and stressed the importance of ensuring the People Committee did not stray into Audit Committee business.

Agreeing with the point made by Mr Haslett, the Chair said it was incumbent upon Committee members to ensure this did not happen and explained that the People Committee would examine in more detail the issues within the Finance Report presented to the Board earlier.

Mr Abraham referred to the revised Standing Orders and said it would be important, as the new Committee structure embedded, to ensure that nothing was omitted from Committee consideration. He indicated his support for the Chair/Committee Chairs' meetings and said he had found these helpful.

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

14 **Date of Next Meeting**

The next Trust Board meeting will take place on Thursday 16 December 2021 at 10am. Arrangements to be confirmed.

15 **Any Other Business**

(i) Update on Clinical Response Model Business Case

Mr McNeill briefed members on recent discussions he had had with DoH colleagues in relation to the CRM Business Case in relation to the affordability of the business case.

At the Chair's request, Mr McNeill agreed to keep members apprised of developments.

(ii) Audit and Risk Assurance Committee

The Chair explained that, as risk assurance would transition from the Safety Committee to the Audit Committee, it had been suggested that the Audit Committee should now be known as the Audit and Risk Assurance Committee.

Mr Abraham proposed the renaming of the Committee to the Audit and Risk Assurance Committee. This proposal was seconded by Mr Ashford.

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

SIGNED: _____

DATE: _____

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TB/16/12/2021/02

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD – 21 OCTOBER 2021

		INDIVIDUAL ACTIONING	UPDATE
	PUBLIC		
1	Cover paper to accompany policies detailing the changes from any previous versions and the reasons why changes have been made	MP	Arrangements will be put in place to action this.
2	Board members to be kept informed of arrangements around December Trust Board/ workshop	CM	E-mail 3/12/21 confirming that meetings will be held via Zoom
3	Arrangements to be made for members to visit Magee facility for BSc programme	CM	Postponed until further notice
4	Trust accounts 2021-22 – Mr Abraham to be kept apprised of regional discussions around the technical accounting issue	PN	To be discussed at the ARAC Committee
5	Patient Stories – share presentation and links to the reports referenced in the presentation	CM	Actioned 25/10/21

TB16/12/2021/03

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Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

PRESENTATION OF PAPER

Date of Trust Board:	16 December 2021
Title of paper:	Self Service Business Intelligence (BI) Reporting Model
Brief summary:	This presentation will demonstrate progress made by the Data and Analytics team in relation to the provision of self-service analytics to support evidence based decision making.
Recommendation:	**For Approval** ☐ **For Noting** ☒
Previous forum:	SMT – 28/9/21
Prepared and presented by: **Date:**	Tracy Avery, Head of Informatics Hannah Orr, Senior Data Analyst Maxine Paterson, Director of Planning, Performance & Corporate Services 9 December 2021

TB/16/12/2021/04

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Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

PRESENTATION OF PAPER

Date of Trust Board:	16 December 2021
Title of paper:	Safeguarding – role of Trust Board
Brief summary:	At the request of Mr Abraham, the Lead Non-Executive Director for Safeguarding, Trust Board will receive a presentation from Mr Des Flannagan, Head of Safeguarding, covering the following points: • What safeguarding encompasses in NIAS • Board level accountability • Legislation & Statutory requirements • Partnerships • Governance • NIAS safeguarding/ Achievements and Current Risks
Recommendation:	**For Approval** ☐ **For Noting** ☒
Previous forum:	SMT – 7/12/21
Prepared and presented by: **Date:**	Des Flannagan, Head of Safeguarding Lynne Charlton, Director Quality, Safety & Improvement 9 December 2021

Safeguarding and NIAS Accountability

December 2021

Des Flannagan
Head of Safeguarding, NIAS

What we will cover

- What safeguarding encompasses in NIAS
- Board level accountability
- Legislation & Statutory requirements
- Partnerships
- Governance
- NIAS safeguarding/ Achievements and Current Risks

What safeguarding encompasses for NIAS

- Prevention of harm and abuse through provision of high quality care.

- Effective responses to allegations of harm and abuse, and responses that are in line with local multi agency procedures.

What is expected of us?

- Close attention to safeguarding is core to delivering quality care.
- Key to this assurance will be the Internal assurance processes in NIAS and Board accountability
- Senior leadership support and scrutiny are vital to protect the vulnerable groups.

Legislation

- Safeguarding (Child & Adult) is supported by legislation.

- The Board needs to assure itself that NIAS is compliant with legislation and guidance.

- Regulators assess us against the legislation and guidance.

Statutory requirements

- Safeguarding needs leadership from the most senior level throughout NIAS

Exec- Oversee strategic direction ensures accountability for Trust.
Non Exec- Independent scrutiny and hold service to account. Ensure quality and safety not pushed from agenda by other operational or financial pressures.

Leads on strategy, objectives and priorities.
Ensure NIAS is compliant with policy and leads on implementation of safeguarding recommendations.
To provide Specialist and Operational safeguarding leadership.
Support safeguarding staff in NIAS and undertake safeguarding supervision/particular focus on learning from practice.
Develop and deliver safeguarding training.
Learning from SAI/ CMR other Ambulance

To consider safeguarding issues and needs of patient.
Report safeguarding concerns in timely manner.
Safeguarding is everyone responsibility.

Statutory requirements

- Safeguarding policies & procedures

  Child & Adult at risk procedures, Safeguarding allegations against staff, Domestic Abuse policy.

  Training (at all levels across the workforce)

- Clinical governance procedures
- Partnership working at various levels across Trusts
- Safeguarding supervision (TIC)(addressing practice issues)
- Safer recruitment processes particularly for private providers
- DBS Checks/referrals, staff not aligned to a professional register

Leadership & Staff culture to safeguarding

- Risks of neglect harm and abuse will be reduced where there is strong leadership and a shared value base where:

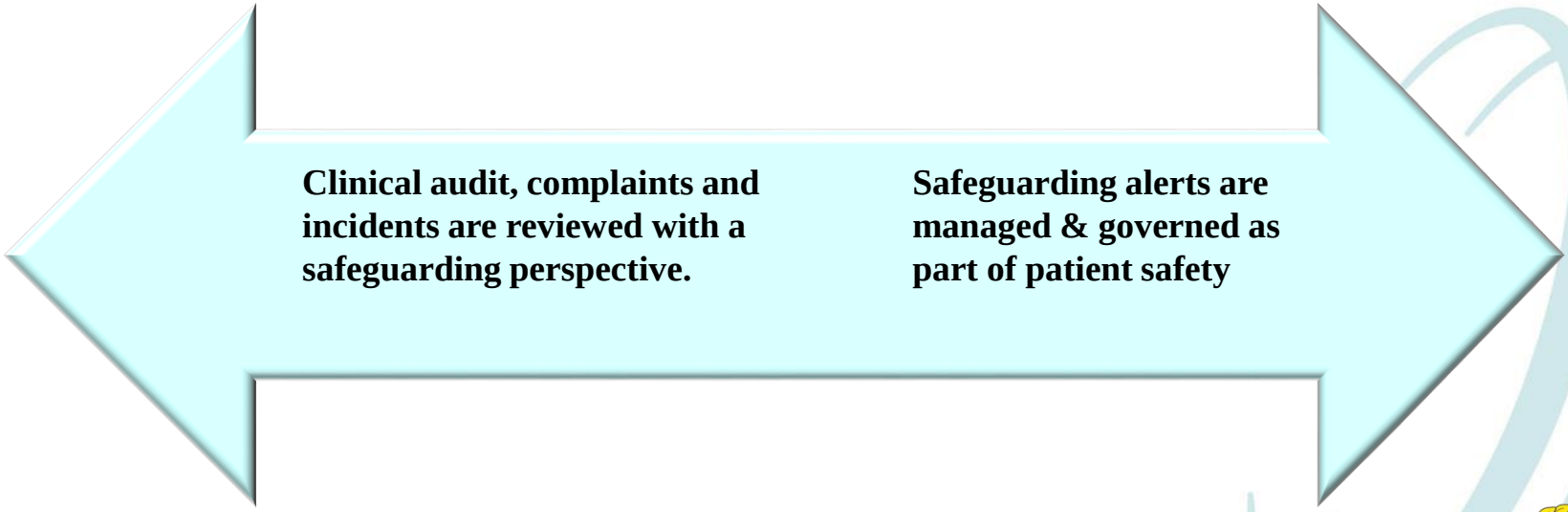
- Leadership is required from the most senior level and throughout the service.

Partnerships

- NIAS is a key partner in safeguarding.
- As we educate our workforce we need to educate our partners.
- Listening and learning from the to the voice of patient.
- Partnerships beyond the traditional statutory agencies is crucial.

Governance

Integrating safeguarding into the service's governance systems enable a service to and be accountable for it's safeguarding activity.



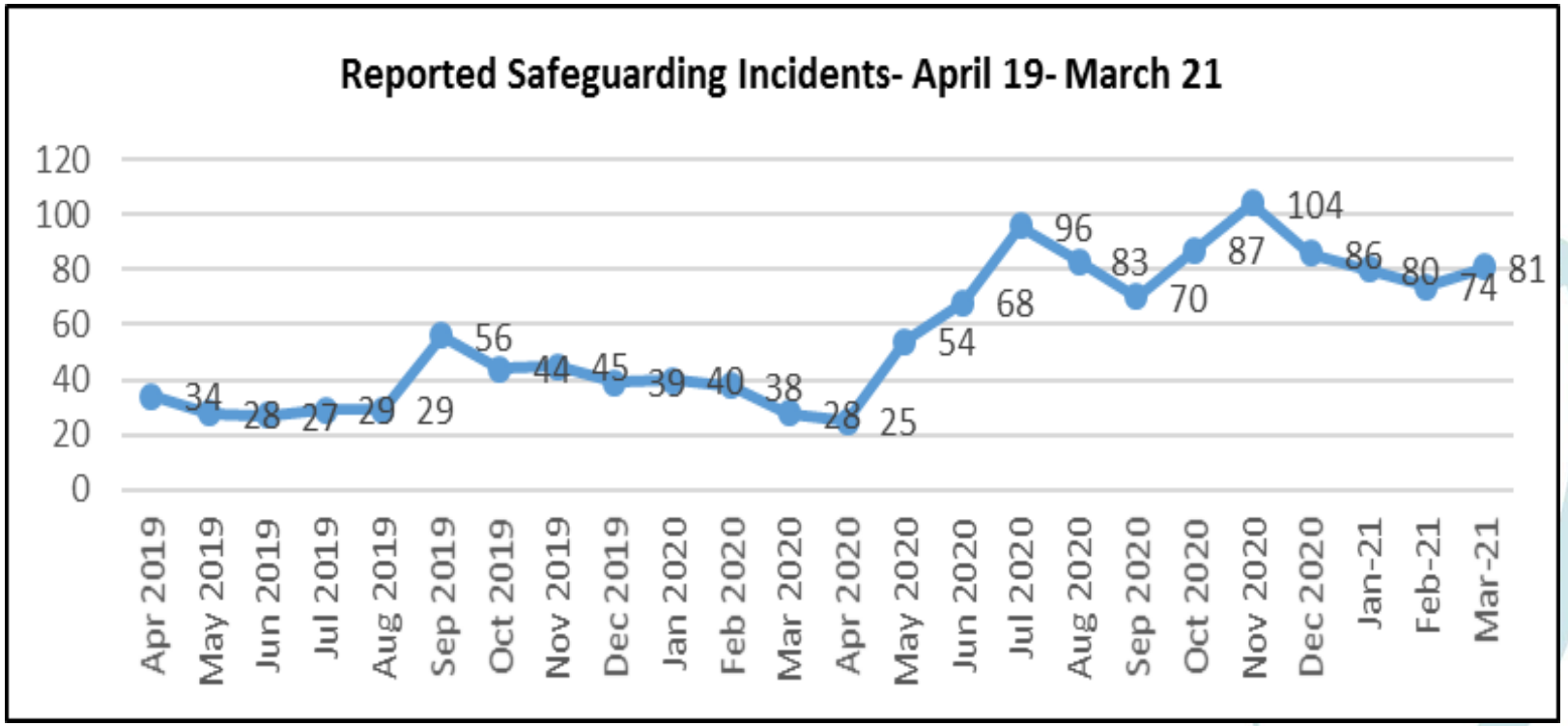
NIAS Safeguarding Governance

- Safeguarding Group meets weekly to review all safeguarding cases this include input from the Risk Manager and Clinical improvement lead.

- Datix incidents and complaints not marked as safeguarding should be reviewed in the context of safeguarding.

Recognising Risks and Achievements

Progress - 108 percent increase in referrals 2020-21.



Safeguarding Structures across the UK

Ambulance Trust	Head of Safeguarding	Safeguarding professionals
London (LAS)	1	8
South East	1	5
Yorkshire	1	3
North West	1	4
East of Eng	1	6
North East	1	4
East Midlands	1	2
Wales	1	8
Scottish	1	3
NIAS	1	0

Recognising risks and achievements

- We are providing robust oversight of those cases referred for safeguarding
- We are communicating with partners agencies and addressing challenges in referral pathways
- We are challenging safeguarding decisions
- Workforce training and safeguarding skills is improving and seen weekly in referrals.

Recognising risks and achievements

- We would benefit from an allegations policy (procedures/pathway) with a safeguarding focus.
- What is not referred – the unknown.
- Domestic abuse policy for the workforce.
- Welfare pathways remain complex which increase risks to vulnerable patients

Final words …

- Safeguarding workload will continue to increase for all areas of NIAS.
- Safeguarding vulnerable children & adults is complex, frequently under review and we must ensure we continue to work effectively.
- There is more to do…and the message remains that it is everyone's responsibility.

Thank you … any questions?

Safeguarding legislation and policy references.

- *The Children (NI) Order 1995*
- *Children's Services Co-operation Act (NI) 2015*
- *Safeguarding Vulnerable Groups (NI) Order 2007*
- *Human Rights Act 1998*
- *Mental Capacity Act (NI) 2016*
- *Mental Health (NI) Order 1986*

- *Adult Safeguarding Operational Procedures (HSCB, 2016) Multi agency procedures for protecting adults at risk and in need of protection*
- *Co-operating to Safeguard Children and Young People (SBNI, 2017)*

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TB/16/12/2021/05

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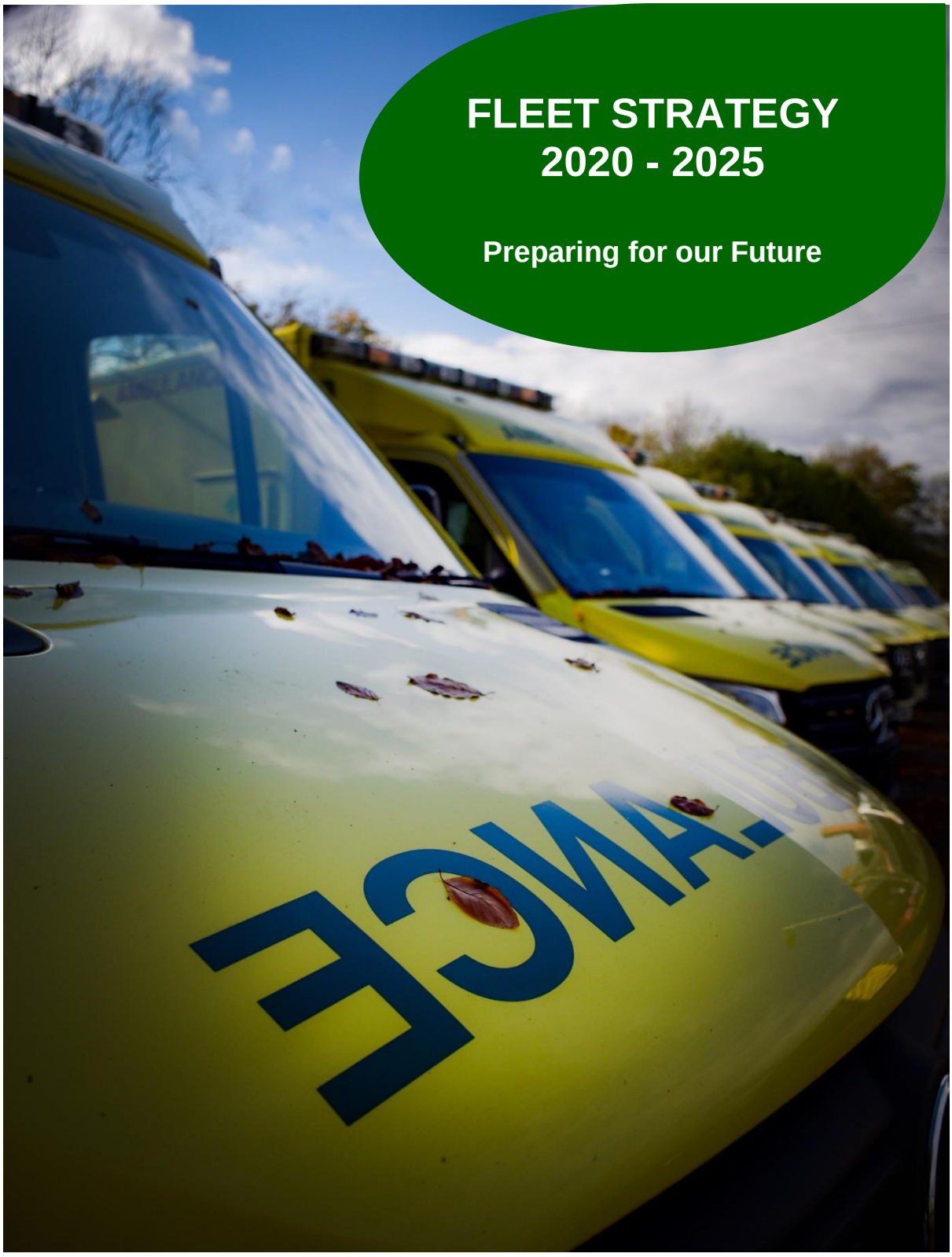
Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

PRESENTATION OF PAPER

Date of Trust Board:	16 December 2021
Title of paper:	NIAS Fleet Strategy 2020-2025, Preparing for Our Future
Brief summary:	Following a request from Trust Board to extend the consultation on the NIAS Fleet Strategy 2020 -2026, the draft Strategy was re-issued internally via Sharepoint and the NIAS Pulse publication on Friday 16 April and externally via the NIAS website on Wednesday 21 April. The Fleet Strategy was re-issued along with a number of engagement questions. The consultation period ended on Wednesday 12 May. The extension has not resulted in any material change to the document but has highlighted issues to be considered in the design specification of future new vehicles. Trust Board is asked to approve the Fleet Strategy
Recommendation:	**For Approval** ☒ **For Noting** ☐
Previous forum:	SMT – 23/11/21
Prepared and presented by: **Date:**	Brian McNeill, Director CRM Programme, Estate & Fleet 9 December 2021

Northern Ireland Ambulance Service
Health and Social Care Trust



FLEET STRATEGY 2020 - 2025

Preparing for our Future

Contents

Northern Ireland Ambulance Service
Health and Social Care Trust

FOREWORD

I am delighted to introduce this Fleet Strategy which supports the Northern Ireland Ambulance Service's implementation of the Department of Health's 'Health and Wellbeing 2026: Delivering Together' where it is recognised that NIAS staff cannot operate safely, effectively and efficiently without a fit for purpose infrastructure, sound environmental objectives and commitment to the whole of our community.

NIAS must begin planning for our next generation of vehicles to ensure we have the right type and quantity of vehicles to match our response models, take advantage of developing technologies and reduce our carbon footprint. Environmental challenges must and will influence current and future decision making for all aspects of the Northern Ireland Ambulance Service.

This Fleet Strategy has been designed to support the Trust by providing a comprehensive range of medical emergency and support vehicles for the provision of care for the people of Northern Ireland, ensuring effective and sustainable benefits for patients and the wider Health & Social Care arena. Patients and our front-line ambulance clinicians are at the heart of everything we do, and we will continually strive to ensure we provide fit for purpose, value for money, safe, efficient and sustainable vehicles that best meet their needs, whilst minimising, wherever practicable, carbon and other emissions and environmental issues.

Michael Bloomfield, Chief Executive
Northern Ireland Ambulance Service

OUR VISION FOR NIAS FLEET SERVICES

The Northern Ireland Ambulance Service (NIAS) Health & Social Care Trust has a central role to play in the implementation of the Department of Health's 'Health and Wellbeing 2026: Delivering Together' strategy and can contribute to addressing many of the priorities within it. The Trust has developed a long-term strategy 'Caring today, planning for tomorrow – **Our Strategy to Transform: 2020 – 2026** that sets out how we will maximise this contribution by addressing our current challenges and bring tangible benefits to patients, staff and communities over the coming decade.

This Fleet Strategy has been developed to compliment and support the implementation of our **Strategy to Transform**. In addition to describing our fleet replacement programme, the Strategy sets out how we will ensure our fleet has the right profile to support effective provision of service whilst reducing our impact on the environment over the next 6 years.

Whilst it is recognised that Northern Ireland does not yet have a Climate Act, NIAS is highly conscious of its responsibility to, where possible, improve the environment for people through reducing its Fleet CO_2 emissions, improving sustainability and adapting to renewable energy, whilst continuing to meet public need through the delivery of a safe and effective ambulance service.

Operating an ambulance fleet has obvious environmental impacts. Much has been achieved to date through technological advances to mitigate the impact of our base vehicles. We will continue, wherever practicable, to explore the opportunity to adopt more environmental practices. We will endeavour to reduce our carbon footprint by adopting new technologies such as electric and hybrid vehicles as these become viable options. We will also seek out greener energies for our vehicle system power, such as hydrogen fuel cells and solar power. By utilising vehicle management information supplied by telemetry systems we will aim to improve vehicle and driver performance to improve efficiency and reduce environmental impact.

At its heart, this Strategy aims to ensure the NIAS Fleet is fit for purpose, value for money, safe, efficient and sustainable whilst minimising, wherever practicable, carbon and other emissions and environmental issues.

Fleet Strategy on a Page

The Strategic Priorities of the Fleet Strategy are to:

- Ensure value for money
- Ensure reliability, availability and safety
- Protect the environment

These priorities are underpinned within each of our Fleet Strategic Themes

Facts & Figures

In 2018-2019

We received **218,000 urgent & emergency care calls** of which **195,000** resulted in an **ambulance arriving on scene**

59,000 calls were for immediately life-threatening conditions **(Category A)**

89,000 calls were for serious but not immediately life-threatening conditions **(Category B)**

47,000 calls were for not immediately life-threatening or serious conditions **(Category C)**

We made **200,000 non-emergency journeys**, taking people to and from hospital appointments or for routine treatment

We currently have:

Circa 1,400 staff supported by **250 volunteer first responders** and almost **100 volunteer car drivers**

275 frontline vehicles (116 frontline, double-crewed emergency ambulances, 43 rapid response ambulance cars, 112 non-emergency and 4 NISTAR vehicles) coordinated by **one Emergency Control Room** and **one Non-Emergency Control Room** across **five operating divisions** and out of **59 ambulance stations or deployment points**

NIAS has an annual operating **budget of circa £80m**

Our Business

The Northern Ireland Ambulance Service Health & Social Care (HSC) Trust responds to the needs of the population of Northern Ireland (NI) of 1.9 million people in the pre-hospital environment. NIAS has an operational area of approximately 5,500 square miles, serviced by a fleet of 275 frontline vehicles. We provide ambulance care, treatment and transportation services to the people of NI 24 hours per day, 7 days per week, and 365 days per year. Services include, but are not limited to:

Responding to urgent and emergency calls
Non-emergency patient care and transportation
Specialised health transport services
Training and education of ambulance professionals
Planning for coordination of major events

Our Mission

To consistently show compassion, professionalism and respect to the patients we care for.

Our Values & Behaviours

NIAS has adopted the new HSC Values and expected behaviours and will work to embed these across all our functions and activities.

Working together

We work together for the best outcome for people we care for and support. We work across HSC and with other external organisations and agencies, recognising that leadership is the responsibility of all.

Excellence

We commit to being the best we can be in our work, aiming to improve and develop services to achieve positive changes. We deliver safe, high quality, compassionate care and support.

Openness & Honesty

We are open and honest with each other and act with integrity and candour.

Compassion

We are sensitive, caring, respectful and understanding towards those we care for and support and our colleagues. We listen carefully to others to better understand and take action to help them and ourselves.

These values, and the behaviours they instil, form the foundations for the culture and ethos for the whole organisation.

Our Range of Responses

Double-crewed emergency ambulance

Rapid response paramedic cars

Helicopter Emergency Medical Services

Clinical Support Desk (CSD) – providing clinical advice, and referral when needed, over the phone (Hear & Treat)

Appropriate Care Pathways (ACPs) and direct referral routes avoiding hospital emergency departments e.g. for falls, COPD, heart failure, palliative care and diabetes

Community paramedics – commissioned in specified rural areas to support the provision of primary care services for patients with long-term conditions and the assessment and treatment of minor illnesses and injuries, while maintaining the ability to provide an emergency response in life-threatening situations.

Community First Responders (CRFs) – volunteers trained in vital life-saving skills for those experiencing or at risk of cardiac arrest

Specialised intervention for our frequent callers to identify underlying needs and engage with social, community or secondary care services on their behalf

Multi-agency mental health triage team for those in mental health crisis

Emergency preparedness and specialist resources for major incidents, complex or hazardous environments and mass casualty events

Northern Ireland Specialist Transfer and Retrieval Team (NISTAR) – dedicated service for children and babies requiring urgent transfer between hospitals

Non-emergency **Patient Care Services** and transportation

NEW CLINICAL RESPONSE MODEL

A study undertaken on behalf of NIAS by specialist consultants 'Operational Research in Health' in December 2019 predicts that demand for urgent and emergency care in NI will increase by 2.8% per year over the next five years. This finding was a key driver in the Trust's decision to introduce a new Clinical Response Model (CRM).

New Clinical Response Model

The NIAS new Clinical Response Model (CRM) came into operation in November 2019 and defines how we deliver our core service for Urgent & Emergency Care (UEC). It focuses on achieving optimal outcomes for patients by providing the right response, in the right place, based on clinical need, for every call. The model uses evidence-based prioritisation of categories for presenting conditions when someone calls 999, and new response targets aligned to these categories.

The primary aim is to identify and get treatment to patients with a life-threatening issue fastest, and for all other patients ensure we provide the most appropriate response for their clinical needs. The diagram below describes the model:

The proposed response time standards for the new CRM are shown in Table 1.

Table 1: CRM – Proposed new response time standards

Call type	Category	Proposed response time target
999 immediately life threatening	Category 1	Mean 08.00 mins 90th centile = 15 mins
999 potentially serious incidents	Category 2	Mean 18.00 mins 90th centile 40.00 mins
Urgent problem	Category 3	90th centile 120.00 mins
Less urgent problems	Category 4	90th centile 180.00 mins
Non-urgent enquiry	Category 5	No specific targets

Increase in Fleet

Successful implementation of the new CRM is dependent on a significant uplift in workforce establishment levels and related increase in Fleet, subject to investment. The projected increase in Fleet is reflected within this Strategy.

STRATEGIC CONTEXT

NIAS is unique within the HSC in Northern Ireland in that its primary clinical working environment is mobile, i.e. its fleet. The NIAS Fleet is a fundamental enabler of the delivery of an efficient Urgent & Emergency Care (UEC) and Patient Care Service (PCS) to a population of almost 2 million people across NI. It must therefore consistently provide a safe, reliable and technically suitable environment for the care and transportation of patients and NIAS staff for today and into the future, as our service continues to increase and expand within the HSC arena.

To deliver this Strategy between now and 2025 involves elements of change and innovation across every aspect of the organisation. "Our infrastructure" is cited as one of the Trust's seven priority areas for transformation. Plans to expand our workforce in accordance with the Trust's new Clinical Response Model, along with new ways of working, will create a significant reliance on our infrastructure and key assets, such as our Fleet, in being fit for purpose to support effective and efficient operations.

This Fleet Strategy will support the Trust by providing a comprehensive range of medical emergency and support vehicles for the provision of care for the people of NI, ensuring effective and sustainable benefits for patients and the wider HSC. Patients and our front-line ambulance clinicians are at the heart of everything we do, and we will continually strive to ensure we provide fit for purpose, value for money, safe, efficient and sustainable vehicles that best meet their needs, whilst minimising, wherever practicable, carbon and other emissions and environmental issues.

This Fleet Strategy sets out the key drivers and rationale for the future Fleet. The programme for the development of our Fleet is based on the premise of future-proofing this asset as change takes place and on efficient sustainability, whilst reducing our impact on the environment.

We have a large and diverse assets inventory and we will work towards rebalancing our vehicle numbers and types to support the introduction of the new CRM and other key developments as they arise. Replacing vehicles at the optimal time through the utilisation of our fleet replacement programme, scheduling regular maintenance with other servicing requirements and unplanned repairs to reduce downtime, and ensuring proper fiscal management are paramount.

The NIAS Fleet Services will demonstrate though the implementation of this Strategy that services will be provided to an efficient and high-quality standard, and service provision, quality and performance will be reviewed on a regular basis.

The detail of this Strategy focuses on the next 6 years, until 2025. However, we recognise the need for flexibility and adjustment in order to ensure that it remains relevant and achievable as new and emerging innovations and technologies become available, particularly in terms of safety, efficiency, value for money, the environment and sustainability.

This Strategy incorporates how we as an organisation must manage and grow our fleet to meet the predicted increase in demand for UEC, and to maximise our services to our patients through improved operational performance and improved patient experience. It sets out our future direction, which will continue to be driven by the organisation's needs.

WHERE WE ARE NOW

NIAS currently receives an average of 600 emergency and routine calls per day. During 2018-2019 frontline ambulance clinicians responded to a total of 195,000 urgent and emergency calls with a vehicle arriving on scene, and over 200,000 non-emergency journeys.

Fleet Replacement Programme (2014-2019)

We have a clear understanding of our current Fleet profile, with the majority of vehicles 5 years old or less.

The Trust's fleet replacement programme has enabled the replacement of Accident & Emergency (A&E) Ambulances, PCS vehicles and Rapid Response (RRV) cars every five years, on a rolling basis as detailed in Table 2 below. As the Support Fleet varies according to type and use, the replacement cycle is between 5 years to in excess of 10 years for more specialised vehicles.

Table 2: Number, Average Age and Replacement Cycle of Specific Vehicles

Vehicle Type	Total	Average Age	Annual Replacement over 5 Years
A&E Ambulance	**116**	3.2	23.2
Patient Care Service	**112**	3.2	22.4
Rapid Response Vehicle	**43**	3.5	8.6
NISTAR	**4**	3.7	0.8
Officer/Incident Response	**20**	3.5	4
Training Officers	**7**	4.1	1.4
Medical Directorate	**2**	1.1	0.4
Community Paramedic	**1**	1.1	0.2
Emergency Planning Vehicles	**13**	7.7	2.6
Hazardous Area Response Team	**5**	1.4	1
Education Vehicles	**3**	12.1	0.6
Fleet Maintenance	**2**	4.6	0.4
Stores	**2**	2.6	0.4
Grand Total	**330**	**3.98**	**66**

This Strategy will inform the development of a new Fleet Replacement Business Case to cover 2020 -2025.

Fleet Mileage

NIAS vehicles covered 7.9 million miles during 2018-2019.

Table 3: Breakdown of average miles per vehicle, per year for the A&E, PCS, RRV and Support fleet

31/03/2019	Average miles per vehicle per year
A&E	33,775
PCS	21,624
RRV	20,144
Support	12,583

Fleet Revenue and Capital Spend

The revenue and capital spend on Fleet during 2019 is set out in Table 4.

Table 4: Revenue and Capital spend 2019

FUEL COSTS	£1,902,000
MAINTENANCE COSTS	£1,116,420
INSURANCE COSTS	£106,560
ACCIDENTS	£47,010

Totals

Capital: £4,295,665

Revenue: £3,171,990

Developments

Significant development and progress has occurred in recent years.

- Successful delivery of our 5-year fleet replacement programme; ensures the Trust has a modern, reliable fleet of the correct vehicle type dependent on job role, that meets current safety and environmental legislation and standards.
- Introduction of emergency response cars fitted with Start/Stop technology; minimises unnecessary engine idling and fuel usage, thereby reducing vehicle CO_2 emissions.
- Introduction of ECO-RUN on a number of vehicles to trial the system; an automatic idling control system fitted to A&E vehicles in order to reduce unnecessary idling and fuel usage, thereby reducing vehicle CO_2 emissions.
- Introduction of vehicle-based renewable energy systems; high efficiency solar panels fitted to the roofs of Emergency Ambulance vehicles from 2019.
- Introduction of a number of electric emergency response cars with range extenders, with more planned as part of our fleet replacement programme;
- Creation of an electric vehicle charging infrastructure to support the introduction of electric vehicles; nine electric vehicle charging points installed across NI to date with plans in place to roll out further.
- Reconditioning of high value items such as emergency lighting systems in cars, doubling the lifecycle from 5 to 10 years;
- Retaining and reconditioning specialist parts such as ambulance seating and locking mechanisms from decommissioned vehicles for re-use when required.
- Flexibility of fleet and equipment strategies to adapt to the changing operational environment in supporting our clinicians to provide more advanced clinical interventions and improved patient outcomes.
- Introduction of dedicated Vehicle Cleansing Operatives; improves compliance with vehicle cleanliness and hygiene audits, and supports Infection, Prevention & Control requirements; enables ambulance clinicians to concentrate on their core tasks without having to worry about their vehicle being ready for use.
- Scoping the ‘hub and spoke’ structure within our Estates programme. The Trust’s ambition to have a hub and spoke configuration, supported by a ‘Make Ready’ system (Box 1) and incorporating services such as fleet maintenance, will enable us

to become more efficient, thereby improving vehicle availability and reducing downtime.

Box 1: MAKE READY

The 'Make Ready' System is a quality assured vehicle preparation programme, designed to minimise cross infection and maximise patient safety, whilst eliminating the hours of service associated with the cleaning and stocking of vehicles. All of the vehicle preparation is undertaken by specially trained, non-clinical staff, allowing ambulance clinicians to focus on the delivery of high quality patient care.

Key benefits of a Make Ready System

- **Improvement in standards of cleanliness**
- **A significant reduction in lost hours of ambulance availability**
- **A reduction in stock consumption measurable with procurement and financial data**
- **Improved vehicle reliability**
- **An improvement in patient safety measurable in reduction of adverse incidents**
- **Enables effective asset management**
- **Savings made on consumables and drugs stocks with no out of date items being wasted**

GETTING TO WHERE WE WANT TO BE

We will achieve our Fleet vision through the provision of strong foundations while enhancing key services.

The optimal Fleet for NIAS must ensure sufficient ambulance vehicles of the right type and specification are available when required to meet the planned delivery of services, and to provide reasonable contingency for unplanned but foreseeable events.

We will focus on our five strategic themes as highlighted in our vision for Fleet Services and we will work closely with the Trust's Estates and Digital strategies to maximise efficiency for NIAS Fleet.

Our Fleet Strategy is ambitious but we believe it is achievable if we put in place the necessary support, investment and related infrastructure and work with the following underpinning principles:

Partnership Working

- Working with our internal Fleet Groups (A&E and PCS) who adopt the themes of the Strategy in their work plans
- Working in partnership with our estate colleagues in relation to the development of the Hub and Spoke model in order to build a network of Fleet Maintenance & Repair Workshop locations, to improve business continuity considerations and to solve organisational logistical problems
- Working collaboratively with the CRM programme as it evolves to ensure the timely procurement of additional vehicles by type, according to role
- Working collaboratively with our Regional Ambulance Training Centre (RATC) colleagues to support the delivery of planned Driver Training Programmes for new recruits to frontline clinical roles and to support the planning and delivery of familiarisation training when introducing changes to our Fleet, e.g. through the introduction of automatic gearboxes, hybrid and/or fully-electric vehicles and new technological advances related to Fleet and equipment
- Working collaboratively with other regional emergency services i.e. he Police Service of Northern Ireland (PSNI) and the Northern Ireland Fire & Rescue Service (NIFRS) in order to share learning and best practice
- Continuing to work nationally with the relevant groups to shape and influence the direction of future ambulance Fleet services and vehicles

Leadership

- We have leaders at all levels truly committed to NIAS values and behaviours and these are displayed at all times in all that we do
- We invest in and develop staff and leaders to be the best they can be

Excellence in Delivery

- We get the basics right, first time, every time
- We have in place enough vehicles at the right place, at the right time, of the right type to service operational needs

- We provide vehicles that are clean, safe and as energy-efficient as possible, with minimum downtime, to support ambulance clinicians in the provision of quality patient care
- We provide reasonable contingency for unplanned but foreseeable events/incidents
- Our maintenance colleagues are skilled, deliver consistent vehicles back into operational service, add value to the department and are supported by managers to achieve their best
- Fleet Services staff will have their appraisals and objectives linked directly to the delivery of the Fleet Services Strategy

Supporting the Achievement of the Trust's Key Goals and Priorities

The Trust has identified four key goals and seven areas of priority for transformation, as described in Table 5 below.

Table 5

Goals		Key Priorities
Our patients will feel professionally cared for; always with compassion and respect	**Our staff will feel positive and proud to work for NIAS**	1. *Delivering care* 2. *Our workforce* 3. *Organisational health* 4. *Quality improvement* 5. *Digital enablers* 6. *Our infrastructure* 7. *Communication and engagement*
Our stakeholders and partners will have confidence in us as a reliable provider at the centre of urgent and emergency care	**Our communities will continue to value and trust us**	

This Fleet Strategy aligns to the Trust's key priorities as described below:

Delivery of Care

Patients and our front-line ambulance clinicians are at the heart of everything we do, and we will continually strive to ensure we provide fit for purpose, value for money, safe, efficient and sustainable vehicles that best meet their needs, whilst minimising, wherever practicable, carbon and other emissions and environmental issues.

Our Workforce

We will collaborate with related functions across the Trust to ensure the timely planning and delivery of familiarization and training for all of our frontline staff when making changes to our Fleet, e.g. through the introduction of automatic gearboxes, hybrid and/or fully-electric vehicles and new technological advances related to Fleet and equipment.

Quality Improvement

Quality and improvement will be central when researching and procuring additional and replacement Fleet and equipment with a focus on value for money, safety, efficiency and sustainability, whilst reducing our impact on the environment.

Organisational Health

Transforming NIAS means more than just changing some of our systems and processes. We welcome the investment that will support some of the major changes we are making in implementing our new CRM, including the recruitment of almost a third again of our frontline workforce – more than 300 extra clinicians. This alone will have wide ranging impact on how the organization operates, and our corporate services and infrastructure, including Fleet, will necessarily expand to accommodate these changes.

Digital Enablers

NIAS is open to new technologies as they emerge and become reliable. We have a workforce dispersed right across the country and our frontline staff are on the move most of their working day or night. We therefore have a strong need to provide seamless connectivity and an ability to be able to communicate with every individual member of staff no matter where they are working. We will work flexibly and efficiently to support the introduction of all new technologies within the Trust's mobile clinical working environment, i.e. its Fleet.

Our Infrastructure

We will strive to future-proof our Fleet as change takes place and on efficient sustainability, whilst reducing negative impact on the environment. Over time we will move to a new model of hub & spoke locations to support the introduction of 'Make Ready' systems.

We will endeavor to reduce the Trust's carbon footprint by adopting new technologies such as electric and hybrid vehicles. We will also seek out greener energies for our vehicle system power, such as hydrogen fuel cells and solar power. By utilising vehicle management information supplied by telemetry systems we will aim to improve vehicle and driver performance to improve efficiency and reduce environmental impact.

Communication and Engagement

Fleet Services recognise that our staff, i.e. the people who work in the NIAS clinical mobile environment, are key to the successful implementation of this Strategy. We therefore pledge to continue to work in partnership with our unions, staff representatives, managers and others in relation to new Fleet initiatives, respecting any impacts on our staff, ensuring they have a voice and input to the way we develop.

New Clinical Response Model (CRM)

Successful implementation of the new CRM is dependent on the introduction of an additional 4,387 hours of cover per week. This requires an uplift in workforce establishment levels and related increase in Fleet to meet the increased hours of cover and to ensure delivery of commissioned hours.

In addition to the ongoing management and replacement of our current Fleet inventory, Fleet Services will procure and make ready an additional 95 vehicles over the lifespan of this Strategy, subject to investment, in order to support the Trust to fully implement the new CRM, as detailed in Table 6 below:

Table 6: CRM – Fleet uplift

Vehicle Type	Baseline 2019-2020	CRM Uplift	Total Future Requirement
A&E Ambulance	**116**	**51**	**167**
Patient Care Service	**112**	**0**	**112**
Rapid Response Vehicle	**43**	**0**	**43**
NISTAR	**4**	**0**	**4**
Officer/Incident Response	**20**	**26**	**46**
Training Officers	**7**	**1**	**8**
Medical Directorate	**2**	**0**	**2**
Community Paramedic	**1**	**TBC**	**1**
Emergency Planning Vehicles	**13**	**0**	**13**
Hazardous Area Response Team	**5**	**0**	**5**
Helicopter Emergency Medical Service	**0**	**1**	**1**
Sub Total	**322**	**79**	**401**
Education Vehicles	**3**	0	3
Fleet Maintenance	**2**	0	2
Stores	**2**	2	4
Community Resuscitation Team	**0**	4	4
Complex Case Team	**0**	5	5
Logistics Team	**0**	5	5
Sub Total	**7**	**16**	**23**
Grand Total	**329**	**95**	**427**

Barriers to Success

Fleet Team

The NIAS Fleet service is currently delivered by a small team consisting of a manager, a supervisor and two mechanics. A review of the structure is required to ensure the service is appropriately resourced to achieve our vision, particularly in terms of taking forward the green agenda and supporting the implementation of the CRM programme as it evolves.

Strong Fleet management foundations to enable efficient and effective services in order to proactively support the Trust to achieve its key goals and priorities

Fleet Maintenance & Repair

We are heavily reliant on external contractors to carry out essential fleet maintenance and repairs across NI. The COVID-19 pandemic highlighted that this reliance proved a significant risk to fleet business continuity, when external contractors largely closed during the lockdown in the early months of the pandemic.

We will therefore collaborate with colleagues during the development of the Trust's Estates Strategy to ensure that, along with Make Ready systems, consideration is given to the provision of Fleet Maintenance & Repair Workshops within the hub and spoke model.

Theme 1 Operational Need

Delivery of Urgent & Emergency Care and non-emergency Patient Care Services to the population of Northern Ireland is our core business, at the heart of out-of-hospital healthcare provision. Our services are an important and integral part of the emergency and non-emergency healthcare environment, not simply transporting patients but providing advanced medical interventions to the 'sickest quickest' in the pre-hospital arena.

At the core of these services in the Trust's Fleet; a Fleet that must be fit for purpose, value for money, safe, efficient and sustainable in order to meet both the operational needs of the organization and the needs of our patients both now and into the future.

AIM

We aim to continuously improve our Fleet Services to meet the needs of the organization and our patients over the lifespan of this Strategy

This will be achieved by ensuring:

- Vehicles are procured in accordance with HSC guidance and in line with the Trust's 5-year vehicle replacement programme
- The correct specification of vehicle is procured for the role the vehicle will undertake
- Fleet of the correct size and type to enable the organization, as it continues to grow and expand, to operate efficiently and effectively on a 24/7 basis across NI (Appendix A)
- An effective and proactive maintenance / servicing regime aimed at reducing vehicle breakdowns or unscheduled repairs, thereby reducing Vehicle off Road
- Collaborate with the Trust's Estates Department with regard to the development of a hub & spoke estate, to include vehicle maintenance workshops and the 'Make Ready' system
- Where possible, to work with other ambulance services, emergency and other healthcare providers to leverage combined purchasing power through centralized procurement.
- Maintenance and servicing is carried out in accordance with legal, manufacturer and Trust agreed requirements
- Collaborate with the PCS Review in order to improve reliability of our scheduled care transport
- A progressive approach to migrate vehicles to cleaner fuel technologies as options become viable
- Minimize, wherever practicable, carbon and other emissions and environmental issues
- Promotion of better driving and accident reduction
- Effective management of Fleet Insurance requirements
- Continue to use technology to better understand our fleet & logistics
- Continued introduction of telematics within vehicles
- Continued use of solar and battery storage technologies and other renewable energies to support off-grid travel across the Trust

Benefits

- Responsive to operational need
- Lower our carbon footprint
- Increased use of smart technology
- Increased vehicle availability

Measure of Success

- Right number and type of vehicle in the right place at the right time
- Delivery & commissioning of new and replacement vehicles to plan
- Vehicle compliance – MOT / maintenance / servicing
- Vehicle availability – reduced VoR rates
- Reduction in accidents
- Introduction of telematics within vehicles
- Introduction of 'Make Ready' system
- Introduction of Vehicle Maintenance Workshops across the Trust

Theme 2 Fleet Agility

The detail of this Strategy focuses on the next five years, until 2025. However, we recognise the need for flexibility and adjustment in order to ensure that it remains relevant and achievable as new and emerging innovations and technologies become available, particularly in terms of safety, efficiency, value for money, the environment and sustainability.

In an ever changing environment, this Fleet Strategy will need to be agile to meet operational needs and the needs of our patients. Fleet Services will demonstrate though the implementation of this Strategy that services will be provided flexibly and to an efficient and high-quality standard, and service provision, quality and performance will be reviewed on a regular basis.

AIM

We aim to ensure the NIAS Fleet is fit for purpose, value for money, safe, efficient and sustainable both now and into the future whilst minimising, wherever practicable, carbon and other emissions and environmental issues.

We hope to achieve these aims by:

- Achieving approval of our Fleet Replacement Business Case 2020-2025
- Effectively and efficiently managing the implementation of the fleet replacement programme over the lifespan of this Strategy. Replacing vehicles at the optimal time, scheduling regular maintenance with other servicing requirements and unplanned repairs to reduce downtime, and ensuring proper fiscal management are paramount.
- Working towards rebalancing our vehicle numbers and types to support the introduction of the new CRM and other key developments as they arise.
- Flexibility of fleet and equipment strategies to adapt to the changing operational environment in supporting our clinicians to provide more advanced clinical interventions and improved patient outcomes.
- Delivering an operational fleet that is fit for purpose and affordable in conjunction with the Trust's operational, clinical and financial plans.
- Engaging with all departments within the Trust that use our vehicles to ensure provision of appropriate specialist single and multi-role vehicles within established funding. Engagement with vehicle design groups that assess the viability and clinical effectiveness of equipment and consumables will be critical to support the changing requirement, and input from operational staff, managers and trade union representatives will be instrumental in maintaining a frontline focus on the vehicle's clinical effectiveness
- Continuing to explore the market for vehicles to meet the requirements of the organization such as automatic gearboxes and potential hybrid and electric vehicles that meet load requirements. Already we are seeing the innovative development of a prototype A&E ambulance through the national Project ZERRO initiative (Box 2), however, the reality of this is still a number of years away.
- Scoping the 'Hub and Spoke' structure within our Estates programme. The Trust's ambition to

- Understanding the required number of vehicles to support ongoing operational delivery to provide best patient care and experience.
- Ensuring best outcomes for patients by having the right vehicle at the right place at the right time.

have a hub and spoke configuration, support by a 'Make Ready' system and incorporating services such as fleet maintenance, will enable us to become more efficient, thereby improving vehicle availability and reducing downtime.

Benefits

- Responsive to organization change
- Collaborative working with related key
- functions and stakeholders

Measure of Success

- Fleet Replacement Business Case approved and implemented effectively
- CRM Business Case approved and required number and types of vehicles procured
- Make Ready / regional Maintenance Workshops progressed through Estates strategy

Box 2: PROJECT ZERRO

Zero Emission Rapid Response Operations Ambulance

The project, funded by Innovate UK, is a collaboration between ULEMCo, London Ambulance Service, Mellor Coachcraft, Lyra Electronics and Ocado to:

• Build and demonstrate a zero-emission, fit-for-purpose emergency ambulance
• Average miles: 200 miles/day
• Expected Max range: 250 to 300 miles
• Supported by NHSI with input from other UK NHS Trusts
• 2.5 year project

Theme 3 Quality & Safety

We are dedicated to providing operational and service excellence which is sustainable and innovative, putting our patients and frontline clinicians at the heart of what we do. We will demonstrate this commitment through delivering high standards of health, safety and environmental management.

AIM

We aim to continually improve our performance, always seeking to reduce risk. We believe in always doing the right thing and in doing it safely, without unnecessary risk to health or to the environment.

This aim will be achieved by supporting the following initiatives that underpin quality and safety:

- Conduct a review of the current Fleet management structure to ensure it is appropriately resourced to meet the requirements of this Strategy
- Establish an Accident Reduction Group aimed at promotion of better driving and reduction of accidents.
- Promote better driving: new recruits to PCS, A&E and Driving Instructor roles must undertake and successfully complete an appropriate formal ambulance driver training qualification before becoming operational – see Appendix B for further detail.
- Collaborate with the NIAS Regional Ambulance Training Centre and other related functions to ensure the timely planning and delivery of familiarization and training for all of our frontline staff when introducing changes to our Fleet, e.g. through the introduction of automatic gearboxes, hybrid and/or fully-electric vehicles and new technological advances related to Fleet and equipment.
- Promote improvement of compliance with Infection Prevention & Control (IPC) standards; new recruits to all patient-facing roles must undertake and successfully complete IPC training before becoming operational. Training is incorporated into the following ambulance education programmes:
- Ergonomic principles for safety in the workplace are included in vehicle design
- All vehicles procured include suitable safety systems and technologies to reduce risks to the driver, crew and patient
- Promote improvement of compliance with IPC standards: existing staff in patient-facing roles are required to undertake yearly IPC refresher training, rotating on an annual basis through e-learning and tutor-led programmes.
- Introduction of dedicated Vehicle Cleansing Operatives; improves response time performance and patient outcomes by increasing the number of hours frontline ambulance clinicians are available to respond and provide care to patients, otherwise spent cleaning and stocking ambulances; improves vehicle cleanliness and hygiene; supports compliance with IPC standards
- Work flexibly and efficiently to support the introduction of all new technologies within the Trust's mobile clinical working environment, i.e. the NIAS Fleet.
- Review opportunities to use low emission vehicles and alternative fuels as they come onto the market.

- PCS Students: Ambulance Care Assistant programme
- Emergency Medical Technician (EMT) Students: Associate Ambulance Practitioner programme
- Paramedic Students: Foundation Degree in Paramedic Science (and the forthcoming BSc in Paramedic Science programme).

- Contribute to the development and implementation of a new Quality and Safety Strategy to further enhance Fleet Services.
- Encourage our staff to be physically active by replacing car journeys with cycling and walking (where appropriate and feasible) to improve their health and wellbeing.

Benefits

- Effective contribution to the Trust's quality and safety priorities
- Collaborative working with related key functions and stakeholders

Measure of Success

- Reduction in accidents & incidents
- Improved IP&C compliance
- Improved health and wellbeing of our staff
- Reduction of carbon emissions
- Achievement of roll-out of new technologies related to Fleet

Theme 4 Sustainability & the Environment

While COVID-19 is posing an unprecedented challenge globally, there is increasing recognition of the Climate Crisis as the greatest global challenge we face in this century. Within the 2015 Paris Climate Change Accord[1], 197 countries agreed to set emission targets that would limit global temperature rise by 1.5 degrees Celsius by capping greenhouse emissions at "net zero" – or absorbing as much carbon as they emit – by 2050.

The UK Committee on Climate Change advice for Government is to reduce Greenhouse Gases (GHG) to zero by 2050. The UK Clean Air Strategy 2019[2] has also said that air pollution is the top environmental risk to human health in the UK.

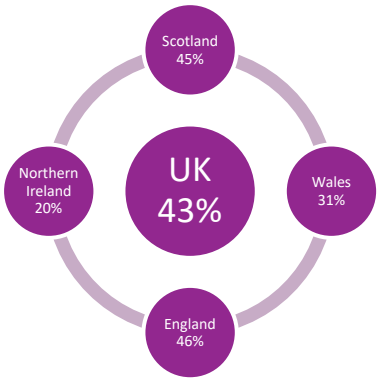
TEDxStormont 'Countdown'

TEDxStormont 2020 hosted 'Countdown' – a global initiative to champion and accelerate solutions to the climate crisis, turning ideas into action. The online event, broadcast from Belfast, took place on Saturday 10 October 2020 as part of the global launch. Nichola Mallon, NI Minister for Infrastructure, gave the following stark warning in her keynote speech:

"There is no doubt that climate change is the single biggest environmental crisis we face today. It is an emergency. Meeting the net zero target by 2050 is too late. We can't wait. We, all of us, must act. And act now."

Figures published by the Department of Agriculture, Environment and Rural Affairs (DAERA)[3] in June 2020 revealed that NI is hindering the UK's net zero progress, as demonstrated in Figure 1 below.

Figure 1



[1] United Nations Paris Climate Agreement (2015)
https://unfccc.int/process-and-meetings/the-paris-agreement/the-paris-agreement

[2] UK Clean Air Strategy (2019)
https://www.gov.uk/government/publications/clean-air-strategy-2019

[3] Northern Ireland Climate Change Adaptation Programme (2019-2024)
https://www.daera-ni.gov.uk/publications/northern-ireland-climate-change-adaptation-programme-2019-2024

NI is currently the only region in the UK and Ireland without any specific legislation to tackle the global crisis. However, an announcement made on 21 October 2020 confirmed that a Climate Change Bill, developed by a group of legal experts, scientists, academics and environmentalists, is to be presented to the NI Assembly. The draft legislation declares a climate emergency and proposes a series of targets to cut carbon emissions.

The Bill envisages NI being carbon neutral by 2045 by cutting emissions across energy, transport, business, waste management and agriculture. The introduction of this legislation will build on a commitment within the New Decade, New Approach agreement[4] to reduce greenhouse gases.

AIM

NIAS Fleet Services is highly conscious that operating a large fleet of vehicles of various types has obvious environmental impacts. We will therefore, until the targets within the NI Climate Change Bill are known, where possible, replace our vehicles on a year on year basis with greener and environmentally friendly vehicle capabilities to reduce GHG emissions and related pollutants, reduce fossil fuel consumption, and protect the environment.

How we hope to achieve this aim is described below:

GREEN VEHICLES

A&E and PCS

Whilst ideal reduced or zero carbon emission alternatives for our double-crewed A&E and PCS vehicles are not currently available, we do know that the market is changing and we expect a new range of vehicles to be available within the lifespan of this Strategy.

For example, work is in progress nationally through the Project ZERRO initiative, as identified within the NHS publication Delivering a 'Net Zero' National Health Service[5], to work towards road-testing for what would be the world's first zero-emission A&E ambulance by 2022.

We will therefore continue to collaborate with UK Ambulance Trusts through the National Ambulance Strategic Fleet Group, and others, in relation to Project ZERRO and other fleet manufacturer developments of greener vehicles.

We plan to trial reduced or zero carbon emission A&E and PCS vehicle options, subject to market availability (and subject to business case approval and related investment), in order to test our true requirements and gain operational feedback.

[4] New Decade, New Approach, January 2020
[5] Delivering a 'Net Zero' National Health Service, January 2020

Emergency Response Cars

NIAS is conscious that we do not currently meet the UK Government's 2020 target of 95g c02/km for cars. We are therefore currently piloting a number of BMW i3 electric cars with range extenders with anticipated combined C02 emissions of 13g/km.

It is our aim to replace a minimum of 50% of our emergency response cars with either hybrid or fully electric fuel capabilities, over the lifespan of this Strategy, subject to the availability of suitable options and related investment.

Electric Vehicle Charging Points

The Trust will continue to roll out charging points across our estate in order to support the implementation of a strategy of hybrid and electric vehicles. Fleet Services will work closely with our Estates colleagues in this regard.

The Estates Strategy will provide more detail on the Infrastructure requirements and options.

It should be noted that electric vehicles will reduce our fuel costs, but an increase in electrical usage will occur, which will require an adjustment to budgets; however, our ambition to use renewable energy across our Estate will have a considerable impact on our CO2 emissions.

Other initiatives include:

- The implementation of sustainable/green management practices to adopt cleaner fuels and technologies
- Embedding green criteria in the fleet procurement process to significantly reduce GHG emissions and air pollutants from vehicles
- Seeking out greener energies for our vehicle system power such as hydrogen fuel cells and power
- Continue to measure emissions from our fleet and develop comparison calculations for ultra and low emission versus petrol & diesel vehicles in order to inform future decisions
- Monitor electricity consumption from electric charging points
- Implement a fuel management monitoring system and robust data capture to ensure savings and fuel consumption are tracked
- Utilising vehicle management information systems, we will aim to improve vehicle and driver performance to improve efficiency and reduce environmental impact
- Ensure additional and replacement emergency response cars are fitted with Start/Stop technology to minimise unnecessary engine idling and fuel usage, thereby reducing vehicle CO2 emissions.
- Continue to fit ECO-RUN, an automatic idling control system to A&E vehicles to reduce unnecessary idling and fuel usage, thereby reducing vehicle CO2 emissions.
- Continue to retain and recondition specialist parts such as ambulance seating and locking mechanisms from decommissioned vehicles for re-use when required.
- Continuing to collaborate with other regional emergency services in order to share learning and best practice in terms of the development of a greener fleet.
- Continuing to work nationally with the relevant groups to shape and influence the direction of future ambulance Fleet services and vehicles
- Promoting alternative forms of transport and encouraging our staff to

- Continue to Introduce vehicle-based renewable energy systems; high efficiency solar panels fitted to the roofs of A&E vehicles.
- Continue to recondition high value items such as emergency lighting systems in cars, doubling the lifecycle from 5 to 10 years;
- Safe disposal of batteries

consider if business travel is needed (Box 3).

- Continued use of solar and battery storage technologies and other renewable energies to support off-grid travel across the Trust

Longer Term Strategy

- Meet government climate and environmental targets
- Continue to monitor alternative fuel vehicle development

Benefits

- Responsive to organizational change
- Contribute to the green agenda

Measure of Success

- Sustainable/green management practices to adopt cleaner fuels and technologies implemented
- Green criteria embedded in Fleet procurement process
- Procurement of low emission emergency response cars
- Systems in place to measure emissions from fleet and comparison calculations developed for ultra and low emission versus petrol & diesel vehicles and used to inform decisions
- Systems in place to monitor and report on electricity consumption from electric charging points

Box 3: PROMOTING THE GREEN AGENDA

Travelling to the Workplace

Encourage staff to consider alternative ways of getting to and from the workplace, such as:

- Cycling and walking (where appropriate and feasible) for increased wellbeing
- The use of public transport or park and ride schemes
- Car sharing
- Promote the Cycle to Work Scheme
- Provide electrical vehicle charging facilities to encourage the purchase of low emission vehicles
- Actively promote the benefits of hybrid and electric vehicles

Business Travel

This Strategy is also linked closely to the Digital Strategy, helping to promote remote working and communication technologies to reduce our actual business travel around the region. We will encourage staff to review travel options available to them, which can increase efficiency, reduce travel time and mileage and minimize emissions, such as:

- Can you reduce travel by working remotely?
- Does there need to be an 'in person' meeting? Will an audio or web conference meet the business need?
- Can a more sustainable mode of travel be used such as walking, cycling or public transport?
- Is there a low emission vehicle available?
- Can the journey be shared with a colleague?
- What is the best time for the meeting to minimize journey disruption?

Theme 5 Digital Enablers

The Bengoa Report[6] states '*To deliver a sustainable world class service into the future will require all of us to work together very differently. We need an infrastructure that makes this possible'.*

NIAS recognises that the optimisation of technology utilisation and improvements in connectivity across NIAS vehicles, systems and the wider HSC will greatly enable and support the delivery of our emergency and non-emergency care services. It is widely acknowledged that the ambulance vehicle (including emergency response cars) is the key operating environment for the frontline ambulance clinician and it is essential that through the use of digital technology we can support our mobile and regional workforce.

Our vehicles are now connected hubs, able to receive and send critical data relating to calls and patients across the secure NIAS network. Within each vehicle there is a secure vehicle area network (VAN) for two-way communication between NIAS command and control systems and vehicle devices as well as externally supporting the transmission of patient clinical data in advance of arrival at Emergency Departments (EDs). The ambulance is a 'connected' mobile treatment centre benefitting from technological advances in clinical equipment and logistical tracking of assets.

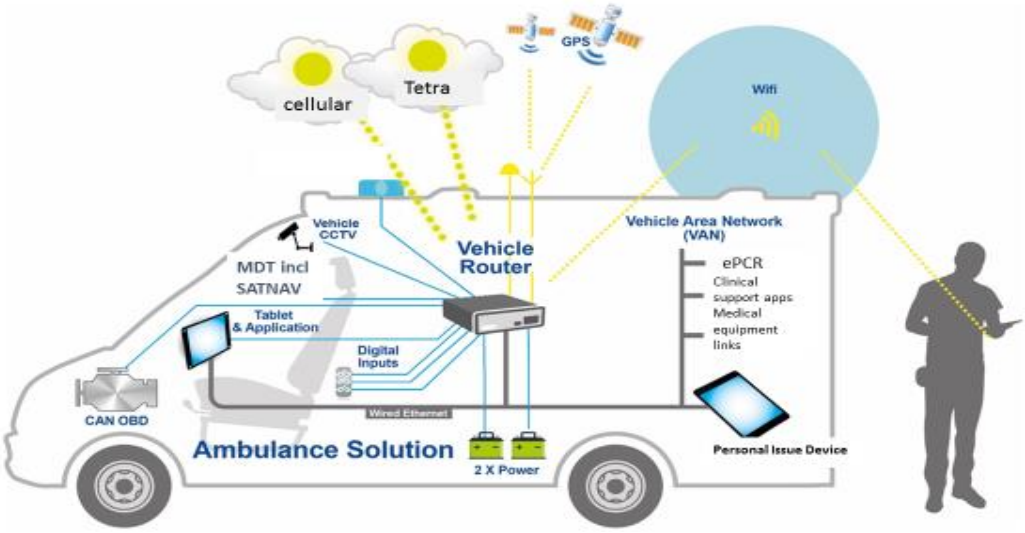
The Trust is making enormous progress to achieving the above ambition through its **REACH** programme - **R**egional **E**lectronic **A**mbulance **C**ommunication **H**ub.

The aim of **REACH** is to build an 'end to end' electronic solution for patient records, replacing the current paper based system, supported by personal issue devices and a vehicle communications infrastructure and technical infrastructure to enable data sharing between NIAS systems and the wider HSC.

The key objectives of **REACH** are:

- Supporting the patient journey from the 999 call to the patient destination
- Improving patient safety and the reduction of risk with real time data and clinical decision support tools available at scene

[6] Systems, Not Structures (October 2016)
https://www.health-ni.gov.uk/publications/systems-not-structures-changing-health-and-social-care-full-report



AIM

The aim of Fleet Services is to work flexibly and efficiently with key functions and stakeholders across the Trust to support the continued roll-out and introduction of all new technologies within the NIAS mobile clinical working environment, i.e. its Fleet.

Significant developments achieved to date include:

- Mobile data systems now on a single platform that allows seamless switching between Emergency and Non-Emergency staff to support call response
- Communications technology installed within the frontline ambulance fleet, i.e. A&E, PCS and emergency response cars. This includes the ability to support up to 4 cellular networks and the tetra network for radio communications technologies, including a wired Ethernet interface, Wi-Fi as a 'hot spot' access point for devices within the vehicle.
- Black box technology
- MDT – mobile data terminal. Smart based tablet fixed at the front of the vehicle with software for the allocation and mobilisation of vehicles. Two-way communication is supported from CAD systems at command and control with mobile data systems in the vehicles to
- Roll-out of new Digital Trunk Radio – base radio and hand-held portable radios. Radios also act as pagers linked to the MDT system for when crews are away from the vehicle
- CCTV/Dashboard footage
- **Roll-out of the ePCR (electronic care record) – an end to end electronic solution for recording patient clinical records**
  - integrated with command and control systems to receive call and known patient information;
  - integrated with the master patient index for Health & Care Number look up in the mobile environment;
  - integration of medical devices with the ePCR
  - ability to transmit patient information, observations, any change in condition, ECG reading etc. to Clinical Workstations in EDs

receive critical call information and provide status updates back to control. The MDT also has in-built satellite navigation systems.

- onward transmission of ePCR to the ED whilst en-route to the hospital

- **Personal Issue Electronic Devices**
- Windows tablet - allows access to the NIAS network, Sharepoint, emails etc.
- Mobimed smart software for e-PCR

Benefits

- Improved patient care through use of technological advances
- Regional Wi-Fi across our estate and in vehicles
- Flexible access to systems and services, any place, any time controlled by business need
- Use of technology to better understand our fleet and logistics

Measure of Success

- 100% of vehicles have a Wi-Fi communications infrastructure supported by cellular and tetra networks
- Key call and incident data is communication to and from vehicles via the central communication hubs
- All frontline staff are accessing NIAS networks and systems from the vehicles
- Integration of medical devices with patient systems

COMMUNICATION & ENGAGEMENT

Significant communication and engagement took place during the development of this Strategy to get it to where it is today, with individuals and groups such as:

- CRM Programme Director
- Fleet Manager
- Cenex Low Emission Vehicle Research & Consultancy
- Projects Development and Implementation Manager
- Clinical Training Manager
- NIAS Driver Training Advisory Group (DTAG) Representative
- NIAS Fleet Group
- NIAS Chair and Chief Executive
- Senior Management Team
- Operational Managers
- Trust Board

A sincere word of thanks goes to all those who had a keen interest in the development of the Strategy and provided many positive contributions.

CONCLUSION

This Strategy outlines an ambitious programme of work for over its lifetime up to 2025, agreed with those listed above. It will require tangible investment in NIAS; the programme of work cannot be realised without approval of the Fleet Replacement Business Case 2020-2025.

The implementation of this Strategy and achievement of milestones will be monitored by NIAS Governance processes through regular highlight reports so that we can adapt to changing circumstances, measure progress and manage risks along the way.

Priority Actions

1.	Achieve approval of our Strategy and develop a supporting business case to secure funding for a Fleet Replacement Programme 2020-2025.
2.	Review the Fleet Management structure to ensure it is resourced appropriately to meet the requirements of this Strategy.
3.	Meet the operational need for Fleet in terms of vehicle numbers, type and configuration.
4.	Ensure the stability of the age and mileage profile of the Fleet through effective management of the fleet replacement programme.
5.	Ensure the timely procurement and availability of additional vehicles to meet the requirements of the CRM programme.
6.	Ensure vehicle specifications conform with relevant safety guidelines and specifications.
7.	Trial, through the approval of a business case, reduced or zero carbon emission A&E and PCS vehicle options, subject to market availability, to test our true requirements and gain operational feedback.
8.	Replace a minimum of 50% of emergency response cars with reduced or zero carbon emission options, subject to market availability and investment.

Appendix A: Vehicle Types

Below is a description of the main types of vehicles currently in use within the NIAS Fleet and an overview of the roles each perform.

Accident & Emergency (A&E) Ambulance

A&E ambulances (as used by the majority of UK and Ireland ambulance services) have a chassis/cab base construction with a chassis weight limit of 5.5 tonnes. A&E ambulances require the grater chassis weight limit to facilitate the clinical workspace requirement and the extra equipment carried (both medical and operational, such as mechanized tail lifts). These ambulances are specifically designed for the pre-hospital treatment and transportation of the most seriously ill patients. Patients are provided with the highest standard of pre-hospital care at the scene of their illness or injury and during their journey to hospital. A&E ambulances are based on light commercial vehicles and are a chassis cab with a modular body. They incorporate sophisticated control systems to safeguard vehicle reliability, patient monitoring and communications. They provide a mobile treatment centre for the practice of life-saving paramedic interventions at the point of need.

Rapid Response Vehicles (RRV)

RRVs are deployed to life-threatening calls as a first response and are crewed by an individual paramedic. They are intended to quickly deliver enhanced clinical care and patient outcomes through early arrival, assessment, intervention, treatment and care. The RRV fleet comprises of 43 vehicles. Where possible, these will be four-wheel drive to enable them to access the varied terrain they encounter in the course of service delivery.

Though they do not transport patients, RRVs do carry equipment similar to a full scale A&E ambulance. The mode of operation is that they remain available for the majority of their shift times (due to the non-transport element) and they remain out in the community rather than being based in ambulance stations. Thus the activation times, travel times, and unavailability times are all kept to a minimum.

The early presence of a paramedic at the scene of an incident, or seriously ill patient, can improve the outcome for the patient and also speed up the management of the incident by having the patient ready for transportation on arrival of the A&E ambulance.

Patient Care Service (PCS) Vehicles

PCS vehicles are a less complex vehicle than A&E ambulances and are a van conversion (similar in nature to a large minibus) with a chassis weight limit of 3.5 tonnes. The non-emergency PCS ambulance provides transport and care for patients travelling to hospital for pre-planned appointments, patients travelling between hospitals and thereafter for discharge to home.

The PCS is increasingly used to carry out an Intermediate Care Service (ICS) in order to transport and transfer patients who require more than basic care. Intermediate Care Vehicles (ICV) are used to transport patients with mobility difficulties or who require some clinical intervention such as oxygen therapy, but not a paramedical level of care. These vehicles are adapted to accommodate wheelchairs and stretcher and bariatric patients.

As a result, non-emergency patient transport work is becoming more specialized and with inter-hospital transfers requiring the use of trolleys rather than wheelchairs (or no assisted movement), fewer patients are being carried per vehicle across the PCS/ICS as a whole, thereby increasing the number of journeys.

NIAS has commenced a dedicated review of the Patient Care Service, the finding of which will inform the future profile of the NIAS Fleet.

Emergency Planning and Hazardous Area Response Teams (HART)

These are specialist vehicles designed to support the management of major medical emergencies or incidents by providing communications and specialist equipment at the scene of major incidents or mass casualty events. HART vehicles are also a mix of vehicle types that provide further equipment for specialist hazardous operations e.g. rescue from height, chemical incidents, mountain or difficult terrain and confined space rescue. These vehicles do not transport patients.

NI Specialist Transport and Retrieval Team (NISTAR)

These vehicles are of a similar design to A&E ambulances with increased medical equipment and doctor-led specialist teams for the transportation of acutely sick babies, children and adults. The service is based in Belfast, however it operates throughout NI, including transportation of patients to specialist centres throughout the island of Ireland.

Management and Support vehicles

The vehicular requirements of divisional management are determined by the roles and responsibilities of the management team.

There are five officers currently on-call who must respond to a major incident at any time after 5pm Monday to Friday and twenty-four hours a day on Saturday, Sunday and public holidays. In addition, pagers will alert all officers to a major occurrence and those who are available will respond in their vehicles and be tasked appropriately to the incident. These officers' vehicles carry basic life-saving equipment and management protocols for major incidents and for serious incident management.

During normal working hours these vehicles are available for incidents in addition to facilitating operational management of a geographical area in terms of estate, human resource and fleet resource management.

Maintenance and Stores Vehicles

Maintenance and Stores vehicles are all currently based in Belfast and provide an 'out-of-hours' on-call service, breakdown recovery and minor repairs. The staff who provide the maintenance and stores 'out-of-hours' service are also required to play their part in major incidents by driving to the scene and managing the Emergency Communications Vehicle and Emergency Equipment Vehicle.

Appendix B: AMBULANCE DRIVER TRAINING PROGRAMMES

A suite of ambulance driving qualifications have been developed and regulated to meet the core requirements of NHS Ambulance Trusts, Independent Ambulance Services and Voluntary Aid Services for learners working or intending to work in patient transport and urgent & emergency care.

Developed by Futurequals in partnership with the NHS Ambulance Service Driver Training Advisory Group (DTAG), these qualifications meet the requirements for ambulance service drivers to claim exemptions under the Road Traffic Act and to operate to the specification of the high speed driver training regulations of the Department for Transport.

FAQ Level 3 Award in Patient Care Services: Ambulance Driving	The purpose of this qualification is to provide the learner with the skills, knowledge and understanding necessary to drive a range of patient care ambulance vehicles safely and commensurate with patient safety and vehicle empathy.
FAQ Level 3 Certificate in Emergency Response Ambulance Driving	This qualification has been developed to meet the core requirements of NHS Ambulance Trusts for learners working or intending to work as emergency clinical practitioners and emergency care support staff. The requirement for competency is safe response to emergency calls and the conveyance of patients to the definitive place of care.
FAQ Level 4 Diploma in Emergency Response Ambulance Driving Instructure	This qualification provides a trainee Ambulance Driving Instructor with the enhanced knowledge, behaviours, understanding and skills required to instruct, coach, support and assess learners in the delivery of routine and emergency response and demonstration driving, including knowledge and understanding of the driving legislation, regulation, standards and agreed ways of working to a safe and competent level as set out in the High Speed Driver Training Competencies. Learners will understand the Human Factors that can influence attitude to risk for a developing emergency response ambulance driver, focusing on 3 main areas: completion of the Ambulance Driver Risk Index, developing a working knowledge of the Goals for Education framework and completion of the Driving Instructor Ambulance Driver Risk Index to measure progress and development.

SOURCES OF INSPIRATION

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http://aace.org.uk/wp-content/uploads/2015/09/Ambulance-2020-and-beyond-the-AACE-vision.pdf

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https://www.bitc.org.uk/event/challenge-2030-make-the-climate-crisis-history-transport/

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http://www.candocities.org/sites/default/files/Belfast.pdf

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https://www.health-ni.gov.uk/publications/health-and-wellbeing-2026-delivering-together

Mobilising Sustainable Transport for Development
https://sustainabledevelopment.un.org/index.php?page=view&type=400&nr=2375&menu=1515

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https://www.sduhealth.org.uk/policy-strategy/engagement-resources.aspx

NHS – The NHS Long Term Plan
https://www.longtermplan.nhs.uk/

Northern Ireland Ambulance Service HSC Trust – Our Strategy to Transform 2020-2026
http://www.nias.hscni.net/wp-content/uploads/2020/05/NIAS-Our-Strategy-To-Transform-2020-2026-V19-06.03.2020-HP.pdf

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https://www.daera-ni.gov.uk/publications/northern-ireland-climate-change-adaptation-programme-2019-2024

Northern Ireland Executive – Outcomes Delivery Plan 2019
https://www.executiveoffice-ni.gov.uk/publications/outcomes-delivery-plan-december-2019

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Supporting Wellbeing and Resilience in Belfast 2018-2021, making life better together (2018).
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https://www.ted.com/tedx/events/40679

The Paris Agreement (2015).
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The Carter Report – Operational Productivity and Performance in England NHS Ambulance Trusts
https://improvement.nhs.uk/documents/3271/Operational_productivity_and_performance_NHS_Ambulance_Trusts_final.pdf

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https://www.translink.co.uk/corporate/corporateresponsibility

Translink Strategy – 'Get on Board' 2016-2021
https://www.translink.co.uk/corporate/publicationsanddocuments/corporatepublications

UK Clean Air Strategy 2019
https://www.gov.uk/government/publications/clean-air-strategy-2019

TB/16/12/2021/06

Return to Agenda

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

PRESENTATION OF PAPER

Date of Trust Board:	16 December 2021
Title of paper:	Update on implementation of the NIAS Corporate Plan
Brief summary:	The purpose of this report is to provide a summary of progress to date to NIAS Trust Board on how well the organisation is delivering the key deliverables identified within the annual Corporate Plan 2021/22. These deliverables are linked to the strategy: Caring Today, Planning for Tomorrow: Our Strategy to Transform 2020-2026.
Recommendation:	**For Approval** ☐ **For Noting** ☒
Previous forum:	SMT
Prepared and presented by: **Date:**	Neil Walker, Head of Performance Maxine Paterson, Director of Planning, Performance & Corporate Services 9 December 2021

Northern Ireland Ambulance Service
Health and Social Care Trust

Trust Board Corporate Plan Progress Report

1.0 Introduction

The purpose of this report is to provide a summary of progress to date to NIAS Trust Board on how well the organisation is delivering the key deliverables identified within the annual Corporate Plan 2021/22. These deliverables are linked to the Strategy: Caring Today, Planning for Tomorrow: Our Strategy to Transform 2020-2026.

The Corporate Plan is a critical component for the Trust to monitor and measure progress against corporate and operational objectives set for financial year 2021/22. This year has seen the Trust implement processes to review and scrutinise the delivery of the Corporate Plan at the Directorate level and this is outlined within this paper.

For 2021/22, the Trust has broken down the Corporate Plan objectives that are applicable to each Directorate and created Directorate Plans. It is at this level that we assess and scrutinise our delivery of the Corporate Plan. During the year, we have held meetings with each Directorate, to baseline the delivery of the objectives and monitor the progress against the same.

The Directorate Plans have been developed using four corporate themes:

1. Trust Corporate objectives
2. Operational Directorate objectives
3. Strategic Improvement Programme objectives
4. Internal Audit recommendations

The key Directorate objectives have been derived from these themes and are strongly linked to the strategic priority areas of the Trust.

The performance management process to assess the progress of delivery for each of these deliverables is carried out on a monthly basis. These meetings are held with the senior management team within each directorate, to capture feedback on delivery and establish mitigation on any risks and issues identified on delivery.

Section 2.0, outlines the Trust's performance against delivery of the Corporate Plan for period ending 30th October 2021

The Trust is using a BRAG (Blue, Red, Amber, Green) rating as the method to monitor progress and an indication of the assessment that deliverables identified in the Corporate Plan have been or will be delivered by the completion date.

Traffic Light BRAG Monitoring Description Key	
RED	Deliverable forecast to be delivered significantly (i.e. in excess of one quarter) outside completion date or beyond year end.
AMBER	Deliverable forecast to be (but no more than one quarter) of completion date.
GREEN	Deliverable forecast to be delivered by the completion date.
BLUE	Deliverable complete.

2.0 Summary Position

The table below shows a summary of the progress made against our deliverables within the Corporate Plan for the period ending 30 October 2021.

Traffic Light	30th October 2021
Significant Delay	8%
Risk Delay	2%
On Track	66%
Complete	14%
Not yet Commenced	10%

8% of our deliverables within our Corporate Plan are at Significant delay and have been impacted by the current COVID-19 position. This has meant that staff have been unable to be released for training and Senior Management have been unable to make the visits to staff they would have otherwise planned to.

The 2% identified as a Risk to delay, are a result of either work taking longer than was planned to start or the need for a business case to get funding. Finally the 10% of deliverables not yet started, have been identified as those to be progressed in 2022 and will need inputs from a regional level to complete.

The trajectory for delivering our Corporate Plan is trending positively, that being said, we need to be mindful of the environment we are operating in at the present time. Although as we enter the new year, we will continue to focus on the delivery of the Corporate Plan through the Performance Management Structures and assessment arrangements we have established. COVID-19 and the pressures which it places upon our services remains a significant issue that we need to manage and continue to mitigate against.

Appendix A contains all the Directorate plans for visibility.

3.0 Risk and Issues

Due to the ongoing COVID-19 situation within Northern Ireland, there is a key risk on staff availability to deliver some of our key objectives through 2021/22. The ability to free staff time for training, participation in strategic transformation programmes and focus on long term corporate objectives, continues within the Trust.

Another risk to our delivery is the availability of funding from the Department. We have a number of business cases that we need to develop and funding to be sought to deliver on some of our objectives and within the current climate, the possibility of funding being redirected is a risk to the Trust.

The ongoing impacts of COVID-19 remains a significant issue to be managed, whilst delivering against our corporate plan. This issue is most notably impacting our ability to effectively engage with our wider

staff groups across our organisation with station visits. Engagement does continue, albeit virtually at this time.

Again, not only has the continued COVID-19 issue impacted our staff engagement, it has also caused delays in accessing secondary care pathways for our Clinical Support Desk and is impacting our ability to deliver Hear and Treat as well as See and Treat target.

Appendix A

Below are the Directorate plans for 2021/22

Directorate	**Directorate Plan**
CRM	1. NIAS Corporate Plan - Director of CR
HR	2. NIAS Corporate Plan - Director of HR
Planning, Performance & CS	3. NIAS Corporate Plan - Director of Pla
Finance	4. NIAS Corporate Plan - Director of Fir
Quality, Safety & Improvement	5. NIAS Corporate Plan - Director of Qu
Operations	6. NIAS Corporate Plan - Director of Op
Workforce Planning	7. NIAS Corporate Plan - Director of Wo
Medical	8. NIAS Corporate Plan - Medical Direct

NIAS Corporate Plan - Programme Director for CRM

ID	Work Stream	Key Objective	OWNER	Actions	PROGRESS	Notes	PLAN START	PLAN END	PLAN DAYS	ACTUAL START	ACTUAL END
1	1.0 Delivering Care	We will develop a supporting business case to secure funding in order to improve our service to patients through increased workforce and supporting infrastructure.	Programme Director for CRM	**1.** Develop and submit the Strategic Outline Case for CRM.	Completed			01/05/2021			
				2. Develop and submit the Outline Business Case for CRM.	Completed			01/10/2021			
6	6.0 Our Infrastructure	We will develop a suite of supporting infrastructure strategies for Estates in year one to address pressing issues.	Programme Director for CRM	**1.** Develop a draft Estates Strategy for approval by Trust Board Sept 2021.	On Track			01/07/2021			
				2. Complete a consultation exercise with stakeholders.	On Track			01/08/2021			
				3. Fleet Strategy to be presented to Trust Board after consultation.	On Track			01/09/2021			
		We will develop a suite of supporting infrastructure strategies for Fleet in year one to address pressing issues.	Programme Director for CRM	**1.** Develop the strategy.	On Track			01/09/2021			
				2. Complete a consultation exercise with stakeholders.	On Track			01/09/2021			
		We will develop a sustainability strategy for the organisation.	Programme Director for CRM	**1.** Complete condition and functional suitability surveys for the estate.	On Track			01/07/2021			
				2. Complete feasibility studies for NIAS HQ Campus.	On Track			01/09/2021			
				3. Develop and implement a new contract for maintenance.	On Track			01/03/2022			
		Our Infrastructure - Develop plans for the maintenance and upgrade of current NIAS Estate.	Programme Director for CRM	**1.** Develop plans to end the current TSSC contract for provision of maintenance by 2nd February 2022.	On Track			01/03/2022			
				2. Set up a new Facilities management Contract by April 2022.	On Track			01/03/2022			
				3. March 2022 Install Maintenance Manager on 3I Estates system and set up Help desk.	Not Commenced			01/03/2022			
		Estates Strategy to be finalised following engagement process.		**1.** Develop a sustainability strategy for Fleet & Estates. Agree revised ten year plan with DOH. Complete feasibility studies for: - HQ Campus Project - Braodaway Hub at - Boucher Road NIFRS ELDC - Craigavon Station at - Craigavon Hospital - Altnagelvin station at - Gransha Park	Not Commenced	Added as new objective within Estates					
		Finalise the Trusts Fleet strategy for Trust Board approval.		**1.** Complete an engagement on Draft Fleet Strategy April - June Present Draft2 Fleet Strategy to Trust Board 19 August 2021	Completed			01/08/2021			

				Lead the development of plans to achieve efficiencies in the procurement and management of Fleet through: **2.** IPC Audits (vehicles) . Lead Improvement in vehicle conditions audits. Continuous rectification of damaged excessive wear due to amount if cleaning. Additional technical capacity to manage these repairs regionally (Mechanic in a van)	On Track			01/03/2022			
				3. Fleet maintenance. Improve NIAS business continuity and resilience by increasing in house capacity for fleet repairs in light of the pandemic and the potential for contractors closing for extended periods.	On Track			01/03/2022			
				4. Acquire Omagh Fire Station as an additional NIAS in-house workshop Set up a Project Team for introduction of, Low , Ultra Low and zero emission vehicles, as per the approved Fleet Replacement bus case.	On Track			01/03/2022			
				5. Undertake a Review of Fleet Function. Increase if specific fleet technical support in divisions.	On Track			01/03/2022			
				6. Replace the Fleet Management System. Current system will not operate on Microsoft Edge and internet explorer is no longer supported from August 2021.	On Track			01/03/2022			
		Develop a Sustainability strategy for the Trust	Programme Director for CRM	**1.** Develop a draft Sustainability strategy for the Trust.	On Track			01/03/2021			
				2. Develop a strategy and project for provision of e charging through the Trusts.	On Track			01/03/2022			
				3. Review facilities for safe cycle storage.	On Track			01/03/2022			
		Implement prior and current year Internal Audit recommendations.	Programme Director for CRM	**1.** Lead a task and finish Group to ensure full implementation of Internal Audit recommendations relevant to my area of responsibility i.e. Fleet and Estates.	On Track			Sept/Oct 2019 - 2021 - 2022			
7	**7.0 Communication and Engagement**	We will ensure an ongoing effective programme of engagement with staff across the organisation.	All Directors	**1.** Evidence visits to stations.	Delayed with Issues	Delayed due to Covid		01/03/2022			

NIAS Corporate Plan - Director of HR

ID	Work Stream	Key Objective	OWNER	Deliverables	PROGRESS	Notes	PLAN START	PLAN END	PLAN DAYS	ACTUAL START	ACTUAL END
2	2.0 Our Workforce	We will develop a Recruitment and Selection Strategy , which will include the appropriate approach to support the delivery of a skilled and effective workforce.	Director of HR	**1.**Review HSC and ambulance sector processes & create an outline plan to develop the strategy.	Completed			01/09/2021			
				2. Hold engagement sessions with stakeholders including recruiting managers, Occupational Health and trade union representatives to deliver a framework plan to deliver strategy.	Completed			01/12/2021			
				3. Submit strategy for approval to SMT and Trust Board.	On Track			01/03/2022			
		We will continue to secure reductions in sickness absence.	Director of HR	**1.** Establish new framework and action plan to ensure best practice and deliver improvements.	On Track			01/09/2021			
				2. Create a baseline dashboard to track current performance of absence and attendance.	At Risk	Questions remain of the quality of data		01/12/2021			
				3. Action plan to be presented to People Committee for approval.	Not Commenced			01/12/2021			
				4. Develop an improvement plan to include effective procurement and contract management and establish OH and stakeholder engagement mechanisms to deliver related improvements.	Not Commenced			01/12/2021			
		To design and deliver a Health and Wellbeing strategy and action plan that delivers outcome focused HWB initiatives and improvements.	Director of HR	**1.** Workforce engagement sessions designed, implemented, and used to inform a priority plan and to ensure the involvement of our people in the design and prioritisation of plans.	On Track			01/06/2021			
				2. Submit new HWB strategy (with clear links to baseline assessment, sickness information and other workforce health evidence) and action plan with prioritised actions designed to achieve defined outcomes for approval – TB/PFOD Committee and then publish with clear communications plan. –Q3	On Track			01/09/2021			
				3. Develop Corporate Management of aggression Policy & Procedures.	On Track			01/12/2021			
		To develop new operating models and systems of HR Governance to ensure full assurance, statutory compliance and delivery of best practice and effective governance arrangements	Director of HR	**1.** Review of governance and reporting arrangements for Equality and HR screening and EQIA processes for Trust policy Matrix and calendar of statutory reporting arrangements developed Q2	On Track			01/06/2021			
				2. Ensure delivery of specific actions required to ensure closure of outstanding internal audit recommendations Q2	On Track			01/06/2021			
				3. Design and deliver a new HR model to incorporate a business partner approach and deliver key related recommendations of AACE HR Review. Q3	On Track			01/12/2021			

		Deliver the organisation's workforce work streams to support the Trust response to COVID	Director of HR	Ensure design full implementation of processes/initiatives to support the Trust in the response to COVID to include: **1.** Partnership working approach with trade unions	On Track						
				2. Risk assessment/OH/ employment processes related to the management of underlying health conditions linked to COVID.	On Track						
				3. Full consideration/consultation and implementation of terms and conditions implications and related processes	On Track						
3	**3.0 Organisational Health**	We will develop a revised HR delivery model to support and empower staff.	Director of HR	**1.** Create roadmap to deliver the revised HR model, including any support business case generation.	On Track			01/09/2021			
				2. Obtain approval for the revised HR model by SMT and People Committee.	On Track			01/12/2021			
				3. Commence implementation of the new HR model.	Not Commenced			01/03/2021			
		We will deliver an organisational culture programme.	Director of HR	**1.** Action plan to be submitted to People Committee for approval.	Not Commenced			01/09/2021			
				2. Launch the NIAS culture programme.	Not Commenced			01/09/2021			
				3. Presented achieved progress to Trust Board.	Not Commenced			01/03/2022			
7	**7.0 Communication and Engagement**	We will ensure an ongoing effective programme of engagement with staff across the organisation.	All Directors	**1.** To undertake leadership visits to stations and other locations to engage directly with staff and complete related feedback reporting.	Delayed with Issues	Delayed due to covid		01/03/2022			
				2. Evidence visits to stations.	Delayed with Issues	Delayed due to covid					
				3. Ensure workforce engagement involvement and communication around HR Work streams.	Delayed with Issues	Delayed due to covid					

NIAS Corporate Plan - Director of Planning , Performance & Corporate Services

ID	Work Stream	Key Objective	OWNER	Deliverables	PROGRESS	Notes	PLAN START	PLAN END	PLAN DAYS	ACTUAL START	ACTUAL END
4	**4.0 Quality Improvement**	We will develop the planning function within the organisation to support both internal effective planning regime and external facing role within the HSC.	Director of Planning , Performance & Corporate Services	**1.** Assess and agree Corporate Planning cycle/timetable with Trust Board.	Completed			01/08/2021			
				2. Deliver corporate plan to Trust Board.	On Track	Andoni to follow up on what the agreed planning cycle was		01/06/2021			
				3. Develop relationships and profiles across the HSC to contribute towards the new planning and commissioning model.	On Track	Plan services on community needs		01/03/2022			
		We will develop the Performance function, role and reporting to support the organisation in utilising information to draw insight and evidence to support effective decision-making across the organisation.	Director of Planning , Performance & Corporate Services	**1.** Draft integrated quality and performance report that will be available for Trust Board.	Completed			01/06/2021			
		Develop an approach to support the organisation in identifying opportunities for improvement across non-clinical processes to optimise capacity, resource utilisation and productivity and value for money		**1**. Deliver the first iteration of the Integrated Performance and Quality report at Trust Board. June 2021 Obtain endorsement on the documents used by SMT/NEDs to support their scrutiny on the performance of strategic plans. -Corporate Scorecard -Strategic Portfolio Report	Completed	HR piece to be included		01/06/2021			
				2. Along with DoF, support each Director to co-ordinate the delivery of audit recommendations in line with targets to achieve 80% completion of aged recommendations in 2019-2020 and earlier to ensure Satisfactory Audit Opinion is achieved in 2021-2022	On Track			01/03/2022			
				3. Benchmarking and baseline exercise to assess corporate processes and practices to derive opportunities for improvement.	On Track			01/09/2021			
		We will establish the Programme Management Office as a function coupled with the processes and resources required to support the transformation agenda.	Director of Planning , Performance & Corporate Services	**1.** Initiate the SIG forum to take forward the oversight, monitoring and assurance around implementation of the strategic plan.	Completed			01/06/2021			
				2. Present portfolio highlight report to Trust Board to provide assurance over delivery of the strategic plan.	On Track	To be tabled at December Trust Board. DHCNI report to be used as a reflection of how to present progress reports.		01/08/2021			

				3. Develop the infrastructure of contributing stakeholders across staff, Trade Unions and patients to contribute to SIG and patients.	Not Commenced	Need to schedule & align meetings with Trade Unions in advance of SIG and bring forward any concerns that they may have.		01/09/2021			
				4. Agree and implement a communication plan for transparent stakeholder updates on progress.	Completed			01/09/2021			
		We will develop and embed a robust governance strategy and assurance reporting in conjunction with Medical and QSI Directorate.	Director of Planning , Performance & Corporate Services	**1.** Deliver proposals to enhance governance arrangements within NIAS to Trust Board.	Completed			01/05/2021			
				2. Agree transition process to migrate corporate risk management to the directorate of planning, performance and corporate services.	Completed			01/06/2021			
				3. Delivery of the recommendations captured within the Board Assurance Workshop and Board Effectiveness Assessment Tool.	Completed	Tool completed - Board Assurance workshop scheduled for Dec 16th		01/03/2022			
		We will continue to develop capacity and capability in providing timely and accurate information across AQIs, CQI and KPIs for the management and operational performance and clinical quality reporting.	Director of Planning , Performance & Corporate Services	**1.** Develop a business to use the DoH Data Lake to manage our information.	Not Commenced	Not yet developed		01/09/2021			
				2. Run series of Data Labs to educate and support management of the utilisation of the BI server and dashboards.	Not Commenced			01/09/2021			
		We will develop the information governance team to ensure evidence of all aspects of Data Protection and UK GDPR have been implemented within the organisation.	Director of Planning , Performance & Corporate Services	**1.** Track and provide assurance on delivery of audit recommendations at each audit committee.	On Track			01/06/2021			
				2. Develop plan to implement Data Security and Protection Toolkit.	Not Commenced	Dates need revised		01/09/2021			
				3. Develop process for capturing compliance with IG policies and procedures and deliver to Audit Committee for approval.	On Track			01/03/2022			
		Support the Trusts continued management and response to the COVID-19 Pandemic	Director of Planning , Performance & Corporate Services	**1.** Deliver assurance and performance reporting to Trust Board as per schedule	On Track	Head of Performance will coordinate updates around the organisation on assurance and performance and how we are managing it		01/03/2022			
5	**5.0 Digital Enablers**	We will consolidate and refresh our technology infrastructure (for example our telephony and dispatch systems) to maintain the service, reduce risk and improve resilience.	Director of Planning , Performance & Corporate Services	**1.** Drive REACH training and device roll out. Ensure this is sustained throughout year to achieve delivery of benefits realisation.	On Track			01/03/2022			
				2. Initiate procurement of Telephony Business Case with intention of commencing change programme.	On Track			01/12/2021			
				3. Develop and obtain approval for Business Case for CAD with development of accompanying procurement and change implementation programme.	On Track			01/03/2022			
				4. Implement all feasible recommendations from the internal audit report on cyber security.	On Track	Potential issues with access		01/03/2022			

6	**6.0 Our Infrastructure**	We will ensure appropriate and suitable accommodation is made available for our staff.	Director of Planning , Performance & Corporate Services.	**1.** Complete the successful transition of staff to new accommodation at Knockbracken.	Completed	Though utilisation of current space could be revised more efficiently		01/09/2021			
7	**7.0 Communication and Engagement**	We will develop a communication and social media strategy to engage with the public and service users.	Director of Planning , Performance & Corporate Services	**1.** Complete stakeholder engagement for the Communication and the Social Media Strategies.	On Track			01/08/2021			
				2. Obtain Trust Board Approval for Communication Strategy.	On Track			01/08/2021			
				3. Develop and obtain approval of the NIAS social media strategy.	On Track			01/10/2021			
		We will ensure an ongoing effective programme of engagement with staff across the organisation.	All Directors	**1.** Evidence visits to stations	Delayed with Issues	Delayed due to Covid		01/03/2022			

NIAS Corporate Plan - Director of Finance

ID	Work Stream	Key Objective	OWNER	Deliverables	PROGRESS	Notes	PLAN START	PLAN END	PLAN DAYS	ACTUAL START	ACTUAL END
3	**3.0 Organisational Health**	Achieve an overall satisfactory internal audit opinion for the organisation for 2021/22.	Director of Finance	**1.** Set up an internal review structure/ framework to follow-up on recommendations and ensure delivery of agreed actions.	On Track	Monthly Meeting in place		01/06/2021			
				2. Support Directors in achieving compliance with audit recommendations and evidence progress towards delivery of prior year recommendations.	On Track	Detailed spreadsheet shared with Directors		01/03/2022			
				3. Conduct twice yearly formal reviews to evidence compliance with internal audit outstanding recommendations.	On Track	Consistency could be improved on quality and response level		01/03/2022			
4	**4.0 Quality Improvement**	Ensure effective management and oversight arrangements of delegated budgets to deliver breakeven position in support of overall organisational financial responsibilities.	Director of Finance	**1.** Identification and monitoring of in year pressures, for example pay awards, and developments, for example transformation allocations.	On Track			01/03/2022			
				2. Ongoing monitoring and reporting of the financial position,income, expenditure and achievement of savings	On Track			01/03/2022			
				3. Contribute to DoH monitoring regime and regional exercises.	On Track			01/03/2022			
				4. Regular formal reporting via Financial Management arrangements with Directors and Budget Holders.	On Track			01/03/2022			
		Improve financial engagement at Board level through the implementation of new sub committee. Work with Chairs of new committees to establish an appropriate oversight of financial issues	Director of Finance	**1.** In conjunction with Trust Board, further develop and embed agreed Terms of Reference for new and established sub committee as part of an iterative process.	On Track	Two new committees set up		01/03/2022			
				2. Implement, develop and embed sub committee arrangements.	Completed			01/03/2022			
				3. Review and evaluate operation of sub committee to ensure clarity of duties and responsibilities between sub committees and Trust Board.	Completed			01/03/2022			
				4. Ensure the provision of appropriate support to sub-committees and Trust Board, specifically with a view to ensure that Non Executive Directors are satisfied with the format, level and frequency of financial reporting.	On Track			01/03/2022			
		To develop and improve arrangements in place in respect of business cases to improve oversight, governance and approvals.	Director of Finance	**1.** Review and dissemination of extant guidance.	On Track			01/03/2022			

				2. Review of business case proforma and costing schedules.	On Track	Maxine to share 5 case business model		01/03/2022			
				3. Further development of business case database and subsequent monitoring and reporting.	On Track			01/03/2022			
				4. Training as appropriate for relevant managers.	On Track			01/03/2022			
		Support the achievement of breakeven through advice on income levels and the financial consequences of service delivery, service developments and the achievement of savings requirements.	Director of Finance	**1.**Engagement with DoH/HSCB to agree income levels and savings requirements as part of the Trust Delivery Plan.	On Track			01/03/2022			
				2. Ongoing monitoring of actual income levels against plan.	On Track			01/03/2022			
		Implement arrangements for specific payments agreed in 2020- 21 and also further additional initiatives to be finalised in 2021-22 within agreed parameters and timescales (specific examples include, inter alia, the recognition payment and holiday entitlements).	Director of Finance	**1.** Review roles and responsibilities in regard to payments.	On Track			01/03/2022			
				2. Development of detailed plans outlining specific actions between Finance, Human Resources and Shared Services.	On Track			01/03/2022			
				3. Review of timetabling and resources required to ensure the accurate and timely payment of arrears	On Track			01/03/2022			
		Review and agree strategy and procedures for the application of NIAS Charitable Trust Funds and grants.	Director of Finance	**1.** Continued review of General and Specific Charitable Trust Funds and available grants.	On Track			01/03/2022			
				2. Update of procedures and processes in respect of Charitable Trust Funds.	On Track			01/03/2022			
				3. Develop, agree and apply a strategy for expenditure of Charitable Trust Funds.	On Track			01/03/2022			
		Continued contribution to the planning for and management of the NIAS response to Covid-19, including the recovery from the initial stages of the pandemic.		**1.** Maintain appropriate access and distribution of Personal Protective Equipment and associated consumables	On Track			01/03/2022			
				2. Ensure that appropriate arrangements are in place to identify and access funds to meet the costs of Covid-19.	On Track			01/03/2022			
				3. Ensure that the arrangements for the treatment of the impact of 2020-21 are appropriately managed and controlled.	On Track			01/03/2022			
7	**7.0 Communication and Engagement**	**7.4** We will ensure an ongoing effective programme of engagement with staff across the organisation.	All Directors	**1.** Leadership walk arounds.	Delayed with Issues	Delayed due to Covid		01/03/2022			
				2. Evidence visits to stations.	Delayed with Issues	Delayed due to Covid		01/03/2022			
				3. Participate in other staff engagement initiatives.	Delayed with Issues	Delayed due to Covid		01/03/2022			

NIAS Corporate Plan - Director of Safety, Quality & Improvement

ID	Work Stream	Key Objective	OWNER	Deliverables	PROGRESS	Notes	PLAN START	PLAN END	PLAN DAYS	ACTUAL START	ACTUAL END
1	**1.0 Delivering Care**	We will commence a coordinated and phased return of PCS resources to NEAC Control and reduce usage of Voluntary and Private Ambulances.	Director of Safety, Quality & Improvement	**1.** Design a quality and safety assurance framework for the independent service providers.	At Risk	Starting in January		01/03/2022			
4	**4.0 Quality Improvement**	We will develop a new Quality and Safety strategy that focuses on continual improvement, measuring and evidencing the quality of our services for our patients.	Director of Safety, Quality & Improvement	**1.** Develop the new Quality and Safety strategy.	On Track	New Resources starting in January - Papers sent to SMT		01/09/2021			
				2. Staff and Service User engagement	Not Commenced	New Timeframe to be revised		01/11/2021			
				3. Obtain approval for the Quality and Safety strategy at the Safety Committee.	Not Commenced			01/12/2021			
				4. Achieve quality improvement targets at level 1 and 2 as outlined in Attributes Framework	Not Commenced			01/03/2022			
		We will demonstrate an improvement in our measurement against Ambulance Quality Indicators to better evidence the safety and quality of our patient care.	Director of Safety, Quality & Improvement	**1.** Build the performance reports in line with AQIs.	On Track			01/09/2021			
				2. Start regular reporting of AQIs to Safety Committee and Trust Board.	On Track			01/06/2021			
		We will implement an Improvement plan to develop in our processes in Safeguarding, in partnership, with social care services across HSC.	Director of Safety, Quality & Improvement	**1.** Produce Safeguarding Policies and Procedures.	Completed			01/09/2021			
				2. Appoint a Safeguarding Lead and bring to post.	On Track			01/09/2021			
				3. Agree regional pathway for welfare referrals.	On Track			01/12/2021			
				4. Implementation of the new pathway for welfare referrals.	On Track			01/03/2022			
				5. Complete a benchmark of CPIs against other services.	At Risk			01/03/2022			
		We will improve our response to calls related to falls who are aged over 65.	Director of Safety, Quality & Improvement	1. Obtain approval to commence the work programme.	On Track			01/07/2021			
				2. Establish a NIAS Fall Improvement Group with agreed aim, outcome and process measures.	On Track			01/08/2021			
				3. Integrate collaboration with PCS team.	At Risk			01/10/2021			
				4. Agree falls response framework outlining tiered response in line with AACE falls governance framework Level 1 – falls concern – no known injury/illness Level 2 – fall -minor injury/illness Level 3 – fall- serious injury/illness.	On Track			01/10/2021			
				5. Implementation of agreed falls response framework.Effective systems of monitoring and evaluation of impact and outcomes & reporting to SQEP and Trust Board.	On Track			01/10/2021			

		We will maintain high standards of vehicle and station cleanliness.	Director of Safety, Quality & Improvement	**1.** Develop an options appraisal for the future configuration and model for vehicle and station cleaning across the organisation.	On Track			01/12/2021			
				2. Carry out engagement sessions with relevant stakeholder and bring options for approval to Trust Board.	Not Commenced			01/03/2022			
				3. Undertake actions to implement preferred option model.	Not Commenced			01/03/2022			
		Provide direction, leadership and support to staff during Trust COVID-19 response	Director of Safety, Quality & Improvement	**1.** Director leadership to Trust wide fit testing programme to ensure provision of adequate protection for staff delivering direct patient care during COVID-19 Pandemic.	On Track			01/03/2022			
				2. Director leadership a staff testing service for COVID-19 to provide support and assurance to staff and family members and to maintain service delivery by facilitating safe return to work for staff required to self-isolate	On Track			01/03/2022			
				3.Director Leadership to the development & dissemination of Infection Prevention & Control Operational COVID-19 Guidance which reflects current Public Health Guidance to ensure staff are made fully aware of any changes to guidance and how it impacts on their roles and responsibilities, including the need for and use of PPE in differing circumstances.	On Track			01/03/2022			
				4. Director Leadership to the implementation of preventative measures within the working safely in COVID Guidance to aim for reduction of risk to lowest reasonably practicable level.	On Track			01/03/2022			
7	**7.0 Communication and Engagement**	We will develop the range of ways Service users can give us feedback and be involved in service development.	Director of Safety, Quality & Improvement	**1.** Deliver the actions of the PHA NIAS PPI action plan.	On Track			01/03/2022			
		Ensure a collective leadership approach, with meaningful and effective staff engagement to encourage staff to feel empowered to initiate improvements and collaborate in new ways of working.	Director of Safety, Quality & Improvement	**1.** Leadership Walk Rounds at station and departmental level to actively hear what matters to them and to action feedback as appropriate	Delayed with Issues	Delayed due to Covid		01/03/2022			
				2.Crew ride alongs with A&E and PCS crews to see and appreciate the context in which our operational staff work within in and hear what matters to them in the clinical & care environment and action feedback as appropriate.	Delayed with Issues	Delayed due to Covid		01/03/2022			
				3. Engage all staff in co-design and in the co-delivery of service improvements and Quality Improvement projects.	On Track			01/03/2022			
				4. Approval of the 'Supporting Staff with Incidents. Complaints Claims and Coroner's cases' Policy to set out the organisational framework for engagement with staff in these circumstances to ensure the provision of support and advice to staff prior to, during and after their involvement in Incidents, Complaints, Claims and Inquests	Completed			01/03/2022			
		We will ensure an ongoing effective programme of engagement with staff across the organisation.	All Directors	**1.** Evidence visits to stations.	Delayed with Issues	Delayed due to Covid		01/03/2022			

NIAS Corporate Plan - Director of Operations

ID	Work Stream	Key Objective	OWNER	Deliverables	PROGRESS	PLAN START	PLAN END	PLAN DAYS	ACTUAL START	ACTUAL END
1	**1.0 Delivering Care**	We will develop an Improvement Plan to deliver the best possible response times to patients within existing resources.	Director of Operations	**1.** Delivery of CAT1 implementation plan actions relating to call stack management, and staff roles.	On Track		01/12/2021			
				2. Assess the CAT2 response performance baseline and identify improvement opportunities.	On Track		01/12/2021			
				3. Plan and deliver the implementation of the identified improvement opportunities.	On Track		01/03/2022			
		We will deliver a Patient Care Service Improvement Programme to improve the quality of our service for this important group of service users.	Director of Operations	**1.** Conclude the PCS assessment and generate proposals for improvement.	On Track		01/09/2021			
				2. Seek approval from SMT and Trust Board to implement proposed improvements.	On Track		01/09/2021			
				3. Implement PCS improvement recommendations and measure benefits against expectations to SMT.			01/03/2022			
				4. Demonstrate utilization productivity increase of 5% against the 2020/21 baseline.			01/03/2022			
		We will commence a coordinated and phased return of PCS resources to NEAC Control and reduce usage of Voluntary and Private Ambulances.	Director of Operations	**1**. Re-establish the number of substantive crews performing non-emergency transport to pre-pandemic levels.	On Track		01/12/2021			
		We will deliver a Patient Safety Plan within EAC to assist in managing periods of high demand.	Director of Operations	**1.** Implement the set of protocols within the patient safety plan.			01/03/2022			
2	**2.0 Our Workforce**	We will undertake a review of our Operations Structure to provide more effective support for staff, including on a 24/7 basis.	Director of Operations	**1.** Complete the stakeholder engagement activities.	On Track		01/09/2021			
				2. Obtain approval of the outcome paper by Trust Board for approval.			01/12/2021			
				3. Consultation with stakeholders.			01/03/2022			
4	**4.0 Quality Improvement**	We will implement a Programme of transformation and improvement for our Emergency Ambulance Control Room.	Director of Operations	**1.** Introduce a new roster pattern into the Control Room.			01/12/2021			
				2. Deliver an average 90% shift coverage to meet demand patterns and facilitate staff well-being.			01/03/2022			

7	**7.0 Communication**	We will ensure an ongoing effective programme of engagement with staff across the organisation.	All Directors	**1.** Evidence visits to stations.			01/03/2022			

NIAS Corporate Plan -Programme Director of Strategic Workforce

ID	Work Stream	Key Objective	OWNER	Deliverables	PROGRESS	PLAN START	PLAN END	PLAN DAYS	ACTUAL START	ACTUAL END
2	**2.0 Our Workforce**	We will develop a comprehensive workforce plan for the whole organisation designed to support our strategy and to ensure our quality of service meets the performance trajectory requirements in terms of time and quality.	Programme Director of Strategic Workforce	**1.** Embedding the workforce planning methodology and framework to frontline operations.			01/12/2021			
				2. Roll out of the methodology and framework to the Medical directorate.			01/03/2022			
4	**4.0 Quality Improvement**	Continue to support the Trust's response to the COVID-19 Pandemic.		**1.** Operate as a member of Tactical Gold Command (Ongoing) and lead areas of work as and when identified**.**			Ongoing			
7	**7.0 Communication and Engagement**	Ensure implementation of a NIAS Appraisal System by April 2022 that includes a KSF Refresh as part of the revised PDPR Policy, Procedure and Practice		**1.** Engage with Trade Unions and secure commitment to work in partnership on NIAS KSF Refresh.			01/04/2022			
				2. Lead the KSF Refresh and identify any barriers to delivery in line with agreed plan. Make recommendations to SMT and JCNC that will minimise related barriers to delivery.			01/04/2022			
				3. Lead the Consultation process for the new PDPR Policy and Procedure.	Completed		01/08/2021			
				4. Implement PDPR Pilot (incorporating KSF Refresh) and evaluate how meaningful the revised process is to staff and managers.			01/11/2021			
				5. Revise process to reflect feedback and learning. Merge KSF Refresh in the new PDPR Process, Policy & Procedure			01/12/2021			
				6. Develop related Toolkit, guidance and training programme.			01/03/2022			
		Lead the Communication with NIAS staff in relation to the revised Organisational Structure to ensure roles and responsibilities are understood		**1.** Support related Directors to finalise the staffing structures for Corporate and Clinical Governance functions, within available funds			01/10/2021			

				2. Develop revised Organisational Chart and agree with SMT.			01/10/2022			
				3. Develop and agree a Communication & Engagement Plan (Dec 2022), Deliver plan within the agreed timeframes.			01/12/2022			
		We will ensure an ongoing effective programme of engagement with staff across the organisation.	All Directors	**1.** Complete a range of Leadership Visits			01/03/2022			
				2. Engage with Trade Unions and Staff on Programme activities as agreed with SMT. - Appraisal by September 2021	On Track		01/09/2021			
				- Restructuring by December 2021			01/12/2021			
				- Retention and Flexible Working by March 2022			01/03/2022			
				3. Consult with Trade Unions and Staff on the new Appraisal system.	On Track		01/09/2021			
				4. Engage with Trade Unions and Staff on the KSF Refresh and the creation of related profiles.	On Track		01/12/2021			

NIAS Corporate Plan - Medical Director

ID	Work Stream	Key Objective	OWNER	Deliverables	PROGRESS	Notes	PLAN START	PLAN END	ACTUAL START	ACTUAL END
1	1.0 Delivering Care	We will develop an Improvement Plan to deliver the best possible response times to patients within existing resources.	Medical Director	**1.** Introduce the HCP/IFT framework by completing the delivery of the training module to existing and new staff and engaging with HCP across NI.	Completed	Implemented on Oct 19th		01/09/2021		
		We will continue to embed our Appropriate Care Pathways developing safe alternatives to ED in order to reduce demand on frontline services increasing the levels of Hear and Treat and See and Treat practice.	Medical Director	**1**. Deliver the Hear and Treat and See and Treat levels in line with the Strategic Plan.	Delayed with Issues	Delayed due to access pathways due to COVID		01/03/2022		
		We will increase the capacity and skillset of CSD clinicians.	Medical Director	**1.** Recruit and train additional CSD clinicians to have 24/7 cover.	On Track	Frank Rafferty can provide detail on number of staff recruited		01/12/2021		
				2. Increase the capacity and skill mix of the CSD clinicians.	On Track			01/12/2021		
		We will improve the governance around medical equipment.	Medical Director	**1.** Introduce a standardized paramedic response bag aimed at improving governance around medical equipment.	On Track	Neil Sinclair is leading		01/03/2022		
				2. Review the provision of drug packs to emergency crews.	On Track	Completed once already with an increase in drugs available (incl Phenrox) , drug bags are provisioned now by the newly appointed pharmacist Catherine Hannah. Catherine is also reviewing current policies and procedures in place.		01/03/2022		
		We will improve cardia arrest survival rates across Northern Ireland.	Medical Director	**1.** Launch a pre-hospital cardiac arrest strategy and create implementation plan.	On Track	Link with Dr. Russell & Stephany Lecky ; Got basic life support on school curriculum for teacher training		01/03/2022		
2	2.0 Our Workforce	Launch the Strategic Review of Clinical Education	Medical Director	**1.** Submit a review of the Training School structures to support the development of an education academy for NIAS to SMT and Trust Board.	On Track	Structure has been created and the review has already been submitted to SMT / Also will be shared with the Safty committee		01/03/2022		
				2. Train up to 48 additional Paramedics, 25 AAPs and 25 ACAs with appropriate investment.	On Track	Frank Orr can provide detail on numbers trained up. Funding committed for next Cohort.		01/09/2021		
				3. Launch the Newly Qualified Paramedic (NQP) support project within the Medical Education Programme.	On Track	System is currently in place to support NQP's for adequate mentorship - Link with Neil Sinclair for more detail if needed.		01/12/2021		

		We will continue to work with HSCB and Primary Care to develop a model for training Advanced Paramedics to work on a rotational basis in Primary Care.	Medical Director	**1.** Receive feedback and signoff on business case.	Completed	Business Case is completed - Link with Neil Sinclair		01/06/2021		
				2. Develop a training programme in conjunction with the education provider, and recruit to posts.	On Track	Frank Orr is working with the Universities		01/03/2022		
4	**4.0 Quality Improvement**	We will provide assurances of the appropriate infrastructure, training and protection of staff of the Hazardous Area Response Team (HART).	Medical Director	**1.** Review the scope and provision of HART to increase managerial oversight and support.	On Track			31/12/2021		
				2. Adoption of SORT model.	At Risk	Subject to funding , Business case required (Billy Newton)		31/12/2021		
				3. Enhanced provision for MTA capability.	On Track			31/12/2021		
		Provide strategic direction and clinical guidance in relation to the Trust response to the COVID - 19 pandemic	Medical Director	**1**. Inntroduce a scheme of screening of asymptomatic staff for COVID-19	Completed	Lateral flow testing has been made available to all NIAS staff since June 21st with work ongoing to increase uptake.		Ongoing		
				2. Provide clinical updates to Assurance Committee & Trust Board in relation to the ongoing threat of the COVID-19pandemic.	On Track			Ongoing		
				3. Engage on behalf of NIAS with other trusts, PHA and DoH to provide strategic clinical guidance in relation to prehospital care	On Track	Represented on multiples clinical advisory groups ; Stroke , Major Trauma		Ongoing		
				4. Provide oversight of HART response to COVID-19	Completed	This has ceased as COVID has become normal business following the downgrading of COVID as an infectious disease		Ongoing		
				5. Develop working relationships with partner agencies in order to develop contingency practices to mitigate impact of pandemic.	Completed	Done - Collaborative working with PSNI , NIFRS , NISTAR & with voluntary ambulance drivers to facilitate enhanced operational response and facilitate large number of transfers between sites		Ongoing		
5	**5.0 Digital Enablers**	We will continue the implementation of the REACH programme building connectivity across HSC in the mobile environment.	Medical Director	**1.** Complete Stage 4 (Go-Live) of REACH Programme.	Completed	Go live commenced - Marianne Johnston is lead		01/06/2021		
				2. Complete Stage 5 (Divisional Rollout) of REACH Programme.	Delayed with Issues	In the middle of stage 5 but experiencing delays to release staff for training - Davey McCartney rolled out in the West Division		01/09/2021		
				3. Complete Stage 6 (Regional Rollout) of REACH Programme.	Delayed with Issues	Davy McCartney & Marianne Johnston to provide updates		01/03/2022		
6	**6.0 Our Infrastructure**	We will engage with the DOH-led approach to exit from EU.	Medical Director	**1.** Implement DoH recommendations.	Completed	Continuation of regional meetings in place to monitor impact - Led by Billy Newton		01/04/2021		
7	**7.0 Communication and Engagement**	We will ensure an ongoing effective programme of engagement with staff across the organisation.	All Directors	**1.** Evidence visits to stations.	Delayed with Issues	Delayed due to COVID		01/03/2022		
				2. Online NIAS group engagement sessions via Zoom	On Track			Ongoing		

				3. Social media communication e.g. Twitter	On Track			Ongoing		
				4. Operational support to emergency crews via voluntary BASICS response	On Track			Ongoing		
				Engagement with external stakeholders via: **5.** representation of NIAS in broadcast media	On Track			Ongoing		
				6. Direct meetings with partner agencies e.g. DoH / HSC / PSNI / NIFRS / NASMeD	On Track			Ongoing		

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

PRESENTATION OF PAPER

Date of Trust Board:	16 December 2021
Title of paper:	Transformation Team Portfolio Delivery Report December 2021
Brief summary:	The attached report is presenting the first update to the Trust Board on our progress in relation to delivering the Transformation Programme Portfolio which is delivering Our Strategy to Transform 2020-2026. The report will provide an overview of the programmes and projects that are underway within the Transformation Portfolio, including highlighting the key issues and risks while also presenting the current status of each programmes/projects. As part of the update presentation, we will also be providing Board members with a more detailed overview of one of the current programmes, the 'REACH Programme'. We will have the Programme Manager in attendance to present this and to answer any specific questions that members may have. No decisions are required by the Trust Board at this time. As this will be the first time that we have presented the Transformation Programme Portfolio report to the Board. At the end of the presentation, Board members will be asked for their feedback on how the format, content and flow of the presentation works for their purpose and understanding. Any feedback is welcome and will be taken into consideration when presenting future Transformation Programme Board Updates.

Recommendation:	For Approval ☐ For Noting ☒
Previous forum:	SMT – 7/12/21
Prepared and presented by: **Date:**	Charlie Thompson (Head of Strategic Transformation) Maxine Paterson Director of Performance, Planning and Corporate Services 9 December 2021

TRANSFORMATION TEAM

Transformation Team Portfolio Delivery Report Dec 2021

1 **Transformation Team Portfolio Plan**

2 **Portfolio Delivery Summary Dashboard**

3 **Programme / Project Status & Rationale**

4 **Portfolio Issues**

5 **Portfolio Risks**

6 **Programme / Project RAG Status Reports**

Transformation Team Portfolio Plan

- The Transformation Portfolio encompasses all of the different transformation programmes and projects within NIAS which collectively will deliver the strategic objectives of Our Strategy to Transform 2020-2026.

- The portfolio is managed by the Head of Transformation and is governed by the Strategic Implementation Group (SIG), under the direction of Director and Assistant Director of Planning, Performance and Corporate Services

- Each Programme and Project will be developed individually but the delivery methodology, reporting structures and templates will follow a consistent approach

- The purpose of this approach is to embed a structured process to enable the planning, implementation, delivery, monitoring and review of programmes & projects in a controlled manner.

- Our Governance Structure : The Senior Management Team (SMT) established the Strategy Implementation Group (SIG) to be accountable for the full oversight and delivery of Our Strategy to Transform 2020-2026 and it's Transformation Portfolio with overall accountability resting with the Trust Board. An annual schedule of SIG meetings has been established in accordance with this.

- The methodology used for our Portfolio, Programme and Project delivery is based on our tailored approach that incorporates best practices from MSP (Managing Successful Programmes) and PRINCE2 Project Management methodologies blended with business and continuous improvement techniques. Our Transformation Team will provide the tools, techniques and documentation to support delivery.

Portfolio Delivery Summary Dashboard

8 Programmes / Projects have been reviewed

Programme / Project Overview

•There are currently 8 Programmes / Projects within the Transformation Portfolio.

•Of these 8 , 1 is currently in the Project Close stage – this means that the project is putting in place ongoing benefit management arrangements and is completing project closure documentation and will be continually monitored.

- •HR Transformation Programme
- •PCS Review & Improvement Programme
- •Strategic Workforce Planning Programme
- •Strategic Review of Clinical Education
- •Telephony ICCS Replacement Project
- •CAD Replacement Project
- •REACH Programme
- •IFT / HCP Project

4 Risks Escalated

Portfolio Risk Overview

Within this Portfolio we have identified a number of risks and 4 of these have been identified as high level Portfolio risks.

0 Issues Escalated

Portfolio Issue Overview

Within this Portfolio we have we have not identified any issues that are required to be escalated at a Portfolio level at this time but this will be kept under constant review.

Programme / Project Status and Rationale

Portfolio RAG Levels

This is an overall measure of the likelihood of successful delivery of the project, which is to be reported in the monthly Project Highlight Reports. This will initially be scored by the Project Manager (as per the table below) as part of the Project Highlight Report, but will be reviewed by the Portfolio Analyst to consider the rating in the context of the wider portfolio delivery. The Project Manager should consider the status of the project against Time, Cost, Benefits and Scope and any other relevant project factors (e.g. robustness of stakeholder engagement, confidence in dependencies, level of risk associated to delivering the project outputs).

RAG	**Criteria (Critical metric by which the project manager will assess the likelihood of delivering the current project lifecycle stage successfully)**
Green	The successful delivery of the project current stage to time, cost and quality appears highly likely (>80% probability of success) with no major outstanding issues that, at this stage, appear to threaten delivery significantly.
Amber	Successful delivery of the project current stage appears feasible (40 – 80% probability of success) but significant issues already exist, requiring management attention. These appear resolvable at this stage and if addressed promptly, should not present a cost/plan overrun.
Red	Successful delivery of the current project stage appears to be unachievable (<40% probability of success). There are major issues on project definition, time, cost, quality and/or benefits delivery, which at this stage do not appear to be manageable or resolvable. The project may need re-scoping and/or its overall viability reassessed.
Complete	Complete, resolved and/or passed

Programme/Project Status & Rationale

Programme / Project Title	SRO	Current RAG Status	RAG Rationale
HR Transformation Programme	Michelle Lemon		Programme is currently underway and it is at the initial scoping phase. A programme scoping workshop has been facilitated by the Transformation Team with the HR Dept SMT to inform the Programme Mandate. At the first workshop we attempted to identify and prioritise the key priority projects and activities to be delivered. We also attempted to put outline timescales around some of these activities and we are in the process of refining these and identifying projects that could be progressed in the short-term 6-12 months followed by mid and longer term activities. HR are now working on identifying a Departmental Programme Lead to work alongside the Transformation Team to facilitate the review and support the development of a HR Improvement Programme.
PCS Review & Improvement Programme	Rosie Byrne		The Transformation Team has now been engaged to provide some corporate support on progressing the PCS Project. Work on developing an improvement programme has now commenced within PCS, focusing on critically evaluating the findings from previous reviews, assessing the current situation and it will also look to address any outstanding service specific PCS recommendations to improve the service currently delivered. This programme is being led by the NIAS Transformation Team with interim support from colleagues at AACE. An agile and sprint approach will be used and we will attempt to identify opportunities to realise quick win improvements.
Strategic Workforce Planning Programme	Roisin O'Hara		This Programme is currently sitting at amber due to the delays faced by REAP 4. An engagement plan is being put in place with EAC Workforce Planning Team to identify possible timeframe to complete plan.
Strategic Review of Clinical Education	Dr Ruddell		The Programme Board has been fully established with 6 work-streams identified to deliver the 6 high level objectives outlined in the programme brief. Staff Engagement has commenced & the Staff Survey has been developed and is ready to launch. The AACE review of course delivery and clinical governance is complete and funding has been secured for NIAS Staff entry to BSc Honours Degree in Paramedicine at Ulster University.

Programme/Project Status & Rationale

Programme / Project Title	SRO	Current RAG Status	RAG Rationale
Telephony ICCS Replacement Project	Maxine Paterson		This project has moved to amber to highlight an expected delay of 3 months. The Project Team is confident that this delay will not increase the score of the financial risk. Payment milestones are heavily weighted towards Solution Build & Delivery which will be completed in this financial year. The design stage is ongoing with a draft High Level Design presented to NIAS for review and sign off and a low level project plan has been produced. The build and test stage commenced w/c 22/11/21.
CAD Replacement Project	Rosie Byrne		A DAC has been approved by PaLS for temporary continuation of current services post 31st December 2021. A Business Case in support of the approved DAC has been submitted to DHCNI and we are awaiting notice of final approval. We are in the process of finalising our re-write of the CAD Replacement Business Case to reflect initial comments received from DHCNI and we would intend to be in a position to resubmit this Business Case by early Dec 2021 for approval. A "letter of Understanding" between NIAS and MIS has been produced to be signed and exchanged (following Business Case approval) for completion prior to the 31st Dec 2021. We will begin developing the Statement or Requirements (SOR) for the new CAD system based on the London Ambulance Service SOR once the Business case has been submitted.
REACH	Dr Ruddell		Go Live with SWAH & PCI (West) has commenced with plans in place for HEMS, PCI (Belfast) RVH . Staff training plan is in place on a weekly basis / Staff ED training carried out at SWAH and Antrim ED. Initial meetings held with clinical staff at Causeway ED and a staff survey has been released to look at early feedback and benefits/issues.
IFT / HCP Project	Dr Ruddell		The new IFT/HCP system has now been implemented and we had a go live date on 19th October 2021. The new system launch proved to be very successful and no major issues where encountered as part of the system transition. The original project objectives were realised and within the next month a full post project evaluation will be completed to close off the project.

Portfolio Issues

High Level Issue Status and Rationale

	Programme / Project Title	Issue Description	Raised By	Owner	Date Raised	Current RAG Status	Risk Mitigation Plan
		None to report					

Portfolio Risks

High Level Risk Status and Rationale

Programme / Project Title	Risk Description	Raised By	Owner	Date Raised	Current RAG Status	Risk Mitigation Plan
CAD Replacement Programme	In light of the current financial pressures facing Health at this time there is a potential risk that we may not secure the required funding to support the development of a new CAD replacement System.	Project SRO and Head of Strategic Transformation	SRO	Dec 2021		To be discussed with MP?
Risks to the delivery of the overall Transformation Programme due to current operational pressures	As we are currently already in REAP 4 and there are likely to be additional winter pressures placed on NIAS operational staff it is becoming increasingly difficult to get access to the key managers/staff to facilitate the delivery of the transformation programmes/projects.	Director of PPCS & Head of Strategic Transformation	Director of PPCS	Dec 2021		To be discussed with MP?
Due to a limited capacity requests for support from the Information Management Team will need to be managed to ensure they are best positioned to provide the required support to the Transformation Programmes/Projects	At present the Information Management Team is getting an increasing number of requests for support and these requests need to be coordinated, managed and prioritised around key projects.	Director of PPCS	Director of PPCS	Nov 2021		It was discussed at the previous SIG and the Director of PPCS agreed to raise this issue with the Head of Informatics and Information Governance and in also agreed that all requests would be directed through the Head of Informatics & Information Government.
Due to current limited capacity within the transformation team this could have a detrimental impact on supporting delivery across our programme of work including the various interdependencies across the transformation programme.	At present due to staff sickness absence are capacity is reduced and this is affecting our ability to support key transformation programmes/projects.	Head of Strategic Transformation	Director of PPCS	Nov 2021		SMT have given approval to recruit some temporary staff and we are in the process of progressing this with HR.

TRANSFORMATION TEAM

Board Focus
Programme/Project Update

Summary of the REACH Programme

What is at the Core of the REACH Programme?

Developing the technology and communications infrastructure in the mobile environment

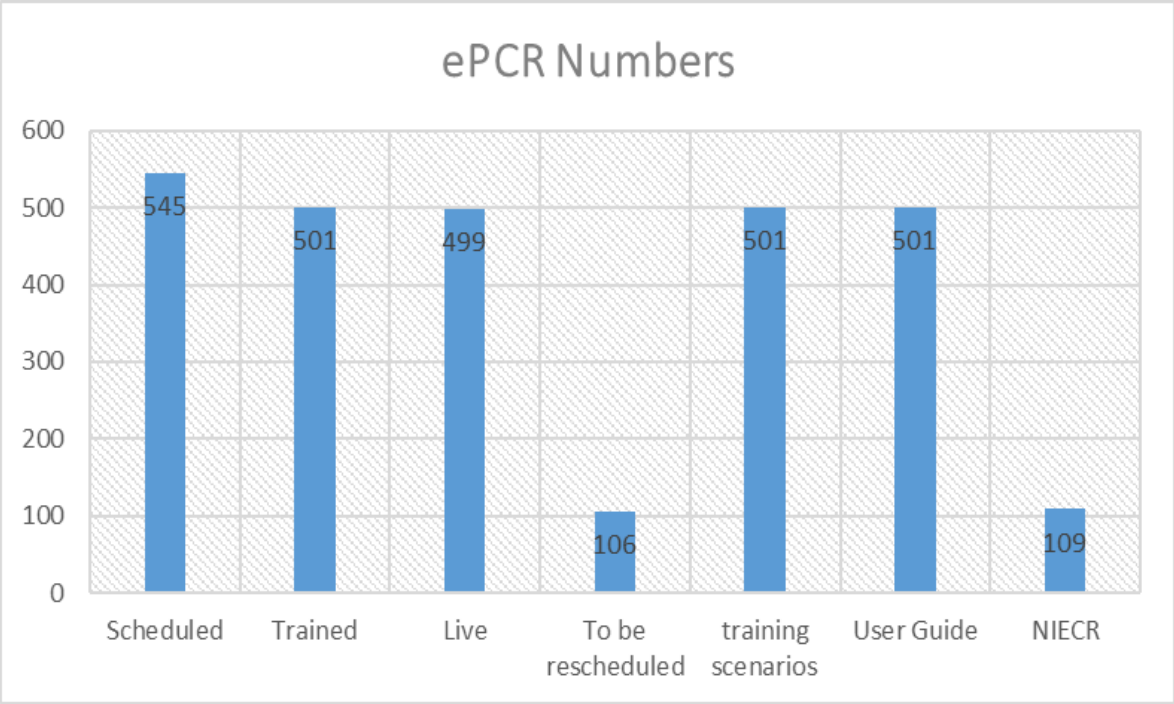
Driving forward some of the key digital enablers within NIAS Strategy to Transform

Building the “digital ambulance” to support mobile communications, connecting our clinicians, connecting our patients supporting quality and safe patient care.

Roll out of ECPR to date

Plan	Actual	Challenges
Planned Go Live Nov 2020 @Ulster hospital ED	Project paused	CoVID-19 impact Staff training challenges Resources at Ulster ED
Planned Go Live April 2021 @Ulster ED	Revision of planning and roll out paused	Impact of planned move to new critical care building @Ulster Nov 21 REAP levels in SE division Inability to get staff trained Change to roll out plans
Go Live @ Altnagelvin ED Sept 2021	Go Live @ Altnagelvin ED Sept 2021	Phased roll out increasing on a weekly basis Managing technical issues, connectivity, hardware with a small team. Managing dependencies with IT across the other Trusts Only trained staff using ePCR – working with Ops, Training and RMC departments to manage training
Go Live @SWAH Oct 2021	Go Live @SWAH Oct 2021	
Go Live @ Altnagelvin PPCI Oct 21	Go Live @ Altnagelvin PPCI Oct 21	
Go Live @ Antrim ED Oct 21	Plan revised to Nov 21	Getting all ED staff trained. Hospital have asked to delay roll out buy a number of weeks. Challenge will be managing increasing gaps between training delivery and use of ePCR
Go Live for non conveyed patients “treat and leave” Nov 21	Go Live for non conveyed patients “treat and leave” Nov 21	Managing technical issues, connectivity, hardware with a small team. Increasing demand on helpdesk.

Current numbers of staff @22/11/21



A&E staff scheduled up to beginning of Dec 2021 – 77% are trained and on live environment

Approx 16% of staff will have to be rescheduled

Inclusion criteria to date
Regional – non conveyed patients
West – Altnagelvin ED, SWAH ED, Alt pPCI
North: Antrim ED (30 Nov)

Summary of key features and deliverables of REACH Programme

Product	Outcome	Benefit
Wifi hub in every vehicle	Connectivity to NIAS secure network	**Staff / Technical-** Greater opportunities for mobile communications and connected workforce
Personal Issue devices for all front line staff	Technical capabilities to support a mobile workforce	**Staff** - Greater opportunities for mobile communications and connected workforce
Interface with Mobimed ePCR and C3 command and control system	Data used once Auto population features of software	**Quality** -Reducing duplication of repeat data input for staff. Handover times – populate back to control
Interface with Health and Care Number Master patient index	Staff can look up HCN in mobile environment	**Quality** -Single common identifier across HSC Enabler for NIECR access in mobile environment
Mobile access to NIECR summary record	Staff have read only access to key patient summary information	**Patient safety** -Informed clinical decision making Informed patient pathways and destination decisions
Interface with NIAS Corpuls 3 defibrillators	Transmission of Obs/ECGs etc. in real time to patient record	**Patient safety** - All clinical information in one place. Live updates of patient observations, 12 lead ECG
Clinical Workstations at EDs	View of patient records at ED	**Patient safety** - Ability to forward plan patient care /resources based on advanced knowledge of patient clinical information from scene. Live updates of patient observations, 12 lead ECG
ePCR software	Database of all patient records	**Governance** – greater security and compliance in completion of records **Quality –** ability to report using Business intelligence tools

Next Stages

- Roll out with Belfast Trust RVH
- Roll out with Belfast PPCI
- Switch on HEMS pathway

Key dependencies - technical interface with regional electronic document transfer (EDT) system to notify GPs automatically for patients left at home

Write back to NIECR.

HSC WiFi roaming

Current Challenges:

Time/sync issue on devices (MS Windows /Mobimed) Fix planned by Dec 21

Poorer than expected battery life on devices – working to optimise battery settings. Chargers at front of vehicles – installing secondary charging brackets in back.

Loss of connectivity with some HSC Wifi roaming – BSO dependency

Pace of roll out and managing issues within a small team

Staff acceptance of change process

Thank you for listening

What do you think of our format used to present the Transformation Programme Update ?

Are there any areas for improvement ?

Return to Agenda

TB/16/12/2021/07

Return to Agenda

PERFORMANCE REPORT AND COVID UPDATE

TRUST BOARD

NORTHERN IRELAND AMBULANCE SERVICE

December 2021

Introduction

- *This report provides an update on the pressures currently being faced by the Northern Ireland Ambulance Services during the latest surge of the COVID-19 pandemic, and outlines the key measures being taken to address these challenges. This report also provides a high level overview of performance in relation to the pressures described*

- *It is clear that COVID continues to have a significant impact across the Health & Social Care Systems with increasing infection rates, pressures on inpatient beds and patient flow through hospitals impacting on NIAS access at EDs. After the most challenging year to date and, in line with recent announcements from the Minister, undoubtedly a difficult winter lies ahead and planning to manage pressures as best possible are ongoing*

- *In recognition of the COVID related service pressures NIAS have faced to date , and challenges the additional pressures the winter months will undoubtedly bring NIAS have arrangements to bring forward a range of initiatives to best mitigate*

- *Regional context and direction would support this approach , with development of a local framework for a granular identification of need and plan to meet. This is being developed across a range of initiatives through a dedicated "Surge Planning Group"*

Resource Escalation Action Plan (REAP) Clinical Safety Plan (CSP)

REAP

- *The REAP is a strategic tool that provides a 7 day forecast identifying any potential areas of particular challenge across a range of indicators, and is very helpful to inform service delivery planning assumptions as well as supporting regional discussions for collaborative working. NIAS is currently in REAP level 4 and based on current pressures the duration of REAP 4 is likely to continue, in keeping with a number of other ambulance Trusts.*

CSP

- *Maintaining clinical safety in response to unexpected peak demand levels exceeding available resources requires the alteration of the response model to protect prioritisation of those patients with the greatest clinical need are prioritised with a range of agreed actions to be implemented .*

- *Nationally ambulance Trusts are / have developed Clinical Safety Plans (CSP) to operationally support the REAP , and NIAS has established a Task & Finish Group to take this forward on behalf of the organisation*

- *There can be negative effects on service delivery for several reasons; however, it is affected, primarily, by a lack of resource and/or an increase in demand that results in there being insufficient NIAS resources to safely meet the clinical needs of the patients.*

- *The triggers within a CSP are primarily focused / restricted to an excessive volume of time bound responses waiting resource allocation at periods of high demand*

- *The plan will be designed to be both simple and dynamic to implement supporting operational response in a timely and appropriate manner enabling a NIAS-wide response as soon as identified triggers are met*

- *The NIAS CSP is in draft form , and whilst near completion may require re-profiling of existing / additional resources to fully implement*

Current Pressures

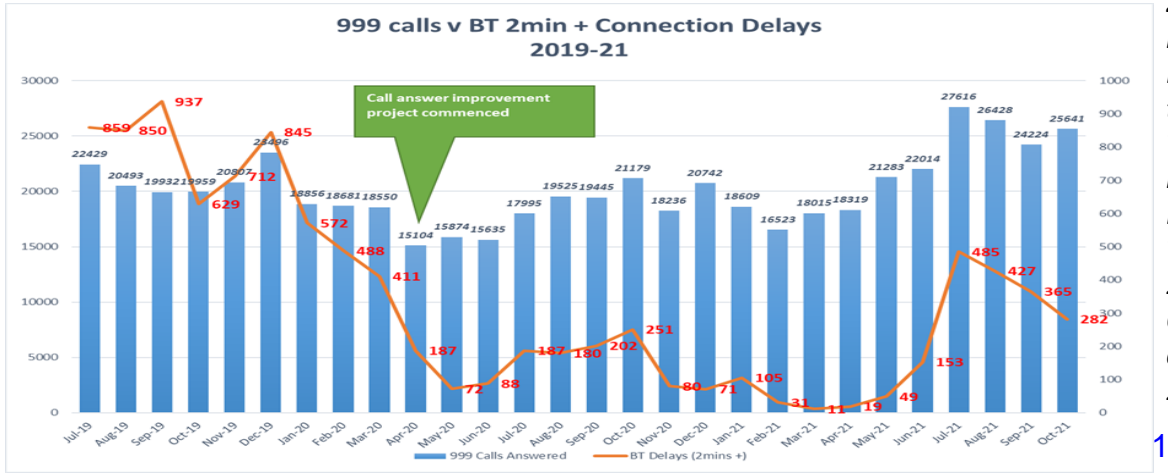
INCREASED DEMAND

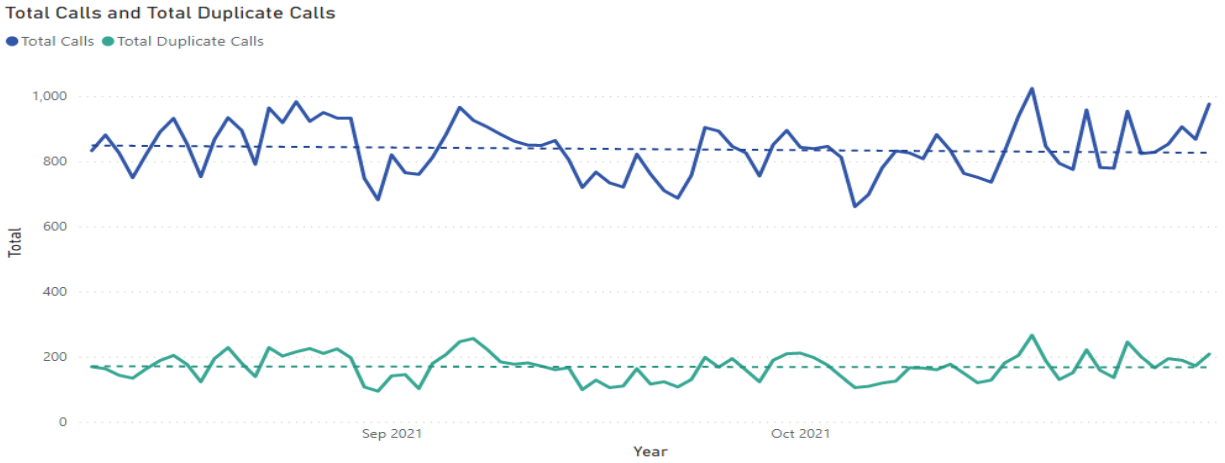
Whilst the volume of patients NIAS currently convey remains relatively static we continue to experience periods of significant peaks in the volume of 999 calls we received. Despite this recent call handling response time within 5 seconds has remained strong against the 5 second standard

In November 2021 in recognition of the pressures that duplicate calls place on control rooms following national agreement supported by NDOG & NASMED it was proposed that a new BT filtering process duplicate calls could be identified by BT call handlers, and where appropriate reduce the numbers being passed to Emergency Ambulance Control Rooms

This was briefly introduced, but due to other pressures within BT and the delivery of their SLA this was again stood down, and remains under review.

Following a spike in the volume of NIAS BT Delays (2 min +) in the month of July 21 the improvement trajectory is noted with x 203 fewer delays in October 21 compared to July 2021





999 CALLS ANSWERED & BT DELAYS 2 min+ CONNECTION DELAYS

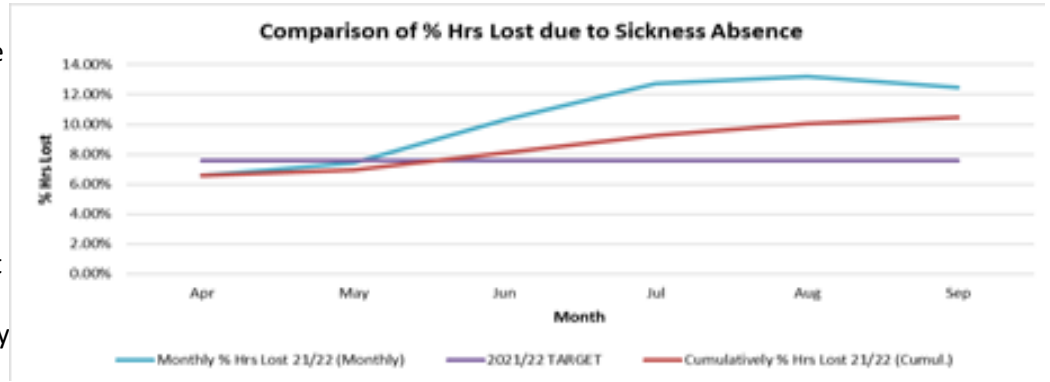
- *The volume of 999 calls answered continues to remain high in comparison to previous years with **25,641** emergency calls answered in October. 999 call answer performance within 5 secs has also improved from 79% in July to 86% in October. The Year to date performance to October is 88%. Extremely high demand and staff abstractions continue to provide the main challenges to achieving the performance target of 90% within 5 secs.*
- *The number of duplicate calls and calls cancelled by caller continues to remain high. In October EAC recorded 5726 duplicate calls and a further 2395 incidents where calls were cancelled by callers. Duplicate calls and calls cancelled accounted for 30% of 999 call demand dealt with by EAC.*
- *The number of BT connection delays at 2min continue to reduce from the recent peak in July 21 with 282 delays recorded in October.*
- *October 2021 saw the completion of an EMD training course with 8 new qualified EMDs. There are also 8 additional trainee EMDs currently in training which is due to be completed in early January 2022.*

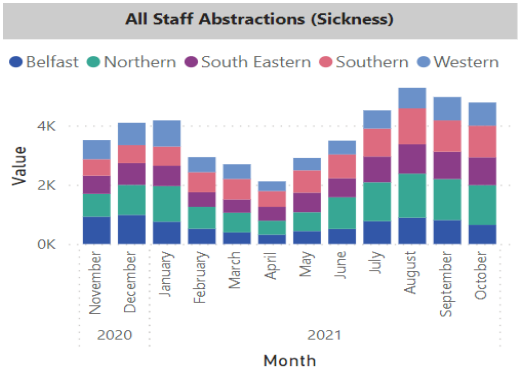
Current Pressures

STAFF ABSTRACTIONS

The Trust is experiencing rising numbers of staff abstractions due to sickness absence together with absences attributable to COVID-19 and self isolation requirements.

A very difficult staffing position was experienced during late August, early September due to higher than normal abstraction levels, however an improving picture has been seen over the last few weeks. The monthly figure for September shows a decrease on the August monthly figure and this reduction may be aided by having routinely paid enhanced overtime rates which has resulted in an improved operational cover.





- Figures demonstrate that monthly and cumulative sickness absence levels between July and September 2021 are significantly higher than figures in the same period in 2020/21. The cumulative absence figures have increased in the last three months from 9.3% in July 2021 (vs 7.5% in July 2020) to 10.1% in August 2021 (vs. 7.8% in August 2020) to 10.48% in September 2021 (vs. 8% in September 2020)

- Despite improved absence management and health & wellbeing initiatives being in place to support staff to return to work, ongoing extreme pressures within the working environment e.g. increased demand; reduced frontline operational cover in a number of Divisions; staff abstractions due to COVID-19 and hospital turnaround times resulting in late finishes and missed rest breaks, are undoubtedly contributing to the current higher than normal sickness absence levels.

- Figures reported are for all staff (excluded Bank Staff and Non-Executive Directors) and demonstrate hours lost, with average days lost based on a standard 7.5 hour day, consistent with Regional HSC Reporting of Sickness Absence. HRPTS figures are correct at time of reporting but may be subject to change.

2021/22 Monthly Sickness Absence including Comparators to Previous Reporting Year (2020/21)						
MONTH	Apr	May	Jun	Jul	Aug	Sep
NIAS ABSENCE TARGET (2020/21)	REDUCE SICKNESS ABSENCE RATES BY 5% ON 2020/21 PERFORMANCE TO 7.6% (TBC)					
NIAS cumulative % hrs lost (20/21)	6.8%	6.9%	7.2%	7.5%	7.8%	8.0%
NIAS monthly % hrs lost (20/21)	6.8%	6.9%	7.9%	8.2%	9.2%	8.9%
NIAS cumulative % hrs lost (21/22)	6.56%	6.97%	8.09%	9.28%	10.08 %	10.48 %
NIAS monthly % hrs lost (21/22)	6.56%	7.41%	10.34 %	12.76 %	13.19 %	12.48 %
Monthly % hrs lost (S/T)	1.47%	1.50%	1.84%	2.1%	2.25%	2.24%
Monthly % hrs lost (L/T)	5.09%	5.91%	8.5%	10.66 %	10.94 %	10.24 %
Monthly % hrs lost COVID 19 (Self-Symptomatic and self-isolation)	1.12%	0.91 %	1.88%	1.22%	1.33 %	1.98%
Av. days lost (7.5 hrs) per Employee per Mth	1.32	1.43	2.02	2.58	2.67	2.51
Av.NIAS estimated costs (£'000)	£347	£399	£570	£476	£958	£473
NIAS Cumulative % Hrs Lost:	(2021/22)					

Current Pressures

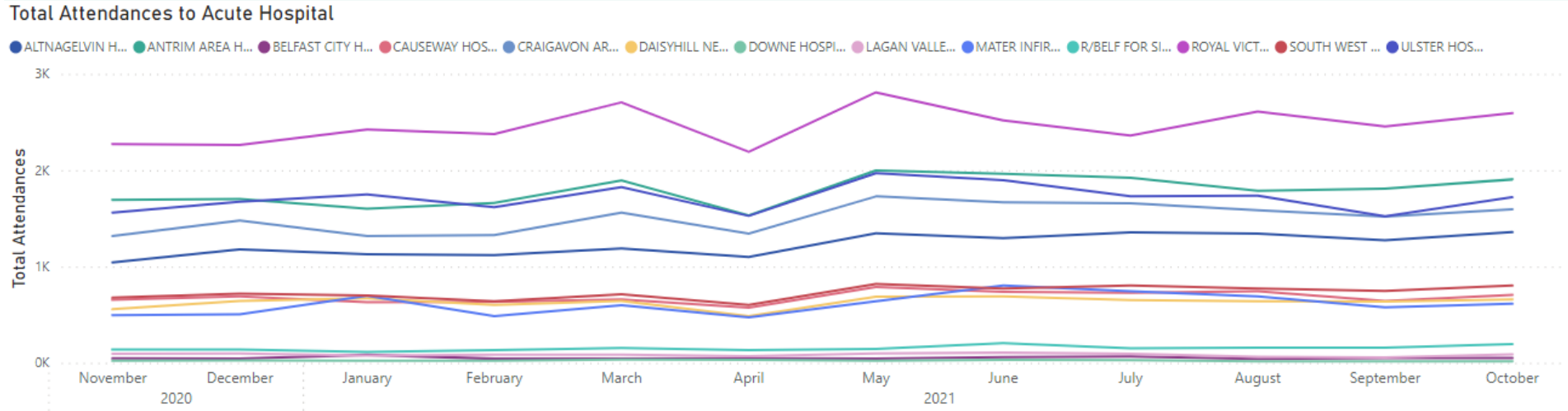
HANDOVER TIMES

The total turnaround time standard of 30 minutes from arrival at an ED includes a 15 minute standard for crews to hand over their patient within 15 minutes. Whilst NIAS can influence this to a limited degree much of the issue is outside our direct control.

Handover times for NIAS crews at Emergency Departments remain a very significant challenge. Whilst recognising the factors influencing delayed handover times are multi factorial NIAS continue to work with Acute Trusts to improve this element of the total turnaround time.

In addition to focusing on the handover / turnaround times NIAS have a focus on addressing a range of the resulting impacts on our service and staff

Hospital Activity



Patient Handover Times

Acute Hospital Attended	Total Attendances	Handovers	Handovers Over 15min Target	% Over 15mins	Total Time Lost (Hours)
ALTNAGELVIN HOSPITAL	14726	14154	11368	80.32%	4,278.44
ANTRIM AREA HOSPITAL	21466	17398	14710	84.55%	6,756.74
BELFAST CITY HOSPITAL	628	539	352	65.31%	95.14
CAUSEWAY HOSPITAL	8189	6682	5421	81.13%	3,583.30
CRAIGAVON AREA HOSPITAL	18093	16948	14448	85.25%	7,700.08
DAISYHILL NEWRY	7571	7063	6090	86.22%	3,118.48
DOWNE HOSPITAL	294	235	171	72.77%	47.60
LAGAN VALLEY LISBURN	1019	846	479	56.62%	137.14
MATER INFIRMORUM	7326	6039	4955	82.05%	2,414.77
R/BELF FOR SICK CHILDREN	1827	1519	824	54.25%	214.69
ROYAL VICTORIA	29572	23119	20046	86.71%	12,792.32
SOUTH WEST ACUTE HOSPITAL	8774	8478	6015	70.95%	2,168.58
ULSTER HOSPITAL	20527	16663	14696	88.20%	9,773.15
Total	**140012**	**119683**	**99575**	**83.20%**	**53,080.44**

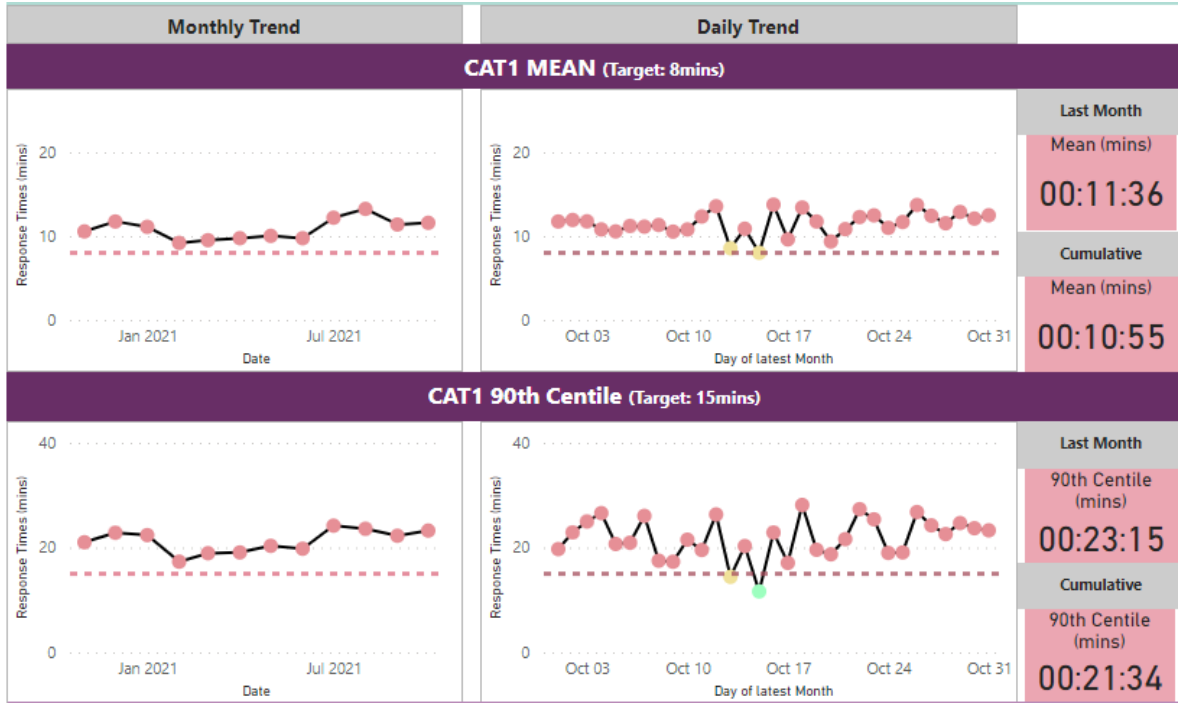
The target hospital Handover at ED is 15 minutes.

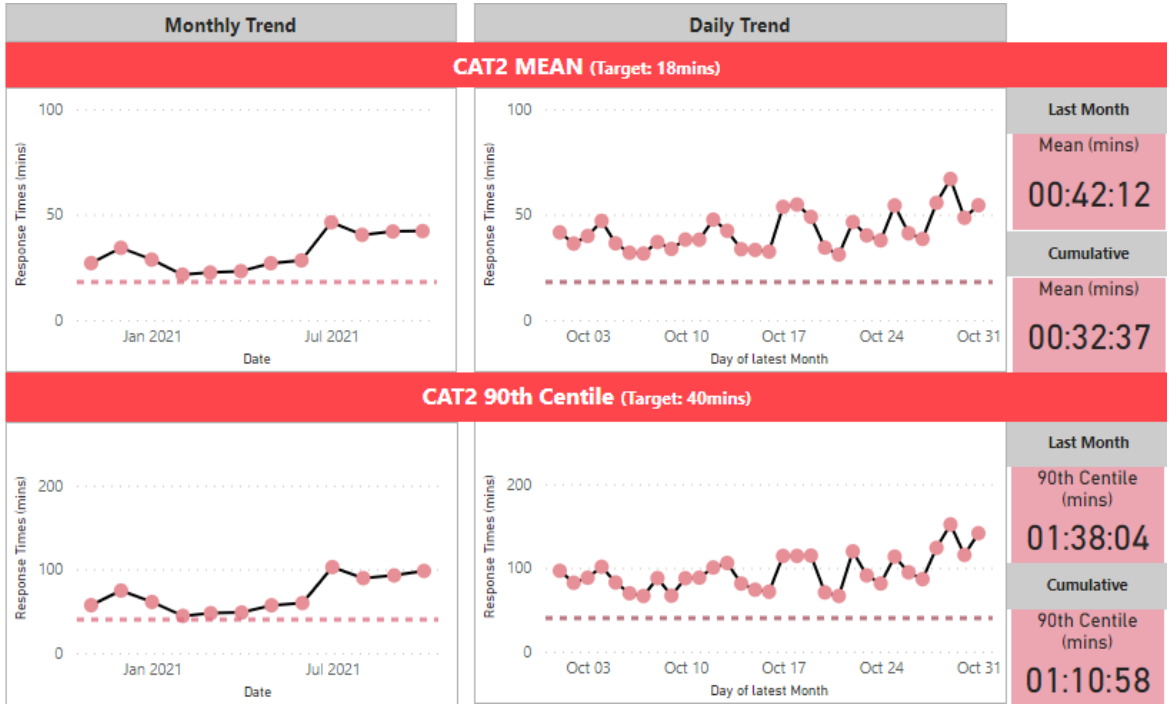
In the last 12 months, the average performance has been 32 minutes, and 83% of the Handovers are over 15 minutes, resulting in in circa 53k hours lost.

In October 2021, the average performance has been 45 minutes, with 87% of Handovers over 15 minutes and 8k hours lost (eq. to 673 12-hours shifts per month or 21 12-shifts per day).

This is an increase of 8% from September 2021

Current Pressures – Impact on Response Time Performance





- The combination of service pressures has lead to the escalation to REAP level 4 and has continued to impact on a reduction in performance against Category 1 and Category 2 calls against both the mean and 90th centile standards despite maximising resources and implementing a range of mitigating actions (which are highlighted in later slides).
- Reflective of the significant sustained pressures over recent months the cumulative position for Cat 1 mean response time continues to trend in a deteriorating position since the October Trust Board with the cumulative Cat 1 mean now 00:10:55 compared to 00:10:50 in September; similarly the 90th centile cumulative position is now 00:21:34 compared to 00:21:24
- Similarly increases in the cumulative Cat 2 response position now a mean of 00:32:37 compared to 00:31:26 at October Trust Board report, and 90th centile current cumulative performance of 01:10:58 compared to the August cumulative position of 01:07:50
- The Information Team continue to refine their reports that supports a deep dive into identification of particular pinch points of pressure, and weekends remain an area for additional focus for dynamic allocation of resources.

Current Pressures

INCREASED CALL DEMAND

- *The sustained increase in 999 calls particularly in the last 4 months is noted on slide 4. NIAS continues to recruit and train to EMD tier within EAC to maximise staff numbers available and welcomed 8 new staff from the last recruitment round into control in October following training to begin their mentored call taking*

- *EAC continue to avail of the regionally agreed availability for Critical Shift Payments to address shortfall in staff to maximise cover and maintain performance*

- *During times of peak pressures, both for NIAS and across the wider HSC and in keeping with Acute Trusts we continue to use media messaging when required. Cognisant of striking the balance in messaging include to note our appreciation of the public's understanding and would ask for continued patience and consideration of other options to address needs. Important to note however if the situation is immediately life threatening we would advise patients call 999 without delay*

INCREASED HANDOVER TIMES

- *Slide 5 has clearly demonstrated the impact on time lost for NIAS due to delayed handover times which remains to have a very significant impact on our resource availability and resultant response times , staff and ultimately patient experience*

- *It is recognised that the reasons for handover delays are multi factorial, and much of the ability to handover patients to EDs in a timely manner is directly linked to both Acute Hospital and the wider HSC system influences, including:*
  - *Reduced physical space within EDs due to the requirement to comply with social distancing, and often COVID vs Non COVID areas*
  - *Lack of dedicated ambulance handover areas*
  - *Poor patient flow through hospitals . This can be linked to a range of elements including, but not exhaustive: in-patient bed capacity ; ICU pressures ; increasing numbers of complex delayed discharges ; community capacity / pressures ; lack of domiciliary care availability*

- *The impact on NIAS from handover delays is more significant than the lost production hours at EDs previously highlighted, and we are very cognisant of the additional consequences for our crews including late finishes, missed meal-breaks, and lost hours due to compensatory rest*

- *NIAS continue to work internally , locally with Trusts, and regionally with Health & Social Care Board and Departmental colleagues to seek and support solutions to reduce delays*

Actions Taken To Address Current Pressures & Support Staff

In parallel to the development of a local framework based on an identification of need for winter surge planning a range of initiatives ongoing to be supplemented, and new to be introduced, will support staff and assist in addressing performance pressures. This will be supported by the "Surge Planning Group", and include:

- *On-going NIAS regional autonomy to direct NAIS arrivals to EDs based on agreed pressure triggers to equalise pressures and contribute to managing number of crews at EDS*
- *Task & Finish Group to reduce morning late finishes by ensuring appropriate fleet allocation and relieving night crews , alternative shift patterns*
- *Potential re-introduction of "receivers" at hospitals*
- *Additional HALOs supported across 3 of the larger EDs over the winter until end March 2022*
- *CSD review of calls and suitability for PCS on an ongoing basis*
- *Additional staff welfare support at EDs*
- *Supporting the introduction of dedicated ambulance handover areas*
- *Managing staff abstractions to maximise cover*
- *Completion of Clinical Skills Update Training for 26 Officers who can provide additional response cover or scene management / staff support*
- *Review of existing in-house training programmes to identify potential to reduce in order to release quantified elements of front line cover*

Actions Taken To Address Current Pressures

STAFF

- At the August Trust Board NIAS reported the pause in the current Paramedic Foundation Degree course for four weeks to support operational cover. This cohort of staff have been returned to their studies
- Station Officers continue to "book on" when on duty to both support staff and at times attend to Cat 1 calls as appropriate for their ability to do so, and provide locality cover. To maximise the potential for Station Officers to contribute to operational cover Ops Directorate have arranged with RATC to provide a one day condensed course to bring Officers up to speed on the basic skills they might require to respond to the type of calls they might encounter. To date 26 Officers have completed this training.
- Operational staff abstractions (combination of staff sickness and Covid abstractions) continue to impact on the ambulance cover provided. A recent review of protocols has been undertaken to identify improvements in the management of Covid abstractions designed to reduced the number and duration of Covid related absences.
- Due to the impact of staff abstraction levels on ambulance cover provided, the Trust is maximising the support available from voluntary and private ambulance services. Given the current circumstances, we are needing to secure the maximum support from VAS and PAS and there will be a potential corresponding increase in spend on this area. Whilst funding is not hindering arrangements this is however being closely monitored. That being said as Covid restrictions lift, and social events return the capacity for many providers to provide support is reduced
- In November 2020 NIAS took the decision to rationalise the level of PCS cover that could be provided, and key priority work streams identified for cover. This facilitated the movement of some PCS staff to provide A&E support that would protect 999 responses to higher acuity calls.
- Enhanced overtime rates have routinely been paid, which have increased operational cover.
- Re-profiling of duties of PCS cover to provide A&E support to help alleviate the operational pressures. Remains under regular review
- In the previous wave of pandemic pressures NIAS arranged support from blue light colleagues to increase operational cover. In REAP 4 NIAS has put in place arrangements with NIFRS to again secure additional blue light driving support. We have again explored this potential to be introduced should it be required, however due to pressures within their own organisation this is currently not an option, but remains a future potential.
- It is recognised that the steps taken by the Trust will not completely alleviate the full extent of the pressures being faced by staff but it is hoped they will improve the situation to some degree as much as possible

Clinical Performance

CHALLENGES

- Trust Board has been advised that due to operational pressures, normal clinical audit processes have been suspended. This includes
- Reporting on clinical performance indicators for key care bundles (e.g. stroke, myocardial infarction, hypoglycaemia
- Audit of patient report forms (outside of current students in training)
- Key staff involved in audit (clinical support officers) have been working to support operation cover and focussing on development of students in training in order to improve frontline availability of staff
- Training programmes have twice been paused due to COVID pressures but are now running at full capacity
- The implementation of REACH will significantly improve the ability to facilitate audit through direct interrogation of electronically submitted patient report forms

PROGRESS

- REACH went live in September 2021 within the Western Trust area and a rollout plan is active for all other divisions.
- The HEMS team have extended their remit to responding to critical medical calls in addition to serious trauma
- The Medical Directorate has taken on a Clinical Fellow on a part-time basis to progress clinical reviews and research
- The Trust still contributes to national audit around the areas of myocardial infarction, stroke, and serious trauma
- Specific audit programmes are already underway in respect of cardiac arrest outcomes, administration of penthrox and HEMS team activity, with significant development of business information tools which will be further facilitated by the ongoing roll-out of REACH.
- A Lead Pharmacist took up post on 1 November 2021 and initial workstreams include a review of NIAS policy and procedures, and further development of PGDs.
- The Trust has appointed a Head of Professional Practice who will take up post in December 2021, and recruitment of a Clinical Service Improvement Lead for acute care programmes is underway.
- A new protocol for the management of Healthcare Professional and Interfacility Transfer calls was introduced on 19 October 2021.
- A strategic review of the delivery of clinical education within NIAS has commenced with progress reports being made to the NIAS Safety, Quality, Patient Experience and Performance Committee.
- Areas of responsibility currently being audited include the management of medical devices, management of controlled drugs, clinical education and clinical audit.

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Trust Board Finance Report

October 2021 (Month 7)

Contents

Executive Summary

Statutory financial performance targets	RAG status
Manage within allocated Revenue Resource Limit (RRL) / Achieve financial break-even	
The Trust is reporting a breakeven position for the seven months ending 31 October 2021 and forecasting a breakeven position at year end, subject to a number of assumptions particularly in respect of assumed income, Covid-19 costs and efficiency savings. The Trust continues to work with HSCB and DoH to finalise the resource requirements in relation to these issues and other financial pressures and deficits for the current year and beyond.	
Manage within allocated Capital Resource Limit (CRL)	
The Trust has received a Capital Resource Limit (CRL) allocation of £7.962m. This includes allocations for Fleet & Estate, ICT and Backlog Maintenance. The Trust is currently forecasting full spend against the CRL allocation at year end, but there are a number of risks in relation to this. The Trust continually reviews capital schemes to understand and mitigate against these risks.	
Prompt payment target-95% of suppliers within 30 days	
Cumulative performance at 97.0% at 31 October 2021 (Month 7). As aged invoices are cleared and paid, performance between months can vary.	

Manage within allocated Revenue Resource Limit (RRL) / Achieve financial break-even

The Trust is currently reporting a breakeven position for the seven months ending 31 October 2021 (Month 7), and also at the end of 2021-22, subject to a number of key risks and assumptions particularly in respect of Agenda for Change, investment, Covid-19 costs and efficiency savings. Significant progress has been made in these areas since the Month 5 Report to Trust Board. Specifically:

* The agreed RRL at Month 7 is £108.115m of which £87.786 is recurrent (Previously £88.106m of which £87.369m is recurrent).
* Covid-19 Costs - The current forecast £12.6m of Covid-19 costs will be fully funded across the areas of Workforce (£3.6m), Service Delivery (£7.2m), Equipment & Supply (£1.2m) and Corporate Cleaning (£0.6m). These have largely been agreed. These estimates do not include any potential impact of the recently discovered Omicron variant.
* Efficiency Savings – The Trust has received a letter from DoH/HSCB requesting that Trusts should now cease discretionary spending in areas that would not have an immediate impact on service delivery. This has been considered by the Senior Management Team, but opportunities to reduce spend further are limited. Beyond this additional request, no further efficiency savings requirements are expected in the year. The Trust has been set a target of £2.602m. Initial estimates were that only £1m of this target would be met, and this will only be on a non recurrent basis. Additional non recurrent support has been indicated by HSCB and further measures have been identified to achieve the balance of savings required in 2021-22.
* Agenda for Change – The costs of regrading, pay awards and holiday pay will be fully funded. The 2021-22 pay arrangements have recently been agreed and issued by DoH.
* Investment – Clinical Response Model (£2.5m) and NIAS Training (£3.5m) (these schemes have largely been agreed). Other areas remain under discussion, the most significant of which is the Cohort 4 Paramedic Course which is planned to commence in March 2022, but will run well into the 2022-23 financial year with associated costs.
* The Trust is working through a process of review with DoH/HSCB and to finalise the position in relation to these funds.
* Accounting Treatment - There will be no major in year changes to accounting treatment.

Directorate Financial Position

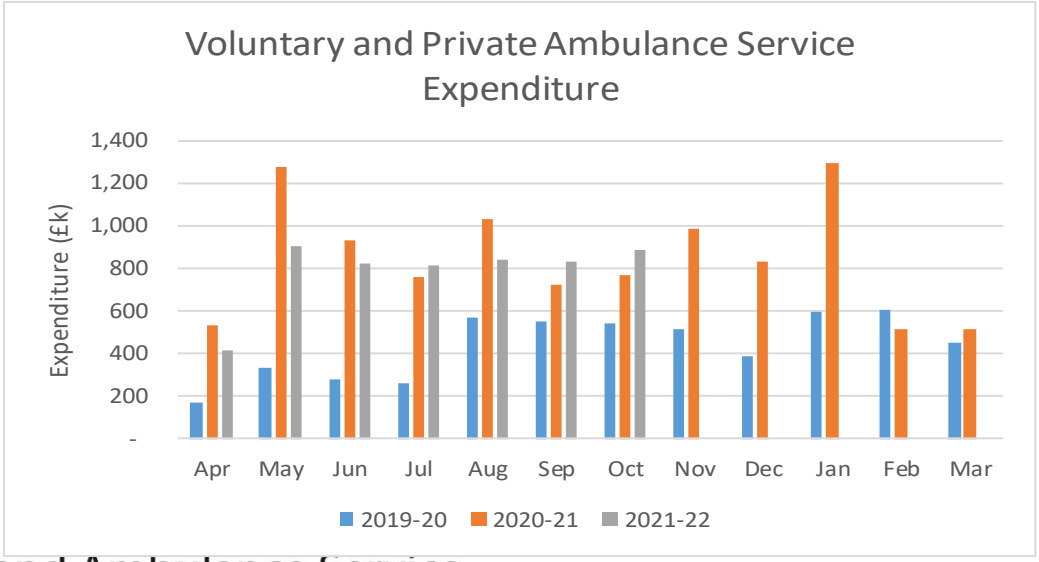
- Underlying the overall financial forecast is a complex budgetary position within each Directorate. Actual expenditure by Directorate at October 2021 (Month 7) is shown opposite.
- The level of underspends against the pay budget is reducing as vacancies across the Trust are filled. Any underspend is used to fund overtime costs to maintain services and provide operational cover. There are also significant levels of sickness absence that can create a financial pressure beyond budgeted levels.
- Expenditure on Voluntary and Private Ambulance Services is also being incurred to maintain cover and performance.
- The significant additional expenditure, particularly in respect of Covid-19, is included in the financial assumptions in the current year. Funding beyond this year cannot currently be assumed, though pressures due to Covid-19 are not expected to reduce in the medium term.
- A programme of work to revise the financial management framework to reflect this exceptional expenditure and incorporate the revised organisational structure and the conclusions of the Demand & Capacity exercise is underway. This involves significant engagement with operational managers and budget holders. This work will be reflected in Financial Reporting in 2022-23.

Description	Expenditure at October 2021 (Month 7)
NIAS TOTAL	64,302
HQ DIRECTORATES	13,411
DIR OF CRM, FLEET & ESTATES	751
DIRECTOR OF FINANCE	1,166
DIRECTOR OF HUMAN RESOURCES	1,088
MEDICAL DIRECTOR	6,721
DIRECTOR OF OPERATIONS	651
DIRECTOR OF PLAN, PERF & CORP	2,307
DIRECTOR OF SAFETY, QUAL & IMP	372
CHIEF EXECUTIVE'S OFFICE	355
OPERATIONS DIRECTORATES	50,891
BELFAST AREA MANAGER	6,538
REGIONAL CONTROL CENTRES	11,565
SOUTHEAST AREA MANAGER	6,759
NORTH AREA MANAGER	10,057
SOUTH AREA MANAGER	7,629
WEST AREA MANAGER	8,343
WEST AREA MANAGER	8,343

Voluntary & Private Ambulance Services

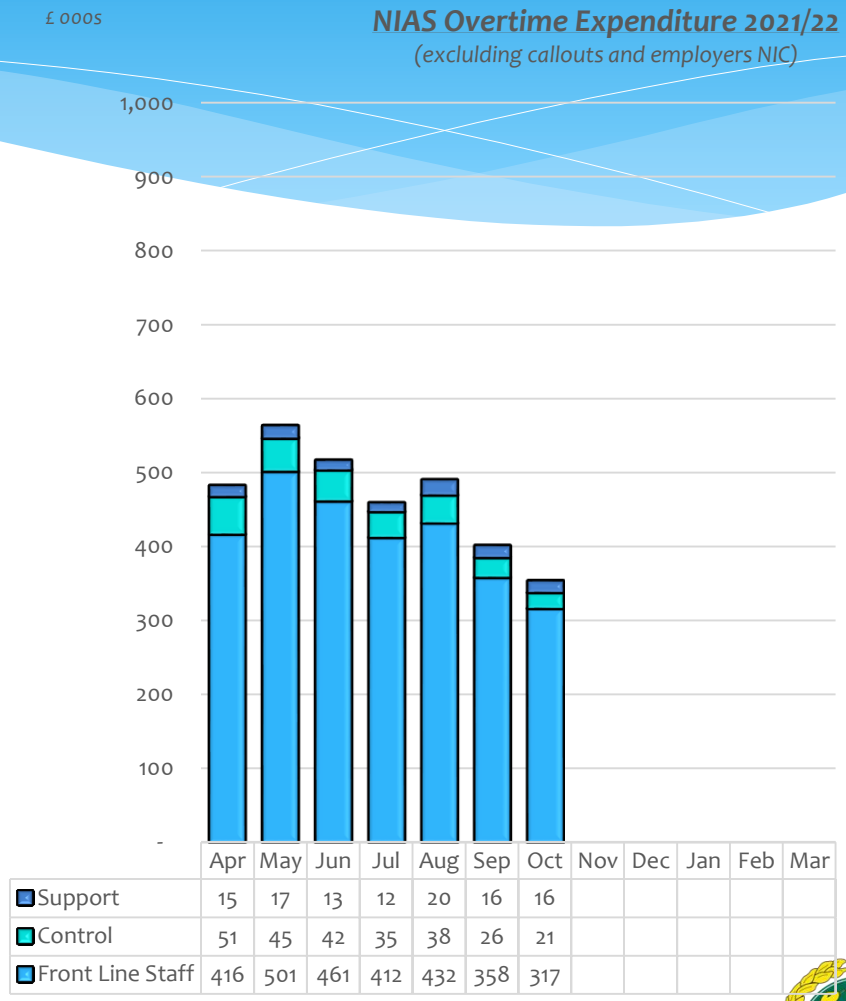
The Trust benefited from significant additional funds in 2020-21 as part of the response to Covid-19. A similar level of support has been provided in 2021-22 which has been applied to additional support from VAS/PAS to maintain and enhance ambulance provision during this difficult period. The Trust welcomes the support that VAS/PAS has given NIAS and HSC during this time.

* Expenditure on VAS/PAS in 2019-20 was £5.2m. Expenditure in 2020-21 was £10.1m. Expenditure by month is shown below. This level of expenditure has been affordable given operational vacancies within the Trust and also with the additional resources provided in response to the pandemic. As the output of the training school fills vacancies and the impact of the pandemic recedes, levels of expenditure should reduce.
* The sustained impact of Covid-19 has resulted in the continued reliance on VAS/PAS to maintain services in the current year. While expenditure has reduced compared to the same period last year, the Trust remains at the highest level of escalation and VAS/PAS spend remains significant. The reduced spend is primarily due to a reduction in available VAS/PAS as they are also impacted by Covid-19 and are beginning a return to their core business areas, for example sporting and other events.



Overtime Expenditure

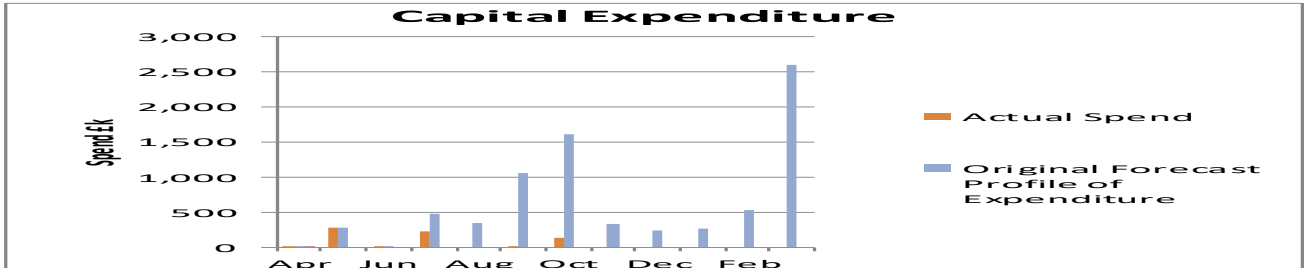
* The Trust relies significantly on the use of overtime for the provision of services, predominantly for the provision of Ambulance cover. This reliance is for a number of reasons including vacancies, planned and unplanned absences and additional cover or programmes of work.
* Overtime is payable to staff in pay bands 1-7 under Agenda for Change (AfC) terms and conditions at a rate of time plus one half, with the exception of public holidays which are paid a double time.
* Overtime is paid monthly in arrears and claims should routinely be submitted within three months of the work being carried out. Staff also have the option of taking time off in lieu as an alternative to an overtime payment.
* Given the varying requirements for overtime, expenditure can vary significantly at different times in the year. However, even with this variability, overtime is remarkably consistent between years averaging circa £6m per annum.
* The Trust has instigated a programme of work to recruit substantively to positions and rotas that have historically been filled with overtime. There is however a significant lead time for the recruitment and training of these staff.
* Regionally, additional enhancements have been introduced to encourage staff to undertake additional shifts. These are estimated at a further £600k additional costs between August and October and are not currently included in this graphical analysis.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Support	15	17	13	12	20	16	16					
Control	51	45	42	35	38	26	21					
Front Line Staff	416	501	461	412	432	358	317					

Manage within allocated Capital Resource Limit (CRL)

- The Trust has received a Capital Resource Limit (CRL) allocation of £7.962m (Previously £7.747m). This includes allocations for Fleet & Estate (£5.964m), ICT (£2.018m) and Backlog Maintenance (£0.250m). In addition, a bid of £0.470m has been put forward as part of the Monitoring Round process for backlog maintenance schemes.
- Expenditure has traditionally been profiled towards the end of the financial year due to a number of factors, including business case approval, the availability of funds, procurement timescales, supplier capacity, internal capacity, project risks and lead times. Significantly, expenditure on fleet is profiled to the end of the financial year to maintain a smooth fleet age profile.
- These risks have been compounded recently due to a number of factors including EU exit, the global movement of goods, the global availability of raw materials and also associated costs of materials, production and delivery. The Trust continually reviews capital schemes to understand and mitigate against these risks.
- In an effort to bring forward expenditure from the end of the financial year, the Trust has recently entered into tenders for accident and emergency vehicles beyond the traditional one year cycle. This option is also being explored for other vehicle procurements. This should allow orders to be placed earlier in the annual replacement cycle and has provided some certainty in relation to pricing. Capacity with suppliers is also being explored to purchase additional vehicles should further funding become available.
- Provisional figures for expenditure at October 2021 (Month 7) is £0.654m against this allocation of £7.962m. The Trust currently forecasts full spend against the CRL allocation at year end.



Prompt Payment of Invoices

* The Trust is required to pay non HSC trade creditors in accordance with the Better Payments Practice Code and Government Accounting Rules. The target is to pay 95% of invoices within 30 calendar days of receipt of a valid invoice, or the goods and services, whichever is the latter. A further regional target to pay 70% (increased from 60%) of invoices within 10 working days (14 calendar days) has also been set.

* Performance by number of invoices paid for each of these measures is shown below. A range of plans are in place to improve and maintain performance in this area. As aged invoices are cleared and paid, performance between months can vary.

* In 2020-21, both the 70% and 95% targets were achieved for the first time in a number of years. The Trust will continue with efforts to maintain this level of performance in 2021-22.

Number	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD Cum	Target
Total bills paid	2,644	2,969	3,217	2,441	3,035	2,907	2,750						19,963	
Total bills paid within 30 calendar days of receipt of undisputed invoice	2,616	2,907	3,177	2,274	2,887	2,824	2,687						19,372	
% bills paid on time 30 days	98.9%	97.9%	98.8%	93.2%	95.1%	97.1%	97.7%						97.0%	>95%
Total bills paid within 10 working days (14 calendar days)	2,196	2,447	2,846	1,934	2,551	2,564	2,437						16,975	
% bills paid on time 10 days	83.1%	82.4%	88.5%	79.2%	84.1%	88.2%	88.6%						85.0%	>70%

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TB/16/12/2021/09

Northern Ireland Ambulance Service
Health and Social Care Trust

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TRUST BOARD

PRESENTATION OF PAPER

Date of Trust Board:	16 December 2021
Title of paper:	Being Open Policy
Brief summary:	This policy defines the organisation's commitment to 'Being Open' by establishing a culture where: • Service users receive rapid and open disclosure and emotional support when they experience serious incidents. • They receive the information they need to enable them to understand what happened and the reassurance that everything possible will be done to ensure that a similar type of incident does not occur again. • Staff involved are treated justly/appropriately. • HSC professionals, service users and carers are appropriately supported when things go wrong. • Service users/carers receive timely information about the outcome of any investigation. The Policy was discussed at the November Safety Committee and a number of amendments suggested. However the Committee Chair deemed the Policy to be of such significance that he wished to bring it to the attention of Trust Board.
Recommendation:	**For Approval** ☐ **For Noting** ☒
Previous forum:	SMT – 16/11/21

	Safety Committee – 25/11/21
Prepared and presented by:	Ms Katrina Keating, Risk Manager Dr Nigel Ruddell, Medical Director Ms Lynne Charlton, Director QSI
Date:	9 December 2021

Northern Ireland Ambulance Service
Health and Social Care Trust

Title:	**Being Open Policy – saying sorry when things go wrong**		
Author(s):	Katrina Keating, Risk Manager in conjunction with the Regional Working Group on Adverse Incidents		
Ownership:	Dr Nigel Ruddell, Medical Director Lynne Charlton, Director of Quality, Safety & Improvement		
Date of SMT Approval:	16.11.21	**Date of SQEP Committee Approval:**	25.11.21
Operational Date:	25.11.2021	**Review Date:**	November 2022
Version No:	1.0	**Supercedes:**	N/A
Key Words:	Incidents, Near Misses, Learning, Just Culture, Safety Leadership, Involvement, Improvement, Regional Risk Matrix, DATIX, Complaints, Legal, Risk Management, Serious Adverse Incidents (SAIs), Coroner.		
Links to Other Policies / Procedures:	Learning From Incidents Policy & Procedures, Learning From Serious Adverse Incidents (SAIs) Procedure, RIDDOR Policy, Corporate Risk Management Policy & Procedures, Management of Medical Devices Policy, Claims Management Policy, Whistle Blowing Policy, Health and Safety Policy, Safeguarding Referral Procedure, Information Governance Policies and Procedures, Major Incident and BCP Procedures.		

Version Control:			
Date:	**Version:**	**Author:**	**Comments:**
25th November 2021	1.0	Katrina Keating	Regional Policy

1.0 INTRODUCTION / PURPOSE OF POLICY:

When things go wrong harm may occur. This can have devastating emotional and physical consequences on the individual, their family and carers, and can be distressing for the professionals involved.

'Being Open' is a set of principles that health and social care staff should use when offering an explanation and apologising to service users and/or their carers when harm has resulted from an incident.

"saying sorry is not an admission of liability"

'Being Open' involves:

- Acknowledging, apologising and explaining when things go wrong.
- Keeping service users and carers fully informed when an incident has occurred.
- Conducting a thorough review into the incident and reassuring service users, their families and carers that lessons learned will help prevent the incident recurring.
- Providing support for those involved to cope with the physical and psychological consequences of what happened.
- Recognising that direct and/or indirect involvement in incidents can be distressing for health and social care staff, permission will be given to seek emotional support.

The Northern Ireland Ambulance Service Health and Social Care Trust (NIAS) is committed to improving the safety and quality of the care we deliver to the public. This 'Being Open' policy expresses this commitment to provide open and honest communication between our staff and a service user (and/or their family and carers) when they have suffered harm as a result of their treatment. It is based on published guidance by the National Patient Safety Agency (NPSA) and also complies with step 5 of 'Seven Steps to Patient Safety' (Appendix 1).

1.1 Background:

Openness and honesty towards service users are supported and actively encouraged by many professional bodies including the Health and Care Professions Council (HCPC). General Medical Council, the Royal College of Nursing, the Medical Defence Union and the Medical Protection Society.

The duty of candour has received support through the Joint statement from the Chief Executives of statutory regulators of healthcare professionals.

This is supported by the HCPC and reflected in the 'Standards of conduct, performance and Ethics (standard 8), Openness and honesty when things go wrong: the professional duty of candour, issued by the GMC and NMC in 2015 summarising their position on this and provides guidance on how to follow the principles set out in Good Medical Practice (GMC) and The Code: Professional standards of practice and behaviour for nurses and midwives (NMC).

In September 2005 the National Patient Safety Agency (NPSA) called on all NHS organisations to develop local 'Being Open' policies. Their guidance was replaced in November 2009 by Being Open: communicating service user safety incidents with service users, their families and carers in response to changes in the health and social care environment and in order to strengthen 'Being Open' throughout the NHS.

They also produced a Being Open Framework to act as a best practice guide on how to create an open and honest environment through:

- aligning with the Seven steps to patient safety (Appendix 1) which outlines for leaders of health and social care organisations how to create an open and fair culture;
- ensuring a 'Being Open' policy is developed that clearly describes the process to be followed when harm occurs. This relates directly to, and expands upon, step 5;
- committing publicly to 'Being Open' at board and senior management level;
- identifying senior clinical counsellors to mentor and support fellow health and social care professionals involved in incidents.

This policy is based upon adopting openness, transparency and candour throughout the organisation and is modelled on the NPSA Being Open policy and the 'Being Open' Framework document.

1.1.2 *Recommendations from Inquiry Reports*

In recent years there have been a number of reports arising from diverse inquiries into health and social care both in England and Northern Ireland and all of these have included recommendations in regard to Being Open and Duty of Candour. The summary of the relevant recommendations are in Appendix 9 and include the Francis Report (2013), the Donaldson Report (2014) and the Hyponatraemia Inquiry (O'Hara 2018).

Although there is currently no statutory duty of candour in Northern Ireland, as recommended by the Donaldson and O'Hara reports, the suggestion has been endorsed by previous Northern Ireland health ministers. Furthermore, work is ongoing to implement the recommendations arising from the O'Hara Report through the IHRD Implementation Programme. This work includes the introduction of a statutory duty of candour and a revised regional Being Open policy, which will eventually replace this policy.

1.1.3 *The organisation will have the following foundations to implement 'Being Open' successfully:*

A. Open and fair culture

Promoting a culture of openness is vital to improving service user safety and the quality of health and social care systems. A culture of openness is one where health and social care:

- staff are open about incidents they have been involved in;
- staff and organisations are accountable for their actions;
- staff feel able to talk to their colleagues and superiors about any incident;
- organisations are open with service users, the public and staff when things have gone wrong and explain what lessons will be learned;
- staff are treated fairly and are supported when an incident happens.

To achieve this goal of openness with the public, the Trust has adopted the nationally recognized seven steps to patient safety in their risk management strategy and will continuously strive to achieve these objectives contained within the steps (Appendix 1).

B. 'Being Open' policy & associated training

A 'Being Open' policy that sets out the process of communication with service users, and raising awareness about this, will provide staff with the confidence to communicate effectively following an incident.

An elearning programme that provides information on the fundamentals of applying the Being Open Process and includes a case study.

C. Staff and service user support

To ensure both staff and service users support the implementation of 'Being Open' it is vital that:

- Service users, their families and carers feel confident in the openness of the communication following a service user safety incident, including the provision of timely and accurate information;

- health and social care professionals understand the importance of openness and feel supported by their health and social care organisation in delivering it, and that where appropriate they undertake the Being Open e-learning programme.

To implement '*Being Open'* successfully, the organisation will have the following foundations:

A. a culture that is open and fair;
B. a '*Being Open'* policy and mechanisms to raise awareness about it;
C. staff and service user support for '*Being Open'.*

1.1.4 *Prevented and 'no harm' incidents*

The Trust encourages staff to report all service user safety incidents; even those that were prevented (i.e. 'near misses'), insignificant and minor incidents. These are often the type of incidents which, if addressed promptly and taken seriously, will lead to

minimising or preventing more serious incidents. This monitoring of all incidents will lead to the achievement of a high quality safety culture.

It is not a requirement of these guidelines that prevented and no harm service user safety incidents are discussed with service users as this would cause undue and unnecessary anxiety. This does not absolve staff of their responsibility to report such incidents to ensure that they are recorded, monitored and reported through the Trust incident reporting system (DATIX).

1.1.5 *Being Open*

The main thrust of this 'Being Open' policy is concerned with service user safety incidents which cause moderate, major or catastrophic harm (Appendix 2). It describes the process of 'Being Open' and gives advice on the 'do's and don'ts' of communicating with service users and/or their carers following harm.

The focus is on rapid and open disclosure and emotional support to service users and families who experience serious incidents. They also address ways to support and educate clinicians involved in such incidents.

The Trust will approach these issues from the service user's point of view, asking, "What would I want if I were harmed by my treatment?"

While Trust employees and caregivers may have competing interests, including legitimate concerns about legal liability, our frame of reference is the simple question, **"What is the right thing to do?"**

1.1.6 *Definitions*

Harm is defined as injury (physical or psychological), disease, suffering, disability or death. In most instances it can be considered to be unexpected if it is not related to the natural cause of the service user illness or underlying condition. The injury or damage can be described as physical, psychological (or both), suffering, disability or death. It can be rated as insignificant, minor, moderate, major or catastrophic (Appendix 2).

Service User[1]: this term refers to a patient, service user, family (of a service user and/or family of a victim), carer or nominated representative.

1.2 Purpose:

This document is relevant to all board, executive, managerial and staff and by explaining the principles behind 'Being Open' it ensures that service users and families who experience incidents which have caused moderate, major or catastrophic harm receive rapid and open disclosure along with emotional support. It also addresses ways to support and educate staff involved in such incidents.

[1] As per the draft Statement of what you should expect in relation to a Serious Adverse Incident Review, January 2019

1.3 Objectives:

This policy defines the organisation's commitment to 'Being Open' by establishing a culture where:

- Service users and carers receive rapid and open disclosure and emotional support when they experience serious incidents which cause moderate, major or catastrophic harm.
- They receive the information they need to enable them to understand what happened and the reassurance that everything possible will be done to ensure that a similar type of incident does not occur again.
- Ways to support and educate health and social care staff involved in such incidents are addressed.
- Staff involved are treated justly and appropriately.
- Health and social care professionals, managers, service users and carers are appropriately supported when things go wrong.
- Service users and carers receive timely information about the outcome of any investigation.

2.0 SCOPE OF THE POLICY:

The Northern Ireland Ambulance Service Health and Social Care Trust encourages staff to report all service user safety incidents, including those where there was no harm or it was a 'near miss' event.

The 'Being Open' principles apply to any incident where any harm has occurred to a service user. The 'Being Open' process outlined in the policy must be followed where incidents are of moderate, major or catastrophic severity as defined in Appendix 2, a and b, and within the Trusts Procedure For The Reporting and Management of Adverse Incidents. Incidents that are regarded as insignificant or minor do not require implementation of the Being Open process, although the principles should be applied (section 1.1.4).

This policy applies to all staff working on behalf of the Trust.

This policy establishes a culture of openness as a basic principle of how we interact with service users which then underpins other policies. It sets the scene of openness as a founding principle behind:

- Complaints Policy and Procedures.
- Learning From Serious Adverse Incidents (SAIs) Procedure.
- Disciplinary Policy and Procedures.
- Procedure For The Reporting and Management of Adverse Incidents.
- Information Governance Policies and Procedures.
- Risk Management Strategy.
- Consent arrangements.
- Capability Policy and Procedures.

It also complements standards as set out by professional bodies.

3.0 ROLES/RESPONSIBILITIES

This policy is aimed at all levels of health and social care staff. The following responsibilities and accountabilities reinforce the concept of this 'Being Open' culture of openness applying throughout the organization.

3.1 Trust Board:

Trust Board are responsible:

- For actively championing the 'Being Open' process.
- For promoting an open and fair culture that fosters peer support and discourages the attribution of blame. This should result in staff being empowered to improve service user care by learning from mistakes rather than denying them.

3.2 Chief Executive:

The Chief Executive is responsible for ensuring the infrastructure is in place to support openness between health and social care professionals and service users and/or their carers following an incident that led to moderate, major or catastrophic harm.

3.3 Executive Directors:

The Medical Director and the Director of Quality, Safety & Improvement (DQSI) hold overall professional responsibility for managing the 'Being Open' process.

3.4 Directors & Assistant Directors:

Hold responsibility within their own directorate for managing the 'Being Open' process.

3.5 All Line Managers:

- Ensure all staff are aware of the "Being Open" policy.
- Support staff, particularly those who will have a key role in managing the being open process.
- Support staff involved in service user safety incidents, including advising on sources of appropriate support such as the Inspire Service.
- In addition to completing an incident reporting form, notify the Risk Management Team when an incident has caused moderate harm or more.
- When an incident has result in major or catastrophic harm the following should also be informed directly:

Medical Director Director QSI Director responsible for Service area	} that the 'Being Open' process has } been initiated for an incident } causing major or catastrophic harm

3.6 All Staff:

All staff working within the organisation will be expected to adhere to this policy and are responsible and accountable for:

- Ensuring that service user incidents are acknowledged and taken seriously.
- Treating concerns with compassion and understanding.
- Reporting as soon as they are identified.
- Informing their line manager.
- Participating in the review process.
- Communicating in a timely, truthful & clear fashion.
- Recording and documenting discussions with service users and families.
- Complying with the Being Open policy.
- Undertaking the Being Open e-learning programme where appropriate.

4.0 KEY POLICY PRINCIPLES:

4.1 Key Policy Statement(s)

Service user safety incidents will be managed using the principles outlined in this 'Being Open' policy. Each incident will trigger a 5 stage process as set out in Appendix 4; with modifications in certain circumstances detailed in Appendix 5.

4.2 The principles of 'Being Open' should also apply to the full spectrum of unexpected or unplanned clinical events. Especially where there is a risk of moderate, major or catastrophic harm, a rapid and open disclosure of these changes in a service user's medical condition e.g. a fall resulting in major injury such as a fracture/haemorrhage. This should be communicated and discussed with the service user and, where appropriate, their family. **See Appendix 2B – grades and consequent actions following service user safety incidents. NOTE: apply the principles (insignificant and minor) and apply the Being Open Process (moderate, major and catastrophic).**

Also, in keeping with the 'Being Open' philosophy, any details of a service user's illness, treatment and the factors causing and/or contributing to the service user's death which are discussed with relatives should be recorded in the clinical record.

4.3 All service user safety incidents will be acknowledged and reported as soon as possible in line with the Procedure For The Reporting and Management of Adverse Incidents; denial of a concern makes further open and honest communication more difficult.

4.4 The most appropriate person must communicate with the service user about an incident in a truthful open and timely manner. Information must be based solely on the facts. Service users will not receive conflicting information from different members of staff.

4.5 Service users and/or their families (unless there are confidentiality issues) will receive a sincere apology and expression of sorrow or regret for the harm caused by a service user safety incident.

Both verbal and written apologies will be given. Verbal apologies are essential because this allows face-to-face contact and they should be given as soon as staff are aware of the incident. Delay is likely to increase anxiety, anger or frustration.

The NI Ombudsman has issued a 'Guidance on Issuing an Apology' leaflet which provides helpful guidelines regarding issuing an apology (Appendix 9).

10 principles of 'Being Open'

1. Acknowledge incident
2. Communicate – truthful, timely, clear
3. Apology
4. Service user, family & carer support
5. Support for Professions
6. Risk management
7. Multidisciplinary responsibility
8. Clinical Governance
9. Confidentiality
10. Continuity of care

4.6 Support for the Service user

A key part of 'Being Open' is considering the service user's needs, or the needs of their carers or family in circumstances where the service user has been involved in a serious service user safety incident or died. The Trust will ensure early identification of, and provision for, the service user's practical and emotional needs.

Service users and/or their carers can reasonably expect to be kept fully informed of the issues surrounding a service user safety incident in a face-to-face meeting. They will be treated sympathetically with respect and consideration. They will be provided with support in a manner appropriate to their needs.

This includes providing the names of people who can give assistance and support, and to whom the service user has agreed that information about their health care can be given. This person (or people) may be different to both the service user's next of kin and from people whom the service user had previously agreed should receive information about their care prior to the service user safety incident.

The Trust will provide information on services offered by all the possible support agencies (including their contact details) that can give emotional support, help the service user identify the issues of concern, support them at meetings with staff and provide information about appropriate community services.

Contact details will be provided of a staff member who will maintain an ongoing relationship with the service user, using the most appropriate method of communication from the service user's and/or their carer's perspective. Their role is to provide both practical and emotional support in a timely manner.

It is important to identify at the outset if there are any special restrictions on openness that the service user would like the health and social care team to respect. It is also

important to identify whether the service user does not wish to know every aspect of what went wrong, to respect their wishes and reassure them this information will be made available if they change their mind later on.

Public information statement
'*Being Open*' if things go wrong:
We will

- tell you if we know something has gone wrong;
- listen to you if you see something is wrong;
- say sorry;
- find out what happened and why;
- keep you informed;
- answer your questions;
- work to stop it happening again.

4.7 Support for Families, Carers:

Service users and/or their carers may need considerable practical and emotional help and support after experiencing a service user safety incident. Support may be provided by service users' families, social workers, religious representatives, relevant NIAS staff. Details of the Service User Client Council should also be available among others. Where the service user needs more detailed long-term emotional support, advice should be provided on how to gain access to appropriate counselling services, e.g. Cruse.

A service user and/or their family may, at any time through this process wish to avail of advocacy or representation if they feel this would help them to understand and address issues.

4.8 Support for staff:

These guidelines apply to all staff that have a role in providing service user care. The Trust acknowledges that most incidents usually result from system failures and it is unusual that incidents arise solely from the actions of an individual. Senior managers and senior clinicians must participate in incident investigation and clinical risk management.

When a service user safety incident occurs, health and social care professionals involved in the clinical care may also require emotional support and advice. Both the staff who have been involved directly in the incident and those with the responsibility for 'Being Open' discussions should be given access to assistance, support and any information they need to fulfil this role.

To support staff involved the Trust will:

- Actively promote an open and fair culture that fosters peer support and discourages the attribution of blame. The Trust will work towards a culture where blame is the enemy of learning and where human error is understood to be a consequence of flaws in the health and social care systems, not necessarily the individual.

- Create an environment in which staff are encouraged to report service user safety incidents. Staff should feel supported throughout any incident investigation process.
- Provide facilities for formal and informal debriefing of the clinical team involved in an incident separate from the requirement to provide statements for the investigation. Individual feedback about the final outcome of the service user safety incident will be available.
- Provide advice and training on the management of service user safety incidents.
- Where appropriate provide counselling by professional bodies for staff distressed by service user safety incidents.
- Avail of the support services provided by staff representative organisations and ensure staff have access to the information they can provide.
- Ensure the availability of the Peer Support Team as a listening ear and to comfort them if they become distressed. Peer support can be reached via email: staff.peersupport@nias.hscni.net or via a number of mobile telephone numbers available on SharePoint.
- Recognise that there is a need for health and social care staff to develop the skills necessary to be effective when communicating with service users and/or their carers in these rare but very distressing circumstances. The Trust will provide training to assist communicating in these difficult situations.

4.9 Service user safety incidents will be investigated to uncover the underlying cause(s). Investigations should focus on improving systems of care. The 'Being Open' policy is part of an integrated approach to addressing service user safety incidents. They are embedded in an approach to risk management that includes incident reporting, analysis of incidents and decision about staff accountability.

4.10 This policy applies to all members of the teams that have key roles in providing the service user's care. This should be reflected in the way that service users, their families and carers are communicated with when things go wrong. This will ensure that the 'Being Open' process is consistent with the philosophy that incidents usually result from systems failures and rarely from the actions of an individual.

To ensure full involvement in the 'Being Open' process, it is important to identify clinicians, and managers who will support it. Both senior managers and senior clinicians who are local leaders must participate in incident investigation and clinical risk management.

4.11 The guidelines will require support of service user safety and quality improvement processes through the assurance and governance framework in which service user safety incidents are investigated and analysed and to find out what can be done to prevent a recurrence.

The findings of any investigation should be disseminated to all relevant persons and monitored so they can learn from events. This will also facilitate the move towards increased awareness of service user safety issues and the value of 'Being Open'.

4.12 Full confidentiality of and respect for service users, carers and staff will be maintained. Consent will be sought from individuals prior to disclosing information

beyond the clinicians involved in treating service users. Communication with parties outside of the clinical team should also be on a strictly need-to-know basis.

4.13 Service users are entitled to expect, and the Trust will ensure, that they will receive continuity of care with all the usual treatment and continue to be treated with dignity, respect and compassion.

5.0 IMPLEMENTATION OF POLICY

5.1 Dissemination

This policy covers all areas of the organisation's business and applies to all incidents involving service users, staff and visitors, as well as those incidents where individuals are not affected. It also includes contractors involved in patient care, students, volunteers, bank and agency staff or locums and any other with patient safety / patient care involvement. All staff working on behalf of the Trust should be provided with access to this policy. The latest version of this policy (and related documents) is available on SharePoint (Corporate Documents and Medical Directorate).

5.2 Resources

Being Open Training is mandatory for all staff as above. Appropriate training and guidance will be provided by the QSI Directorate / Risk Management Team / Regional Ambulance Clinical Training Team as appropriate to ensure that all Trust employees understand their responsibilities under this policy and are able to effectively fulfil their obligations to report adverse incidents (final arrangements pending at time of publication). HRPTS will be used to record staff training.

5.3 Exceptions

There are no exceptions to this policy and to the organisation's commitment to being open and learning from adverse incidents.

6.0 MONITORING

This policy will be reviewed on a regular basis by the Risk Management Team in the light of best practice, changing legislation or new/updated policy guidance.

7.0 EVIDENCE BASE / REFERENCES

Procedure For The Reporting and Management of Adverse Incidents
Risk Management Strategy
National Patient Safety Agency documents
Australian Open Disclosure Framework
Seven steps to patient safety: full reference guide – (NPSA July 2004)
Being open: communicating patient safety incidents with patients, their families and carers (NPSA, 2009)
'Being Open' Framework – (NPSA, November 2009)
Openness & Honesty when things go wrong: the professional duty of candour (NMC/GMC 2015)
https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/openness-and-honesty-professional-duty-of-candour.pdf
Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis Report) (Feb, 2013)
Right time, right Place (Donaldson Report) (2014)
Inquiry into Hyponatraemia-related Deaths (O'Hara) (2018)
Guidance on issuing an apology, NIPSO June 2016

https://nipso.org.uk/site/wp-content/uploads/2018/05/N14C-A4-NIPSO-Guidance-on-issuing-an-apology-June-2016-1.pdf

8.0 CONSULTATION PROCESS

This policy was developed by the Regional Adverse Incident Work Group chaired by the Assistant Director, Risk Management & Governance, South Eastern Health & Social Care Trust. Consultation was completed via email with relevant Assistant Directors and staff within all organisations included in the working group.

Trust consultation took place with Trade Unions, Senior Managers, Assistant Directors and Directors within the organisation. The final content of the document was agreed by the Safety, Quality, Experience and Performance Committee.

9.0 APPENDICES / ATTACHMENTS

Appendix 1: Seven steps to patient safety
Appendix 2a: Grade and definition of patient safety incident
Appendix 2b: Grades and consequent actions following Service User Safety Incidents
Appendix 3: Benefits for Service Users and Staff
Appendix 4: The 'Being Open' process
Appendix 5: Being open in particular circumstances
Appendix 6: NPSA 'Being Open' safety alert November 2009
Appendix 7: Guidance on issuing an apology – NI Ombudsman
Appendix 8: Inquiry reports relating to duty of candour

10.0 EQUALITY STATEMENT:

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment was carried out on the 8th November 2021. The outcome of the Equality Screening for this policy is:

Major impact ☐

Minor impact ☐

No impact. ☒

Katrina Keating **Date: 25th November 2021**

Lead Author

Dr Nigel Ruddell **Date: 25th November 2021**

Lead Director

APPENDIX 1 – NPSA SEVEN STEPS TO PATIENT SAFETY:

National Patient Safety Agency. *Seven steps to patient safety*. *The full reference guide*. 2004.

APPENDIX 2A – GRADE AND DEFINITIONS OF PATIENT SAFETY INCIDENT:

Definitions for grading of Service User Safety Incidents

Insignificant

Incident prevented / Near Miss
Any service user safety incident that had the potential to cause harm but was prevented and no harm was caused to service users receiving NHS-funded care. Incidents that did not lead to harm but could have, are referred to as near misses. *(Doing Less Harm. NHS. National Patient Safety Agency 2001).*

Incident not prevented
Any service user safety incident that occurred but insignificant harm was caused to service users receiving NHS-funded care.

Minor harm

Any service user safety incident that required:

- Minor injury or illness requiring first aid/intervention;
- Requiring increased service user monitoring;
- Increase in hospital stay by 1-3 days.

Moderate harm

Any service user safety incident that resulted in a moderate increase in treatment* and that caused significant but not permanent harm to one or more service users receiving NHS funded care.

**Moderate increase in treatment is defined as a return to surgery, an unplanned readmission, a prolonged episode of care, extra time in hospital or as an outservice user, cancelling of treatment, or transfer to another area such as intensive care as a result of the incident.*

Major harm

Any service user safety incident that appears to have resulted in permanent harm* to one or more service users receiving NHS-funded care.

**Permanent harm directly related to the incident and not related to the natural course of the service user's illness or underlying condition is defined as permanent lessening of bodily functions, sensory, motor, physiological or intellectual, including removal of the wrong limb or organ, or brain damage.*

Catastrophic

Any service user safety incident that directly resulted in the death* of one or more service users receiving NHS-funded care.

**The death must be related to the incident rather than to the natural course of the service user's illness or underlying condition.*

APPENDIX 2B – GRADES AND CONSEQUENT ACTIONS FOLLOWING SERVICE USER SAFETY INCIDENTS

	Insignificant	Minor		Moderate	Major	Catastrophic
Definition	Not requiring first aid or any intervention.	Requires extra observation or minor treatment.		Significant but not permanent harm – moderate increase in treatment.	Permanent harm arising directly from incident.	Resulted in the death.
Example		Intervention required. Requires first aid. Increased service user monitoring. Additional medication. Increased hospital stay (1-3 days). No return to surgery. No readmission.		Semi-permanent physical/ emotional injury/trauma/harm. Treatment given. Recovery expected within 1 year. Return to surgery. Unplanned readmission. Prolonged episode of care. Extra time in hospital (4-14 days) or as an outservice user. Cancellation of treatment. Transfer to another area e.g. ICU.	Permanent physical/ emotional injuries/trauma/ harm. Increased hospital stay >14 days.	The death must be related to the incident rather than to the natural course of the service user's illness or underlying condition.
Action	↓	↓		↓	↓	↓
	Apply the principles of 'Being Open'.			Apply the 'Being Open' process Stages I →VI.		
	Report the incident in line with the Procedure For The Reporting and Management of Adverse Incidents. Review the incident to determine its cause and take local action to prevent it happening again. The principles of the 'Being Open' policy apply but no documented actions are required.			A higher level of response is required in these circumstances. Report the incident in line with Procedure For The Reporting and Management of Adverse Incidents. The Area Manager or relevant Assistant Director and the Risk Management Team should be notified immediately and will be available to provide support and advice during the 'Being Open' process if required.		

APPENDIX 3 – BENEFITS FOR SERVICE USERS & STAFF:

Benefits for Service Users:

Being open when things go wrong has not always been part of Health and Social Care culture. However evidence shows that being open and honest is fully supported by service users and they are more likely to forgive and understand health and social care errors when they have been discussed fully in a timely and thoughtful manner. Research and the feedback from those involved in a serious service user safety incident indicate that the service users would like:

- To know when a safety incident affects them.
- An acknowledgement of the distress that the incident caused.
- A sincere and compassionate statement of regret for the distress being experienced.
- A factual explanation of what happened.
- A clear statement of what is going to happen from then onwards.
- A plan about what can be done to repair or redress the harm done.

Benefits for Staff:

Being open has several benefits for health and social care staff including:

- Satisfaction that communication with service users and/or their carers following a service user safety incident has been handled in the most appropriate way.
- Improving the understanding of incidents from the perspective of the service user and/or their carers.
- The knowledge that lessons learned from incidents will help prevent them happening again.
- Having a good professional reputation for handling a difficult situation well and earning respect among peers and colleagues.

APPENDIX 4 – 'BEING OPEN' PROCESS:

'Being Open' is a process rather than a one-off event and can be considered in 6 stages with documentation being a constant feature throughout the process.

Stage I	Stage II		Stage III	Stage IV	Stage V
Service user incident detection and recognition	Preliminary Team discussion Inform service user/carer	Plan further Being Open process	Initial Being Open meeting/contact	Follow-up meetings/ contacts	Being Open process completed
Service user safety incident recognised Prompt care and actions to prevent any further harm Incident reporting Identify staff and service user support & communication needs	Minor Initial assessment to determine level of response – grading Provide open honest factual information Offer initial verbal apology/expression of regret/sympathy Offer initial support Discuss further contacts	Moderate, Major, Catastrophic Establish the facts Decide the process Identify lead person & clarify if this is lead contact Agree with SU/Family who will meet with who when and where Identify support needed	Explain the process Offer apology/ regret/sympathy and support Provide factual details Explain learning process Invite questions/ comments/take notes Agree any further contact	Confirm meeting in writing and provide written apology Keep in touch as agreed at meeting Trust investigation process Feedback method agreed with SU/family	Feedback from the investigation process, learning and actions - to service users/ family and carers - to other Trust staff and partners Monitoring
No Being Open process required for near miss or no harm incidents	End of the Being Open process for low harm incidents		May be end of Being Open process or may agree further contact		End of Being Open process

Documentation

Keep written records of all *Being Open* contacts/discussions:

- **When** (date/time)
- **Who** was involved
- **What** information was given by who

Record incident review process & learning outcomes

Adapted From: National Patient Safety Agency. 'Being Open' Framework.

DETAILS OF KEY STAGES OF BEING OPEN PROCESS

STAGE I: INCIDENT DETECTION AND MANAGEMENT

The 'Being Open' process begins with the recognition that a service user has suffered moderate harm, major harm, or has died, as a result of a service user safety incident.

Detection of the incident

A service user safety incident may be identified by:

- A member of staff at the time of the incident.
- A member of staff retrospectively when an unexpected outcome is detected.
- A service user and/or their carers who expresses concern or dissatisfaction with the service user's health and social care either at the time of the incident or retrospectively.
- Incident detection systems such as incident reporting or medical records review.
- Other sources such as detection by other service users, visitors or non-clinical staff.

Priority

As soon as a service user safety incident is identified, the top priority is prompt and appropriate clinical care and prevention of further harm. Where additional treatment is required this should occur whenever reasonably practicable after a discussion with the service user and with appropriate consent. An incident report form should be completed which will trigger the Trust processes for reporting and then investigating and analysing incidents. If the incident is considered to meet Serious Adverse Incident criteria, the incident should also be escalated to the appropriate directorate senior manager and Risk Management Team to ensure timely appropriate management which may result in a serious adverse incident report to HSCB.

Service user safety incidents occurring elsewhere

A service user safety incident may have occurred outside the Trust. The individual who first identifies the possibility of an earlier service user safety incident should notify their line manager and the Risk Management Team. The same individual, or a colleague, should make contact with their equivalent at the organisation where the incident occurred and establish whether:

- The service user safety incident has already been recognized.
- The process of 'Being Open' has commenced.
- Incident investigation and analysis is underway.

The 'Being Open' process and the investigation and analysis of a service user safety incident should occur where the incident took place.

Criminal or intentional unsafe act – service user safety incidents are almost always unintentional. However, if at any stage following an incident it is determined that harm may have been the result of a criminal or intentional unsafe act, the Risk Management Team and the relevant Director should be notified immediately. The Incident Reporting Policy should be referred to.

STAGE II: INFORM SERVICE USER/CARER

Provide open honest factual information

Offer initial verbal apology / expression of regret / sympathy

An expression of genuine sympathy, regret and an apology for the harm that has occurred.

Appropriate language and terminology are used when speaking to service users, their families and carers.

Offer initial support

Staff should ensure the service user, their family and/or their carers:

- Are informed that an incident investigation is being carried out if appropriate.
- Show understanding of what happened is taken into consideration, as well as any questions they may have.
- Are provided with information on the complaints procedure if they wish to have it.

Consideration and formal noting of the service user's, their family's and carers' views and concerns, and demonstration that these are being heard and taken seriously.

Discuss further contacts

An offer of practical and emotional support for the service user, their family and carers. This may involve getting help from third parties such as charities and voluntary organisations, as well as offering more direct assistance. Information about the service user and the incident should not normally be disclosed to third parties without consent.

Discussions with service users and/or their carers are documented and that information is shared with them.

This is the end of the Being Open process for low harm incidents

STAGE III: PRELIMINARY TEAM DISCUSSION/ Plan further Being Open Process

The team, including the most senior health professional involved in the service user safety incident, and a line manager should meet as soon as possible after the event to:

- Establish the basic clinical and other facts.
- Assess the incident to determine the level of immediate response.
- Identify who will be responsible for discussion with the service user and/or their carers = 'Being Open' coordinator.
- Consider the appropriateness of engaging service user support at this early stage. This includes the use of a facilitator, a service user advocate or a health and social care professional that will be responsible for identifying the service user's needs and communicating them back to the health and social care team.
- Identify immediate support needs for the health and social care staff involved.
- Ensure there is a consistent approach by all team members around discussions with the service user and/or their carers.

Assessment to determine level of response

All incidents should be assessed initially by the health and social care team to determine the level of response required. The nature and subsequent grading of the incident will determine the level of response.

Incident	Level of Response
Insignificant harm (including prevented service user safety incident)	It is not a requirement of this policy to communicate prevented service user safety incidents and insignificant incidents to service users and/or carers.
Minor harm	Unless there are specific indications or the service user requests it, the communication, investigation and analysis, and the implementation of changes will occur at local service delivery level with the participation of those directly involved in the incident. Communication should take the form of an open discussion between the staff providing the service user's care and the service user and/or their carers. Reporting to the Risk Management Team will occur through standard incident reporting mechanisms and monthly data will provided to Directorate teams for analysis to detect high frequency events. Review will occur through aggregated trend data and local investigation. Where the trend data indicates a pattern of related events, further investigation and analysis may be needed. ↳Apply the principles of 'Being Open' – locally.
Moderate harm **Major harm** **Death**	A higher level of response is required in these circumstances. Report the incident in line with incident reporting procedures.

	Line management and the Risk Management Team should be notified immediately and will be available to provide support and advice during the 'Being Open' process if required. ↳Apply the 'Being Open' process – Stages I → VI.

Timing of discussion with service user and/or carers

Preliminary discussions with the service user and/or their carers should occur as soon as possible after recognition of the service user safety incident. Factors to consider when timing this and any future 'Being Open' discussions include:

- Clinical condition of the service user.
- Service user preference (i.e. meeting place and timing, who leads the discussion(s).
- Availability of key staff involved in the incident and in the 'being open' process.
- Availability of the service user's family and/or carers.
- Availability of support staff e.g. Interpreter, independent advocate.

The 'Being Open' coordinator role

It is essential to carefully consider the choice of the individual to communicate with service users and who informs the service user and/or their carers about a service user safety incident. Getting it right at the start of the process will reassure the service user and may lead to a favourable outcome. This should be the most senior person responsible for the service user's care and/or someone with experience and expertise in the type of incident that has occurred. They should:

- Have a good grasp of the facts relevant to the incident.
- Be senior enough or have sufficient experience and expertise in relation to the type of service user safety incident to be credible to service users, carers and colleagues.
- Have excellent interpersonal skills, including being able to communicate with service users and/or their carers in a way they can understand and avoiding excessive use of medical jargon.
- Be willing and able to offer an apology, reassurance and feedback to service users and/or their carers.
- Be able to maintain a medium to long term relationship with the service user and/or their carers, where possible, and to provide continued support and information.
- Be culturally aware and informed about the specific needs of the service user and/or their carers.

If for any reason it becomes clear during the initial discussion that the service user would prefer to speak to a different health and social care professional, the service user's wishes should be respected. A substitute with whom the service user is satisfied should be provided.

Use of a substitute health and social care professional for the 'Being Open' discussion

In exceptional circumstances, if the 'Being Open' coordinator, who usually leads the discussion, cannot attend, they may delegate to an appropriately trained substitute. The qualifications, training and scope of responsibility of this person should be clearly delineated.

Assistance with the initial 'Being Open' discussion

The health and social care professional communicating information about a service user safety incident should be able to nominate a colleague to assist them with the meeting. Ideally this should be someone with experience or training in communication and 'Being Open' Policy.

Responsibilities of trainee and social care professionals

Staff in training should not lead the 'Being Open' process except when all of the following criteria have been considered:

- The incident resulted in insignificant or minor harm;
- They have expressed a wish to be involved in the discussions;
- The senior health and social care professional responsible for the care is present for support;
- The service user and/or their carers agree to their involvement.

Where a trainee health and social care professional who has been involved in a service user safety incident asks to be involved in the 'Being Open' discussion, it is important they are accompanied and supported by a senior team member. It is unacceptable for a trainee to communicate service user safety information alone or to be delegated the responsibility to lead a 'Being Open' discussion unless they volunteer and their involvement takes place in appropriate circumstances (i.e. they have received appropriate training and mentorship for this role).

Service user safety incidents related to the environment of care

In such cases a senior manager of the relevant service will be responsible for communicating with the service user and/or their carers. A senior member of the multidisciplinary team should be present to assist at the initial 'Being Open' discussion. The health and social care professional responsible for treating the injury should also be present to assist in providing information on what will happen next and the likely effects of the injury.

Involvement of health and social care staff who made the mistake

Some service user safety incidents result from errors made by the health and social care staff caring for the service user. In these circumstances the member(s) of staff involved may or may not wish to participate in the 'Being Open' discussion with the service user and/or their carers. Every case where an error has occurred needs to be considered individually, balancing the needs of the service user and/or their carers with those of the health and social care professional concerned.

In cases where the health and social care professional that has made an error wishes to attend the discussion to apologise personally, they should feel supported by their colleagues throughout the meeting and should be made aware of staff representation organization support. In cases where the service user and/or their carers express a preference for the health and social care professional not to be present, it is advised that a personal written apology is handed to the service user and/or their carers during the first 'Being Open' discussion.

Stage IV: Initial 'Being open' discussion

Content of the initial 'Being Open' discussion

The service user and/or their carers should be advised of the identity and role of all people attending the 'Being Open' discussion before it takes place. This allows them the opportunity to state their own preferences about which health and social care staff should be present.

The content of the initial 'Being Open' discussion with the service user, their family and carers should cover the following:

- An expression of genuine sympathy, regret and an apology for the harm that has occurred.

- The facts that are known are agreed by the team. Where there is disagreement, communication about these events should be deferred until after the investigation has been completed.

- The service user, their family and/or their carers:

    - Should be informed that an incident investigation is being carried out.
    - Understanding of what happened is taken into consideration, as well as any questions they may have.
    - Provided with information on the complaints procedure if they wish to have it.

- Consideration and formal noting of the service user's, their family's and carers' views and concerns, and demonstration that these are being heard and taken seriously.

- Service user's account of the events leading up to the service user safety incident are fed into the incident investigation for example, through Root Cause Analysis (RCA) whenever applicable.

- Provide carers and those very close to the service user with access to information to assist in making decisions if the service user is unable to participate in decision-making or if the service user has died as a result of an incident. This should be done with due regard to confidentiality and in accordance with the service user's instructions.

- Ensure carers are provided with known information, care and support if a service user has died as a result of a service user safety incident. The carers should also be referred to the coroner for more detailed information.

- Discussions with service users and/or their carers are documented and that information is shared with them.

- Appropriate language and terminology are used when speaking to service users, their families and carers.

- Assurance that an ongoing care plan will be developed in consultation with the service user and will be followed through followed by an explanation about what will happen next in terms of the short through to long-term treatment plan and incident analysis findings.

- Assurance that the service user will continue to be treated according to their clinical needs and that the prospect of, or an actual dispute between, the service user and/or their carers and the health and social care team will not affect their access to treatment.

- Information on likely short and long-term effects of the incident (if known). The long-term effects may have to be presented at a subsequent meeting when more is known.

- An offer of practical and emotional support for the service user, their family and carers. This may involve getting help from third parties such as charities and voluntary organisations, as well as offering more direct assistance. Information about the service user and the incident should not normally be disclosed to third parties without consent.

STAGE V: FOLLOW UP DISCUSSIONS

Follow-up discussions with the service user, their family and carers are an important step in the 'Being Open' process – there may be more than one:

- The discussion(s) should occur at the earliest practical opportunity.
- Consideration should be given to the location and timing of meeting, based on both the service user's health and personal circumstances.
- Feedback should be given on progress to date and information provided on the investigation process.
- Repeated opportunities should be offered to the service user and/or their carers to obtain information about the service user safety incident.
- There should be no speculation or attribution of blame. Similarly, the member of staff communicating the incident must not criticise or comment on matters outside their own experience. Tell the service user and family what happened. Tell what happened now; leave details of how and why to later i.e. Stage V.
- The service user and/or their carers should be offered an opportunity to discuss the situation with another relevant professional where appropriate.
- A written record of the discussion should be kept and shared with the service user and/or their carers.
- All queries should be responded to appropriately.
- If completing the process at this point, the service user and/or their carers should be asked if they are satisfied with the investigation and a note of this made in the service user's records.
- The service user should be provided with contact details so that if further issues arise later there is a conduit back to the relevant health and social care professionals.

STAGE VI: PROCESS COMPLETION

Communication with the service user, their family and carers

After completion of the incident investigation, feedback should take the form most acceptable to the service user. Whatever method is used, the communication should include:

- The chronology of clinical and other relevant facts including an explanation of details of how and why.
- Details of the service user's, their family's and carers' concerns and complaints.
- A repeated apology for the harm suffered and any shortcomings in the delivery of care that led to the service user safety incident.
- A summary of the factors that contributed to the incident.
- Information on what has been and will be done to avoid recurrence of the incident and how these improvements will be monitored.
- An ongoing clinical management plan. This may be encompassed in discharge planning policies addressed to designated individuals e.g. Gp.
- Reassurance that they will continue to be treated according to their clinical needs, even in circumstances where there is a dispute between them and the health and social care team. They should also be informed that they have the right to continue their treatment elsewhere if they prefer.

It is expected that in most cases there will be a complete discussion of the findings of the investigation and analysis. In some cases information may be withheld or restricted, for example, where communicating information will adversely affect the health of the service user; where investigations are pending coronial processes; or where specific legal requirements preclude disclosure for specific purposes. In these cases the service user will be informed of the reasons for the restrictions.

Communication with the GP and other community care service providers

In certain circumstances, it may be prudent to communicate with the service user's GP, describing what happened providing summary details of:

- The nature of the service user safety incident and the continuing care and treatment.
- The current condition of the service user.
- Key investigations that have been carried out to establish the service user's clinical condition.
- Recent results.
- Prognosis.

Documentation

Throughout the Being Open process it is important to record discussions with the service user, their family and carers as well as the incident investigation.

Written records of the 'Being Open' discussions should consist of:

- The time, place and date, as well as the name and relationships of all attendees.
- The plan for providing further information to the service user, their family and carers.
- Offers of assistance and the service user's, their family's and carers' response.
- Questions raised by the service user, their family and carers, and the answers given.
- Plans for follow-up meetings.
- Progress notes relating to the clinical situation and an accurate summary of all the points explained to the service user, their family and carers.
- Copies of letters sent to the service user, their family and carers, and the GP.
- Copies of any statements taken in relation to the service user safety incident.
- A copy of the incident report.

APPENDIX 5 – BEING OPEN IN PARTICULAR CIRCUMSTANCES:

The approach to being open may need to be modified according to the service user's personal circumstances. The following gives guidance on how to manage different categories of service user circumstance.

When a service user dies

When a service user safety incident has resulted in a service user's death it is crucial that communication is sensitive, empathic and open. It is important to consider the emotional state of bereaved relatives or carers and to involve them in deciding when it is appropriate to discuss what has happened. The service user's family and/or carers will probably need information on the processes that will be followed to identify the cause(s) of death. They will also need emotional support. Establishing open channels of communication may also allow the family and/or carers to indicate if they need bereavement counselling or assistance at any stage.

> "it may be appropriate to wait for the coroner's inquest before holding the '*Being Open'* discussion"

Usually, the 'Being Open' discussion and any investigation occur before the Coroner's inquest. In certain circumstances the Trust may consider it appropriate to wait for the coroner's inquest before holding the 'Being Open' discussion with the service user's family and/or carers. The coroner's report on post-mortem findings is a key source of information that will help to complete the picture of events leading up to the service user's death. In any event, an apology should be issued as soon as possible after the service user's death, together with an explanation that the coroner's process has been initiated and a realistic timeframe of when the family and/or carers will be provided with more information.

Children

When a child reaches 16 years they acquire the full rights to make decisions about their own treatment and their right to confidentiality becomes vested in them rather than their parents or guardians. However, it is still considered good practice to encourage competent children to involve their families in decision-making.

Children younger than 16 years who understand fully what is involved in the proposed procedure can also give consent (Frazer competent). Where a child is judged to have the cognitive ability and the emotional maturity to understand the information provided, he/she should be involved directly in the 'Being Open' process after a service user safety incident. The opportunity for parents to be involved should still be provided unless the child expresses a wish for them not to be present.

Where children are deemed not to have sufficient maturity or ability to understand, consideration needs to be given to whether information is provided to the parents alone or in the presence of the child. In these instances the parents' views on the issue should be sought.

Service users with mental health issues

'Being Open' for service users with mental health issues should follow standard procedures, unless the service user also has cognitive impairment (see below). The only circumstances in which it is appropriate to withhold service user safety incident information from a mentally ill service user is when advised to do so by a consultant psychiatrist who feels it would cause adverse psychological harm to the service user. However, such circumstances are rare and a second opinion (by another consultant psychiatrist) would be needed to justify withholding information from the service user. Except where exceptional circumstances prevail, it is inappropriate to discuss service user safety incident information with a carer or relative without the express permission of the service user; to do so may constitute an infringement of the service user's Human Rights and/or a breach of Data Protection legislative provisions.

Service users with cognitive impairment

Some individuals have conditions that limit their ability to understand what is happening to them. They may have authorized a person to act on their behalf by an enduring power of attorney. In these cases, steps must be taken to ensure this extends to decision-making and to the medical care and treatment of the service user. The 'Being Open' discussion would be held with the holder of the power of attorney.

Where there is no such person the clinicians may act in the service user's best interests in deciding who the appropriate person is to discuss incident information with, regarding the welfare of the service user as a whole and not simply their medical interests. However, the service user with a cognitive impairment should, where possible, be involved directly in communications about what has happened. An advocate with appropriate skills should be available to the service user to assist in the communication process.

Service users with learning disabilities

Where a service user has difficulties in expressing their opinion verbally, an assessment should be made about whether they are also cognitively impaired (see above). If the service user is not cognitively impaired they should be supported in the 'Being Open' process by alternative communication methods (e.g. given the opportunity to write questions down). An advocate, agreed on in consultation with the service user, should be appointed. Appropriate advocates may include carers, family or friends of the service user. The advocate should assist the service user during the 'Being Open' process, focusing on ensuring that the service user's views are considered and discussed.

Service users with different language or cultural considerations

Contact must be made with the Equality Team when booking interpreters.

Service users with different communication needs

A number of service users will have particular communication difficulties, such as a hearing impairment. Plans for the meeting should fully consider these needs.

Service users who do not agree with the information provided

Sometimes, despite the best efforts of health and social care staff or others, the relationship between the service user and/or their carers and the health and social care professional breaks down. They may not accept the information provided or may not wish to participate in the 'Being Open' process. In this case the following strategies may assist to deal with the issue as soon as it emerges:

- Where the service user agrees, ensure their carers are involved in discussions from the beginning.
- Ensure the service user has access to support services.
- Where the senior health professional is aware of the relationship difficulties, provide mechanisms for communicating information, such as the service user expressing their concerns to other members of the clinical team.
- Offer the service user and/or their carers another contact person with whom they may feel more comfortable. This could be another member of the team or the individual with overall responsibility for clinical risk management.
- Use a mutually acceptable mediator to help identify the issues between the health and social care organisation and the service user, and to look for a mutually agreeable solution.
- Ensure the service user and/or their carers are fully aware of the formal complaints procedures.
- Write a comprehensive list of the points that the service user and/or their carer disagree with and reassure them you will follow up these issues.

APPENDIX 6 – NPSA 'BEING OPEN' SAFETY ALERT NOVEMBER 2009:

Alert

Patient Safety Alert

NPSA/2009/PSA003
19 November 2009

NHS
National Patient Safety Agency

National Reporting and Learning Service

Being Open

Communicating with patients, their families and carers following a patient safety incident

Being open is a set of principles that healthcare staff should use when communicating with patients, their families and carers following a patient safety incident in which the patient was harmed.

Being open supports a culture of openness, honesty and transparency, and includes apologising and explaining what happened.

In 2005, the National Patient Safety Agency (NPSA) issued a Safer Practice Notice advising the NHS to develop a local *Being open* policy and to raise awareness of this policy with all healthcare staff.

The guidance has now been revised in response to changes in the healthcare environment and in order to strengthen *Being open* throughout the NHS.

The revised *Being open* framework (available at **www.nrls.npsa.nhs.uk/beingopen**) should be used in conjunction with this Alert to help develop and embed *Being open* in each NHS organisation.

The *Being open* principles are fully supported by a wide range of royal colleges and professional organisations, including the Medical Defence Union, Medical Protection Society, NHS Litigation Authority and Welsh Risk Pool.

Tools to support organisations in the implementation of this Alert are available at: **www.nrls.npsa.nhs.uk/beingopen**

Endorsed by:

Action Against Medical Accidents
Department of Health
Healthcare Inspectorate Wales
NHS Confederation (England)
NHS Confederation (Wales)
NHS Litigation Authority
Medical Defence Union
Medical Protection Society
Royal College of General Practitioners
Royal College of Nursing
Royal College of Obstetricians and Gynaecologists
Royal College of Physicians
Royal College of Psychiatrists
Welsh Assembly Government
Welsh Risk Pool

Action for the NHS

For action by Chief Executives of organisations commissioning and providing healthcare.

Deadlines:

- Actions underway: **22 February 2010**
- Actions completed: **23 November 2010**

Actions:

1) **Local policy:** Review and strengthen local policies to ensure they are aligned with the *Being open* framework and embedded with your risk management and clinical governance processes.
2) **Leadership:** Make a board-level public commitment to implementing the principles of *Being open*.
3) **Responsibilities:** Nominate executive and non-executive leads responsible for leading your local policy. These can be leads with existing responsibilities for clinical governance.
4) **Training and support:** Identify senior clinical counsellors who will mentor and support fellow clinicians. Develop and implement a strategy for training these staff and provide ongoing support.
5) **Visibility:** Raise awareness and understanding of the *Being open* principles and your local policy among staff, patients and the public, making information visible to all.
6) **Supporting patients:** Ensure Patient Advice and Liaison Services (PALS), and other staff have the information, skills and processes in place to support patients through the *Being open* process.

worth repeating...

This Alert replaces the *Being Open Safer Practice Notice* (2005)

NPSA Reference Number: NPSA/2009/PSA003
Gateway Reference: 13015
1097 November 2009

National Reporting and Learning Service
National Patient Safety Agency
4-8 Maple Street, London, W1T 5HD
T: 020 7927 9500 F: 020 7927 9501
www.nrls.npsa.nhs.uk

APPENDIX 7 – GUIDANCE ON ISSUING AN APOLOGY – NI OMBUDSMAN:

When the Ombudsman investigates a complaint and finds maladministration, he/she may recommend that the public service provider offers an apology. In these circumstances the complainant may have been waiting a considerable period of time for the organisation to provide a full explanation as to what went wrong and to acknowledge any failings.

What is an apology?

An apology can be defined as a 'regretful acknowledgement of an offence or failure'. Mistakes can be made by one member of staff, a whole team or there may be systemic failures within an organisation. When things do go wrong, most people who have had a bad experience may simply seek an acknowledgement and, if appropriate, to be given an explanation and an apology.

Why apologise?

In many cases an apology and explanation may be a sufficient and appropriate response to a complaint. The value of this approach should not be underestimated. A prompt acknowledgement and apology, where appropriate, can often prevent the complaint escalating. It can help restore dignity and trust in the public service provider and can be the first step in putting things right.

What are the implications of an apology?

Although there is no legislation in this area of law which applies specifically to Northern Ireland, the Compensation Act 2006 governing England and Wales states that 'an apology, an offer of treatment or other redress, shall not of itself amount to an admission of negligence or statutory duty.' The timely provision of a full apology may in fact reduce the chances of litigation.

What is a meaningful apology?

Each complaint is unique so your apology will need to be based on the individual circumstances. It is important when you are making an apology, you understand how and why the person making the complaint believes they were failed and what they want in order to put things right. Failing to acknowledge the complainant's whole experience is only a partial apology and therefore less effective.

To make an apology meaningful you should:

- Accept you have done wrong. You should include identifying the failure along with a description of the relevant action or omission to which the apology applies. This

should include any failings that the Ombudsman identified in her investigation that warrant an apology. Your description must be specific to show that you understand the effect your act or omission has had on the complainant. It must also acknowledge if appropriate, that the affected person has suffered disappointment, hurt, anxiety, upset or loss;

- Clearly explain why the failure happened and include that the failure was not intentional or personal. If there is no explanation, however, one should not be offered. Care should be taken to provide full explanations rather than excuses;
- Demonstrate that you are sincerely sorry. An apology should be an expression of sorrow or at the very least an expression of regret. The nature of the harm done will determine whether the expression of regret should be made in person as well as being reinforced in writing; or simply in writing;
- Reassure the complainant that you will not repeat the failure. This may include a statement of the steps that have been taken, or will be taken, to address the failure, and, if possible, to prevent a reoccurrence;
- Provide the complainant with a statement of specific steps proposed to address the grievance or problem, by mitigating the harm or offering a remedy.

How should I make an apology?

There is no 'one size fits all' apology but the following points reflect some general good practice:

1. The timing of an apology is very important. Once you establish that you have done wrong, apologise. If you delay, you may lose your opportunity to apologise.

2. The language you use should be clear, plain and direct.

3. Your apology should not be conditional by qualifying the apology by saying for example: 'I apologise if you feel that the service provided to you was not acceptable' or 'if mistakes have been made, I apologise'.

4. To make an apology meaningful, do not distance yourself from the apology.

    a. Generalised apologies such as 'I am sorry for what occurred' or 'mistakes were made' do not sound natural or sincere. It is much better to accept responsibility by stating 'It was my fault'.

5. Avoid enforced apologies such as 'I have received the Investigation report from the Ombudsman and am therefore carrying out her recommendations by apologising to you for the shortcomings identified in her report.'

6. It is also very important to apologise to the right person or the right people.

Who should apologise?

If, in his / her investigation report, the Ombudsman has made a recommendation that an apology should be provided to the complainant, then we would expect to see the Chief Executive, Director or Head of Department of the public service provider involved making the apology.

Who should receive the apology?

The apology should be sent directly to the complainant who is named in the Ombudsman's Investigation report. We will not, as a matter of course, review apologies prior to them being issued. However, in order to monitor compliance with the Ombudsman's recommendations, we would expect to receive a copy of the apology letter within the time required by the Ombudsman.

The benefits to organisations of apologising

It is important to remember that an apology is not a sign of weakness or an encouragement to take legal action. An apology can be a sign of confidence and competence and demonstrates a willingness to learn from mistakes and a commitment to put things right. To apologise in a fulsome and timely manner is good administrative practice and is an important part of effectively managing complaints.

Contact Details

Freepost:	Freepost NIPSO
or	The Northern Ireland Public Services Ombudsman Progressive House 33 Wellington Place BELFAST BT1 6HN
Telephone:	028 9023 3821 or Freephone: 0800 34 34 24
Text Phone:	028 9089 7789
Email:	nipso@nipso.org.uk
or	By calling, 9.00am & 5.00pm, Monday to Friday, at the above address.

APPENDIX 8 – INQUIRY REPORTS RELATING TO DUTY OF CANDOUR:

Miscellaneous Inquiry Recommendations Relating to Being Open and a Duty of Candour

The Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis Report) (Feb, 2013)

In 2013, Robert Francis QC published the final report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. Of the 290 recommendations detailed in the report, 12 were related to a requirement for 'openness, transparency and candour'.

These were defined as:

- Openness: enabling concerns to be raised and disclosed freely without fear, and for questions to be answered.
- Transparency: allowing true information about performance and outcomes to be shared with staff, service users and the public.
- Candour: ensuring that service users harmed by a health and social care service are informed of the fact and that an appropriate remedy is offered, whether or not a complaint has been made or a question asked about it.

Recommendation 180 of the report reads 'Guidance and policies should be reviewed to ensure that they will lead to compliance with Being Open, the guidance published by the National Patient Safety Agency'.

Right time, right Place (Donaldson Report) (2014)

On 8 April 2014 former Health Minister Edwin Poots announced his intention to commission former Chief Medical Officer of England, Professor Sir Liam Donaldson, to advise on the improvement of governance arrangements across the HSC. This was subsequently published in January 2015 by his successor, Jim Wells.

Amongst the recommendation within this was that there should be the introduction of a Duty of Candour, in Northern Ireland in line with the Making Amends that examined the handling of complaints, incidents and medical negligence claims in a whole systems manner for England.

The Review Team considered that priority in Northern Ireland should be given to the areas covered by its recommendations and this included:

"a duty of candour should be introduced in Northern Ireland consistent with similar action in other parts of the United Kingdom"

Furthermore he suggested that:

".In Northern Ireland, it is already a requirement to disclose to service users if their care has been the subject of a Serious Adverse Incident report. There is no similar requirement for adverse incidents that do not cause the more severe degrees of harm. In promoting a culture of openness, there would be considerable advantages in Northern Ireland taking a lead and introducing an organisational duty of candour to match the duty that doctors and nurses are likely to come under from their professional regulators." **p36, § 4.5.3 Duty of candour**

Inquiry into Hyponatraemia-related Deaths (O'Hara) (2018)

The Inquiry into Hyponatraemia-related deaths in Northern Ireland was established in 2004 and chaired by Lord Justice O'Hara. His report, published in 2018, found that there had been

significant failings both in the care of five children in Northern Ireland's hospitals, leading to their deaths, and in the subsequent dealings with their families.

Amongst the many recommendations in the report were those relating to the issue of candour and openness.

Candour

1. A statutory duty of candour should now be enacted in Northern Ireland so that:

   i. Every health and social care organisation and everyone working for them must be open and honest in all their dealings with service users and the public;
   ii. Where death or serious harm has been or may have been caused to a service user by an act or omission of the organisation or its staff, the service user (or duly authorised representative) should be informed of the incident and given a full and honest explanation of the circumstances;
   iii. Full and honest answers must be given to any question reasonably asked about treatment by a service user (or duly authorised representative);
   iv. Any statement made to a regulator or other individual acting pursuant to statutory duty must be truthful and not misleading by omission;
   v. Any public statement made by a health and social care organisation about its performance must be truthful and not misleading by omission;
   vi. Health and social care organisations who believe or suspect that treatment or care provided by it, has caused death or serious injury to a service user, must inform that service user (or duly authorised representative) as soon as is practicable and provide a full and honest explanation of the circumstances;
   vii. Registered clinicians and other registered health and social care professionals, who believe or suspect that treatment or care provided to a service user by or on behalf of any health and social care organisation by which they are employed has caused death or serious injury to the service user, must report their belief or suspicion to their employer as soon as is reasonably practicable.

2. Criminal liability should attach to breach of this duty and criminal liability should attach to obstruction of another in the performance of this duty.

3. Unequivocal guidance should be issued by the Department to all Trusts and their legal advisors detailing what is expected of Trusts in order to meet the statutory duty.

4. Trusts should ensure that all health and social care professionals are made fully aware of the importance, meaning and implications of the duty of candour and its critical role in the provision of health and social care.

5. Trusts should review their contracts of employment, policies and guidance to ensure that, where relevant, they include and are consistent with the duty of candour.

6. Support and protection should be given to those who properly fulfil their duty of candour.

7. Trusts should monitor compliance and take disciplinary action against breach.

8. Regulation and Quality Improvement Authority (‘RQIA’) should review overall compliance and consideration should be given to granting it the power to prosecute in cases of serial non-compliance or serious and wilful deception.

TB/16/12/2021/10

Northern Ireland Ambulance Service
Health and Social Care Trust

MINUTES OF THE AUDIT COMMITTEE HELD ON THURSDAY 7 OCTOBER 2021 AT 10AM BY ZOOM (DUE TO COVID-19)

PRESENT:	Mr W Abraham	Non-Executive Director (Chair)
	Mr D Ashford	Non-Executive Director
IN ATTENDANCE:	Mr M Bloomfield	Chief Executive (joined the meeting at 10.40am)
	Mr N Gray	Northern Ireland Audit Office
	Ms C Hagan	ASM (External Auditors)
	Ms N Lappin	Trust Chair
	Ms C McKeown	Head of Internal Audit, BSO Internal Audit
	Mrs L Mitchell	Independent Adviser to Committee
	Mr P Nicholson	Interim Director of Finance
	Ms M Paterson	Director of Planning, Performance & Corporate Services
	Mr A Phillips	Assistant Director of Finance
	Mrs C Mooney	NIAS Board Secretary
	Mr I McCutcheon	Financial Accounting Manager, NIAS
APOLOGIES:	Ms R Byrne	Director of Operations
	Ms L Charlton	Director of Quality, Safety & Improvement
	Mr S Knox	Northern Ireland Audit Office
	Ms M Lemon	Interim Director of Human Resources
	Dr N Ruddell	Medical Director
	Mr C Carlin	Boardroom Apprentice

Welcome, introduction and format of meeting

The Chair welcomed everyone to the meeting and explained that he had extended an invitation to the Trust Chair to attend in observer capacity.

1 **Apologies**

Apologies were noted from Ms Charlton, Ms Byrne, Ms Lemon, Mr Knox, Dr Ruddell and Mr Carlin.

2 **Declaration of Potential Conflict of Interest & Confirmation of Quorum**

The Chair confirmed that the meeting was quorate and asked those present to declare any conflicts of interest now or as the meeting progressed.

The Chair noted fact that, in accordance with the Trust Standing Orders, the Non-Executive Director (NED) membership of the Audit Committee 'shall consist of not less than three members'. He drew this requirement to the Trust Chair's attention in the context of appointing additional NEDs when this was possible.

The Chair also stressed the confidentiality of information presented.

3 **Previous Minutes (AC07/10/21/01)**

It was noted that the minutes of the previous meeting held on Thursday 24 June 2021 had been **APPROVED** by e-mail and had been presented to the Trust Board on 19 August 2021.

4 **Matters Arising (AC07/10/21/02)**

The Chair noted that the actions arising from the meeting on 24 June had been progressed.

5 **Committee Chair's Business**

5.1 **Update on outstanding IA recommendations**

The Chair drew the Committee's attention to his update on outstanding IA recommendations that had been circulated to attendees earlier and highlighted the salient points. He reminded the meeting that he had met separately with the Head of Internal Audit and the Trust Chief Executive and Director of Finance and acknowledged that the meetings had been held during a difficult time for the Trust in terms of the ongoing

REAP Level 4. However he said that he had found these meetings to be productive and useful.

The Chair said that he had been encouraged by the progress which had been made and added that, rather than merely revise timescales, management had carefully considered each recommendation.

The Chair indicated that he intended to continue the process of these additional meetings for the foreseeable future. He said that, after speaking with the Trust Chair, he was scheduling an additional meeting of the Audit Committee at the beginning of December with a single focus on examining in more detail the outstanding recommendations. The Chair said that he would request the relevant Directors to attend the meeting to provide an update on progress and added that, given the focus of the meeting, he had also extended an invitation to the Trust Chair to attend.

Mr Ashford welcomed the progress which had been made and acknowledged that the recommendations which remained outstanding were likely the more difficult to implement. He said that he agreed with the approach being proposed by the Chair and welcomed in particular the support of the Transformation Team in progressing the PCS recommendations.

Mr Nicholson said he very much appreciated the Committee's ongoing support in this work.

6 **Standing Item**

6.1 **Direct Award Contract (DACs) (AC07/10/21/04)**

Mr Nicholson reminded the meeting that the volume of DACs and magnitude of the expenditure had resulted in 'Direct Award Contracts' being presented to the Committee as a standing item and advised that the presentation of the information would continue to evolve.

At Mr Nicholson's request, Mr Phillips highlighted the salient points of the report, advising that, due to the volume of DACs, a separate list would be kept of closed DACs. He explained that the Trust had put in place arrangements to provide food to

frontline staff at station or ED. Mr Phillips explained that the Trust had a regional supplier who had been unable to support NIAS across its geography.

At the Chair's request, Mr Phillips provided further clarification around the categories used. The Chair suggested that it would be helpful to include a further column to provide a brief descriptor of its purpose and referred in particular to a DAC which had been used to provide transport but the company's name may have been misleading as to the services it offered.

Mr Phillips advised that a DAC was intended for a certain period of time and value and that, once the period of time had expired, it would become necessary to put a further DAC in place.

Mr Phillips advised that he had become aware of a number of providers being used for Occupational Health Services (OHS) advice and said that it was likely that DACs would be required for these.

Mr Ashford welcomed the information and suggested that it would be helpful to clarify those DACs which had been categorised as completed and live. He also queried the appropriateness of work being included as a DAC and referred specifically to 'Collision and Bodywork Repair'.

Responding, Mr Phillips explained that it was his understanding that there had been a delay in awarding the substantive contract and it had been necessary to have a DAC to cover an extension of the existing contract.

Responding to a further query from Mr Ashford, Mr Nicholson clarified that the company in question had been used to provide protective screens between desks. He said that this work had been carried out as part of the immediate and urgent response to Covid-19 to protect staff.

Mr Ashford said it would be important to ensure that DACs were in keeping with their original aim.

The Committee **NOTED** the DAC update.

6.2 **Fraud Update – verbal update**

Mr Phillips reported that, while there were no new fraud cases, work had continued to close off a number of existing cases and no fraud had been proven. He advised that, in relation to the National Fraud Initiative, only two cases from a total of 548 remained to be closed with no issues identified other than a case relating to a fraud allegation. Mr Phillip welcomed the assistance given by BSO in closing off cases.

Mr Phillips advised that he would be attending a regional fraud meeting in the coming weeks and indicated that International Fraud Awareness Week would take place between 15-19 November. He advised of Counter Fraud's plans to launch new e-learning and said he hoped to have this included in the mandatory training for the year. He commented that discussions were also ongoing in relation to completing fraud risk assessments and arranging Fraud Liaison Officer training.

Mr Nicholson referred to important work being undertaken by BSO Counter Fraud funded by the DoH and said that this would provide an additional layer of support and assurance around preliminary investigations for fraud.

The Committee **NOTED** the verbal Fraud Update.

7 Internal Audit

7.1 **Progress Report (AC07/10/21/05)**

At the Chair's request, Ms McKeown took members through the key points of the report. She explained that it included a summary of the progress made against the 2021-22 Internal Audit Plan on page 4 as well as providing a summary of the audit reports finalised since the last Committee meeting.

Ms McKeown drew the Committee's attention to page 5 of the report which set out the findings in relation to the Fire Safety audit carried out in April/May 2021 and which had received a satisfactory level of assurance. She said that five key findings had been identified from the audit and she outlined these to the Committee. Ms McKeown indicated that management had accepted the audit findings.

Ms McKeown drew the Committee's attention to one finding in particular which related to the need to rate/prioritise the severity/importance of any actions recommended by the Fire Risk Assessor.

The Chair commented that the Trust Board had focused on fire safety in earlier Trust Board meetings and welcomed the audit findings, saying it reflected the significant work which had been taken forward in the interim.

Agreeing with the comments made by the Chair, Mr Ashford said that the discussion at Trust's Assurance Committee had clearly reflected the amount of work required to ensure fire safety was improved to an acceptable level. He welcomed the progress made and said that it was one of the best fire safety audits he had had sight of. Mr Ashford referred to the point made by Ms McKeown in relation to the prioritisation of actions and stressed the importance of this.

The Committee **NOTED** the IA Progress Report.

7.2 **Mid-Year Follow-up Review of Outstanding Internal Audit Recommendations 2021-22 (AC07/10/21/06)**

Ms McKeown acknowledged the positive engagement with the Trust during what had been a very challenging period and referred to the progress which had been made in addressing the outstanding recommendations. She reported that 135 (68%) of the outstanding 198 had now been fully implemented, and 63 (32%) remained as partially implemented.

Ms McKeown advised that Internal Audit had reviewed 93 recommendations with 50 of the 93 being categorised as significant in that they specifically related to findings as a result of limited or unacceptable assurance. She added that 21 (42%) of these 50 recommendations had been confirmed as implemented during the review with the remaining 29 (58%) partially implemented. Ms McKeown also noted that management had set a number of implementation dates between now and December, indicating a thoughtful approach to these recommendations.

Mr Ashford welcomed the progress which had been made despite the pressures facing the Trust. He acknowledged that the 63 recommendations which had been categorised as partially implemented would be the most difficult ones to address. He agreed with the approach adopted by the Chair in terms of having an additional meeting in December to focus specifically on those outstanding recommendations.

Referring to the recommendations around the PCS review, Mr Bloomfield acknowledged that this had stalled during the pandemic. He advised that arrangements had recently been made for the review to be taken forward by the Transformation Team. He advised that other Trusts had engaged with private ambulance providers to provide transport because NIAS had been unable to do so and further acknowledged that now would not be an opportune time to engage with Trusts in relation to providing transport in a more joined up way.

Mr Bloomfield acknowledged that the recommendations around culture would take time to implement and said that he had discussed this with Ms McKeown. He welcomed Mr Ashford's comments in relation to the progress which had been made despite the recent challenges and cautioned that these challenges would continue over the winter months. Mr Bloomfield said that he found the Chair's approach helpful.

The Chair said he hoped the additional scrutiny placed on this issue by the Committee would indeed be helpful and was of the view that the critical period to deal with recommendations would be between now and the December meeting.

Ms McKeown said she accepted the long-term actions associated with the recommendations around PCS and culture and clarified that, while Internal Audit did not expect to see the total transformation of these areas, it did expect to see evidence that progress was being made.

She said that Internal Audit would be happy to engage with management in discussing the evidence required to close off recommendations.

Mr Ashford said that he looked forward to the outworkings of the PCS review. He acknowledged the need for the review and

stressed the importance of the Trust being ready to make whatever decisions were required. He noted the culture changes within the organisation which were intangible but yet very important.

The Trust Chair welcomed the progress being made. She commented that, while the management comment for a number of recommendations had indicated that progress was being made, Mr Bloomfield's explanation had indicated that, at a different level, it had not been possible to make progress at this particular time. She suggested that, as Non-Executive Directors, it would be helpful to know when progress had not been possible.

Ms McKeown suggested that, in such circumstances, it may be necessary to revise implementation dates and provide the rationale for doing so to the Committee. However she said that Internal Audit colleagues would work through this process with Trust colleagues.

The Chair thanked Ms McKeown for presenting her report which was **NOTED** by the Committee and stressed the need to continue to adopt a focused approach.

7.3 **BSO Shared Service Update (AC07/10/21/07)**

Ms McKeown reminded the meeting that Internal Audit carried out a programme of Shared Service audit assignments as part of the BSO Internal Audit Plan. She indicated that the recommendations within these reports were the responsibility of the BSO Management to progress and added that the reports would be presented to the BSO Governance & Audit Committee.

Ms McKeown reported that, since the last Audit Committee, an Accounts Payable Shared Service audit had been undertaken and had been given a satisfactory level of assurance. She pointed out that there were no significant findings which would impact on the assurance provided.

The Committee **NOTED** the BSO Shared Service Update.

7.4 **Head of Internal Audit Mid-Year Assurance Statement (AC07/10/21/08)**

Ms McKeown drew the Committee's attention to this paper which, she explained, summarised the previous two papers.

The Chair and Mr Ashford confirmed they had no queries.

The Committee **NOTED** the HIA Mid-Year Assurance Statement.

7.5 **Internal Audit Annual General report 2020-21 (AC07/10/21/09)**

Ms McKeown explained that, in order to assist in sharing learning across the HSC, BSO Internal Audit compiled a General Annual Report across the HSC each year. She advised that the report summarised the performance and outcome of Internal Audit activity in the HSC during 2020-21.

Ms McKeown reported that Internal Audit had achieved 81% against a target of 85% in terms of issuing a draft report within four weeks of fieldwork completion and said she was comfortable with this, given the context of Covid-19.

Referring to page 2 of the report, Ms McKeown cautioned against a comparison of assurances in the last two years across HSC reports in terms of Internal Audit's limited ability to visit patient-facing clinical areas.

Ms McKeown explained that the remainder of the report focussed on follow-up actions and she reported that, by the year end, 71% of outstanding recommendations across HSC had been implemented; 28% had been partially implemented and 1% not implemented. She acknowledged that, over the last three years, the percentage of implemented recommendations had reduced from 77% to 71% but believed this was a positive outturn given the context of Covid-19.

Ms McKeown indicated that there were no Priority 1 recommendations which were 'not implemented' and advised progress had also been made across the HSC to close down some of the older recommendations.

Mr Ashford welcomed the report and referred to the fact that no new Priority 1 findings had been identified for the Trust.

Mr Nicholson thanked Ms McKeown and the Internal Audit team for their assistance to date. He welcomed the satisfactory level of assurance in respect of Fire Safety and conveyed his thanks to Ms Katrina Keating for her work in this area.

The IA Annual General Report 2020-21 was **NOTED** by the Committee.

8 External Audit

8.1 External Audit Draft Report To Those Charged With Governance 2020-21 (AC07/10/21/10)

At the Chair's request, Mr Gray explained that the report before the Committee effectively concluded the 2020-21 audit and advised that this represented the final version of the report which had been discussed in detail at the June meeting. He said that he would be happy to respond to any further queries members may have.

The Chair agreed that the report had been discussed in considerable detail at the last meeting. He thanked Mr Gray for the wording within the report which had been helpful, particularly the reference to the integrity of the financial management within the Trust.

Ms Hagan pointed out that, since the draft report, the Trust Charitable Trust Fund accounts had been signed and certified.

The Chair suggested that it would be important to have early discussion in relation to those issues which had resulted in the qualification of the Trust accounts and said he would welcome an update at the January meeting.

Mr Nicholson said that he would be happy to provide an update to the Committee and assured members that regional discussions were ongoing.

The Committee **NOTED** the External Audit Final Report To Those Charged With Governance 2020-21.

9 **Review of Standing Orders**

At the Chair's invitation, Mrs Mooney highlighted the revisions which had been made to the Standing Orders, in particular the proposal for policies to be approved at Committee level and procedures to have been previously considered by the Trust's Senior Management Team. She pointed out that the Standing Orders remained a live document and, while it was good practice to review these on an annual basis, it may be that further changes would be necessary in the interim as the new Committee structure continued to embed.

Mrs Mooney advised that she had received some minor comments from Directors but nothing which would result in material changes to the document before the Committee.

Mr Ashford asked that, as well as the Trust's Senior Management Team, Committee Chairs should also be able to determine which policies being considered at Committee level were of such a significance and impact on the organisation that they should be brought to the attention of the Trust Board. Mrs Mooney agreed to amend the Standing Orders accordingly.

On a proposal from Mr Ashford which was seconded by the Chair, the Committee **APPROVED** the Standing Orders for submission to the October Trust Board for consideration and with a recommendation for their approval.

10 **DoH correspondence re: Pause in Sponsorship Activities (AC07/10/21/ (AC24/06/21/11)**

The Committee **NOTED** the most recent DoH correspondence advising of a pause in sponsorship activities.

Mr Nicholson acknowledged that, while many activities had indeed been paused, the Trust would still be required to follow-up on business cases, for example, and provide evidence to the DoH Sponsorship Department.

Mr Bloomfield said that he had been involved in initial discussions with DoH colleagues who had hoped that the decision to pause sponsorship activities would assist in some way in responding to the pressures across the HSC system. However he said that the Chair and he would miss the opportunity to meet with the Permanent Secretary in settings such as the Accountability Review meetings to review Trust business.

Continuing, Mr Bloomfield advised that the Trust still intended to produce a Corporate Plan for 2022-23 as it had in previous years.

The Chair said that he looked forward to seeing the Corporate Plan and welcomed the pause in sponsorship activities as a means of alleviating pressure.

11 Closed Meeting

At this point in the meeting, NIAS officers withdrew from the meeting to allow Audit Committee members to meet independently with the Internal and External Auditors in a closed session.

On return to the meeting, the Chair indicated the importance of the January meeting receiving an update on the accrual issue.

Ms Hagan commented that the External Audit Strategy would be considered at the January meeting and it was likely that the accrual issue would be highlighted within the Strategy as a risk.

12 Any Other Business

There were no items of Any Other Business.

13 Date, time and venue of next meeting

The next meeting of the Audit Committee will take place on Thursday 2 December 2021 at 10am (venue and arrangements to be confirmed).

THIS BEING ALL THE BUSINESS, THE CHAIR CLOSED THE MEETING AT 12.30PM

SIGNED: 

DATE: 15 November 2021

AUDIT COMMITTEE – 7 OCTOBER 2021

ACTION LIST

		INDIVIDUAL ACTIONING	UPDATE
1	DAC: • DAC presentation to continue to develop to show the nature of expenditure and complete and live DACs	AP	This will develop further in the coming months
2	External Audit Draft Report To Those Charged With Governance 2020-21: • early discussion on the current position in relation to accrual and how that might impact on the Trust 2021-22 accounts; • update to be provided to the January Audit Committee	PN PN	Listed for January 2022
3	Standing Orders: • amend Policy Determination to include Committee Chairs as well as Senior Management Team to bring policies of significance and impact to attention of Trust Board	CM	Draft SOs amended accordingly. SOs approved at October TB

Northern Ireland Ambulance Service
Health and Social Care Trust

'SAFETY' COMMITTEE REPORT TO TRUST BOARD 16/12/21

The Safety, Quality, Patient Experience and Performance Committee met on Thursday 25 November 2021. Issues discussed included:

1	<u>Strategic Review of Clinical Education</u> This will now be included as a Standing Item on the Committee agenda. Dr Ruddell provided an update on progress for the period 1 October – 9 November. The programme of work has six workstreams, namely: • **Workstream 1: Learning Experience**: We will deliver an improving learning and education experience for our staff and students. • **Workstream 2: Training Material**: We will improve our learning and education material ensuring it is relevant and enables our patient facing staff to deliver high standards of evidence-based, compassionate, person-centred care. • **Workstream 3: Learning Environment**: We will modernise the way we deliver education in a supportive professional learning environment. • **Workstream 4: Clinical Supervision**: We will improve our Clinical Supervision to ensure that our educators, staff and students feel positively supported and encouraged throughout their learning and education to enable our patient facing staff to deliver high standards of evidence-based, compassionate, person-centred care. • **Workstream 5: Operations**: We will improve our resource planning arrangements so that we effectively support our patient facing staff and students throughout their operational • **Workstream 6: Clinical Governance**: We will revise our Clinical Governance Structure to assure we deliver learning and education to our staff and students that is recognised as providing a high standard of evidence-based, compassionate, person-centred care The Committee noted that the first Programme Board, comprising representation from Operations; Education, Learning and Development; HR, Union; Leadership Centre - Education; Strategic Transformation; Student; CSO; Ulster University; Media and Communications; PPI, had taken place on 1 October 2021 and agreed the Programme Brief in principle. This was then fully approved by the Programme Board at its meetng on 2 November. A programme delivery workstream plan has also been developed. Dr Ruddell highlighted key progress within the various workstreams as well as outlining the key deliverables for the next reporting period.
2	<u>'Being Open' Policy</u> This policy defines the Trust's commitment to 'Being Open' by establishing a culture where:

	• Service users receive rapid and open disclosure and emotional support when they experience serious incidents. • They receive the information they need to enable them to understand what happened and the reassurance that everything possible will be done to ensure that a similar type of incident does not occur again. • Staff involved are treated justly/appropriately. • HSC professionals, service users and carers are appropriately supported when things go wrong. • Service users/carers receive timely information about the outcome of any investigation. The Committee suggested a number of amendments to the Policy and, because of its significance, the Committee Chair asked that the Policy be brought to the attention of Trust Board.
3	<u>Serious Adverse Incidents: Position & Learning Outcome Update: April – October 2021</u> The Committee noted that the current pressures being experienced by NIAS and the wider healthcare system continued to impact on the gathering of information, staff availability, manager availability; all of which in turn impact the ability to complete the SAI process in line with the regional target of eight weeks. The Committee also noted that an increased number of SAIs relating to delayed response were under investigation by the Trust.
4	<u>Complaints & Compliments: current position</u> The Committee was advised that, as of 8 November 2021, there were 146 open complaints in the system. Of these, 113 complaints are awaiting investigation reports. As is the case with SAIs, the current pressures being experienced by NIAS are impacting on the Trust's ability to respond to complaints in a timely manner. The Committee also noted the increased number of complaints received as a result of delayed response.
5	<u>ED Turnaround Times</u> The Committee discussed ED turnaround times and the steps being taken by the Trust, and the wider HSC system, to try to resolve the challenges presented.

Northern Ireland Ambulance Service
Health and Social Care Trust

MINUTES OF THE PEOPLE, FINANCE AND ORGANISATIONAL DEVELOPMENT COMMITTEE HELD AT 9.30AM ON THURSDAY 30 SEPTEMBER 2021 (VIA ZOOM DUE TO COVID-19)

PRESENT:	Mr T Haslett	-	Committee Chair
	Mr J Dennison	-	Non Executive Director
	Ms N Lappin	-	Non Executive Director
IN ATTENDANCE:	Mr M Bloomfield	-	Chief Executive
	Ms R Byrne	-	Director of Operations
	Mr B McNeill	-	Programme Director CRM & Strategic Infrastructure
	Mr P Nicholson	-	Interim Director of Finance
	Mrs C Mooney	-	Board Secretary
APOLOGIES:	Ms M Lemon	-	Interim Director of Human Resources

1 Apologies & Opening Remarks

Mr Haslett noted that apologies had been received from Ms Lemon and explained that he would chair today's meeting which would focus on finance, in keeping with the arrangement that Committee meetings would alternate between finance and HR.

2 Procedure

2.1 Declaration of Potential Conflicts of Interest

The Chair asked the meeting to declare any potential conflicts of interest now or as the meeting progressed.

2.2 Quorum

The Chair confirmed the Committee as quorate.

2.3 **Confidentiality of Information**

The Chair emphasised the confidentiality of information.

3 **Previous Minutes (PC30/09/21/01)**

The minutes of the previous meeting held on 8 July 2021 had been agreed by e-mail and **APPROVED** on a proposal from Mr Dennison and seconded by Mr Haslett.

4 **Matters Arising (PC30/09/21/02)**

Mr Dennison asked that the two actions from the July meeting relating to a paper around Key Performance Indicators and a presentation from the Clinical Psychologist in the Belfast Trust should be brought to the December meeting of the Committee rather than 'deferred to a future meeting' as had been noted.

Mr Bloomfield agreed to look at this in Ms Lemon's absence.

Mr Dennison said it was his expectation that, while the focus of the Committee meetings would alternate between finance and HR, members would receive updates in relation to the actions from the previous meetings.

It was agreed that Mr Bloomfield and Mr Dennison would discuss outside of the meeting.

Ms Lappin pointed out that, in the 2021-22 year, there had been six Committee meetings scheduled. However she suggested that in the next schedule of meetings, the number of meetings should increase to eight to allow sufficient focus on HR and Finance. She agreed to discuss further with Ms Lemon and Mrs Mooney. Ms Lappin acknowledged that the Committee was at an embryonic stage and there was a need to understand clearly the business to be transacted as well as ensuring Directors had the capacity to service an increased number of meetings. She suggested that this should be discussed in the first instance by the Trust Senior Management Team.

The Committee **NOTED** the Matters Arising.

5 **Structure and Format for financial reporting (PC30/09/21/03)**

The Committee Chair stressed the importance of ensuring there was no overlap or duplication of financial reporting at the Committee with that of the Audit Committee. He said that he believed the focus of the People Committee should be to look at expenditure and budgets in detail in order to get a better understanding of the information contained in the broader report considered by Trust Board. The Committee Chair noted that the intention would be to improve the format for financial reporting as well as improving financial management and accountability arrangements in the Trust.

The Committee Chair advised that Non-Executive Directors had also considered other Trusts' finance reports in their deliberations.

During the ensuing discussion, members discussed which aspects of the various reports they favoured and Mr Nicholson agreed to reflect this in the October Trust Board finance report.

Ms Lappin said that she very much welcomed the discussion and acknowledged that other Trusts' budgets were much larger than NIAS and, on this basis, she did not expect to have a lengthy report.

Ms Lappin reminded the meeting of the financial management workshop in April 2021 and how the information presented should assist Board members in better interrogating the information and ask pertinent questions. She referred in particular to the area of capital expenditure and said that, at the time, she had asked for work to be undertaken to ensure that monies received were fully utilised. Ms Lappin was of the view that it would be helpful for the Committee to be briefed on what steps had been taken and cited this as an example of further narrative which the Committee would find helpful.

Mr Bloomfield commented on the importance of recognising the difference in budget size between Trusts as well as the range of services other Trusts provided. He said he would be happy to liaise with Mr Nicholson in the development of the new format of finance report with a view to having this presented at the October Trust Board and reminded members of the need for distinction between information needed for Committee and Trust Board consideration. Mr Bloomfield also pointed out that, whereas other Trusts carried

over significant underlying deficits with the exception of the cash-releasing savings requirements, NIAS did not have a recurrent deficit and continued to forecast a breakeven position.

Referring to the reporting of deficits in other Trusts, Mr Dennison noted that NIAS tended to report a breakeven position and he alluded to the statutory obligations of Trusts to breakeven. He acknowledged that, in making certain financial assumptions, the Trust had not yet received those allocations and he questioned why the Trust did not report deficits. He also asked whether the Trust would be better reporting a deficit with the likelihood of the DoH providing additional resources to cover the deficit.

Responding to Mr Dennison's point in relation to financial assumptions, Mr Nicholson indicated that the positive NIAS financial position was as a result of efforts over many years and that the Trust did not have similar underlying deficits as other Trusts. He explained that, in normal circumstances, if a Trust had a deficit, the Health and Social Care Board (HSCB)/Department of Health (DoH) would ask the Trust to develop savings plans in order to address the deficit. Mr Nicholson acknowledged the uniqueness of the past 18 months and said that it would be counter-intuitive to develop savings plans which would diminish services and place further pressure on existing services. He stressed the importance of being aware of the level of income assumptions and the potential implications if such assumptions were unrealistic. Mr Nicholson said that, at Month 5 of the financial year, he was as confident as he could be at this point that the financial assumptions made by the Trust were indeed realistic.

Ms Lappin referred to the fact that, at Month 5, NIAS was already forecasting a breakeven position. She sought further clarification about the deficit position of other Trusts and asked whether other Trusts had forecasted deficit positions on in-year budgets or whether Trusts were carrying forward deficits year-on-year.

Mr Nicholson explained that the underlying deficits may change during the year as a result of other pressures within the Trust and said that Trusts would be working with the HSCB/DoH to develop plans to address the deficits.

Ms Lappin put forward a suggestion that, if Trusts had historical deficits and had further pressures in-year, this would in fact mean

that the deficit would be based on the Trust budget and queried why NIAS was in a different position.

In response, Mr Nicholson explained that NIAS had managed its financial position so the Trust would not have a rolled-forward financial deficit. He advised that, had the Trust not been successful in obtaining, for example the funding for Agenda for Change pay award, there would have been a significant gap in the Trust baseline which would have rolled forward to the following financial year.

Mr Bloomfield commented that a number of Trusts were working on long-term plans to reduce their underlying deficits. He suggested that there was an element of risk involved in terms of financial assumptions but was of the view that it reasonable to assume a breakeven position at this stage.

Mr Bloomfield said that, while the Trust had not been prevented from maintaining and delivering additional services in-year, the Trust was currently at capacity and would not be in a position to deliver anything further or spend more at this time. He clarified that the Trust could not, for example, commence recruitment around the CRM model but that the use of in-year resources, whether it was for overtime or temporary staff, was regularly reported by Mr Nicholson to the HSCB and DoH.

He suggested that, to move to the position suggested by Mr Dennison, would mean the Trust knowingly committing funding without any source of funding having been identified which it could not do. Mr Bloomfield assured members that the Trust utilised all recurrent and non-recurrent funding in order to provide the best level of service possible.

Mr Nicholson reiterated the fact that the Trust had been able to use all available funding. He referred to the fact that the Trust had received £0.5 million last year as well as £2.5 million this year in respect of CRM and said the Trust expected further growth in this next year. He said that he was not aware of any areas where the Trust had not received the necessary funding, particularly in the context of the pandemic.

In response to a question posed by Ms Lappin, Mr Bloomfield confirmed that the Trust did not have more funding than it could utilise. He referred to the scrutiny of prospective posts by the

Senior Management Team and the fact that any posts approved were only approved on a temporary basis until 31 March 2022 as recurrent funding was not available beyond that time.

Mr Bloomfield reminded the meeting that the Operations Directorate utilised approximately 75-80% of the Trust budget for frontline operations and confirmed that the availability of staff, not funding, was the main constraint but stressed that the Trust could not recruit significant numbers beyond its funded establishment.

The Committee Chair thanked members for their contribution to this discussion.

6 (i) **Financial Plan 2021-22 Update (PC30/09/21/04)**

Mr Nicholson drew the Committee's attention to two key figures within the Revenue Resource Limit, namely the £9.4 million of assumed income and £12.6 million in relation to Covid-19.

He explained that the detail on page 22 of the papers was part of the monthly monitoring returns received by the DoH and the HSCB and set out the breakdown of the £9.4 million assumed income. Mr Nicholson advised that the Trust was working through a process of review with the DoH and HSCB and the completion of the necessary investment proposals to release these funds. He added that he had received e-mail confirmation that elements of this funding would be made available to the Trust.

Continuing Mr Nicholson referred to the importance of the accuracy of the estimate and the confidence in terms of receiving the assumed income. He acknowledged that, should the Trust not receive the assumed income, there would likely be a requirement to stand down services or develop savings plans to achieve breakeven. Mr Nicholson further acknowledged that some of the detail was still being worked through. He cited the example of the pay award for which the Trust had assumed that the full costs of the increase would be met. He indicated that the potential impact of holiday pay on overtime had not been included and reminded the meeting that this issue had resulted in the Trust accounts being qualified.

Mr Nicholson took the Committee through the detail of the table set out on page 22 and alluded to the recurrent and non-recurrent nature of funding. He indicated that there had been increased costs in relation to cleaning, personal protective equipment and staff welfare and he did not foresee these reducing over the coming years.

Ms Lappin suggested that it might be helpful for the Committee to have some narrative around the figures provided within the report.

The Committee Chair, noting that the transport costs contained expenditure on VAS/PAS, said that this was not clear from the heading and questioned whether this should in fact be included. He referred to the payroll expenditure and noted that this included overtime costs. The Committee Chair alluded to another Trust finance report where costs had been presented within Directorates and said that he had been keen for Directors to manage their respective budgets.

Mr Bloomfield acknowledged that work was ongoing to ensure Directors were clear as to their respective budget. He accepted that there was further work to do in this regard and said it would be important for Directors to be accountable and have the flexibility and independence to make decisions within their own budgets.

Ms Lappin said she would support a further breakdown of the table on page 23 showing the monthly expenditure.

Mr Dennison expressed his concern at the potential for the Trust not to receive an allocation as a result of the in-year monitoring exercise and sought further clarification around the decision making process as to which services might be stood down, the development of a savings plan and the impact of such a savings plan. He said that such clarification would be helpful as the Trust moved to a new format of financial reporting.

Mr Nicholson acknowledged that to have to reach such a position would be concerning. He explained that other Trusts had examined the potential for reducing overtime as a means of releasing savings, however, for NIAS, as approximately 80%

of the Trust budget was for frontline services, such a move would result in reduced cover. He said that, in order to develop a savings plan, Directors would examine those elements of the budgets where savings could be made in the first instance without having an impact on service delivery.

Agreeing with the points made by Mr Nicholson, Mr Bloomfield advised that other Trusts would undertake a similar exercise and indicated that the options to deliver in-year cash releasing savings were very limited. He reminded the meeting that, while Directors would be able to provide examples of where it might be possible to identify savings, these would have an impact on service delivery and he did not believe it would be necessary to do this in-year.

Mr Dennison believed that it would be important to have a sense of where the Trust might potentially identify savings should the need to do so arise. He suggested that it would be important to identify this as a risk on the Corporate Risk Register as well as identifying mitigating actions. Mr Dennison referred to the importance of having a contingency plan and believed that Trust Board should be advised of the potential for the Trust to identify savings.

Ms Lappin alluded to the point made by Mr Dennison in relation to the need to develop a savings plan and said it was clear that the impact on service delivery would result in a deterioration in response times. Referring to the financial position at August (month 5), Ms Lappin said she was unsure as to what was within the budget heading 'Legal Expenses and Other Service' and queried whether this could be paused in order to identify savings. Likewise, she queried the £373,000 for 'Board Members' and said she would appreciate further narrative as to what this budget heading included.

Ms Lappin agreed with the Committee Chair's earlier comments in relation to Directorate budgets and said it would be helpful for members to have sight of these on a regular basis. She referred to the fact that the Committee would not focus on finance until its February meeting and suggested that a Directorate budget breakdown by spend could perhaps be included in the Finance report for the December Trust Board as

well as detail on actions being taken to address any overspends.

Mr Bloomfield said that it was his intention that the Board would receive regular reports on Directorate expenditure and that this reporting would become a core part of the overall Board Finance report.

The Committee **NOTED** the update received in relation to the Financial Plan 2021-22 Update.

(ii) **Use of Voluntary & Private Ambulance Service Providers (VAS/PAS) (PC30/09/21/04)**

The Committee Chair referred to page 28 of the papers which listed the providers of private ambulance services. He said that it was presumably ultimately the Trust's wish to provide such services through permanent employees and acknowledged that the Trust had utilised these services as a means of providing further support, particularly during the pandemic.

Referring to the list of providers, the Committee Chair sought confirmation from Mr Nicholson that the services had been procured appropriately and that the necessary contracts were in place. He also enquired as to the Trust's plans for the use of VAS/PAS in the future.

Mr Nicholson confirmed that all VAS/PAS services had been procured appropriately and he referred to the framework contract let through the Business Services Organisation (BSO) which provided the Trust with a range of providers. Mr Nicholson indicated that, in some instances, providers may be engaged through a Direct Award Contract (DAC). He said that there had also been some instances where providers may employ sub-contractors and he confirmed that, while this was permissible within the contract, it was only allowed with NIAS' permission. Mr Nicholson acknowledged the significant expenditure on VAS/PAS but pointed out that expenditure had reduced marginally from the previous year.

Ms Byrne noted that Mr Nicholson had referred earlier to the framework specification agreement in place and advised the meeting that she was working with Ms Charlton around the

development of a robust monitoring and assurance process in terms of adherence to the framework.

The Committee Chair referred to the significant expenditure on VAS/PAS and asked if there was financial cover within the RRL or had the Trust been able to cover this expenditure from Covid-19 monies.

Mr Nicholson confirmed that it would be covered from the Covid-19 monies received by the Trust.

Mr Bloomfield advised that discussions were ongoing within the Trust as to how some of the funding currently used for VAS/PAS could potentially be used to recruit additional staff. He pointed out that the expenditure for VAS/PAS was within the £12.6 million of Covid-19 funding.

Ms Lappin asked if the Committee needed to examine VAS/PAS costs in greater detail and said that the Board had asked that, where possible, expenditure on VAS/PAS should be reduced. She suggested that it would helpful to have some narrative around the spend as it would be important to have a clear audit trail if the Trust was asked to justify its expenditure on VAS/PAS.

Referring to page 28 of the papers, Ms Lappin queried how expenditure on the Voluntary Car Service (VCS) compared with previous years.

Mr Nicholson acknowledged that patient taxi costs had increased and noted that VCS costs had reduced during the year. He explained the reference to voluntary driver taxi costs and explained that historically a number of voluntary drivers were also taxi drivers. Mr Nicholson reminded the meeting that the VCS had been stood down at the start of the pandemic and had only recently recommenced.

Ms Byrne referred to the development of dashboards and said that this would provide data on the detail around the usage of VAS/PAS in terms of the types of calls, the appropriateness of these calls and said that this would help in informing the Trust's workforce planning. She acknowledged that there was a need to better articulate the work being done to improve the

management of independent contracts, their utilisation and impact

Ms Lappin accepted that this work might straddle a number of Committees and said that members would look to Directors to decide where best to bring such information for consideration.

Mr McNeill said that the work carried out over the last number of years had identified that the Trust was 4,500 hours short of cover per week. He pointed out that, until this shortage was addressed, the Trust would continue to depend on VAS/PAS to to deliver services and close the gaps.

Mr Bloomfield agreed with the point made by Mr McNeill. He alluded to the reference to the framework specification and stressed the importance of ensuring that VAS/PAS were adhering to the required IPC standards; were using the appropriate equipment; had appropriately trained and qualified staff and were responding to appropriate calls. He said that the further work being carried out around the development of the framework would help in providing the Committee with the necessary assurance.

Ms Byrne alluded to the complexities involved in this work and said that the decision taken at the start of the pandemic to transfer PCS staff to support A&E colleagues had resulted in the Trust needing to utilise VAS/PAS to a greater extent.

Ms Lappin said she appreciated that work was being progressed in this regard but believed it was important to have such discussions at Committee level. She suggested that, when considering the inclusion of some narrative around VAS/PAS, reference should be made to how the Trust had considered in-house options to meet the need and what actions had been taken as a result.

The Committee **NOTED** the update received in relation to the Use of Voluntary & Private Ambulance Providers.

(iii) **Use of HSC Leadership Centre Associates (PC30/09/21/04)**

Mr Nicholson drew the Committee's attention to the paper outlining the process for the engagement of HSC Leadership

Centre Associates as well as a summary of the spend including the project and the associated costs. He confirmed that the information had been reviewed by the Trust's Senior Management Team.

Mr Nicholson said he wished to draw the Committee's attention to two issues in particular, namely that SMT had to approve the use of an Associate in the first instance and the importance of using the agreed process to engage an Associate.

Responding to a question from the Committee Chair, Mr Bloomfield explained that the HSC Leadership Centre documentation for engagement of an Associate required the Trust to provide a specification for the role and the time commitment involved. He added that the Trust would then be provided with a number of Associate CVs to consider. Mr Bloomfield indicated that an Associate would be engaged to undertake discrete pieces of work and would liaise regularly with the relevant Director. He said that the Committee would receive regular updates.

The Committee **NOTED** the update received in relation to the Use of HSC Leadership Centre Associates.

(iv) **Use of Staff Substitution (PC30/09/21/04)**

Mr Nicholson explained that the Trust used Staff Substitution to support specific work streams, generally in situations where expertise should normally be available in-house but capacity was insufficient. He advised that support provided to NIAS by the Association of Ambulance Chief Executives (AACE) had been classified as staff substitution.

Mr Nicholson reminded the meeting that AACE had provided support to NIAS for a number of years and provided additional capacity in areas where NIAS had historically limited, if any, resources. He said that AACE had played a particularly significant role in the planning for and implementation of the new CRM codeset in November 2019. Mr Nicholson reminded the meeting that Mr Bloomfield had provided the June Trust Board with an overview of the support provided in 2020-21 as well as the agreed programme of support in 2021-22.

Ms Byrne was of the view that engagement with AACE had raised NIAS' profile resulting in the Trust's involvement in a number of national groups. She said that she had found AACE support invaluable and had provided the Trust with resilience moving forward.

The Committee Chair noted that the Trust's planned expenditure with AACE had reduced over the last year.

Mr Bloomfield referred to the significant role played by AACE around CRM and said that, as the Trust moved to increase its capacity, the use of AACE would reduce over time.

Mr Dennison expressed his support for the Trust engaging with AACE. He referred in particular to the 2019 benchmarking exercise undertaken by AACE and said he had found that report interesting to read as he took up his position as NED with the Trust.

Mr Dennison suggested that AACE might be able to provide some assistance to Ms Lemon around the progression of the HR Strategy. He further suggested that it would be practical and constructive for the Committee to receive a presentation from AACE on their involvement with the Trust.

Ms Lappin said that, in her capacity as Trust Chair, she had had the opportunity to hear from AACE colleagues at first hand and had found it helpful.

Mr Bloomfield agreed with this suggestion and undertook to speak to Mr Flaherty with a view to making the necessary arrangements.

The Committee **NOTED** the update received in relation to the Use of Staff Substitution.

(v) **Use of Overtime (PC30/09/21/04)**

The Committee Chair acknowledged the fact that the Trust had was a significant reliance on overtime. He stressed the point that overtime was not an entitlement and the Trust had found it increasingly necessary over recent months to use overtime to ensure the provision of services for a number of reasons,

including vacancies, planned and unplanned absences and additional cover or programmes of work. The Committee Chair recognised the complexities associated with reducing and replacing overtime with increasing staff numbers.

Mr Nicholson drew members' attention to the report and acknowledged that expenditure on overtime was significant. He pointed out that, given the varying requirements for overtime throughout the year, expenditure varied. However he indicated that overtime was consistent between years with, on average, expenditure of approximately £6 million per year.

Mr Nicholson further pointed out that the vast proportion of overtime expenditure related to frontline services and Control.

Mr Bloomfield reminded the meeting that the Trust's proportionately high reliance on overtime was the reason why the Trust accounts had received a qualified opinion.

Mr Nicholson explained that the pandemic had impacted on overtime and clarified that increased staff absences due to Covid-19 had limited the pool of available staff to work overtime. However the Trust was still required to provide services.

Continuing, Mr Nicholson advised that, in an effort to fill more overtime shifts, the Trust had availed of a scheme which had been introduced regionally offering enhanced overtime rates. He acknowledged that this had in some instances resulted in unintended consequences, for example 'difficult to fill' shifts had attracted the premium rate and had been filled but at the detriment of other shifts. Mr Nicholson explained that the Resource Management Centre managed this dynamic process.

Mr Nicholson referred to the Internal Audit recommendation in relation to the payment of overtime to Band 8 and above staff and confirmed that the DoH had introduced regional initiatives to allow the payment of overtime to these staff but that this was in specific circumstances and was time limited.

Ms Lappin said she had found it interesting that overtime appeared to be consistent over a number of years. However she expressed concern that overtime expenditure between

April – July 2021 had been considerably higher than the same period in 2020-21 and in 2019-20. She queried whether Mr Nicholson was concerned at this and whether there was potential for an early warning that overtime expenditure could be significantly more this year than the average £6 million.

Responding, Mr Nicholson clarified that the scale for the current year differed slightly and reminded the meeting that the current costs only covered a four month period. He advised that the Operations Directorate had a substantive budget for overtime and said that, as well as covering additional shifts, the budget covered 'involuntary overtime', ie when shifts ran beyond the end of the shift.

Ms Lappin commented that overtime was not necessarily shared evenly throughout the workforce. She asked whether the Trust had put arrangements in place to monitor the extent of overtime worked by staff and the potential implications for safety.

Mr McNeill explained that the Global Rostering System (GRS) allocated shifts and monitored the allocation of overtime with appropriate action then being taken by the Resource Management Centre (RMC) to prevent staff from accessing overtime if there were any safety concerns.

The Committee Chair suggested that the overtime costs should be included within the payroll section in the finance report.

The Committee **NOTED** the update received in relation to the Use of Overtime.

(vi) **Capital Programme 2021-22 (PC30/09/21/05)**

Mr Nicholson advised that the Trust had received a Capital Resource Limit (CRL) allocation of £7.747 million which included allocations for Fleet & Estate, ICT and Backlog Maintenance. He explained that expenditure had traditionally been profiled towards the end of the financial year due to a number of factors, including business case approval, the availability of funds, procurement timescales, supplier capacity, internal capacity, project risks and lead times.

Mr Nicholson added that expenditure on fleet was profiled to the end of the financial year to maintain a smooth fleet age profile and he reminded the meeting that the Trust had a five-year fleet replacement business case in place.

He clarified that there were a large number of business cases for which funding was only available in-year and said that the risks experienced by the Trust had been compounded by a number of factors including EU exit, the global movement of goods, the global availability of raw materials and the associated costs, production and delivery of materials. Mr Nicholson said that the Trust continually reviewed its capital schemes to ensure it understood and mitigated against such risks. He expressed concern in relation to the global issues and said that the Trust Fleet Manager was exploring alternative options.

Mr McNeill explained that of particular concern to the Trust was the provision of Peugeot Boxer vehicles which the Trust purchased for conversion to PCS vehicles. He advised that the delivery which had been expected at the end of September had been delayed. He added that the Fleet Manager was in regular contact with the supplier to assess the risk of the vehicles not being delivered in time. Mr McNeill said that such delays would impact on the availability of capital monies set aside for conversion. He acknowledged that, while such delays were outside the Trust's control, the Fleet Manager continued to work closely with the Finance Department and DoH colleagues.

Referring to the dynamic management of the capital programme, Mr Nicholson said that the Trust also considered the potential for other schemes to be brought forward and said that Trust officers were constantly working with HSCB and DoH colleagues in this regard.

Mr Nicholson referred to a number of significant IT developments, in particular the completion of the REACH programme. He alluded to Body Worn Videos and said that, while the Trust had received funding for this, it would be necessary to conduct a public consultation which could potentially impact on the timescales around the deliverability of the project and the availability of funding.

The Committee Chair queried whether Estate should be removed from 'Fleet and Estate' within the CRL allocation table contained within the paper. He suggested that some elements of the Estate budget could relate to backlog maintenance and that it might be more appropriate to have 'Estate and Backlog Maintenance'.

Mr Nicholson explained that the Trust had limited ability to move between schemes and advised that £250,000 had been allocated for backlog maintenance.

Ms Lappin sought confirmation that the funding would roll forward to the next financial year for those items that might be unavailable in the current financial year.

Mr Nicholson referred to the nuances involved and acknowledged that the Trust had limited flexibility to roll forward funding. He explained that currently, should the Trust underspend on its capital monies in-year by £1 million, for example, that resource would be lost to the Trust and the £1 million would be the first call on the following year's CRL allocation.

Mr Nicholson acknowledged the challenges presented by the capital programme and reminded the meeting that the budget was significant at approximately £8 million.

The Committee Chair suggested that the October Trust Board should be briefed on the potential impacts on funding.

The Committee **NOTED** the update received in relation to the Capital Programme 2021-22.

10 **Date of next meeting**

The next meeting of the People Committee will take place on Thursday 9 December 2021 at 10am (arrangements to be confirmed).

Consideration would be given to face-to-face meetings if permitted.

11 **Any Other Business**

Mr Dennison acknowledged the work involved in producing the papers for today's meeting and asked Mr Nicholson whether he had the necessary resources within the finance team to assist around the new format of financial reporting.

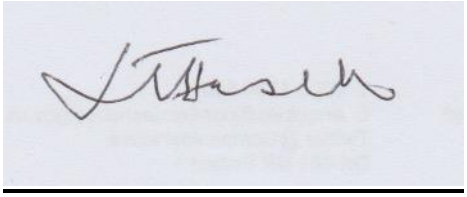
Mr Nicholson thanked Mr Dennison for his comments and noted the pressures placed on all staff as a result of vacancies and Covid-19. However he said that he planned to address the issue of vacancies within the Finance Directorate in the coming months.

Mr Bloomfield said he fully supported and would encourage Mr Nicholson in addressing these vacancies and added that it would be important that these were progressed as soon as possible.

Ms Lappin said that she did not underestimate the pressures placed on Directors. She welcomed the comments from the Chief Executive around ensuring the necessary resources were available to Directors within their respective structures to deliver on the work required.

The Committee Chair thanked those present for their contributions during the meeting and was of the view that the Committee was moving in the right direction with regard to the information being presented.

THIS BEING ALL THE BUSINESS, THE CHAIR DECLARED THE MEETING CLOSED AT 12.30PM.

SIGNED: 

(electronically signed due to Covid-19)

DATE: 29 November 2021

Northern Ireland Ambulance Service
Health and Social Care Trust

ACTION - PEOPLE COMMITTEE – 30 SEPTEMBER 2021

		INDIVIDUAL ACTIONING	UPDATE
1	Use of HSC Leadership Centre Associates: - Bring regular updates to the Committee;	PN	Listed as agenda item for meetings
2	Arrange for AACE to meet with Committee to discuss their involvement with Trust	MB	Arrangements being put in place to invite AACE to a future meeting
3	Paper around KPIs to be brought to future meeting	ML/MB	To be deferred to December meeting
4	Arrangements to be made for Committee to hear from the BHSCT Clinical Psychologist	ML/MB	On December agenda
5	Discuss the alternative nature of the Committee meetings and the need to receive interim updates on HR issues	MB/JD	Actioned
6	Increase of frequency of PFOD meetings to be discussed by Trust Senior Management Team in first instance	MB/CM	Actioned
7	Trust Board to be advised of the potential requirement for the Trust to develop savings plans	PN	The Trust has received confirmation of income and savings plans will not be required

Northern Ireland Ambulance Service Health and Social Care Trust

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