Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

A meeting of Trust Board to be held at 10am on
Thursday 21 October 2021 via Zoom *(due to Covid-19)*

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TB/21/10/2021/01

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Northern Ireland Ambulance Service Health and Social Care Trust

Minutes of NIAS Trust Board held on Thursday 19 August 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 T Haslett	Non Executive Director (joined the meeting at 12.15pm)
	Mr M Bloomfield	Chief Executive
	Ms R Byrne	Director of Operations
	Ms M Lemon	Interim Director of HR
	Mr P Nicholson	Interim Director of Finance
	Dr N Ruddell	Medical Director
Apologies:	Mr J Dennison	Non Executive Director
	Ms R O'Hara	Programme Director – Strategic Workforce Planning
	Ms M Paterson	Director of Performance, Planning & Corporate Services
	Ms A Quirk	Boardroom Apprentice
In Attendance:	Ms L Charlton	Director of Quality, Safety & Improvement
	Mr B McNeill	Programme Director - Clinical Response Model (CRM)
	Mrs C Mooney	Board Secretary
	Mr C Carlin	Boardroom Apprentice

1 Welcome, Introduction & Apologies

The Chair noted that apologies had been received from Mr Dennison, Ms O'Hara, Ms Paterson and Ms Quirk and reminded those present that they should declare any conflicts of interest at the outset or as the meeting progressed.

The Chair said that, on behalf of the Trust Board, she wished to offer her deepest condolences to Ms Paterson on her recent bereavement.

Concluding her introductory remarks, the Chair welcomed Mr Christopher Carlin who would take up position as Boardroom Apprentice on 1 September.

2 Previous Minutes (TB19/08/2021/01)

The minutes of the previous meeting held on 24 May 2021 were **APPROVED** on a proposal from Mr Ashford and seconded by Mr Abraham.

3 Matters Arising (TB19/08/2021/02)

The Chair thanked Directors for meeting with the Non-Executive Directors who had agreed to take on NED Champion roles and said she looked forward to seeing how these roles would contribute to Board meetings.

Mr Nicholson referred to the suite of Information security policies and reminded the meeting that these had been approved by Trust Board via e-mail.

4 Chair's Update

The Chair said she had been pleased to attend the graduation event for Associate Ambulance Practitioner (AAP) Cohort 12 which had taken place at Magee University in July and welcomed the fact that it had been possible to hold the ceremony outside. She advised that, due to the current level of service pressure, these newly qualified staff had immediately commenced frontline duties upon graduation. The Chair said, on behalf of Trust Board, she wished to acknowledge the willingness of these staff to commence their duties immediately.

The Chair referred to the Report of the Independent Review into the Circumstances of Board Member Resignations in the RQIA and the recent workshop organised by NICON to discuss the report and explore the wider governance implications. She said that she had

asked the Chief Executive to give some consideration as to how the Trust might work through the recommendations. The Chair added that NICON was also considering how it could provide support and training around the recommendations.

Continuing, the Chair referred to the meeting with the Minister and Trust Board on 17 August and thanked colleagues for their contributions. She said that she appreciated the engagement with the Minister and DoH colleagues around progress in relation to the CRM business case and the focus in particular on trying to ensure the appropriate resources were in place to progress this further.

The Chair reported that she had also attended a meeting with the Minister and other HSC Chairs. She advised that she had raised the issue of Non-Executive Director appointments and said she anticipated further collaboration with the Public Appointments Unit (PAU) in relation to Mr Cardwell's replacement. The Chair said that, while she did not expect the Trust to receive an immediate permanent replacement, the PAU was willing to explore various options for a temporary replacement. The Chair said that she very much appreciated the additional burden placed on Non-Executive colleagues due to the NED vacancy.

The Chair's update was **NOTED** by members.

5 **Chief Executive's Update**

Commencing his update, the Chief Executive referred to the Performance Report/Covid-19 update and said he wished to highlight a number of key issues. He indicated that, while operational cover had been good over the winter months, it had become much more difficult in recent months. Mr Bloomfield added that the Trust was now seeing high levels of sickness as well as significant numbers of staff not able to report for work due to Covid-19 reasons, mainly the requirement to self-isolate. He clarified that the recent relaxation around self-isolation rules did not apply to health and social care workers.

Mr Bloomfield advised that this was causing considerable difficulties as the Trust worked through the main summer period when staff were less keen to work overtime at a time when demand for

services remained high. He pointed out that the Trust was facing an exceptionally difficult weekend and said that all these factors contributed to an increase in ambulance response times as well as a deterioration in call answering performance.

Mr Bloomfield said that later in the meeting Ms Charlton would highlight the increase in complaints received. He acknowledged that staff exhaustion, compounded by late finishes and difficulties in getting meal breaks on time had resulted in staff also being less likely to work overtime. He added that he had heard at first hand the impact this was having on staff. Mr Bloomfield said that he had also taken the opportunity to visit a number of Emergency Departments (EDs) recently to meet with staff, patients and their families and had heard distressing accounts of patients having to wait in the back of ambulances.

Mr Bloomfield said that, following a meeting on 9 July with Trust Chief Executives and the HSCB Chief Executive, agreement had been reached to implement 'smoothing arrangements' whereby attempts would be made to balance pressures across the system and avoid very long ambulance handover delays at an ED when there were shorter waits at others. He explained that NIAS now had the authority and autonomy to transfer patients to whichever ED they considered appropriate, taking account of clinical need. Mr Bloomfield said that NIAS staff were not to be challenged on their decisions. He added that these arrangements had negated the need for short-term diverts which NIAS was often asked to put in place for a certain number of patients for a specific period of time. He said that such diverts had proved problematic for the Control Room and advised that the new arrangements had been welcomed by the Control Room.

However, Mr Bloomfield emphasised that, while these arrangements would not address handover delays which he believed would only be resolved when patient flow improved, they had gone some way to avoiding some of the large variations in handover delays. Mr Bloomfield advised that all Trusts remained supportive of the arrangements and saw NIAS as the honest broker. He added the Trust would continue to monitor the position and would seek additional resources so the smoothing arrangements would continue.

Mr Bloomfield said that members would be aware of the significant handover delays at the Ulster Hospital. He advised that he had met with Ms Roisin Coulter, recently appointed as South Eastern Health and Social Care Trust (SEHSCT) Chief Executive, to discuss a number of issues and said that they had taken the opportunity to visit the ED and meet with ambulance crews and ED staff. Mr Bloomfield said that the visit was an important visible demonstration of the Trusts' commitment to work together on addressing these issues. He indicated that Ms Coulter was concerned at the impact on staff and patients and was committed to partnership working. Mr Bloomfield added that it had been agreed to arrange a further meeting to discuss what further actions could be agreed to improve the position.

Mr Abraham welcomed the update on ambulance waiting times and in particular the partnership working between Trusts to address the situation. He said he appreciated the need to identify more long-term measures and the Trusts' determination to continue to press for solutions.

Mr Bloomfield acknowledged the importance of balancing pressure at EDs and emphasised that the arrangements put in place would not resolve the difficulties.

The Chair commented that she had received positive feedback from the interim Chair of the SEHSCT following Mr Bloomfield's visit and added that she intended to speak to the interim Chair to reinforce the partnership working.

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

6 **Staff Stories (TB19/08/2021/03)**

The Chair welcomed Ms Emma Hallissey and Mr Peter Donnelly to the meeting.

Introducing this agenda item, Ms Lemon advised that the Trust was trialling a new methodology around gathering staff stories and had engaged with the Belfast Trust in doing so. She acknowledged the challenges that had been presented by Covid-19 but said that work

had progressed. Ms Lemon indicated that, while Trust Board had received reports which reflected the pressures, personal stories proved to be more powerful in terms of relaying the challenges and pressures felt by staff. Ms Lemon extended her thanks to Ms Hallissey, Ms Leonard and Mr Donnelly for their commitment and passion over the last year in terms of peer support.

During the ensuing discussion, Ms Hallissey and Mr Donnelly shared with the meeting their detailed personal experiences of work over the last 18 months.

The Chair referred to the presentation which Ms Hallissey and Ms Leonard had made to the Trust Board in March 2020 and said she had been impressed by the peer support model which had been established to help staff. She said it was important to remember that behind each referral to peer support was a member of staff.

The Chair said that no-one could have foreseen the challenges and pressures experienced by staff in the context of Covid-19 and added that it was important for members to hear at first-hand what staff had experienced and continued to experience.

The Chair said it was her understanding that the area of peer support would be considered by the Trust's People Committee.

Mr Ashford thanked Ms Hallissey and Mr Donnelly for their powerful testimonies. He sought clarification around the support available for peer support and referred to the pressures felt throughout the service and asked whether other pathways would be available to ensure that support was accessible for staff.

Ms Hallissey advised that peer supporters had recently secured supervision services which provided them with the mechanism to ensure they did not feel overwhelmed. She emphasised that peer supporters were not counsellors and were able to signpost individuals to counselling services if required. Ms Hallissey advised that, over the last 12-18 months, peer support had referred staff to Inspire as well as ensuring staff were assessed by a clinical psychologist to ensure referral to the most appropriate routes of treatment. She indicated that there had been a significant number of referrals to high intensity therapy and added that the clinical

psychologist was also able to diagnose Post Traumatic Stress Disorder (PTSD) and provide up to 20 counselling sessions.

Ms Lemon said that, while peer support played a critical role, it would be important not to have an over-reliance. She indicated that the Trust had worked to secure clinical psychology input from Belfast Trust two days a week and said that the clinical psychologist would work directly with the Trust on leading the strategy around how the Trust supported the mental health of staff. Ms Lemon said that this work would contribute to aspects of the wider cultural organisational development work underway, including the wider peer support infrastructure.

Continuing, Ms Lemon agreed with the point made by the Chair earlier in that it was important for members to hear the staff stories at first-hand. She referred to the horticultural programmes available to staff and how staff had found these to be therapeutic. Ms Lemon alluded to the importance of CRM funding and how this would enable the Trust to recruit more staff.

Dr Ruddell welcomed the fact that the peer supporters had secured supervision and said he was conscious of the relentless chain of serious experiences shared with peer supporters. He said that, from his own experience, he was grateful for the numerous follow-up calls and debriefs provided to staff by peer support and emphasised the importance of self-care.

Ms Byrne said it was clear from the experiences shared by Ms Hallissey and Mr Donnelly that they were passionate and caring about the services they offered to staff. She added that as a Trust Board member she would like to acknowledge their significant contribution in this regard and said she knew from feedback from operational staff that their work had been very positively received and was appreciated by staff.

Mr Abraham thanked Ms Hallissey and Mr Donnelly for their presentation. He stated that it was important for the Trust Board to have connections with staff on the ground and the issues facing staff. Mr Abraham believed that this was particularly important as Trust Board tried to ensure that staff had all necessary resources at their disposal to enable them to deliver high quality services. He

said that it was important for him to make every effort to leave the service in a better position when his tenure as Non-Executive Director had finished.

Mr Bloomfield also conveyed his thanks to Ms Hallissey and Mr Donnelly for their powerful and emotive stories and their experiences of staff. He said the Trust was fortunate to have a dedicated team and reminded the meeting that, while arrangements had been made for Ms Hallissey and Ms Leonard to provide substantive peer support, other peer supporters had volunteered to undertake their roles alongside their substantive duties.

Mr Bloomfield referred to the challenging weekend ahead in terms of cover as well as the poor response times. However he said it was important to ensure that staff were supported after traumatic calls, whether that was through being stood down from operational duties for a period of time or going home. Mr Bloomfield added that the Trust would be prepared to defend any impacts of such action and it was important that staff were aware of this.

Concluding the discussion, the Chair assured Ms Hallissey and Mr Donnelly of the Board's continuing support and commitment to peer support. She conveyed her thanks for taking the time to attend the meeting and sharing what were powerful and personal stories. The Chair suggested that it might be important to give some consideration as to how best to communicate the fact that Trust Board had heard the testimonies presented today and acknowledged the pressures felt by staff.

Ms Hallissey and Mr Donnelly both withdrew from the meeting.

7 **Performance Report & Covid-19 Update (TB19/08/2021/04)**

By way of introduction, Mr Bloomfield explained that, while papers referred to performance, targets and standards, the focus was on delivering high quality services to the population. He reminded members that, as he had touched upon some of the key challenges facing the service in his report earlier in the meeting as well as alluding to this in the recent meeting with the Minister, it was not intended that members would be taken through the Performance Report & Covid-19 Update in detail

Ms Lemon acknowledged that, while there had been a significant increase in sickness absence in June, specifically long-term sickness absence, the cumulative sickness absence levels between April and June 2021 increased at a greater rate than in the same period in 2020/21, with a significant increase in monthly sickness absence levels. She advised that mental health and muscular-skeletal remained significant issues.

Continuing, Ms Lemon advised that, in order to address the pressures across the system, the Directors of HR submitted a proposal to the DoH seeking to introduce an enhancement to the Covid-19 critical shift payment. She added that the proposal was currently being considered by the Minister. Ms Lemon said that, if approved, the Trust would move to offer staff the enhanced payment which would assist in planning for weekend cover.

The Chair acknowledged the fact that this was a new development for the Trust and referred to previous discussions on whether such a payment would be possible.

Mr Ashford asked whether management was hopeful that the additional payment would encourage staff to work overtime.

In response, Mr Bloomfield said that it was not yet clear whether staff would avail of the enhanced payment. He indicated that NIAS Gold had held an extraordinary meeting to discuss what further actions could be taken to enhance cover. Mr Bloomfield clarified that the Trust did not have any discretion to move outside the Agenda for Change terms and conditions for overtime but said it was certainly helpful that this was being discussed on a regional basis.

Continuing, Mr Bloomfield pointed to the significant challenges in ensuring cover at the weekend and said that, as the Trust could not delay in ensuring arrangements were in place, the Trust was going at risk in advance of DoH approval and he added that the DoH had been made aware of this.

The Chair commented that it was helpful for Trust Board to be aware of the balance of risks.

Alluding to the sickness absence, Mr Abraham acknowledged that it was a unique scenario and was not indicative of the underlying shift in general sickness absence as a result of different factors.

Ms Lemon acknowledged that there had been a significant increase in mental health related absence. She said that it was clear from emerging patterns that this increase related to Covid-19 and more generally with the particular pressures relating to that within the system. Ms Lemon pointed to the fact that the Trust had historically high sickness levels and said it would be important to maintain a watching brief to ensure that it was a unique situation and did not revert to that position. She referred to discussions at the recent People Committee and said that members had been updated on the work ongoing to address absence levels.

The Chair asked that Board members would be kept informed if the enhanced payment to be approved by the DoH was utilised again prior to the October Trust Board meeting.

Ms Byrne indicated that the REAP was updated each Monday in advance of Tuesday's Senior Management Team meeting. She explained that an action within the REAP was to consider going outside normal arrangements to ensure cover and added that a number of additional actions had been taken to increase cover at the weekend. Such actions included cancelling training, paramedic/EMT split staffing, transfer those qualified Blue Light staff to driving and looking to the National Ambulance Service for additional support.

Ms Byrne referred to the additional information which had been shared with members and explained that, following operational discussions, the call performance monitoring was changed to report on calls answered within 30 seconds against an 80% compliance. She advised that this was in keeping with national practice should NIAS need to enact the full national loss or partial loss of telephony plan or seek national call taking support beyond the current 'buddy system' through the National Ambulance Coordination Centre (NACC). Ms Byrne indicated that NIAS had reverted to reporting against the 5 second response time against a 95% compliance standard as well as continuing to monitor the 30 second

performance against an 80% standard should the Trust consider national assistance was required in the future. She said that the work undertaken had been commendable and was attributed to the efforts of EAC.

The Chair said it was important, given the gravity of the challenges facing the Trust, to note the positive changes which had been made and she asked for her thanks to be conveyed to EAC staff.

Referring to call answering, the Chair commented that daily calls taken would be approximately 700 calls and she sought clarification on whether any of these calls would be duplicate calls.

Ms Byrne confirmed that the duplicate calls correlated to the increase in the overall volume in addition to increased demand.

The Chair asked whether, setting aside duplicate calls, it would be possible to have a sense of what the increased demand was. Ms Byrne undertook to look at this.

Ms Charlton drew members' attention to page 44 of the Board papers and referred to the increase in complaints and the nature of those complaints received. She said that members of the Safety Committee would be aware of a number of stories of delayed responses and poor experiences of those waiting for responses to falls. She welcomed the opportunity to refer to these during the meeting with the Minister and also welcomed the Trust Board's commitment to bring patient stories to future Board meetings.

Dr Ruddell said that the report clearly set out the efforts made to support operational activity. However he alluded to the important workstreams which had been paused during this period. He said that he had previously advised Trust Board of the difficulties in maintaining clinical audits when it had become necessary to divert resources to support operational activity. Dr Ruddell said that, while he completely supported the need to divert resources and ensure services were delivered, such actions inevitably had the potential to lead to challenges later in the year and said it was important that Trust Board remained sighted on this.

Dr Ruddell said that he would bring a report on the unforeseen consequences, both current and long-term, to a future meeting.

Mr Ashford alluded to the Performance Report and references made earlier in the meeting and said that these all reflected the pressures and challenges facing the Trust. He said that, as the pressures decreased, it would take some time for the Trust to return to business as usual.

Mr Bloomfield provided detail on recent correspondence received from a service user in which she had asked for her personal experience to be brought to the attention of the Trust Board. He confirmed that the service user's experiences were being handled through the HSC Complaints Procedure.

Ms Charlton confirmed that she had shared the service user's story with Safety Committee in November 2020 and added that she had spoken to the individual directly about her experience.

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 3) (TB19/08/2021/05)**

Before Mr Nicholson provided the financial report, the Chair advised that the Finance team was somewhat depleted due to a number of staff being seconded to assist with frontline duties. She reminded members to forward any suggestions they may have on the content of the Finance report to herself or Mrs Mooney. The Chair said that Mrs Mooney had e-mailed Committee Chairs with a view to arranging a further meeting in September and she asked colleagues to respond as soon as possible to allow the date to be confirmed.

The Chair alluded to the current pressures and thanked Directors for a comprehensive set of papers for today's meeting.

Mr Nicholson confirmed that, while a number of Finance staff had volunteered, many other support staff had also volunteered to assist elsewhere within the Trust and this was much appreciated.

Commencing his report, Mr Nicholson advised that the Trust was reporting a breakeven position at Month 3 and was forecasting a balanced position at year end. He indicated that, as highlighted in the report, there were a number of key assumptions within this position, particularly in relation to assumed income. Some key areas include £3.5 million for Training and £2.5 million for CRM. He said that the Trust had received indicative support for these schemes but continued to work to ensure they were realised.

Mr Nicholson pointed out that, in addition to this, some of the assumed income would be subject to successful monitoring rounds and said that the Trust was currently working with DoH/HSCB and the region to develop bids as part of this process. He indicated that the Trust would also be asked to articulate the implications of not securing resources. Mr Nicholson acknowledged that this was particularly difficult at present given the operational pressures which had been articulated in the Performance Report and by the Chief Executive.

Referring to VAS/PAS expenditure, Mr Nicholson reported that this had been £2.1 million for the first three months of the year and said that this was a key element of NIAS maintaining services at this time.

Mr Nicholson drew members' attention to page 54 of the papers and welcomed the early indication of capital resources, approaching £8 million, available to the Trust. He pointed out that, while a number of risks to delivery of the programme had been detailed within the report, he would also include risks relating to the availability of staff to both deliver and implement each element within the capital programme. Mr Nicholson indicated that reference had already been made to a number of activities which had been downturned in the context of REAP 4.

Mr Nicholson reported that the Trust's prompt payment performance remained strong and said the Trust had maintained the arrangements to support Operational managers in the authorisation of invoices. He acknowledged that this had been a challenge as staff had taken annual leave and some staff from Finance and other Directorates were supporting operations in more forward facing roles, for example call taking.

Mr Nicholson indicated that the Trust Board would be kept updated on all these issues as the financial year progressed and commented that the Trust remained in exceptional times as monitoring service delivery during the pandemic drove the organisation and its actions, not finance.

The Chair thanked Mr Nicholson for his report and invited questions from members.

Acknowledging the difficulties in the Trust's ability to spend the resources within the capital programme, Mr Ashford referred to the spend profile and said it had been hoped that a significant proportion of these resources would be used in late summer/early autumn. He sought clarification on whether the Trust remained on target to do so.

Mr Nicholson said that he remained hopeful that the resources could be spent over the next few months. He pointed out that a significant element of the programme focussed on catching up on last year's fleet replacement cycle as well as undertaking significant projects such as the replacement telephony system. Mr Nicholson explained that the development, design, testing the implementation of that particular project would only be realised in Quarter 4 of the financial year. He pointed out that, should any projects slip, the Trust would be required to return the necessary resources to the DoH and would experience financial challenges in the next financial year.

In relation to VAS/PAS expenditure, Mr Bloomfield reminded members of previous discussions around the Trust's intention to reduce this expenditure. However, Mr Bloomfield clarified that the current volume and support from VAS/PAS had been less than the Trust had expected given the current context but that this was due to their availability rather than a plan to reduce expenditure. He pointed out that in July/August, the Trust would use all available VAS/PAS services and members would see this usage reflected in future finance reports.

The Chair referred to the fact that the next People Committee would consider finance reports and she asked Mr Nicholson to liaise with

Mr Haslett in relation to what information he would like to see at that meeting.

The Chair took the opportunity to advise members that a recent meeting of HSC Chairs had discussed the issue of budgets and she advised that the Minister would be keen to introduce budgets which would cover 4-5 year period. The Chair advised that the Minister was aware that Trusts did not have their full year budgets and might not be able to deliver full-year effect (FYE) savings.

The Chair thanked Mr Nicholson for his report which was **NOTED** by members.

9 **Duty of Candour – response to public consultation (TB19/08/2021/06)**

Introducing this agenda item, the Chair said that she was aware that the South Eastern Trust had encouraged its staff to respond to the Trust to help inform its own response to the consultation.

She clarified that the draft response before members was the draft Trust response but said that individuals and members of the public could respond to the consultation.

Dr Ruddell confirmed that all staff were afforded and encouraged to respond to the consultation on an individual basis and added that, as an organisation, the Trust had been asked to contribute to the consultation process directly. He emphasised that the Trust would never seek to influence the views of those individuals responding directly.

Continuing, Dr Ruddell explained that the Duty of Candour had arisen from the recommendations emanating from the Inquiry into Hyponatraemia Related Deaths and aimed to embed a culture of openness throughout Health and Social Care. Dr Ruddell said that, while there had been existing processes in place, Judge O'Hara's experience throughout the inquiry had been that these processes were not sufficiently robust and had recommended the introduction of a statutory Duty of Candour both for organisations and individuals across health and social care in Northern Ireland.

Dr Ruddell advised that the Duty of Candour had the potential to introduce criminal charges for organisations and individuals if it was felt that the duties within the legislation had not been met. He pointed out that the proposed NI legislation would differ from the rest of the UK. Dr Ruddell indicated that other Medical Directors responding to the consultation had voiced similar concerns at this differentiation. He said that, while the Trust would not support some of the recommendations, the Trust would support the principle of being open and honest and he added that this had been referenced in the draft response before members.

Dr Ruddell acknowledged that Inquiry had taken significant time to conclude and, in the interim, significant progress has already been made in the approach to SAI reviews. He said that huge efforts had been made to encourage a system whereby individuals feel comfortable to come forward and contribute to SAI reviews as well as embracing the learning culture in order to prevent a recurrence. Dr Ruddell believed that to move to criminal sanctions would be a retrospective step. He pointed out that all registered Health Care Professionals (HCPs) had a clear and professional obligation through their registering bodies to be clear and open. Dr Ruddell acknowledged that Emergency Medical Technicians (EMTs) were not technically professionally registered but the Trust expected all staff to adhere to the principles of openness and honesty.

Continuing, Dr Ruddell expressed concern that the introduction of criminal sanctions could potentially discourage individuals from reporting what might be minor issues to rectify by ensuring the necessary learning was put in place to prevent recurrence.

Dr Ruddell explained the position in England where the Care Quality Commission (CQC) had the ability to prosecute an organisation and had done so. He clarified that there was no mechanism in England whereby individuals could be prosecuted for not appearing to be open and honest. Dr Ruddell indicated that, within the recommendations, while the threshold for prosecution was ‘wilful or serial withholding of information, there was no indication to how this would be determined.

Dr Ruddell indicated that the introduction of such would require a change to contracts of employment, both future and existing contracts.

The Chair commended the Trust on the progress made in encouraging staff to come forward and said that the focus was not necessarily on sanctioning them but ensuring staff learn from mistakes made to improve the delivery of service.

Mr Abraham thanked Dr Ruddell for his detailed explanation and stated that it was helpful to set out the duties of care. He emphasised the importance of providing a thorough debrief when untoward incidents occurred.

Mr Ashford commended Dr Ruddell on the draft response and said he supported the principle that the statutory duty needed to apply across the Trust and not only to registered staff. He expressed his support for SAIs to be overseen by an independent body and suggested there was merit in a body external to health and social care undertaking such a role in order to strengthen the independence.

The draft response to the Duty of Candour consultation was **APPROVED** on a proposal from Mr Ashford and seconded by Mr Bloomfield.

10 **Safeguarding:**

- **Education & Training Strategy**
- **Policy (Adults, Children & Young People)**
- **NIAS (Interim*) Procedures and Referral Process (TB19/08/2021/07)**

At the Chair's request, Ms Charlton explained that the Safeguarding Training and Education Strategy was supported by the attached NIAS Safeguarding Policy and Interim Procedures which recognised that NIAS emergency and transport services interacted with many vulnerable patients and members of the public at risk from abuse and neglect. She emphasised the important role NIAS staff played in knowing when and how to ensure patients were safeguarded appropriately.

Ms Charlton confirmed that Mr Abraham had agreed to assume the role of NED Safeguarding Champion and said she would be meeting with Mr Abraham to discuss how best to deliver training for this role.

Continuing, Ms Charlton referred to the fact that online safeguarding training had now been mandated at level 2 for relevant staff. She acknowledged that the majority of other ambulance services had moved to level 3 but said that NIAS training was in its infancy as mandatory safeguarding training had not been in place within the Trust.

Ms Charlton referred to the Safeguarding Policy and said that, through the Trust's Assurance Framework, the Board would be provided with evidence as to the effective implementation of the policy on a twice-yearly basis.

Ms Charlton clarified the difference between the Policy and Procedures and said that it was important to be pragmatic about the ease of reference to a document while on the road. She explained that the procedure covered issues such as how to use Datix, how to process a patient referral and clarity around the threshold to refer for example. Ms Charlton indicated that it was inevitable that some of these procedures would change when REACH was introduced and said that work was ongoing to streamline the procedures when REACH became fully operational.

The Chair said that she had had the opportunity to meet with Mr Flannagan, Head of Safeguarding, and had been very encouraged by his enthusiasm.

Mr Ashford commended the documents and sought clarification on whether crews would contact the Gateway Team directly.

Responding, Ms Charlton acknowledged that this would prove challenging. She explained that, within the Policy and Procedures, there were two types of referral – safeguarding referrals for those in need of protection and welfare referrals where there was risk of harm but no immediate need of protection. Ms Charlton advised that the former should be processed through the Gateway out-of-hours. She added that the Trust was working with the HSCB to put

arrangements in place that, rather than having to call out-of-hours, an individual within the organisation would navigate the crew to the relevant team. Ms Charlton said that there were currently occasions when referrals had not been accepted and crews, having finished night duty, were called on their personal mobile because there was no other contact number available. She added that it would be important that crews were not contacted after they had finished duty. Ms Charlton said that agreement had been reached that referrals would be submitted electronically and arrangements made for a call-back to crews.

Ms Charlton acknowledged that there were a number of references within the documentation to the Trust's Assurance Committee and undertook to have these amended.

The Safeguarding Education and Training Strategy was **APPROVED** on a proposal from Mr Abraham and seconded by Mr Haslett.

The Safeguarding Policy (Adults, Children & Young People) was **APPROVED** on a proposal from Mr Ashford and seconded by Dr Ruddell.

The NIAS Safeguarding (Interim*) Procedures and Referral Process was **APPROVED** on a proposal from Dr Ruddell and seconded by Mr Ashford.

11 **NIAS Policy:**

- **Supporting Staff Involve in Incidents, Complaints, Claims and Coroner's Inquests (TB19/08/2021/08)**

Introducing this agenda item, Ms Charlton explained that the purpose of the policy was to set out the framework for the provision of support and advice to staff prior to, during and after their involvement in Incidents, Complaints, Claims and Inquests. She described it as an 'important and significant' policy in terms of changing the culture around learning. Ms Charlton advised that the policy had been developed as a regional template which Arms Length Bodies had been asked to adopt. She indicated that the policy had been discussed at the Trust's Safety Committee on a

number of occasions around just culture and the associated principles.

Ms Charlton referred to the content of the policy and said it covered a number of areas, namely:

- Clarifying the availability of support for staff and management, in the event of them being involved or leading on a traumatic or stressful incident, complaint, claim or investigation.
- Identifying responsibilities for staff and managers in these circumstances.
- Providing guidance for managers supporting staff in these situations.
- Providing staff with details of how to access the support available regardless of the extent of their involvement.

Ms Charlton referred in particular to paragraph 1.2 of the policy, 'Introduction', and said that the term 'superiors' would be amended. She acknowledged that the Duty of Candour had not been referenced in the policy but said that the policy could be updated as required.

The policy was **APPROVED** on a proposal by Mr Ashford and seconded by Mr Haslett.

12 **Annual Progress Report to the Equality Commission (TB19/08/2021/09)**

Ms Lemon explained that, due to Covid-19, the Trust had been unable to undertake a full formal public consultation as had been the practice in previous years. She added that the Trust's inability to fully discharge its role had been referenced within the report and a commitment given that the Trust would undertake a retrospective piece of work around Covid-19 and its equality obligations.

The Chair said that she appreciated the fact that the Annual Progress Report had been brought to Trust Board for consideration given the context of the pandemic.

Members **NOTED** the Annual Progress Report to the Equality Commission.

13 **NIAS Annual Report and Final Accounts for the year ended 31 March 2021 (TB19/08/2021/10)**

At this point in the meeting, the Chair declared an interest as Chief Commissioner for the Charity Commission.

The Chair advised that Trust Board was asked to note these final, audited, certified, approved Annual Accounts and Reports for Public Funds for the year ended 31 March 2021. She pointed out that the Annual Accounts and Reports for Charitable Trust Funds for the year ended 31 March 2021 had not been included within members' papers and would be circulated to members at a later date.

She explained that this was the first presentation of these documents in the public domain and they would now be published on the Trust website.

Mr Nicholson reminded the meeting that the documents had been considered on a number of occasions by the Trust's Audit Committee as well as consideration by the In Committee Trust Board meeting in June.

The Chair conveyed her thanks to the Finance team and the Audit Committee for their significant contributions over the last number of months in relation to the final accounts.

Mr Abraham echoed the Chair's comments and said he would like to pass on his thanks to the Finance staff for their work in collaboration with other stakeholders in the preparation of the final accounts. He stated that the professionalism and quality of the team was reflected in the accounts which had been prepared in difficult circumstances.

Members **NOTED** the NIAS Annual Report and Final Accounts for the year ended 31 March 2021.

14 **NIAS Corporate Plan 2021-22 (TB19/08/2021/11)**

In Ms Paterson's absence, Mr Bloomfield reminded members that the Corporate Plan for 2021-22 had been signed off by Trust Board at its meeting on 24 June 2021. He explained that a more user-friendly public version had been created and would be shared with staff and posted on the Trust website. He added that the public version maintained full alignment with the detailed Corporate Plan.

The Chair welcomed the user-friendly version and suggested this approach might be used for other Trust documents.

15 **Committee Business:**

- Safety, Quality, Patient Experience and Performance Committee

- **report & minutes of 10 June 2021**

- **People, Finance & Organisational Development Committee**
  - **minutes of 22 April 2021 & report of 8 July 2021**
- **Audit Committee**
  - **report & minutes of 24 June 2021**
  - **Chair of NIAS Audit Committee Annual Report 2020-21 (TB19/08/2021/12)**

The Chair invited Committee Chairs to highlight any salient points from recent Committee meetings.

Mr Abraham referred to the Trust's limited audit opinion and said that he had arranged to meet with the Chief Executive and the Director of Finance on an ongoing basis to review the Trust's progress in addressing outstanding Internal Audit recommendations. He said that he had also asked to meet with the Head of Internal Audit to review progress.

Referring to the Safety Committee meeting of 10 June, Mr Ashford welcomed the change in timescales of notification of a SAI. He explained that, following a meeting with the HSCB and the PHA, it had been agreed that, as the decision to notify an incident occurred when all of the pertinent information had been gathered from the relevant areas and reviewed by the Rapid Review Group (RRG), NIAS would measure the 72 hours from the date of the RRG meeting.

In Mr Dennison's absence, Mr Haslett provided a brief synopsis of the business transacted at the July People Committee and said it was clear from discussions the extent of work being progressed.

The Chair thanked Mr Abraham, Mr Ashford and Mr Haslett for their comments. She advised of her plans to recognise the work undertaken by the Trust over the last three years at the October Trust Board meeting.

The Chair also alluded to the need to consider the schedule of the People Committee to allow an increase of meetings from six to eight.

16 **Date of Next Meeting**

The next Trust Board meeting will take place on Thursday 21 October 2021 at 10am. Arrangements to be confirmed.

17 **Any Other Business**

Mr Carlin expressed his thanks to the Chair for allowing him to join today's meeting which he had found insightful. He said that he looked forward to his year with the Trust as Boardroom Apprentice.

THIS BEING ALL THE BUSINESS, THE CHAIR CLOSED THE PUBLIC MEETING AT 1.15PM.

SIGNED: _____

DATE: _____

TB/21/10/2021/02

Return to Agenda

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD – 19 AUGUST 2021

		INDIVIDUAL ACTIONING	UPDATE
	PUBLIC		
1	Safeguarding: • Education & Training Strategy • Policy (Adults, Children & Young People) • NIAS (Interim*) Procedures and Referral Process Ensure references to Assurance Committee are amended to read Safety Committee	LC	Actioned
2	Board members to be advised if decision is taken to utilise enhanced payment again before the next Trust Board meeting	MB	Director of Operations communique dated 8/9/21 shared with NEDs 20/9/21
3	Advise members of increased call demand – not including duplicate calls	RB	To be discussed at October Trust Board.
4	A report on the unforeseen consequences, both current and long-term, of pausing workstreams to be brought to a future meeting	NR	Ongoing
5	Look at schedule of People Cttee meetings to increase frequency of meetings from 6 to 8	NL/CM	Discussed at PFOD on 30/9/21. Schedule for 2022/23 will reflect increased frequency of meetings.

TB21/10/2021/03

Return to Agenda

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

PRESENTATION OF PAPER

Date of Trust Board:	21 October 2021
Title of paper:	Patient Stories Care Opinion – Online Service User Feedback
Brief summary:	Members will receive a presentation summarising the key themes identified through online service user feedback received since the launch of Care Opinion in Northern Ireland. A number of individual patient stories will be shared and as well as actions taken by the Trust as a result of the stories.
Recommendation:	**For Approval** ☐ **For Noting** ☒
Previous forum:	n/a
Prepared and presented by: **Date:**	Lynne Charlton, Director of Quality, Safety & Improvement 14 October 2021

TB/21/10/2021/04

Return to Agenda

PERFORMANCE REPORT AND COVID UPDATE

TRUST BOARD

NORTHERN IRELAND AMBULANCE SERVICE

OCTOBER 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, and for this month replaces the normal Trust Board Integrated Performance Report.

- COVID-19 continues to place extreme pressure on all Health Trusts within Northern Ireland. Following an assessment of all available information NIAS has de-escalated to REAP LEVEL 3 – MAJOR PRESSURE on the 04th October 2021, this follows over 3 months in the highest escalation level of REAP 4. Concerns remain with increased demand, reduced front line operational cover in a number of Divisions, staff abstractions and hospital turnaround times all impacting on service delivery.

- In keeping with normal practice when the REAP level alters the strategic intent associated with silver / Gold command structures has been updated .It is the strategic intent of NIAS to respond to and manage the ongoing REAP LEVEL 3 incident in a way which promotes and saves life, reduces humanitarian suffering and is compatible with the vision and values of the Trust ensuring the safety and wellbeing of all staff. In line with the Joint Decision Model (JDM) principles we will review all available information and develop a revised tactical plan that is proportionate to the current dynamic situation, this will include a review of previous decisions made during extreme pressure.

- 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. Whilst we have passed peak annual leave season school holiday, Christmas period is approaching. After the most challenging year to date and, in line with recent announcements from the Minister, undoubtedly a difficult autumn and winter ahead, planning to manage pressures as best possible are ongoing

- In terms of staff welfare, whilst the REAP level has reduced challenges with ambulance turnaround times and late finishes persist, and NIAS continues to provide food and hydration at EDs to support staff, with HALOs & Control Room staff combined focus to endeavour to release staff at end of shift.

Resource Escalation Action Plan (REAP)

- The current pressures across the health and social care system have resulted in the Trust moving to Level 4 of its Response Escalation Action Plan (REAP) – the highest escalation level – with effect from 6 July 2021 and until 3 October 2021. The REAP level has now changed to Level 3 “Major Pressure” on 4 October 2021

- The duration of REAP 4 whilst protracted was in keeping with a number of other ambulance Trusts, and whilst the reduced level of pressure is noted by the move to REAP 3 this remains a tenuous position. In response to this and building on lessons learned whilst in REAP 4 it is timely for the Trust to review the current Gold / Silver arrangements. This will necessitate cross Directorate input with a focus on business continuity to focus on both Covid & winter pressures with plans including governance and assurance structures and clear lines of communication and reporting lines.

- The current assessment of the REAP will continue each Monday and is reported to Senior Management Team on a weekly basis to provide a 7 day forecast of pressures and is attributed to a range of metrics; including significant operational staff abstractions, dropped shift cover and challenges with protracted turnaround delays at a number of Emergency Departments. External factors are also considered (e.g. impact of school holidays, community events and relaxation of restrictions)

- Following the weekly assessment of the REAP level the associated agreed actions to mitigate pressures as much as possible are reviewed with identification of the top 5 priority areas and actions agreed

- NIAS continue to participate at Assistant Director level in regional control room “huddle” zoom calls with all Trusts, to ensure there is a system wide understanding of pressures, and agree any regional plans to address. The Health and Social Care Board and hospital Trusts have agreed to reduce these meetings from 5 days a week to 3. There is also continued collaborative focus at Chief Executive level with senior DoH and HSCB colleagues.

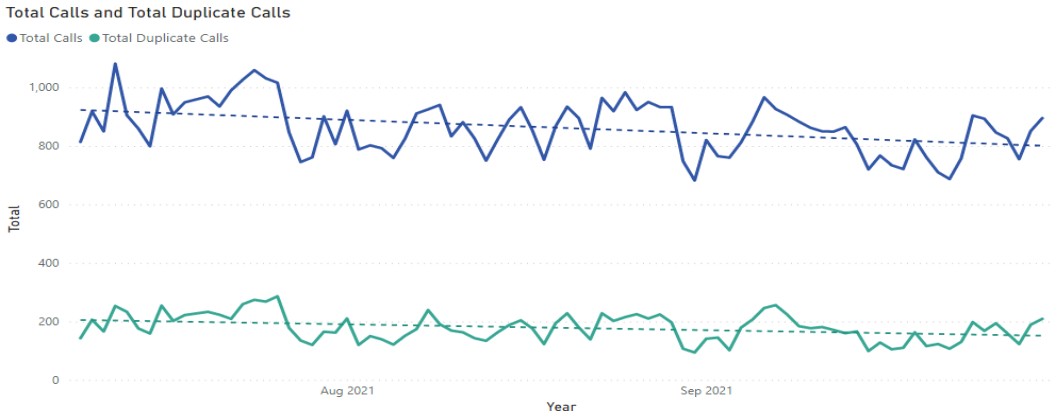
- In addition to the operational 3 weekly regional calls the Director of Operations participates in a call with Health and Social Care Board Director of Commissioning & his Assistant Director with Directors of Acute Services from all hospital Trusts to understand HSC pressures, and strategic plans to support

Current Pressures

INCREASED DEMAND

Whilst it remains the case that the volume of patients NIAS currently convey to EDs has not increased materially, periods of significant peaks in the volume of 999 calls we receive continue. This has undoubtedly impacted on call handling performance. This is a challenge being faced at a UK-wide level.

The volume of duplicate calls and the additional pressures this introduces is recognised nationally. Delays in call answering creates significant clinical risk for patients with unknown conditions waiting in queues with extended delays; patients with Category 1 (immediately life threatening) conditions will be among the queues. Delays in call answering also impacts on BT's ability to continue to answer incoming 999 calls for ambulance services as well as other emergency services.
Recent discussions at NDOG & NASMED are proposing mitigating actions that would involve the introduction of a BT filtering process through which duplicate calls could be identified by BT call handlers.



999 CALLS ANSWERED & BT DELAYS 2 min+ CONNECTION DELAYS

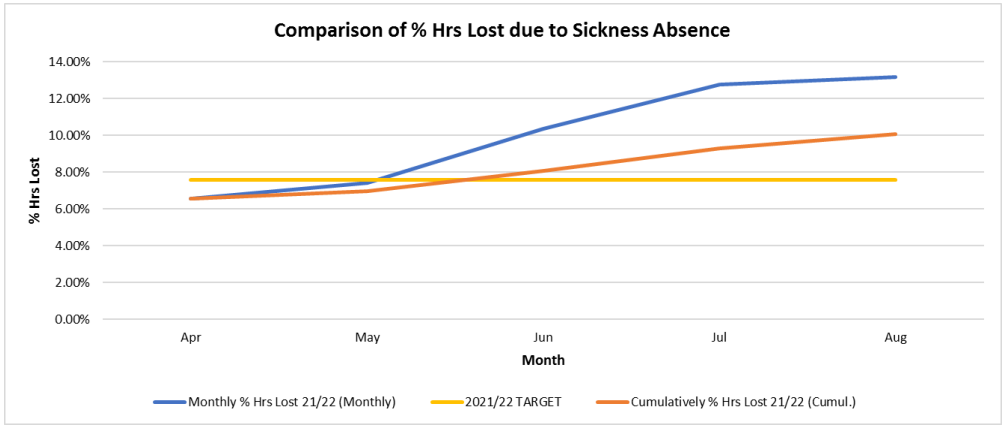
- BT delays at 2min + connection delays peaked in July 2021 - 999 call volume was extremely high at **27,616** 999 calls answered and was a **35%** increase on July 2020 ; 999 taking performance for July was **79.1%** answered within the 5sec standard, and there were **6,353** duplicate calls in July equating to **23%** of call volume for that month.
- BT delays at 2min + connection delays in September 2021 - 999 call volume was extremely high at 24,614 calls answered , 999 taking performance for September was 84.19% answered within the 5sec standard, and there were 4865 duplicate calls in July equating to 19% of call volume for that month.
- Despite September 2021 call volume having reduced from the previous 2 months the call volume remains very high, with the recent 3 months the highest since July 2019 the positive trend in reduced 2+ min delays continues to show a positive trend since July 2021 which we will continue to monitor

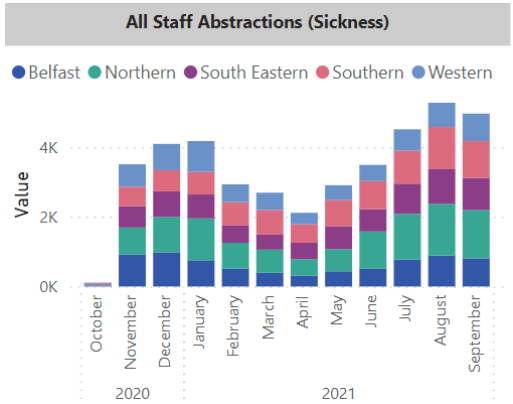
Current Pressures

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, aided by having routinely paid enhanced overtime rates which has resulted in an improved operational cover.



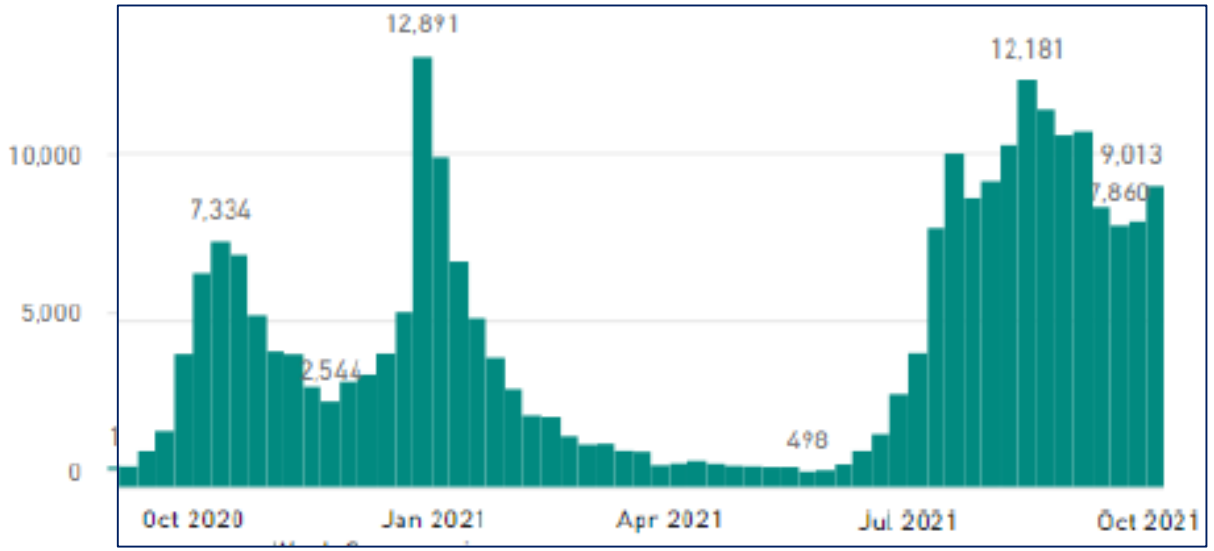


- Figures demonstrate that monthly and cumulative sickness absence levels between April and August 2021 increased at a greater rate than in the same period in 2020/21.
- The cumulative absence figures have increased in the last three months from 8.1% in June 2021 (vs. 7.2% in June 2020), to 9.3% in July 2021 (vs 7.5% in July 2020) to 10.1% August 2021 (vs. 7.8% in August 2020).
- 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**
NIAS ABSENCE TARGET (2021/22)	**REDUCE SICKNESS ABSENCE RATES TO 7.6%**				
NIAS cumulative % hrs lost (20/21)	**6.8%**	**6.9%**	**7.2%**	**7.5%**	**7.8%**
NIAS monthly % hrs lost (20/21)	**6.8%**	**6.9%**	**7.9%**	**8.2%**	**9.2%**
NIAS cumulative % hrs lost (21/22)	**6.56%**	**6.97%**	**8.09%**	**9.28%**	**10.08%**
NIAS monthly % hrs lost (21/22)	**6.56%**	**7.41%**	**10.34%**	**12.76%**	**13.19%**
Monthly % hrs lost (S/T)	1.47%	1.50%	1.84%	2.1%	2.25%
Monthly % hrs lost (L/T)	5.09%	5.91%	8.5%	10.66%	10.94%
Monthly % hrs lost COVID 19 (Self-Symptomatic and self-isolation)	1.12%	0.91%	1.88%	1.22%	1.33%
Av. days lost (7.5 hrs) per Employee per Mth	1.32	1.43	2.02	2.58	2.67
Av.NIAS estimated costs (£'000)	£347	£399	£570	£476	£958
NIAS Cumulative % Hrs Lost:	**(2021/22) 8%**				

Current Pressures – Number of Staff Tested & Positives

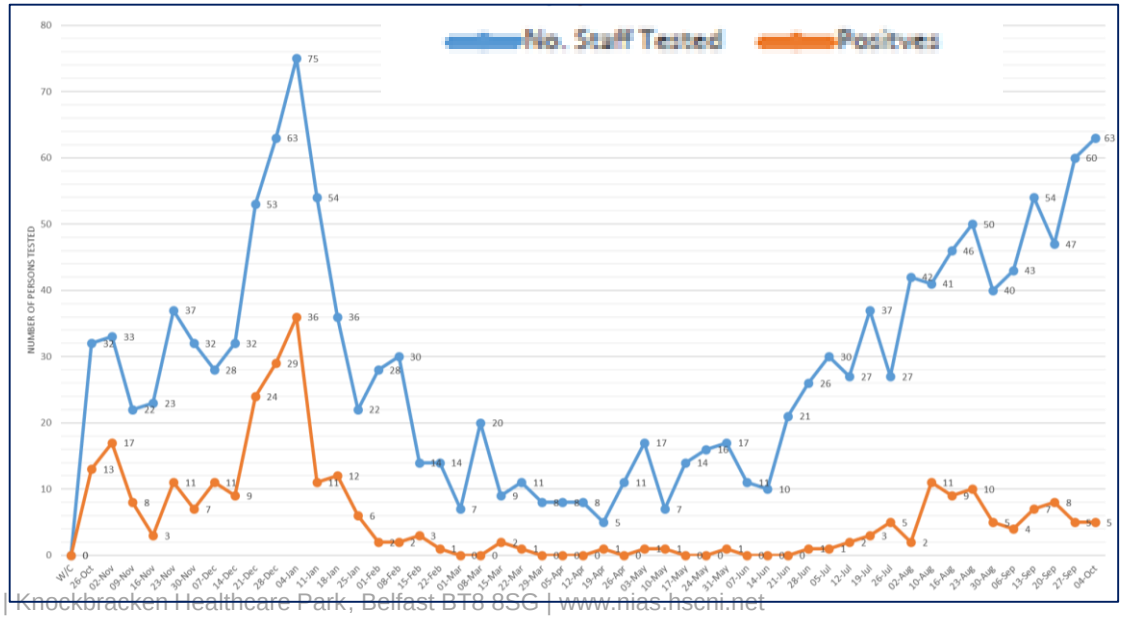
The COVID-19 pandemic to date has been characterised by a number of different 'waves' or 'phases', with waxing and waning case numbers at various times. This graph (right) shows the number of individuals tested positive each week in NI since October 20.



This graph reflects the number of NIAS staff tested each week and the number of COVID-19 positive tests returned.

Staff can be tested either due to experiencing COVID -19 symptoms themselves or as a close contact of an individual who has tested positive for COVID-19. The pattern of the number of *staff tested* within the organisation is similar to that of the number of individuals tested positive each week in NI. In the latest phase an increasing number of staff have been tested weekly since mid June and the number of staff who have a positive test result has increased since mid August.

There is a resulting period of absence from work for those staff either reporting symptoms or identified as a close contact due to the period of self isolation whilst they await a test or following a positive test result. The recent increase in both groups has resulted in increased staff absence and has contributed to increased operational pressures.



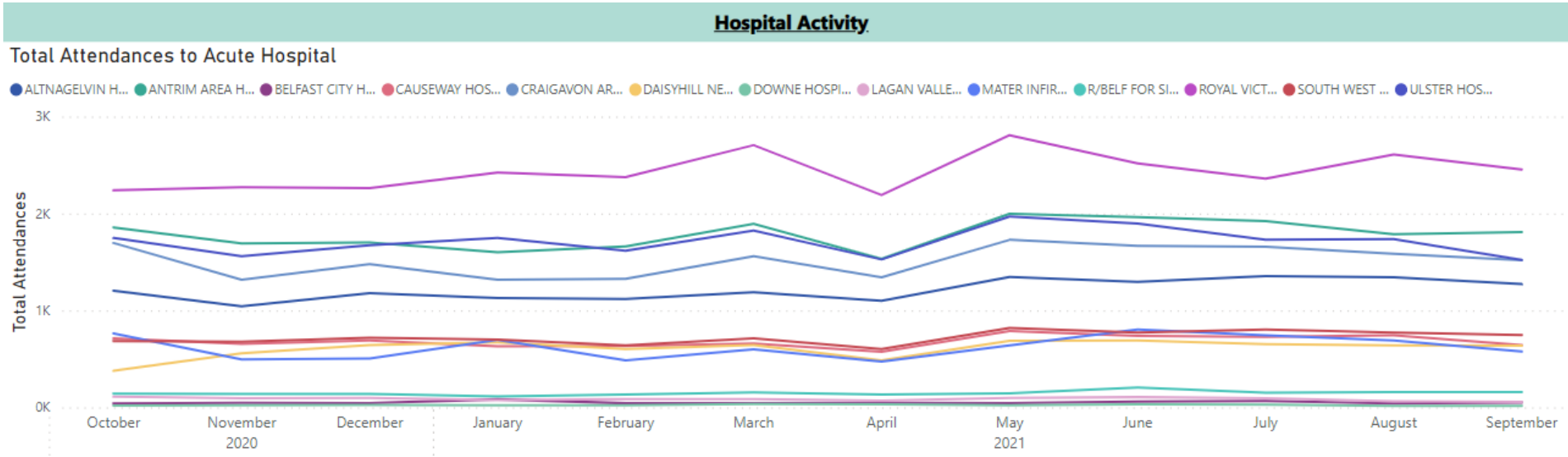
Current Pressures

HANDOVER TIMES

Handover times for NIAS crews at Emergency Departments remain a significant challenge, and maximising HALO cover to support continues.
One of the key actions from the No More Silos Regional Group was that Trusts should as a minimum at the 5 larger EDs provide a dedicated NIAS handover zone Progress on this action has had varying degrees of progress, citing a combination of challenges of identifying a physical space, and staffing of same.
NIAS have been proactively working with Trusts to collaboratively identify a solution to address the delay in implementing this function.

The graph and table refer to the last 12 months, October 2020 to September 2021.

Hospital Activity



Hospital Turnaround Times

Acute Hospital Attended	Total Attendances	Avg. Turnaround Times	Turnarounds Over 30min Target	% Over 30mins	Total Time Lost (Hours)
ALTNAGELVIN HOSPITAL	14572	00:39:39	9311	63.90%	3,072.63
ANTRIM AREA HOSPITAL	21418	00:52:05	17692	82.60%	8,286.27
BELFAST CITY HOSPITAL	617	00:30:47	280	45.38%	70.46
CAUSEWAY HOSPITAL	8195	00:54:40	6269	76.50%	3,669.50
CRAIGAVON AREA HOSPITAL	18195	00:51:31	13698	75.28%	7,098.46
DAISYHILL NEWRY	7289	00:50:52	5483	75.22%	2,761.76
DOWNE HOSPITAL	296	00:33:31	156	52.70%	40.03
LAGAN VALLEY LISBURN	1040	00:30:06	442	42.50%	110.09
MATER INFIRMORUM	7475	00:50:26	5627	75.28%	2,796.53
R/BELF FOR SICK CHILDREN	1772	00:29:52	712	40.18%	197.57
ROYAL VICTORIA	29218	00:58:22	24634	84.31%	14,491.20
SOUTH WEST ACUTE HOSPITAL	8655	00:36:40	4990	57.65%	1,593.28
ULSTER HOSPITAL	20555	00:59:37	17141	83.39%	10,559.08
Total	**139297**	**00:51:36**	**106435**	**76.41%**	**54,746.85**

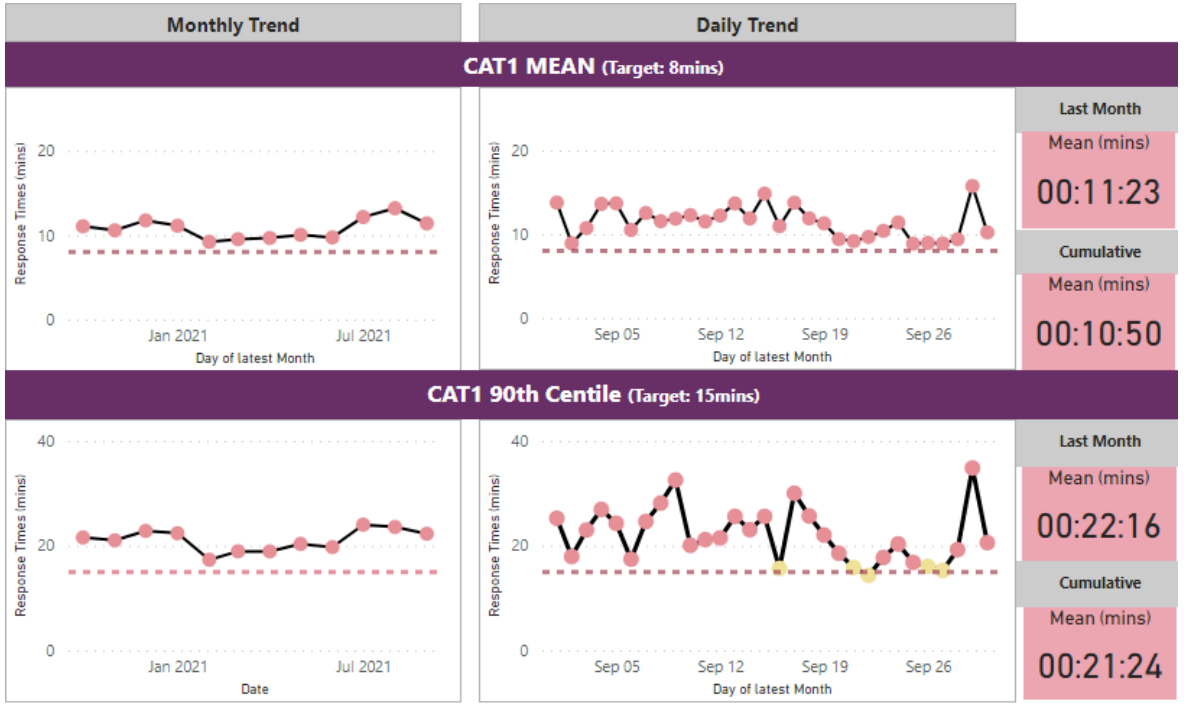
The target hospital turnaround at ED is 30 minutes.

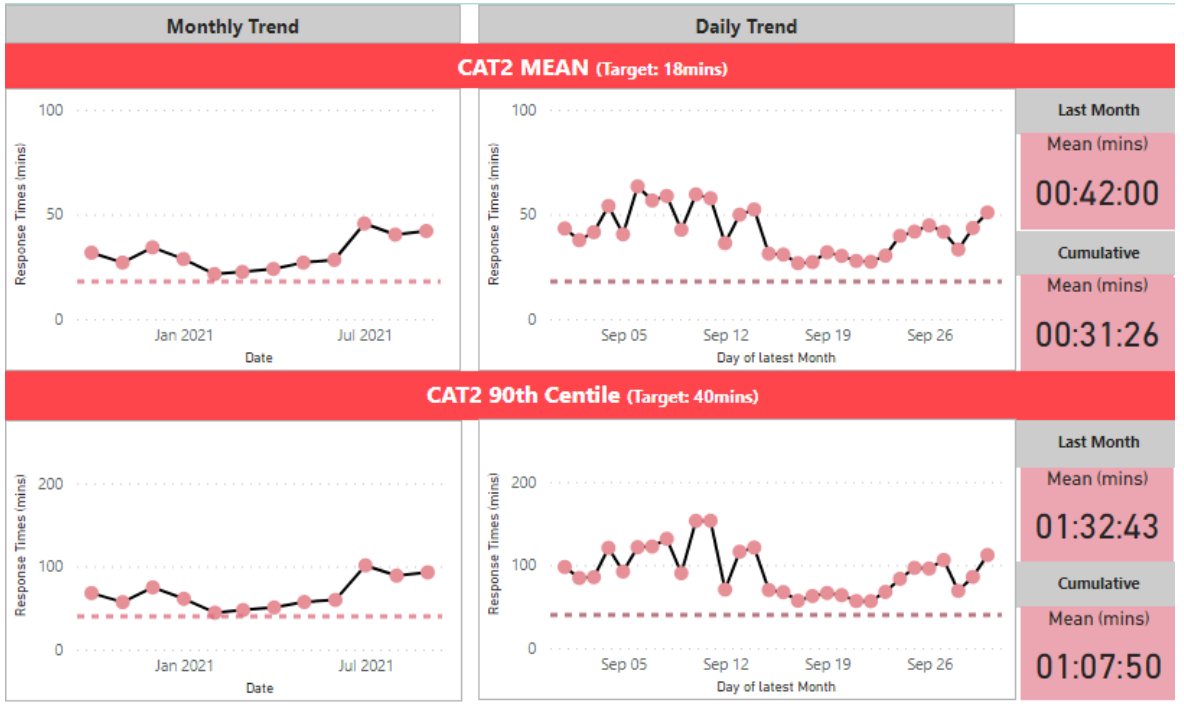
In the last 12 months, the average performance has been 51 minutes, and 76% of the turnarounds are over 30 minutes, resulting in in circa 55k hours lost.

In September 2021, the performance has been 1 hour 5 minutes, with 84% of turnarounds over 30 minutes and 7k hours lost (eq. to 585 12-hours shifts per month or 20 12-shifts per day).

This is an increase of 6% from August 2021

Current Pressures – Impact on Response Time Performance

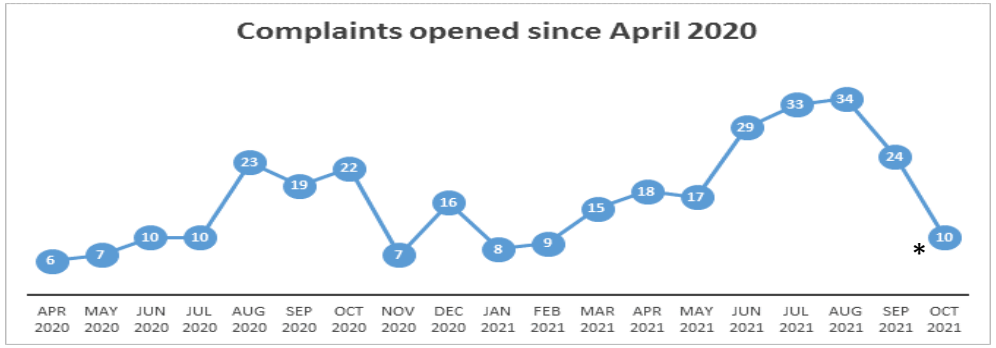




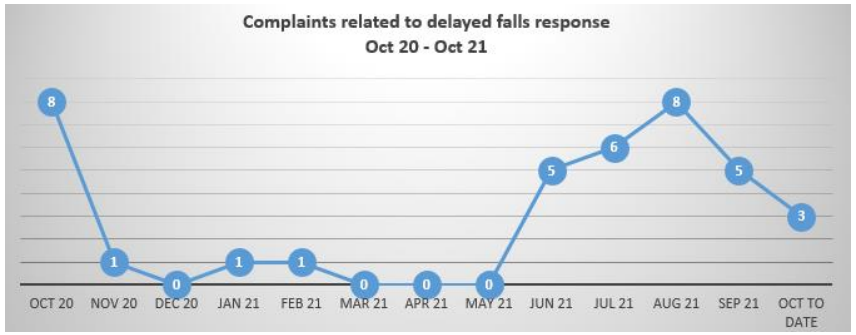
- The combination of service pressures during REAP Level 4 that continued through to 4 October 2021 has continued to impact resulted in a reduction in performance against Category 1 and Category 2 calls against both the mean and 90th centile standards despite maximising resources and implementing a range 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 demonstrate a marginally deteriorated position since the August Trust Board with the cumulative Cat 1 mean now 00:10:50 compared to 00:10:35 in August; similarly the 90th centile cumulative position now 00:21:24 compared to 00:21:01
- Similarly increases in the cumulative Cat 2 response position now a mean of 00:31:26 compared to 00:29:10 at August Trust Board report, and 90th centile current cumulative performance of 01:07:50 compared to the August cumulative position of 01:02:10
- 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 – Impact on Complaints & Serious Adverse Incidents

The graph below shows an increased number of complaints received since June 21 (*Oct data reflects to 13th Oct)



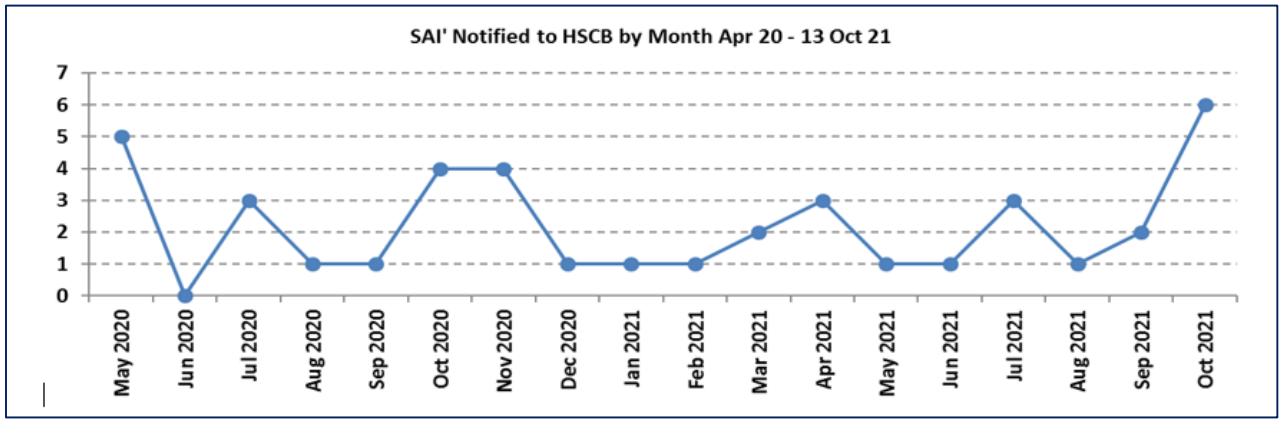
An increasing number of complaints related to delayed transport/response have been received. In particular a key theme of delayed response to falls has been identified (see graph below).



Complaints describe the resulting poor experience for patients and their families/carers as they await an ambulance response and raise concerns regarding pain and maintaining dignity particularly in elderly patients with prolonged waits on the ground. A Quality Improvement Falls Response group has been established internally with an aim to improve response times whilst ensuring that the most appropriate, clinically safe response is provided to people who have fallen.

.

An increase in the number of Serious Adverse Incidents notified to the HSCB has been seen in October (Oct data reflects to 13th Oct). A number of these SAIs have been related to delayed response. A review of each individual case is currently being undertaken to determine the causal and contributory factors to identify learning both internally and externally.



The regional themes of SAIs are shown in the table below. Workforce includes crew and vehicle resources.

Regional Theme
Mismanagement of deterioration: Failure to act on or recognise deterioration
Mismanagement of deterioration: Failure to observe
Mismanagement of deterioration: Assessment of Mental Capacity
Deficient checking and oversight: Misdiagnosis
Deficient checking and oversight: Communication – internal staff
Dysfunctional Patient Flow: Failure of continuity of care
Equipment related errors: Necessary equipment failed or faulty
Other: Workforce
Human Factors: Clinical Decision making
Human Factors: Failure to follow protocol/policy
Human Factors: Other

Actions Taken To Address Current Pressures

INCREASED CALL DEMAND

- The increase in 999 calls particularly in the last 3 months is noted on slide 4. NIAS continues to recruit and train to EMD tier within EAC to maximise staff numbers available
- EAC have also availed of the regional agreed availability for Critical Shift Payments
- Should recent discussions with NDOG & NASMED colleagues come to fruition this will reduce the number of duplicate calls to EAC which will reduce the overall volume of calls received
- On going "buddy" call arrangements continue to be required, in the main on an ad hoc and planned basis
- To raise public awareness of the pressures NIAS are experiencing, and in an attempt to reduce the volume of duplicate calls media messaging regarding the public only calling back should a patient's condition change / deteriorate continues to be utilised, but on a lesser degree than periods earlier in the summer

HOSPITAL TURNAROUND TIMES

- At August 2021 Trust Board an update was provided on the regionally agreed NIAS' authority and autonomy to take patients to the most suitable hospital which may not be the obvious first choice taking account of the individual clinical needs of patients and also ambulance turnaround times, the number of patients in ED and the number of decisions to admit.
- The intention was that this would substantially reduce and, in time, avoid the need for inter-Trust diverts to be sought – other than in exceptional circumstances. To date the request for diverts have been minimal, and the approach regionally acknowledged and welcomed
- It remains the case that this measure will not prevent delayed handovers at ED, but should avoid the variation in handover times that sometimes occurs between sites. NIAS is in discussion with HSCB to provide non-recurrent funds to provide dedicated resource in EAC to support this additional function on behalf of the region
- To support an improvement in ambulance turnaround times at EDs, and seek a collaborative solution for main EDs to provide a dedicated ambulance handover area that would facilitate supporting timely turnaround time for crews NIAS have been exploring solutions to address. Unfortunately despite an initially positive engagement with a voluntary provider to work with NIAS & EDs this has not been successful, but we continue to explore options to address.

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
- Operational staff abstractions (combination of staff sickness and Covid abstractions) continue to impact on the 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 workstreams 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

- End Of Report -

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TB/21/10/2021/05

Return to Agenda

Trust Board Finance Report

August 2021 (Month 5)

Contents

* Executive Summary
* Manage Within Allocated Revenue Resource Limit (RRL)
* Directorate Financial Position
* Voluntary & Private Ambulance Services
* Overtime Expenditure
* Manage Within Allocated Capital Resource Limit (CRL)
* Prompt Payment of Invoices

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 five months ending 31 August 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 £7.747m. 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 96.9% at 31 August 2021 (Month 5). 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 five months ending 31 August 2021 (Month 5), 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. Specifically:

- Agenda for Change – The costs of regrading, pay awards and holiday pay will be fully funded.
- Investment – Clinical Response Model (£2.5m) and NIAS Training (£3.5m) (these schemes have largely been agreed). Other areas remain under discussion including Multi Agency Triage (£70k), Research & Development (up to £62k) and Community Paramedics (up to £600k).
- 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).
- Efficiency Savings – No further efficiency savings will be required. 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. A further £0.965m of non recurrent support has been indicated by HSCB and further measures have been identified to achieve the balance of £0.637m.
- Accounting Treatment - There will be no major in year changes to accounting treatment.
- The agreed RRL at Month 5 is £88.106m of which £87.369m is recurrent.
- The Trust is working through a process of review with DoH/HSCB and the completion of the necessary investment proposals to release these funds. However, the availability of funds may be the subject of DoH bids for in-year monitoring funding for the HSC system. Should the DoH be unable to secure this additional funding, the Trust would be required to stand down services or develop savings plans to achieve break-even. The outcome of the in-year monitoring exercise will not be known until the end of October at the earliest. This will leave limited opportunities to stand down services or develop and implement savings plans. Such a situation could have a major impact on service delivery.

Financial Breakeven Assessment (£k)	Aug	Forecast Year End
Staff Costs	34,852	83,133
Other Expenditure	10,747	27,705
Expenditure Total	45,599	110,838
Income	271	673
Net Expenditure	45,328	110,165
Net Resource Outturn	45,328	110,165
Revenue Resource Limit (RRL)	45,328	110,165
Surplus/(Deficit) against RRL	0	0

Directorate Financial Position

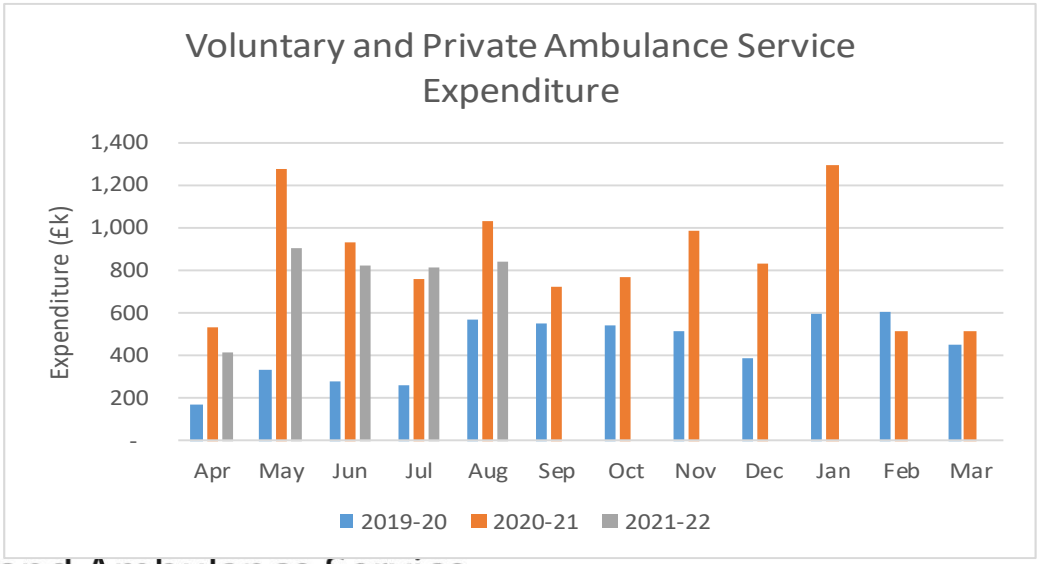
- Underlying the overall financial forecast is a complex budgetary position within each Directorate. Actual expenditure by Directorate at August 2021 (Month 5) is shown opposite.
- The level of underspends against the pay budget is reducing as vacancies across the Trust are filled. Any underspend is 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. Further information will be included in Finance Reports over the rest of the year.

Description	Expenditure at August 2021 (Month 5)
NIAS TOTAL	**45,599**
HQ DIRECTORATES	**9,530**
DIR OF CRM, FLEET & ESTATES	540
DIRECTOR OF FINANCE	860
DIRECTOR OF HUMAN RESOURCES	734
MEDICAL DIRECTOR	4,693
DIRECTOR OF OPERATIONS	450
DIRECTOR OF PLAN, PERF & CORP	1,722
DIRECTOR OF SAFETY, QUAL & IMP	274
CHIEF EXECUTIVE'S OFFICE	258
OPERATIONS DIRECTORATES	**36,069**
BELFAST AREA MANAGER	4,672
REGIONAL CONTROL CENTRES	8,053
SOUTHEAST AREA MANAGER	4,829
NORTH AREA MANAGER	7,142
SOUTH AREA MANAGER	5,446
WEST AREA MANAGER	5,927

Voluntary & Private Ambulance Services

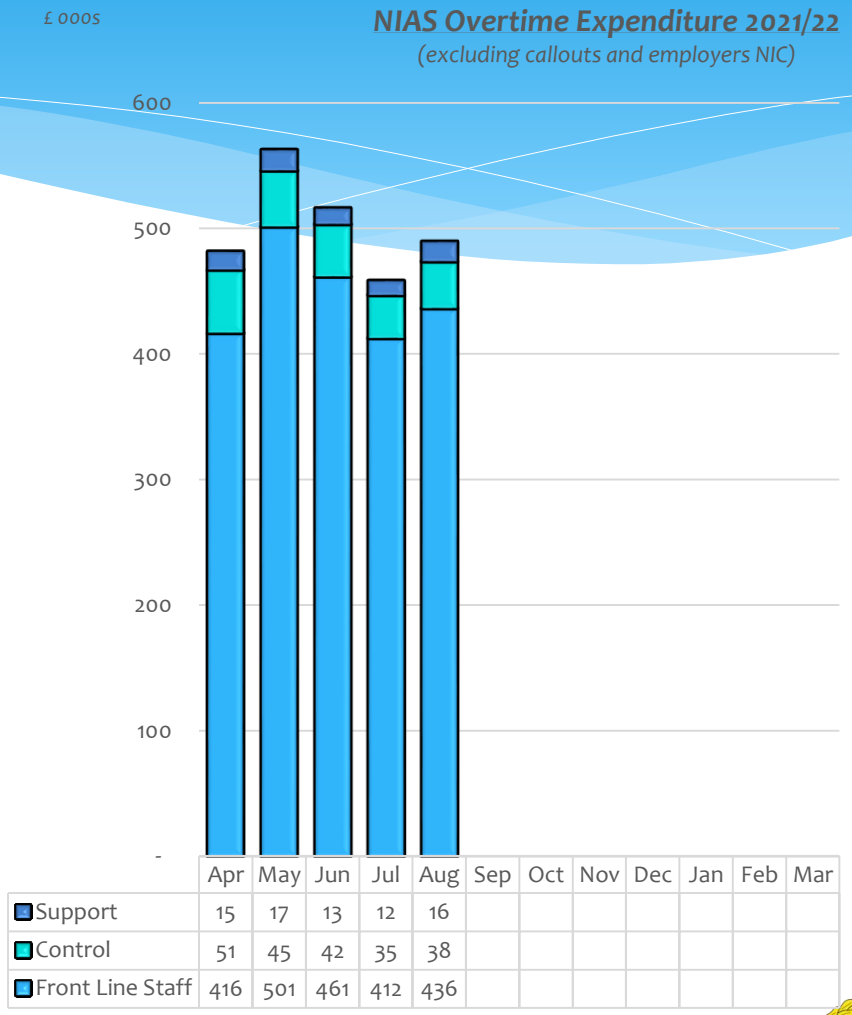
The Trust benefited from significant additional funds in 2020-21 as part of the response to Covid-19. A similar level of support is expected in 2021-22 which will be applied to additional support from VAS/PAS to maintain and enhance ambulance provision during this difficult period. The Trust welcomes 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.



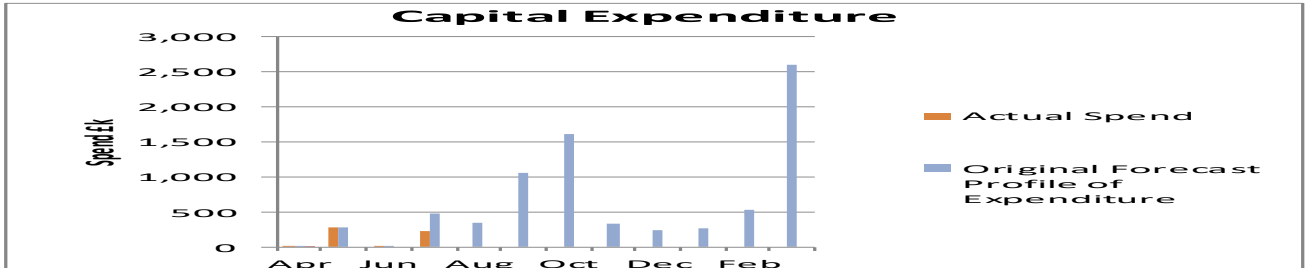
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Support	15	17	13	12	16							
Control	51	45	42	35	38							
Front Line Staff	416	501	461	412	436							

Manage within allocated Capital Resource Limit (CRL)

- The Trust has received a Capital Resource Limit (CRL) allocation of £7.747m. This includes allocations for Fleet & Estate, ICT and Backlog Maintenance as follows:

Project	£k
Fleet & Estate	5,694
ICT	1,803
Backlog Maintenance	250
Total	7,747

- 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.
- Provisional figures for expenditure at August 2021 (Month 5) is £0.510m against this allocation of £7.747m. 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							17,213	
Total bills paid within 30 calendar days of receipt of undisputed invoice	2,616	2,907	3,177	2,274	2,887	2,824							16,685	
% bills paid on time 30 days	98.9%	97.9%	98.8%	93.2%	95.1%	97.1%							96.9%	>95%
Total bills paid within 10 working days (14 calendar days)	2,196	2,447	2,846	1,934	2,551	2,564							14,538	
% bills paid on time 10 days	83.1%	82.4%	88.5%	79.2%	84.1%	88.2%							84.5%	>70%

End of Report

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TB/21/10/2021/06

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Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

PRESENTATION OF PAPER

Date of Trust Board:	21 October 2021
Title of paper:	Review of NIAS Standing Orders
Brief summary:	A detailed review has been undertaken of the Trust's Standing Orders. The attached Standing Orders show the tracked changes, the majority of which have been made with a view to providing further clarification. One major change relates to the approval of policies and procedures which is referenced under 'Policy Determination' (page 61). It is proposed that the Committee Terms of Reference should also form an integral part of the Standing Orders document. Members will be aware that Ms Anne Quirk, former Boardroom Apprentice, had carried out work to ensure consistency across the Committee Terms of Reference. The Audit Committee considered these at its meeting on 7 October and has recommended their approval. The Audit Committee will assume an increased role in relation to risk assurance and approval is also being sought from Trust Board to amend the name of the Audit Committee to the Audit and Risk Assurance Committee.

	If approved, the final Standing Orders will be posted on the Trust website.
Recommendation:	**For Approval** ☒ **For Noting** ☐
Previous forum:	n/a
Prepared and presented by: **Date:**	Carol Mooney, Board Secretary Maxine Paterson, Director of Planning, Performance & Corporate Services 14 October 2021

Northern Ireland Ambulance Service
Health and Social Care Trust

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STANDING ORDERS

And

SCHEME OF RESERVATION AND DELEGATION

October 2021

Northern Ireland Ambulance Service
Health and Social Care Trust

Title:	Standing Orders and Scheme of Reservation and Delegation		
Author:	Mr Andrew Phillips, Assistant Director of Finance		
Ownership:	Mrs Sharon McCue, Director of Finance and ICT		
Date of Audit Committee Approval:	~~18 June 2019~~7 October 2021	Date of Trust Board Approval:	~~18 June 2019~~
Operational Date:	28 June 2019	Review Date:	June 2020
Version No:	V2~~1~~.0	Supercedes:	TW/4/Fin (03) 2014
Key words:	Standing Orders, Scheme of Reservation and Delegation, Standing Financial Instructions		
Other Relevant Policies:	Standing Financial Instructions		

Date	Version	Author	Comments
17 June 2019	V0.1	Andrew Phillips	Standing Orders benchmarked with HSC Trusts
18 June 2019	V1.0	Andrew Phillips	Approved at Audit Committee and Trust Board
???		Carol Mooney	Approved at Audit Committee and T Board

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SECTION A

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1. INTERPRETATION AND DEFINITIONS FOR STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS

1.1 Save as otherwise permitted by law, at any meeting, the Chair of the Trust shall be the final authority on the interpretation of Standing Orders (on which they should be advised by the Chief Executive).

1.2 Any expression to which a meaning is given in the HPSS (NI) Order 1991, the Health and Social Care (Reform) Act (Northern Ireland) 2009 and other Acts/Orders relating to the HSC shall have the same meaning in these Standing Orders and Standing Financial Instructions and in addition:

1.2.1 **"Accounting Officer"** means the HSC Officer responsible and accountable for funds entrusted to the Trust. The officer shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive.

1.2.2 **"Trust"** means the Northern Ireland Ambulance Service (NIAS) Health & Social Care Trust.

1.2.3 **"Board"** means the Chair, Executive and Non-Executive members of the Trust collectively as a body.

1.2.4 **"Budget"** means a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.

1.2.5 **"Budget holder"** means the Director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation.

1.2.6 **"Chair of the Board (or Trust)"** is the person appointed by the Departmental Public Appointments Unit to lead the Board and to ensure that it successfully discharges

its overall responsibility for the Trust as a whole. The expression “the Chair of the Trust” shall be deemed to include the member acting as Chair of the Trust if the Chair is absent from the meeting or is otherwise unavailable.

1.2.7 **"Chief Executive"** means the Chief Officer of the Trust. The Chief Executive is the Trust’s Accounting Officer.

~~1.2.8 **“Assurance Committee"** means a committee whose functions are concerned with the arrangements for the purpose of monitoring and improving the quality and safety of health and social care for which the Northern Health and Social Care Trust has responsibility.~~

1.2.8~~9~~ **"Commissioning"** means the process for determining the need for and for obtaining the supply of healthcare, social care and related services by the Trust within available resources.

1.2.9~~10~~ **"Committee"** means a Committee or Sub-Committee created and appointed by the Trust.

1.2.10~~10~~ **"Committee members"** means persons formally appointed by the Board to sit on or to chair specific Ccommittees.

1.2.11~~12~~ **"Contracting and procuring"** means the systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.

1.2.12~~3~~ **"Director of Finance"** means the Chief Financial Officer of the Trust.

1.2.13~~4~~ **“Funds held on trust”** shall mean those funds which the Trust holds on date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under

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Article 16 of the HPSS (NI) Order 1991. Such funds may or may not be charitable.

~~1.2.15~~ **1.2.14"Member"** means Eexecutive or N~~n~~on-Eexecutive member of the Board as the context permits. Member, in relation to the Board, includes its Chair.

1.2.1~~6~~5 **"Associate Member"** means a person appointed to perform specific statutory and non-statutory duties which have been delegated by the Trust Board for them to perform and these duties have been recorded in an appropriate Trust Board minute or other suitable record.

1.2.1~~6~~7 **"Membership, Procedure and Administration Arrangements Regulations"** means HSS Trusts (Membership and Procedure) Regulations (Northern Ireland) 1994.

1.2.1~~7~~8 **"Nominated officer"** means an officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.

1.2.1~~8~~9 **"Officer"** means employee of the Trust or any other person holding a paid appointment or office with the Trust.

1.2.19 "**Audit and Risk Assurance Committee**" means a Committee whose primary role is to independently contribute to the Board's overall process for ensuring that an effective internal financial control system is maintained.

1.2.20 **"People, Finance and Organisational Development Committee'** (People Committee) means a Committee whose functions are concerned with providing assurance in relation to strategic HR issues and the Trust Board's statutory responsibility to break even.

1.2.21 "**Remuneration Committee & Terms of Service Committee**" means a Committee whose primary role is to advise the Board about appropriate remuneration and

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terms of service for the Chief Executive and all other direct reports to the Chief Executive.

1.2 .22 **"Safety, Quality, Patient Experience and Performance Committee"** (Safety Committee) means a Committee whose functions are concerned with the arrangements for the purpose of monitoring and improving the quality and safety of health and social care for which the Northern Ireland Ambulance Service Health and Social Care Trust has responsibility.

1.2.230 **"Secretary"** means a person appointed to act independently of the Board to provide advice on corporate governance issues to the Board and the Chair and monitor the Trust's compliance with the law, Standing Orders, and DoH guidance.

1.2.241 **"SFI's"** means Standing Financial Instructions.

1.2.252 **"SO's"** means Standing Orders.

1.2.263 **"Member acting as Chair"** means the Nnon-Eexecutive member appointed by the Board to take on the Chair's duties if the Chair is absent for any reason.

1.2.274 **"DoH"** means the Department of Health.

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SECTION B – STANDING ORDERS

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1. INTRODUCTION

1.1 Statutory Framework

The Northern Ireland Ambulance Service (NIAS) HSC Trust (the Trust) is a statutory body which came into existence on 1 April 1995 under the Northern Ireland Ambulance Service Health and Social Services Trust (Establishment) Order (Northern Ireland) 1995.

1.1.1 The principal place of business of the Trust is Northern Ireland Ambulance Service, Headquarters, Site 30, Knockbracken Healthcare Park, Saintfield Road, Belfast, BT8 8SG.

1.1.2 HSC Trusts are provided for under Article 10(1) of the Health and Personal Social Services (NI) Order 1991 and subsequently amended under Health and Social Care (Reform) Act (Northern Ireland) 2009.

1.1.3 The functions of the Trust are conferred by this legislation.

1.1.4 As a statutory body, the Trust has specified powers to contract in its own name and to act as a corporate trustee.

1.1.5 Schedule 3 of the HPSS (NI) Order 1991 specifies the duties, powers and status of HSC Trusts.

1.1.6 ~~Circular HSS (PDD) 8/94 and~~ Tthe Codes of Conduct and Accountability require the Trust to adopt Standing Orders for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions (SFIs) as part of Standing Orders setting out the responsibilities of individuals.

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1.1.7 The Trust will also be bound by such other statutes and legal provisions which govern the conduct of its affairs.

1.2 Health and Social Care Framework

1.2.1 In addition to the statutory requirements, the Minister for Health, through the DoH, issues further directions and guidance. These are normally issued under cover of a circular or letter.

1.2.2 The Codes of Conduct and Accountability require that, ~~inter alia~~among other things, Boards draw up a schedule of decisions reserved to the Board, and ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives (a scheme of delegation). The C~~c~~ode also requires the establishment of A~~a~~udit and R~~r~~emuneration C~~c~~ommittees with formally agreed terms of reference. The Standards of Business Conduct make various requirements concerning possible conflicts of interest of Board members.

1.2.3 The Trust will produce and publish an annual report for each financial year within the timescales set by the DoH. The Annual Report will identify the Chair, Chief Executive and Non-Executive Directors, as well as the Chair and members of the Audit and Risk Assurance Committee, ~~Assurance~~ Safety, People and Remuneration Committees. It will also set out the numbers of meetings of the Board and those C~~c~~ommittees and individual attendance by members.

1.2.4 The Trust will comply with all statutory requirements and Departmental directions, including the DoH Framework Document, Management Statement and Financial Memorandum, the Codes of Conduct and ~~Code of~~ Accountability for Board Members of Health and Social Care bodies and other Codes of Conduct and directions as these apply to the functions, activities and conduct of Boards of Health and Social Care Trusts. Where these

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are updated or replaced, the new provisions and requirements will apply.

1.3 Delegation of Powers

1.3.1 The Trust has powers to delegate and make arrangements for delegation. The Standing Orders set out the detail of these arrangements. Under the Standing Order relating to the Arrangements for the Exercise of Trust Functions by Delegation (SO 5) the Trust is given powers to "make arrangements for the exercise, on behalf of the Trust of any of their functions by a committee, sub-committee or joint committee appointed by virtue of Standing Order 4 or by an officer of the Trust, in each case subject to such restrictions and conditions as the Trust thinks fit or as the Minister for Health may direct". Delegated Powers are covered in Section C of this document – Scheme of Reservation and Delegation.

1.4 Governance

1.4.1 Trust Boards are required to have in place integrated governance structures and arrangements that will lead to good governance and to ensure that decision-making is informed by intelligent information covering the full range of corporate, financial, clinical, social care, information and research governance aspects. This will better enable the Board to take a holistic view of the organisation and its capacity to meet its legal and statutory requirements and clinical, social care, quality, safety and financial objectives.

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2. THE TRUST BOARD: COMPOSITION OF MEMBERSHIP, TENURE AND ROLE OF MEMBERS

2.1 Composition of the Membership of the Trust Board

In accordance with The Northern Ireland Ambulance Service Health and Social Services Trust (Establishment) Order (NI) 1995, ~~the Membership, Procedure and Administration Arrangements regulations~~ the composition of the Board shall be:

2.1.1 The Chair of the Trust (appointed by the Minister for Health following a recruitment process overseen by the DoH Public Appointments Unit)~~appointed by the DoH Public Appointments Unit~~).

2.1.2 Up to five~~5~~ Non-Executive members (appointed by the DoH Public Appointments Unit).

2.1.3 Up to five~~5~~ Executive members (but not exceeding the number of Non-Executive members) including:

(a) the Chief Executive; ~~and~~and

(b) the Director of Finance;

~~.~~

The Trust Board shall have not less than eight~~8~~ members (unless otherwise determined by the Minister for Health and set out in the Trust's Establishment Order or such other communication from DoH).

2.2 Appointment of Chair and Members of the Trust

2.1.1 The Chair and Non-Executive Directors of the Trust are appointed by the DoH Public Appointments Unit.

2.3 Terms of Office of the Chair and Members

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2.3.1 The regulations setting out the period of tenure of office of the Chair and members and for the termination or suspension of office of the Chair and members are contained in Part 2, Articles 7 - 9 of the HSS Trusts (Membership and Procedure) Regulations (NI) 1994.

2.4 Appointment and Powers of Vice-Chair

2.4.1 Subject to Standing Order 2.4.2 below, the Chair and members of the Trust may appoint one of their numbers, who is not also an Eexecutive member, to be Vice-Chair, for such period, not exceeding the remainder of his term as a member of the Trust, as they may specify on appointing him/her.

2.4.2 Any member so appointed may at any time resign from the office of Vice-Chair by giving notice in writing to the Chair. The Chair and members may thereupon appoint another member as Vice-Chair in accordance with the provisions of Standing Order 2.4.1.

2.4.3 Where the Chair of the Trust has died or has ceased to hold office, or where they have been unable to perform their duties as Chair owing to illness or any other cause, the Vice-Chair shall act as Chair until a new Chair is appointed or the existing Chair resumes their duties, as the case may be; and references to the Chair in these Standing Orders shall, so long as there is no Chair able to perform those duties, be taken to include references to the Vice-Chair.

2.5 Joint Members

2.5.1 Where more than one person is appointed jointly to a post mentioned in Part 2, regulation 6 of the HSS Trusts (Membership and Procedure) Regulations (NI) 1994, those persons shall count for the purpose of Standing Order 2.1 as one person.

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2.5.2 Where the office of a member of the Board is shared jointly by more than one person:

(a) Either or both of those persons may attend or take part in meetings of the Board;

(b) If both are present at a meeting they should cast one vote if they agree;

(c) In the case of disagreements no vote should be cast;

(d) The presence of either or both of those persons should count as the presence of one person for the purposes of Standing Order 3.11 Quorum.

2.6 Role of Members

The Board will function as a corporate decision-making body, Executive and Non-Executive members will be full and equal members. Their role as members of the Trust Board will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions.

2.6.1 Chair

The Chair shall be responsible for the operation of the Board and chair all Board meetings when present. The Chair has certain delegated executive powers. The Chair must comply with the terms of appointment and with these Standing Orders.

The Chair shall liaise with the DoH Public Appointments Unit over the appointment of Non-Executive Directors and, once appointed, shall take responsibility for their induction, their portfolios of interests and assignments, and their performance.

The Chair shall work closely with the Chief Executive and shall ensure that key and appropriate issues are

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discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.

The Chair is responsible for leading the Board and for ensuring that it successfully discharges its overall responsibility for the organisation as a whole. The Chair is accountable to the Minister through the Departmental Accounting Officer. The Chair shall ensure that the Trust's policies and actions support the wider strategic policies of the Minister and that the Trust's affairs are conducted with probity.

The Chair has a particular leadership responsibility on:-

- Formulating the Board's strategy for discharging its duties;
- Ensuring that the Board, in reaching decisions, takes proper account of guidance provided by the Minister, the sponsor department, the HSCB or the PHA;
- Ensuring that risk management is regularly and formally considered at Board meetings;
- Promoting the efficient, economic and effective use of staff and other resources;
- Encouraging and delivering high standards of regularity and propriety;
- Representing the views of the Board to the general public;
- Ensuring that the Board meets at regular intervals throughout the year and that the minutes of meetings accurately record the decisions taken and, where appropriate, the views of individual Board members.

The Chair shall also:

- Ensure that all members of the Board, when taking up office, are fully briefed on the terms of their appointment and on their duties, rights and responsibilities, and receive appropriate induction training, including on the financial management and

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reporting requirements of public sector bodies and on any differences which may exist between private and public sector practice;

- Advise the DoH of the needs of the Trust when Board vacancies arise, with a view to ensuring a proper balance of professional, financial or other expertise;
- Assess the performance of individual Board members. Board Members will be subject to ongoing performance appraisal, with a formal assessment being completed in consultation with Committee Chairs as appropriate by the Chair of the Board at the end of each year and prior to any proposed re - appointment or extension of the term of appointment of individual members taking place. Members will be made aware that they are being appraised, the standards against which they will be appraised, and will have an opportunity to contribute to and view their report. The Chair of the Board will also be appraised on an annual basis by the DoH.
- Ensure the completion of the Board Governance Self Assessment Tool on an annual basis. Assurance will be provided through the mid-year assurance statement that the tool is being completed, actions are being addressed and that any exception issues will be raised with the DoH.
- The Chair shall also ensure that Trust Board members are made aware of the Code of Conduct for Board Members of HSC Bodies (2012) including the Nolan "seven principles of public life", and the requirement for a comprehensive and publicly available register of Board Members' Interests. Communications between the Board, the Minister and the DoH shall normally be through the Chair. The Chair shall ensure that the other Board members are kept informed of such communications on a timely basis.

2.6.2 Non-Executive Members

The Non-Executive Members shall not be granted nor shall they seek to exercise any individual executive

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powers on behalf of the Trust. They may however, exercise collective authority when acting as members of or when chairing a Committee of the Trust which has delegated powers.

2.6.31 Executive Members

Executive Members shall exercise their authority within the terms of these Standing Orders, the Scheme of Delegation and the Standing Financial Instructions.

2.6.42 Chief Executive

The Chief Executive shall be responsible for the overall performance of the executive functions of the Trust. He/she is the **Accounting Officer** for the Trust and shall be responsible for ensuring the discharge of obligations under Financial Directions and in line with the requirements of the Accounting Officer Memorandum for Trust Chief Executives issued by DoH.

The Chief Executive shall be directly accountable to the Chair and Non-Executive Members of the Board for ensuring Board decisions are implemented, that the organisation works effectively in accordance with government policy and public service values, and for the maintenance of proper financial stewardship. The Chief Executive should be allowed full scope, within clearly defined delegated powers, for action fulfilling the decisions of the Board.

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2.6.53 Director of Finance

The Director of Finance shall be responsible for the provision of financial advice to the Trust and to its members and for the supervision of financial control and accounting systems. He/she shall be responsible along with the Chief Executive for ensuring the discharge of obligations under relevant Financial Directions.

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~~**2.6.4 Non-Executive Members**~~

~~The Non-Executive Members shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may however, exercise collective authority when acting as members of or when chairing a committee of the Trust which has delegated powers.~~

~~**2.6.5 Chair**~~

~~The Chair shall be responsible for the operation of the Board and chair all Board meetings when present. The Chair has certain delegated executive powers. The Chair must comply with the terms of appointment and with these Standing Orders.~~

~~The Chair shall liaise with the DoH Public Appointments Unit over the appointment of Non-Executive Directors and once appointed shall take responsibility for their induction, their portfolios of interests and assignments, and their performance.~~

~~The Chair shall work closely with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.~~

2.7 Corporate Role of the Board

2.7.1 All business shall be conducted in the name of the Trust.

2.7.2 All funds received in trust shall be held in the name of the Trust as corporate trustee.

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2.7.3 The powers of the Trust established under statute shall be exercised by the Board meeting in public session except as otherwise provided for in Standing Order No. 3.

2.7.4 The Board shall define and regularly review the functions it exercises on behalf of the Minister for Health.

2.8 Schedule of Matters Reserved to the Board and Scheme of Delegation

2.8.1 The Board may resolve that certain powers and decisions may only be exercised by the Board in formal session. These powers and decisions should be set out in Section C - 'Schedule of Matters Reserved to the Board' and shall have effect as if incorporated into the Standing Orders. Those powers which it has delegated to officers and other bodies are contained in the Scheme of Delegation.

2.9 Lead Roles for Board Members

2.9.1 The Chair will ensure that the designation of lead roles or appointments of Board members as required by DoH or as set out in any statutory or other guidance will be made in accordance with that guidance or statutory requirements (e.g. appointing a Lead Board Member with responsibilities for Infection Control or Child Protection Services etc.).

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3. MEETINGS OF THE TRUST BOARD

3.1 Calling Meetings

3.1.1 Ordinary meetings of the Board shall be held at regular intervals at such times and places as the Board may determine. The Board shall determine the minimum number of meetings to be held each year.

In order to meet the social distancing requirements of Covid-19, the Board is unlikely to meet in person for the foreseeable future and so will meet by virtual means. As a result of this, the Trust will make alternative arrangements for public and staff involvement by virtual means.

3.1.2 The Chair of the Trust may call a meeting of the Board at any time.

3.1.3 One third or more members of the Board may requisition a meeting in writing. If the Chair refuses, or fails, to call a meeting within seven days of a requisition being presented, the members signing the requisition may forthwith call a meeting.

3.2 Notice of Meetings and the Business to be Transacted

3.2.1 Before each meeting of the Board a written notice specifying the business proposed to be transacted shall be delivered to every member and to everyone on the Board distribution list and posted on the Trust website at least five working days before the meeting. Lack of service of such a notice on any member shall not affect the validity of a meeting ~~Before each meeting of the Board a written notice specifying the business proposed to be transacted shall be delivered to every member, or sent by post to the usual place of residence of each member, so as to be available to members at least three working days before the meeting. The notice shall be signed by the Chair or by an officer authorised by the~~

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~~Chair to sign on his/her behalf. Lack of service of such a notice on any member shall not affect the validity of a meeting.~~

3.2.2 In the case of a meeting called by members in default of the Chair calling the meeting, the notice shall be signed by those members.

3.2.3 No business shall be transacted at the meeting other than that specified on the agenda, or emergency motions allowed under Standing Order 3.6.

3.2.4 A member desiring a matter to be included on an agenda shall make his/her request in writing to the Chair at least 10 working days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 10 working days before a meeting may be included on the agenda at the discretion of the Chair.

3.2.5 Before each meeting of the Board, a public notice in accordance with circular HSS (PPM) 4/2001 shall be issued detailing the time and place of the meeting. The public part of the agenda shall be posted on the Trust website www.nias.hscni.net at least one week before the meeting (required by section 54 of the Health and Personal Social Services Act (Northern Ireland) 2001).

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3.3 Agenda and Supporting Papers

3.3.1 The Agenda will be sent to members at least five~~5~~ working days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will be despatched no later than three working days before the meeting, save in emergency.

3.4 Petitions

3.4.1 Where a petition has been received by the Trust the Chair may include the petition as an item for the agenda

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of the next meeting, providing it is appropriate for consideration by the Board. The Chair shall advise the meeting of any petitions that are not granted and the grounds for refusal.

3.5 Notice of Motion

3.5.1 Subject to the provision of Standing Orders 3.7 'Motions: Procedure at and during a meeting' and 3.8 'Motions to rescind a resolution', a member of the Board wishing to move a motion shall send a written notice to the Chief Executive who will ensure that it is brought to the immediate attention of the Chair.

3.5.2 The notice shall be delivered at least ~~15~~five clear days before the meeting. The Chief Executive shall include in the agenda for the meeting all notices so received that are in order and permissible under governing regulations. This Standing Order shall not prevent any motion being withdrawn or moved without notice on any business mentioned on the agenda for the meeting.

3.6 Emergency Motions

3.6.1 Subject to the agreement of the Chair, and subject also to the provision of Standing Order 3.7 'Motions: Procedure at and during a meeting', a member of the Board may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Trust Board at the commencement of the business of the meeting as an additional item included in the agenda. The Chair's decision on the inclusion of an item shall be final.

3.7 Motions: Procedure at and during a Meeting

3.7.1 Who may propose

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A motion may be proposed by the Chair of the meeting or any member present. It must also be seconded by another member.

3.7.2 Contents of motions

The Chair may exclude from the debate at his/her discretion any such motion of which notice was not given on the notice summoning the meeting other than a motion relating to:

(a) The reception of a report;

(b) Consideration of any item of business before the Trust Board;

(c) The accuracy of minutes;

(d) That the Board proceeds to next business;

(e) That the Board adjourns; and

(f) That the question be now put.

3.7.3 Amendments to motions

A motion for amendment shall not be discussed unless it has been proposed and seconded.

Amendments to motions shall be moved relevant to the motion, and shall not have the effect of negating the motion before the Board.

If there are a number of amendments, they shall be considered one at a time. When a motion has been amended, the amended motion shall become the substantive motion before the meeting, upon which any further amendment may be moved.

3.7.4 Rights of reply to motions

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a) Amendments

The mover of an amendment may reply to the debate on their amendment immediately prior to the mover of the original motion, who shall have the right of reply at the close of debate on the amendment, but may not otherwise speak on it.

b) Substantive / Original motion

The member who proposed the substantive motion shall have a right of reply at the close of any debate on the motion.

3.7.5 Withdrawing a motion

A motion, or an amendment to a motion, may be withdrawn.

3.7.6 Motions once under debate

When a motion is under debate, no motion may be moved other than:

(a) An amendment to the motion;

(b) The adjournment of the discussion, or the meeting;

(c) That the meeting proceeds to the next business;

(d) That the question should be now put;

(e) The appointment of an 'ad hoc' committee to deal with a specific item of business;

(f) That a member be not further heard; and

(g) A motion under Section 23(2) of the Local Government Act (NI) 1972 resolving to exclude the

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public, including the press (see Standing Order 3.17).

In those cases where the motion is either that the meeting proceeds to the 'next business' or 'that the question be now put' in the interests of objectivity these should only be put forward by a member of the Board who has not taken part in the debate and who is eligible to vote.

If a motion to proceed to the next business or that the question be now put, is carried, the Chair should give the mover of the substantive motion under debate a right of reply, if not already exercised. The matter should then be put to the vote.

3.8 Motion to Rescind a Resolution

3.8.1 Notice of motion to rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the member who gives it and also the signature of three other members, and before considering any such motion of which notice shall have been given, the Trust Board may refer the matter to any appropriate Committee or the Chief Executive for recommendation.

3.8.2 When any such motion has been dealt with by the Trust Board, it shall not be competent for any Executive / Member, other than the Chair, to propose a motion to the same effect within six months. This Standing Order shall not apply to motions moved in pursuance of a report or recommendations of a Committee or the Chief Executive.

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3.9 Chair of Meeting

3.9.1 At any meeting of the Trust Board, the Chair~~,~~ shall preside. In the Chair's absence, the Chair of Audit and Risk Assurance Committee shall assume the position of Chair. ~~In the absence of both the Chair and the Chair of Audit Committee, the Chair of Assurance Committee shall assume the position of Chair.~~

3.9.2 ~~If the Chair, and the Chairs of both Audit and Assurance Committee are absent,~~In the absence of the Chair and Chair of the Audit and Risk Assurance Committee, any such member (who is not also an E~~e~~xecutive Member of the Trust) as the members present shall choose, shall preside.

3.10 Chair's Ruling

3.10.1 The decision of the Chair of the meeting on questions of order, relevancy and regularity (including procedure on handling motions) and their interpretation of the Standing Orders and Standing Financial Instructions, at the meeting, shall be final.

3.11 Quorum

3.11.1 No decisions may be taken at a meeting unless at least one-third of the whole number of the Chair and voting members appointed, (including at least one Non-Executive Director Member and one Executive Director Member) are present.

3.11.2 An officer in attendance for an Executive Director Member but without formal acting up status, may not count towards the quorum.

3.11.3 If the Chair or member has been disqualified from participating in the discussion on any matter and~~/~~or from voting on any resolution by reason of the declaration of a conflict of interest (Standing Order 7), that person shall no longer count towards the quorum. If a quorum is then not

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available for the passing of a resolution on any matter, that matter may be discussed further but not voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting.

3.12 Voting

3.12.1 Save as provided in Standing Orders 3.13 - Suspension of Standing Orders and 3.14 - Variation and Amendment of Standing Orders, every question put to a vote at a meeting shall be determined by a majority of the votes of members present and voting on the question. In the case of an equal vote, the person presiding (ie: the Chair of the meeting shall have a second, and casting vote).

3.12.2 At the discretion of the Chair, all questions put to the vote shall be determined by oral expression or by a show of hands, unless the Chair directs otherwise, or it is proposed, seconded and carried that a vote be taken by paper ballot.

3.12.3 If at least one third of the members present so request, the voting on any question may be recorded so as to show how each member present voted or did not vote (except when conducted by paper ballot).

3.12.4 If a member so requests, their vote shall be recorded by name.

3.12.5 In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote.

3.12.6 A manager who has been formally appointed to act up for an Officer Member during a period of incapacity or temporarily to fill an Executive Director vacancy shall be entitled to exercise the voting rights of the Officer Member.

3.12.7 A manager attending the Trust Board meeting to represent an Officer Member during a period of

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incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Officer Member. An Officer's status when attending a meeting shall be recorded in the minutes.

3.12.8 For the voting rules relating to joint members, see Standing Order 2.5.

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3.13 Suspension of Standing Orders

3.13.1 Except where this would contravene any statutory provision or any direction made by the Minister for Health or the rules relating to the Quorum (Standing Order 3.11), any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the whole number of the members of the Board are present (including at least one member who is an Officer Member of the Trust and one Member who is not) and that at least two-thirds of those members present signify their agreement to such suspension. The reason for the suspension shall be recorded in the Trust Board's minutes.

3.13.2 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chair and Members of the Trust.

3.13.3 No formal business may be transacted while Standing Orders are suspended.

3.13.4 The Audit and Risk Assurance Committee shall review every decision to suspend Standing Orders.

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3.14 Variation and Amendment of Standing Orders

3.14.1 These Standing Orders shall not be varied except in the following circumstances:

(a) Upon a notice of motion under Standing Order 3.5;

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(b) Upon a recommendation of the Chair or Chief Executive included on the agenda for the meeting;

(c) That two thirds of the Board members are present at the meeting where the variation or amendment is being discussed, and that at least half of the Trust's Non-Executive members vote in favour of the amendment;

(d) Providing that any variation or amendment does not contravene a statutory provision or direction made by the Minister for Health.

3.15 Record of Attendance

3.15.1 The names of the Chair and Directors –/– members present at the meeting shall be recorded and, if necessary, the point at which they join, leave or resume their place at the meeting shall also be noted.

3.16 Minutes

3.16.1 The minutes of the proceedings of a meeting shall be ~~drawn up~~drafted, signed and presented to the next Board meeting. ~~and submitted for agreement at the next ensuing meeting where they shall be signed by the person presiding at it.~~

No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate.

A copy of the approved minutes will be posted on the Trust website www.nias.hscni.net following their approval at the next ensuing meeting.

3.16.2 The minutes of all Board Committees shall be formally recorded and brought to the public Board meeting for information except where confidentiality needs to be expressly protected. After each meeting, the Chair of the

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Committee shall present a written report to the next Trust Board meeting. At any point, the Committee Chair shall also draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action.

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3.17 Admission of Public and the Press

See Standing Order 3.1.1 In order to meet the social distancing requirements of Covid-19, the Board is unlikely to meet in person for the foreseeable future and so will meet by virtual means. As a result of this, members of the public, the media and staff will be unable to attend or observe in person. The Trust will make alternative arrangements for public and staff involvement by virtual means.

3.17.1 Reserved sections

Trust Board meetings are held in public to openly demonstrate how decisions within the Trust are made and recorded. On occasion, there may be issues which the Board requires to discuss in private and in this case a "reserved" meeting may be convened with a separate agenda which is not made public.

These may include subjects that are:

a) Demonstrably protected in terms of the Data Protection Act (ie staff or service user personal information); or

b) Commercially sensitive; or

c) Constituted information intended for publication at a later date.

Where a meeting or part of a meeting is dealing with a potentially sensitive or confidential issue, the Chair of the

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meeting should inform those present that the item under consideration is confidential and a reserved section is required The public shall be required to withdraw upon a resolution of the Trust Board as follows:

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

3.17.2 General disturbances

The Chair or the person presiding over the meeting shall give such directions as they think fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Trust's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Trust Board resolving as follows:

`That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Trust Board to complete its business without the presence of the public', Section 23(2) of the Local Government Act (NI) 1972.

3.17.3 Business proposed to be transacted when the press and public have been excluded from a meeting

Matters to be dealt with by the Trust Board following the exclusion of representatives of the press, and other members of the public, as provided in 3.17.1 and 3.17.2 above, shall be confidential to the members of the Board.

Notwithstanding the provisions of 3.17 (1&2) above, the Trust Board shall make arrangements to ensure that any

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discussion of confidential matters relating to staff, patients or commercially sensitive issues are conducted by the Board meeting "In Committee". A separate confidential minute of such meetings will be maintained and approved by the Board at its next meeting. In addressing such matters, they shall operate with full executive powers.

Members and Officers or any employee of the Trust in attendance shall not reveal or disclose the contents of any "In Committee" meeting or papers marked 'In Confidence' or minutes headed 'Items Taken in Reserved section' outside of the Trust, without the express permission of the Trust. This prohibition shall apply equally to the content of any discussion during the Board meeting which may take place on such reports or papers.

3.17.4 Use of mechanical or electrical equipment for recording or transmission of meetings

In order to avoid undue disruption to Board meetings, television crews/press photographers or other media representatives can have access for a maximum of ten minutes prior to the meeting commencing. This will be subject to agreement of the Chair.

Nothing in these Standing Orders shall be construed as permitting the introduction by the public, or press representatives, of recording, transmitting, video or similar apparatus into meetings of the Trust or Committee thereof. Such permission shall be granted only upon resolution of the Trust Board. ~~Trust.~~.

3.18 Observers at Trust Meetings

3.18.1 The Trust will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any of the Trust Board's meetings and may change, alter or vary these t~~T~~erms and ~~C~~conditions as it deems fit.

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3.18 **Procedures for Addressing the Board**

3.18.1 Deputations from any meeting, association, public body or an individual may be permitted to address a meeting of the Board, subject to the following conditions:

- The subject is on the agenda;
- The Board Secretary has received three working days' notice, in writing, of the intended deputation, its purpose and a brief synopsis of content. The presentation/speaking notes must be submitted to the Board Secretary in advance of the meeting. The Chair will decide on the appropriateness of the presentation.

3.18.2 The specified notice may be waived at the discretion of the Chair. Any deputation will be confined to a presentation by not more than two persons, per agenda item, and not to exceed 10 minutes duration. The Chair may at his/her discretion vary the number of individuals permitted to address the meeting. The Chair will decide if a Trust response is appropriate and there will be no right of reply by the speaker. The decision of the Chair will be final on this matter.

The Chair will also consider requests for questions from the public based on the following conditions:

- all questions must be relevant to an item included on the agenda;
- individuals will be restricted to a maximum of two questions each;
- once a question is answered by a member of Trust Board, as directed by the Chair, there will be no further discussions on this question; and
- the decision of the Chair will be final in relation to public questions.

3.18.3 The Trust recognises the important statutory role the Patient and Client Council has in relation to representing the interests of the public in all matters of health and

social care within the Trust's area. The Trust will therefore, grant the right for the Council to request attendance at any Trust Board meeting to raise specific agenda items. The Chair may at his/her discretion allow the Council to be heard during Board discussion of the item in questions

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4. APPOINTMENT OF COMMITTEES AND SUB-COMMITTEES

4.1 Appointment of Committees

4.1.1 Subject to such directions as may be given by the Minister for Health, the Trust Board may appoint Committees of the Trust.

The Trust shall determine the membership and Terms of Reference of Committees and Sub-Committees and shall receive and consider reports of such Ccommittees. Only in exceptional circumstances will the Trust Board delegate executive powers to a Committee. A Committee may only exercise such executive powers as are delegated to it by the Trust Board.

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The Chair of the Trust Board will appoint Non-Executive Directors to Committees of the Board and will nominate one of them as Chair of the Committee.

4.2 Joint Committees

4.2.1 Joint Ccommittees may be appointed by the Trust by joining together with one or more other Trusts consisting, wholly or partly, of the Chair and members of the Trust or other health service bodies, or wholly of persons who are not members of the Trust or other health bodies in question.

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4.2.2 Any Committee or joint Committee appointed under this Standing Order may, subject to such directions as may be given by the Minister for Health, Social Services and Public Safety or the Trust or other health bodies in question, appoint Sub-Committees consisting wholly or partly of members of the Committees or Joint Committee (whether or not they are members of the Trust or health bodies in question) or wholly of persons who are not members of the Trust or health bodies in question or the Committee of the Trust or health bodies in question.

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4.3 Applicability of Standing Orders and Standing Financial Instructions to Committees

4.3.1 The Standing Orders and Standing Financial Instructions of the Trust, as far as they are applicable, shall as appropriate apply to meetings and any Committees established by the Trust. In which case the term "Chair" is to be read as a reference to the Chair of other Committee as the context permits, and the term "member" is to be read as a reference to a member of other Committee also as the context permits. (There is no requirement to hold meetings of Committees established by the Trust in public.)

4.4 Terms of Reference

4.4.1 Each such Committee shall have such Terms of Reference and powers and be subject to such conditions (as to reporting back to the Board), as the Board shall decide and shall be in accordance with any legislation and regulation or direction issued by the Minister for Health. Such Terms of Reference shall have effect as if incorporated into the Standing Orders.

4.5 Delegation of Powers by Committees to Sub-Committees

4.5.1 Where Committees are authorised to establish Sub-Committees, they may not delegate executive powers to the Sub-Committee unless expressly authorised by the Trust Board.

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4.6 Approval of Appointments to Committees

4.6.1 The Board shall approve the appointments to each of the Committees which it has formally constituted. Where the Board determines, and regulations permit, that persons, who are neither members nor officers, shall be appointed to a Committee the terms of such appointment shall be within the powers of the Board as defined by the Minister for Health. The Board shall define the powers of such appointees and shall agree allowances, including

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reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

4.7 Appointments for Statutory functions

4.7.1 Where the Board is required to appoint persons to a Committee and/or to undertake statutory functions as required by the Minister for Health, and where such appointments are to operate independently of the Board, such appointment shall be made in accordance with the regulations and directions made by the Minister for Health.

4.8 Committees Established by the Trust Board

Trust Board Committees will be held by virtual means for the foreseeable future.

The Committees, Sub-Committees, and Joint-Committees established by the Board are:

4.8.1. Audit and Risk Assurance Committee

In line with the requirements of the Cabinet Office's guidance on Codes of Practice for Public Bodies (DF/DFP 03/06), the Audit and Risk Assurance Handbook (NI) 2018, and the ~~circular HSS (PDD) 8/94 on~~ Codes of Conduct and Accountability, an Audit and Risk Assurance Committee will be established and constituted to provide the Trust Board with an independent and objective review of its financial systems, governance and internal control arrangements.

The Terms of Reference will be approved by the Trust Board, will be reviewed on a periodic basis and will be posted on the Trust website www.nias.hscni.net.

The Committee will be comprised exclusively of Non-Executive Directors and shall consist of not less than three members, of which one must have significant, recent and relevant financial experience. A quorum shall

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be two members. None of these members should be the Chair or members of the Remuneration and Terms of Service Committee. One member of the Committee shall be the Chair of the ~~Assurance~~ Safety Committee. The Committee will meet on at least three occasions per year.

4.8.2. Remuneration and Terms of Service ~~and Terms of Service~~ Committee

In line with the requirements of the Codes of Conduct and Accountability, and the Higgs report, a Remuneration and Terms of Service Committee will be established and constituted. As a minimum, the role of the Committee will be to advise the Trust Board about appropriate remuneration and terms of service for the Chief Executive and other Senior Executives including:

(a) All aspects of salary (including any performance related elements ~~/~~ bonuses);

(b) Provisions for other benefits, including pensions and cars; and

(c) Arrangements for termination of employment and other contractual terms.

The Terms of Reference will be approved by the Trust Board, will be reviewed on a periodic basis and will be posted on the Trust website www.nias.hscni.net.

The Committee will be comprised exclusively of the Chair of the Trust and at least two Non-Executive Directors. None of these members should be members of the Audit and Risk Assurance Committee. A quorum shall be two members. The Committee will meet on at least two occasions per year.

4.8.3 ~~Assurance~~ Safety, Quality, Patient Experience and Performance Committee

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In line with the statutory duty of quality which is carried by the Chief Executive, ~~an Assurance~~a Safety, Quality, Patient Experience and Performance Committee will be established and constituted to provide the Trust Board with an independent and objective review that effective and regularly reviewed arrangements are in place to support the implementation, maintenance and development of governance (both clinical and non-clinical) and risk management and that such matters are properly considered and communicated to the Trust Board.

The Terms of Reference will be approved by the Trust Board, will be reviewed on a periodic basis and will be posted on the Trust website www.nias.hscni.net.

The Committee will be comprised exclusively of Non-Executive Directors and shall consist of not less than three members. One member of the Committee shall be the Chair of Audit and Risk Assurance Committee. A quorum shall be two members. The Committee will meet on at least three occasions per year.

4.8.5 People, Finance and Organisational Development Committee

A People, Finance and Organisational Development Committee will be established and constituted to provide the Trust Board with an independent and objective review of Human Resources, Finance and Organisational Development functions.

The Terms of Reference will be approved by the Trust Board, will be reviewed on a periodic basis and will be posted on the Trust website www.nias.hscni.net

The Committee will be comprised exclusively of Non-Executive Directors and shall consist of not less than three members. A quorum shall be two members. The Committee will meet on at least three occasions per year.

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4.8.45 Other Committees

The Board may also establish such other Committees as required to discharge the Trust's responsibilities.

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5. ARRANGEMENTS FOR THE EXERCISE OF TRUST FUNCTIONS BY DELEGATION

5.1 Delegation of Functions to Committees, Officers or Other Bodies

5.1.1 Subject to such directions as may be given by the Minister for Health, the Board may make arrangements for the exercise, on behalf of the Board, of any of its functions by a Committee, Sub-Committee appointed by virtue of Standing Order 4, or by an officer of the Trust, or by another body as defined in Standing Order 5.1.2 below, in each case subject to such restrictions and conditions as the Trust thinks fit.

5.1.2 Section 13, Sschedule 3 of the HPSS (NI) Order 1991 allows for regulations to provide for the functions of Trust's to be carried out by third parties. In accordance with The HSS Trusts (Membership and Procedure) Regulations (NI) 1994, the functions of the Trust may also be carried out in the following ways:

(a) By another Trust or service providing body;

(b) Jointly with any one or more of the following: HSC Trusts, Boards, agencies or a Centre of Procurement Expertise (in respect of procurement and logistics) or service providing body.

5.1.3 Where a function is delegated by these Regulations to another Trust, then that Trust or health service body exercises the function in its own right; the receiving Trust has responsibility to ensure that the proper delegation of the function is in place.

5.1.4 In situations involving the delegation to Committees, Sub-Committees or officers, the Trust delegating the function retains full responsibility.

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5.1.5 Where a function is to be carried out on behalf of the Trust by a third party, appropriate arrangements will be put in place by contract or Service Level Agreement to ensure performance standards, monitoring arrangements and accountability.

5.2 Emergency Powers and Urgent Decisions

5.2.1 The powers which the Board has reserved to itself within these Standing Orders (see Standing Order 2.9) may in emergency or for an urgent decision be exercised by the Chair and the Chief Executive after having consulted at least two Non-Executive Members. The exercise of such powers by the Chair and the Chief Executive shall be reported to the next formal meeting of the Trust Board in public session for formal ratification.

5.3 Delegation to Committees

5.3.1 The Board shall agree from time to time to the delegation of executive powers to be exercised by other Committees, or Sub-Committees, or Joint-Committees, which it has formally constituted in accordance with directions issued by the Minister for Health. The constitution and terms of reference of these Committees, or Sub-Committees, or Joint Committees, and their specific executive powers shall be approved by the Board.

5.3.2 When the Board is not meeting as the Trust in public session, it shall operate as a Committee and may only exercise such powers as may have been delegated to it by the Trust in public session.

5.4 Delegation to Officers

5.4.1 Those functions of the Trust which have not been retained as reserved by the Board or delegated to other Committee or Sub-Committee or Joint-Committee shall be exercised on behalf of the Trust by the Chief

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Executive. The Chief Executive shall determine which functions he–/–she will perform personally and shall nominate officers to undertake the remaining functions for which he–/–she will still retain accountability to the Trust. However, he/she shall not assign absolutely to any other person any of the responsibilities set out in the Management Statement/Financial Memorandum.

5.4.2 The Chief Executive shall prepare a Scheme of Delegation identifying his–/–her proposals which shall be considered and approved by the Board. The Chief Executive, or in his–/–her absence the ~~Deputy Chief Executive or~~ Director of Finance, may approve interim amendments to the Scheme of Delegation, which shall be considered and given retrospective approval by the Board at its next annual review.

5.4.3 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of the Director of Finance to provide information and advise the Board in accordance with statutory or DoH requirements. Outside these statutory requirements, the roles of the Director of Finance shall be accountable to the Chief Executive for operational matters.

5.5 Schedule of Matters Reserved to the Board and Scheme of Delegation of Powers

5.5.1 The arrangements made by the Board as set out in the "Schedule of Matters Reserved to the Board" and "Scheme of Delegation" of powers shall have effect as if incorporated in these Standing Orders.

5.6. Duty to Report Non-Compliance with Standing Orders and Standing Financial Instructions

5.6.1 If, for any reason, these Standing Orders or the Standing Financial Instructions are not complied with in any significant or material respect, full details shall be reported to the Audit and Risk Assurance Committee. All members of the Trust Board and staff have a duty to

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disclose any significant or material non-compliance to the Chief Executive as soon as possible.

5.7 Endowment and Gift Funds

5.7.1 In line with its role as a corporate trustee for any funds held in trust (Standing Order 2.7.2), either as charitable or non-charitable funds, the Trust Board will establish Trust Endowment and Gift Funds Procedures to administer those funds in accordance with any statutory or other legal requirements.

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6. OVERLAP WITH OTHER TRUST POLICY STATEMENTS / PROCEDURES, REGULATIONS AND THE STANDING FINANCIAL INSTRUCTIONS

6.1 Policy Statements: General Principles

6.1.1 The Trust Board will determine an appropriate mechanism for the formal approval of policies and procedures. The formal approval will be recorded in an appropriate minute and will be deemed, where appropriate, to be an integral part of the Trust's Standing Orders and Standing Financial Instructions.

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6.2 Standing Financial Instructions

6.2.1 Standing Financial Instructions adopted by the Trust Board in accordance with the Financial Regulations shall have effect as if incorporated in these Standing Orders.

6.3 Specific Guidance

6.3.1 Notwithstanding the application of Standing Order 6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with all relevant guidance and legislation.

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7. DUTIES AND OBLIGATIONS OF BOARD MEMBERS—/ DIRECTORS AND SENIOR MANAGERS UNDER THESE STANDING ORDERS

7.1 Code of Conduct and Accountability

7.1.1 The Code of Conduct and Code of Accountability for Board Members of Health and Social Care bodies (issued in July 2012), provides the basis on which Board members of HSC bodies should seek to fulfil the duties and responsibilities conferred upon them by DoH. The Code of Conduct and Accountability shall be made available to all Board members. Board members shall subscribe to it and shall be judged upon the manner in which it is observed.

The HSC Code of Conduct (2016) incorporates the principles contained within the Code of Conduct for HPSS Managers 2013 and supercedes it. It is applicable to all HSC employees, including managers, and sets out the core standards of conduct expected by all HSC staff.

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7.2 Declaration of Interests

7.2.1 Requirements for Declaring Interests and Applicability to Board Members

The Trust's policy on Standards of Business Conduct requires Trust Board Members to declare interests which are relevant and material to the HSC Trust of which they are a member. All existing Board members should declare such interests and any Board members appointed subsequently should do so on appointment. Any future relevant and material interests should also be declared immediately by the member upon acquisition.

7.2.2 Interests which are Relevant and Material

Interests which should be regarded as "relevant and material" are:

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(a) Directorships, including Non-Executive Directorships held in private companies or PLCs (with the exception of those of dormant companies);

(b) Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the HSC;

(c) Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the Trust;

(d) A position of authority in a charity or voluntary organisation in the field of health and social care;

(e) Any connection with a voluntary or other organisation contracting for Trust services;

(f) Research funding / grants that may be received by an individual or their department;

(g) Interests in pooled funds that are under separate management.

Where any member of the Trust Board comes to know that the Trust has entered into or proposes to enter into a contract in which he / she or any person connected with him / her (as defined in Standing Order 7.3 below and elsewhere) has any pecuniary interest, direct or indirect, the Board member shall declare his / her interest by giving notice in writing of such fact to the Trust as soon as practicable.

7.2.3 Advice on Interests

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If Board members have any doubt about the relevance of an interest, this should be discussed with the Chair of the Trust or with the Trust's Chief Executive.

Influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

7.2.4 Recording of Interests in Trust Board Minutes

At the time Board members' interests are declared, they should be recorded in the Trust Board minutes.

Any changes in interests should be declared at the next Trust Board meeting following the change occurring and recorded in the minutes of that meeting. The Chief Executive will be responsible for ensuring that the Trust Register of Interests is duly updated. Where a conflict of interest is established or perceived, the Board member shall withdraw and play no part in the relevant discussion unless the Chair deems that it is unnecessary for them to do so.

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7.2.5 Publication of Declared Interests in Annual Report

Where a Board member has an interest in any body which has transacted with the Trust, then the financial quantification of that transaction(s) shall be published in the Trust's Annual Report and Accounts for the year in question, together with an appropriate description of the member's interest. The Chief Executive is responsible for ensuring that this information is reflected in the Register of Interests.

7.2.6 Conflicts of interest which Arise during the Course of a Meeting

During the course of a Trust Board meeting, if a conflict of interest is established, the Board member concerned

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should withdraw from the meeting and play no part in the relevant discussion or decision (see overlap with Standing Order 7.4).

7.2.7 Declaration of Objectivity and Interests for those Officers Engaged in Award of Contract

Trust Officers participating in the preparation, evaluation and award of contracts must complete a declaration of objectivity and interests during the course of the tendering process to ensure the transparency of the process and that decisions made are not compromised. The administration of the declaration process will be handled by the Trust's procurement provider in accordance with appropriate guidance. Where a potential conflict of interest is apparent, the procurement provider will contact the Chief Executive or Director of Finance to agree the appropriate course of action.

7.3 Register of Interests

7.3.1 The Chief Executive will ensure that a Register of Interests is established to record formally any declarations of interests of Board or Committee members. In particular the Register will include details of all directorships and other relevant and material interests (as defined in Standing Order 7.2.2) which have been declared by both Executive and Non-Executive Trust Board members.

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7.3.2 These details will be kept up to date by means of an annual review of the Register in which any changes to interests declared during the preceding twelve months will be incorporated.

7.3.3 The Register will be posted on the Trust website www.nias.hscni.net on an annual basis.

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7.4 Exclusion of Chair and Members in Proceedings on Account of Pecuniary Interest

7.4.1 Definition of Terms used in Interpreting 'Pecuniary' Interest

For the sake of clarity, the following definition of terms is to be used in interpreting this Standing Order:

(a) **"Spouse"** shall include any person who lives with another person in the same household (and any pecuniary interest of one spouse shall, if known to the other spouse, be deemed to be an interest of that other spouse);

(b) **"Contract"** shall include any proposed contract or other course of dealing.

(c) **"Pecuniary interest"**

Subject to the exceptions set out in this Standing Order, a person shall be treated as having an indirect pecuniary interest in a contract if:

(1) He/she, or a nominee of his/her, is a member of a company or other body (not being a public body), with which the contract is made, or to be made or which has a direct pecuniary interest in the same, or

(2) He/she is a partner, associate or employee of any person with whom the contract is made or to be made or who has a direct pecuniary interest in the same.

(d) **Exception to Pecuniary interests**

A person shall not be regarded as having a pecuniary interest in any contract if:

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(1) Neither he–/–she or any person connected with him–/–her has any beneficial interest in the securities of a company of which he–/–she or such person appears as a member, or

(2) Any interest that he–/–she or any person connected with him–/–her may have in the contract is so remote or insignificant that it cannot reasonably be regarded as likely to influence him–/–her in relation to considering or voting on that contract, or

(3) Those securities of any company in which he–/she (or any person connected with him–/–her) has a beneficial interest, do not exceed £5,000 in nominal value or one per cent of the total issued share capital of the company or of the relevant class of such capital, whichever is the less.

Provided however, that where paragraph (3) above applies, the person shall nevertheless be obliged to disclose–/–declare their interest in accordance with Standing Order 7.2.2(b).

7.4.2 Exclusion in Proceedings of the Trust Board

(a) Subject to the following provisions of this Standing Order, if the Chair or a member of the Trust Board has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust Board at which the contract or other matter is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

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(b) The Minister for Health may, subject to such conditions as he–/–she may think fit to impose, remove any disability imposed by this Standing Order in any case in which it appears to him–/–her in the interests of the HSC that the disability should be removed. (see Standing Order 7.4.3 on the 'Waiver' which has been approved by the Minister for Health).

(c) The Trust Board may exclude the Chair or a member of the Board from a meeting of the Board while any contract, proposed contract or other matter in which he–/–she has a pecuniary interest is under consideration.

(d) Any remuneration, compensation or allowance payable to the Chair or a Member by virtue of paragraph 9, Schedule 3 of the Health and Personal Social Services (Northern Ireland) Order 1991 shall not be treated as a pecuniary interest for the purpose of this Standing Order.

(e) This Standing Order applies to a Committee or Sub-Committee and to a Joint Committee or Sub-Committee as it applies to the Trust and applies to a member of any such Committee or Sub-Committee (whether or not he–/–she is also a member of the Trust) as it applies to a member of the Trust.

7.4.3 Waiver of Standing Orders made by the Minister for Health

(a) Power of the Minister for Health to make Waivers

Under regulation 20(2) of the HSS Trusts (Membership and Procedure) Regulations (NI) 1994, DoH may issue waivers if it appears in the interests of the HSC that the disability in regulation 11 (which prevents a Chair or a member from taking part in the consideration or discussion of, or voting on any question with respect to, a matter in which

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he has a pecuniary interest) should be removed. Any waiver that has been agreed will be in line with sub-sections (b) to (d) below.

(b) Definition of 'Chair' for the Purpose of Interpreting this Waiver

For the purposes of paragraph 7.4.3(c) below, the "relevant Chair" is:

(1) At a meeting of the Trust, the Chair of that Trust;

(2) At a meeting of a Committee:

(i) In a case where the member in question is the Chair of that Committee, the Chair of the Trust:

(ii) In the case of any other member, the Chair of that Committee.

(c) Application of Waiver

A waiver will apply in relation to the disability to participate in the proceedings of the Trust on account of a pecuniary interest.

It will apply to:

(1) A member of the Trust, who is a healthcare professional, within the meaning of regulation 5(5) of the Regulations, and who is providing or performing, or assisting in the provision or performance, of –

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(i) Services under the Health and Personal Social Services (Northern Ireland) Order 1991; or

(ii) Services in connection with a pilot scheme under the Health and Personal Social Services (Northern Ireland) Order 1991;

For the benefit of persons for whom the Trust is responsible.

(2) Where the 'pecuniary interest' of the member in the matter which is the subject of consideration at a meeting at which he is present:

(i) Arises by reason only of the member's role as such a professional providing or performing, or assisting in the provision or performance of, those services to those persons;

(ii) Has been declared by the relevant Chair as an interest which cannot reasonably be regarded as an interest more substantial than that of the majority of other persons who:

(a) Are members of the same profession as the member in question,

(b) Are providing or performing, or assisting in the provision or performance of, such of those services as he provides or performs, or assists in the provision or performance of, for the benefit of persons for whom the Trust is responsible.

(d) Conditions which aApply to the Waiver and the rRemoval of having a pPecuniary iInterest

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The removal is subject to the following conditions:

(1) The member must disclose his/her interest as soon as practicable after the commencement of the meeting and this must be recorded in the minutes;

(2) The relevant Chair must consult the Chief Executive before making a declaration in relation to the member in question pursuant to paragraph 7.4.3(b)(2) above, except where that member is the Chief Executive;

(3) In the case of a meeting of the Trust:

(i) The member may take part in the consideration or discussion of the matter which must be subjected to a vote and the outcome recorded;

(ii) May not vote on any question with respect to it.

(4) In the case of a m~~M~~eeting of the Committee:

(i) The member may take part in the consideration or discussion of the matter which must be subjected to a vote and the outcome recorded;

(ii) May vote on any question with respect to it; but

(iii) The resolution which is subject to the vote must comprise a recommendation to, and be referred for approval by, the Trust Board.

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7.5 Standards of Business Conduct

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7.5.1 Trust Policy and National Guidance

All Trust staff and members of must comply with the Trust's Policy on Standards of Business Conduct and the guidance contained circular HSS (GEN1) 1/95.

7.5.2 Interest of Officers in Contracts

(a) Any officer or employee of the Trust who comes to know that the Trust has entered into or proposes to enter into a contract in which he–/–she or any person connected with him–/–her (as defined in Standing Order 7.4) has any pecuniary interest, direct or indirect, the Officer shall declare their interest by giving notice in writing of such fact to the Chief Executive as soon as practicable.

(b) An Officer should also declare to the Chief Executive any other employment or business or other relationship of his–/–her, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

(c) The Trust will require interests, employment or relationships so declared to be entered in a Register of Interests of staff.

7.5.3 Canvassing of and Recommendations by Members in Relation to Appointments

(a) Canvassing of members of the Trust or of any Committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

(b) Members of the Trust shall not solicit for any person any appointment under the Trust or recommend any

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person for such appointment; but this paragraph of this Standing Order shall not preclude a member from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

7.5.4 Relatives of Members or Officers

(a) Candidates for any staff appointment under the Trust shall, when making an application, disclose in writing to the Trust whether they are related to any member or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him liable to instant dismissal.

(b) The Chair and every member and officer of the Trust shall disclose to the Trust Board any relationship between himself and a candidate of whose candidature that member or officer is aware. It shall be the duty of the Chief Executive to report to the Trust Board any such disclosure made.

(c) On appointment, members (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Trust whether they are related to any other member or holder of any office under the Trust.

(d) Where the relationship to a member of the Trust is disclosed, the Standing Order headed 'Disability of Chair and members in proceedings on account of pecuniary interest' (Standing Order 7.4) shall apply.

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8. CUSTODY OF SEAL, SEALING OF DOCUMENTS AND SIGNATURE OF DOCUMENTS

8.1 Custody of Seal

8.1.1 The common seal of the Trust shall be kept by the Chief Executive or a nominated Manager by him–/–her in a secure place.

8.2 Sealing of Documents

8.2.1 Documents should only be sealed following a resolution by the Trust Board. In exceptional circumstances, a document shall be sealed in advance of a resolution by the Trust Board and retrospective resolution sought at the following Trust Board meeting. Where it is necessary that a document shall be sealed, the seal shall be affixed in the presence of the Chief Executive—/—or other Executive Director nominated by the Chief Executive, who is not from the originating department, along with one Non-Executive Director and shall be attested by them.

8.3 Register of Sealing

8.3.1 The Chief Executive shall keep a register in which he–/she, or another manager of the Trust authorised by him–/her, shall enter a record of the sealing of every document.

8.4 Signature of Documents

8.4.1 Where any document will be a necessary step in legal proceedings on behalf of the Trust, it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Executive or any Executive Director.

8.4.2 In land transactions, the signing of certain supporting documents will be delegated to Managers and set out clearly in the Scheme of Delegation but will not include

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the main or principal documents effecting the transfer (e.g. sale–/ purchase agreement, lease, contracts for construction works and main warranty agreements or any document which is required to be executed as a deed).

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1.1 SCHEDULE OF POWERS RESERVED TO THE BOARD

The 'Schedule of Powers reserved to the Board' is sub-divided to correspond with the seven key functions of the Board for which it is held accountable by the Department of Health on behalf of the Minister.

These are:-

1. To establish the overall strategic direction of the organisation within the policy and resources framework determined by the Department/Minister;

2. To oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary;

3. To ensure effective financial stewardship through value for money, financial control and financial planning and strategy;

4. To ensure that high standards of corporate governance and personal behaviour are maintained in the conduct of the business of the whole organisation;

5. To appoint, appraise and remunerate senior executives;

6. To ensure effective dialogue between the organisation and the local community on its plans and performance and that these are responsive to the community's needs;

7. To ensure that the Trust has robust and effective arrangements in place for clinical and social care governance and risk management.

These matters are to be regarded as a guideline to the minimum requirement and shall not be interpreted as to exclude any other issues which it might be appropriate, because of their exceptional nature, to bring to the Board. The Chair, in consultation with the Chief Executive shall determine whether other issues outwith the following schedules of reserved powers shall be brought to the Board for consideration.

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SECTION C - SCHEME OF RESERVATION AND DELEGATION

1.1 DECISIONS RESERVED TO THE BOARD

DELEGATED TO	AUTHORITIES / DUTIES DELEGATED
Trust Board	**General Enabling Provision** The Board may determine any matter, for which it has delegated or statutory authority, in full session within its statutory powers.
Trust Board	**Regulations and Control** 1. Approve Standing Orders (SOs), a Schedule of Matters Reserved to the Board and Standing Financial Instructions for the regulation of its proceedings and business. 2. Suspend Standing Orders. 3. Vary or amend the Standing Orders. 4. Ratify any urgent decisions taken by the Chair and Chief Executive in public session in accordance with Standing Order 5.2 5. Approve a Scheme of Delegation of powers from the Board to Committees and Officers. 6. Require and receive the Declaration of Board members' interests that may conflict with those of the Trust and determine the extent to which that member may remain involved

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DELEGATED TO	AUTHORITIES / DUTIES DELEGATED
	with the matter under consideration. 7. Require and receive the Declaration of Officers' interests that may conflict with those of the Trust. 8. Approve arrangements for dealing with complaints. 9. Adopt the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto. 10. Receive reports from Committees including those that the Trust is required by the Minister for Health, or other regulation to establish and to take appropriate action on. 11. Consider the recommendations of the Trust's Committees where the Committees do not have executive powers. 12. Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate Trustee for funds held on trust. 13. Establish Terms of Reference and reporting arrangements of all Committees and Sub-Committees that are established by the Board. 14. Approve arrangements relating to the discharge of the Trust's responsibilities as an appointee for patients' and clients' property. 15. Authorise use of the seal. 16. Ratify or otherwise instances of failure to comply with Standing Orders brought to the Chief Executive's attention in accordance with Standing Order 5.6. 17. Initiate disciplinary procedures for members of the Board or employees who are in breach of statutory requirements or Standing Orders.

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DELEGATED TO	AUTHORITIES / DUTIES DELEGATED
Trust Board	**Appointments / Dismissal** 1. Appoint the Vice Chair of the Board. 2. Appoint and dismiss Committees (and individual members) that are directly accountable to the Board. 3. Appoint, appraise, discipline and dismiss Executive Directors (subject to Standing Order 2.2). 4. Confirm appointment of members of any Committee of the Trust as representatives on outside bodies. 5. Appoint, appraise, discipline and dismiss the Secretary (if the appointment of a Secretary is required under Standing Orders). 6. Approve proposals of the Remuneration Committee regarding Executive Directors and the Chief Executive.
Trust Board	**Strategy, Plans and Budgets** 1. Define the strategic aims and objectives of the Trust, and approve strategic plans. 2. Approve proposals for ensuring quality and developing clinical and social care governance in services provided by the Trust, having regard to any guidance issued by the Minister for Health.

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DELEGATED TO	AUTHORITIES / DUTIES DELEGATED
	3. Approve the Trust's policies and procedures for the management of risk ~~.~~ ~~4.~~ Approve Outline and Final Business Cases for Capital Investment~~.~~ ~~5.~~4. Approve budgets on an annual basis. ~~6.~~ Approve the Trust's proposed organisational development proposals~~.~~ ~~7.~~5. Ratify proposals for acquisition, disposal or change of use of land and ~~/~~ or buildings. ~~8.~~6. Approve PFI proposals. ~~9.~~7. Approve the opening of bank accounts and Trust banking arrangements. ~~10.~~8. Approve proposals on individual contracts (other than HSC contracts) of a capital or revenue nature in accordance with the Scheme of Delegation. ~~11.~~9. Approve proposals in individual cases for the write off of losses or making of special payments in accordance with the Scheme of Delegation. ~~12.~~10. Approve individual compensation payments in accordance with the Scheme of Delegation. ~~13.~~11. Approve proposals for action on litigation against or on behalf of the Trust in accordance with the Scheme of Delegation.
Trust Board/ Committee	**Policy Determination** ~~1. Ratify policies including personnel policies incorporating the arrangements for the appointment, removal and remuneration of staff.~~

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DELEGATED TO	AUTHORITIES / DUTIES DELEGATED
	All policies will be approved at Committee level and brought to the attention of Trust Board through the regular updates brought forward by the Committee Chairs. Procedures related to policies deemed relevant by a Director will also, where necessary, be presented with its associated policy. These procedures will have previously been considered by the Senior Management Team. In addition, Trust Board will, once per year, be presented with a register detailing the policies, and including such information as review dates and monitoring information, including scrutiny at Committee level. In exceptional circumstances, the Committee Chair or the Trust's Senior Management Team may take a view that the significance of the policy and its impact on the organisation is such that it merits direct consideration by the Trust Board. The Chief Executive will agree this in consultation with the Chair. There may also be regional policies which the Trust Board is required to adopt and these will be considered at Trust Board.
Trust Board	**Audit** 1. Receipt of the annual Report to Those Charged With Governance from the external auditor and agreement of proposed action, taking account of the advice, where appropriate, of the Audit and Risk Assurance Committee. ~~2.~~ 2.Receipt of an annual report from the Internal Auditor and agree action on

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DELEGATED TO	AUTHORITIES / DUTIES DELEGATED
	recommendations where appropriate of the Audit and Risk Assurance Committee.
Trust Board	**Annual Reports and Accounts** 1. Receive and approve the Trust's Annual Report and Accounts. 2. Receive and approve the Accounts for Charitable Trust Funds.
Trust Board	**Monitoring** 1. Receipt of such reports as are required by statute or DoOH regulation and other such reports as the Board sees fit from Committees in respect of their exercise of powers delegated. 2. Continuous appraisal of the affairs of the Trust by means of the provision to the Board as the Board may require from Directors, Committees, and Officers of the Trust as set out in management policy statements. All monitoring returns required by the DoOH shall be reported, at least in summary, to the Board. 3. Receive reports on financial performance against budget and Trust Delivery Plan, including progress in meeting specific strategic, HSCB and DoOH objectives and targets.
Trust Board	Approve procedure for declaration of hospitality and sponsorship.

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DELEGATED TO	AUTHORITIES / DUTIES DELEGATED
Trust Board	Ensure proper and widely publicised procedures for voicing complaints, concerns about misadministration, breaches of Code of Conduct, and other ethical concerns.
Trust Board	Board members share corporate responsibility for all decisions of the Board.

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Trust Board	The Board has ~~six~~ seven key functions for which it is held accountable by the DoH on behalf of the Minister for Health: 1. To establish the overall strategic direction of the organisation within the policy and resources framework determined by the Department/Minister; 2. To oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary; 3. To ensure effective financial stewardship through value for money, financial control and financial planning and strategy; 4. To ensure that high standards of corporate governance and personal behaviour are maintained in the conduct of the business of the whole organisation; 5. To appoint, appraise and remunerate senior executives; 6. To ensure effective dialogue between the organisation and the local community on its plans and performance and that these are responsive to the community's needs; 7. To ensure that the Trust has robust and effective arrangements in place for clinical and social care governance and risk management. ~~1. to ensure effective financial stewardship through value for money, financial control and financial planning and strategy;~~ ~~2. to ensure that high standards of corporate governance and personal behaviour are maintained in the conduct of the business of the whole organisation;~~ ~~3. to appoint, appraise and remunerate senior executives;~~ ~~4. to ratify the strategic direction of the organisation within the overall policies and priorities of the Government and the HSC, define its annual and longer term objectives and agree plans to achieve them;~~

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Trust Board	It is the Board's duty to: 1. act within statutory financial and other constraints; 2. be clear what decisions and information are appropriate to the Board and draw up Standing Orders, a Schedule of Decisions Reserved to the Board and Standing Financial Instructions to reflect these, ensure that management arrangements are in place to enable responsibility to be clearly delegated to Senior Executives for the main programmes of action and for performance against programmes to be monitored and Senior Executives held to account; 3. establish performance and quality measures that maintain the effective use of resources and provide value for money; 4. specify its requirements in organising and presenting financial and other information succinctly and efficiently to ensure the Board can fully undertake its responsibilities; 5. establish Audit and Risk Assurance, ~~Governance~~ People, Safety, and Remuneration Committees on the basis of formally agreed Terms of Reference that set out the membership of the Sub-Committee, the limit to their powers, and the arrangements for reporting back to the main Board.

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1.2 SCHEME OF DELEGATION DERIVED FROM THE CODES OF CONDUCT AND ACCOUNTABILITY

DELEGATED TO:	AUTHORITIES / DUTIES DELEGATED:
Trust Board	HSC Trust Boards must comply with legislation and guidance issued by the DoH on behalf of the Minister for Health, respect agreements entered into by themselves or on their behalf and establish terms and conditions of service that are fair to the staff and represent good value for taxpayers' money.
All Board Members	Subscribe to Codes of Conduct and Accountability.
Chair and Non-Executive Members	Chair and Non-Executive members are responsible for monitoring the executive management of the organisation and are responsible to the Minister for Health for the discharge of those responsibilities.
Chair	It is the Chair's role to: 1. provide leadership to the Board; 2. enable all Board members to make a full contribution to the Board's affairs and ensure that the Board acts as a team; 3. ensure that key and appropriate issues are discussed by the Board in a timely manner, 4. ensure the Board has adequate support and is provided efficiently with all the necessary data on which to base informed decisions;

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	5. lead Non-Executive Board members through a formally-appointed Remuneration Committee of the main Board on the appointment, appraisal and remuneration of the Chief Executive and (with the latter) other Senior Executives; 6. appoint Non-Executive Board members to all Sub-Committees of the main Board; 7. advise the Minister for Health on the performance of Non-Executive Board members.
Chief Executive	The Chief Executive is accountable to the Chair and Non-Executive members of the Board for ensuring that its decisions are implemented, that the organisation works effectively, in accordance with Government policy and public service values and for the maintenance of proper financial stewardship. The Chief Executive should be allowed full scope, within clearly defined delegated powers, for action in fulfilling the decisions of the Board. The other duties of the Chief Executive as Accounting Officer are laid out in the Accounting Officer Memorandum.

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1.3 DECISIONS / DUTIES DELEGATED BY THE BOARD TO COMMITTEES

DELEGATED TO:	AUTHORITIES / DUTIES DELEGATED:
Non-Executive Directors	Non-Executive Directors are appointed by the Minister for Health following a recruitment process overseen by the DoH Public Appointments Unit to bring independent judgement to bear on issues of strategy, performance, key appointments and accountability through the DoH to the Minister and to the local community.
Chair and Directors	Declaration of potential conflict of interests.
Audit and Risk Assurance Committee	The Committee shall contribute to the establishment, review and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisation's objectives. The Committee will: 1. Review the adequacy of all risk and control related disclosure statements (in particular the Governance Statement), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board. 2. Review the adequacy of the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.

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3. Review the adequacy of the policies for ensuring compliance with relevant regularity, legal and code of conduct requirements, including the Trust's Standing Orders and Standing Financial Instructions.
4. Review the adequacy of the policies and procedures for all work related to fraud and corruption.
5. Review the Schedule of Losses and Special Payments and will make recommendations to the Board.
6. Review the effectiveness and findings of the internal and external audit services, considering the implications of, and managements responses to their work.
7. Review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation.
8. Review the Trust's Annual Report and the Financial Statements before submission to the Board, focusing particularly on:
   - The wording in the Governance Statement and other disclosures relevant to the Terms of Reference of the Committee
   - Changes in, and compliance with, accounting policies and practices
   - Unadjusted mis-statements in the financial statements
   - Major judgemental areas
   - Significant adjustments resulting from the audit
9. Ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.
10. Consider and approve relevant policies.

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	~~9.~~
DELEGATED TO:	**AUTHORITIES / DUTIES DELEGATED:**
Remuneration and Terms of Service Committee	The Committee will: 1. Advise the Board about appropriate remuneration and terms of service for the Chief Executive and Senior Executives. 2. All aspects of salary (including any performance-related elements/bonuses); 3. Provisions for other benefits, including pensions and cars; 4. Arrangements for termination of employment and other contractual terms; 5. Make recommendations to the Board on the remuneration and terms of service of the Chief Executive and Senior Executives to ensure they are fairly rewarded for their individual contribution to the Trust - having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such staff; 6. Proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate advise on and oversee appropriate contractual arrangements for such staff; 7. ~~The Committee will~~D~~,~~ determine the necessary arrangements for remuneration of Senior Executives, taking account of DoH guidance. ~~7.~~8. Consider and approve relevant policies.

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~~Assurance~~ Safety, Quality, Patient Experience and Performance Committee	The Committee will be responsible for assuring the NIAS Board that effective and regularly reviewed arrangements are in place to support the implementation, maintenance and development of Governance (clinical and non-clinical) and risk management and that such matters are properly considered and communicated to the Board. ~~The Committee shall contribute to the establishment, review and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisation's objectives. The Committee will:~~ ~~1. Provide assurance that adequate systems and processes are in place to support the achievement of the organisation's objectives and strategically manage clinical and non-clinical risks.~~ ~~2. Provide assurance that adequate systems and processes are in place for the delivery of high quality patient care that is safe, effective and patient focused through the review and monitoring of:~~ ~~• clinical activities;~~ ~~• professional self-regulation;~~ ~~• development and implementation of national standards of care and practice;~~ ~~• clinical audit activity;~~ ~~• professional and clinical performance standards;~~ ~~• continuing professional development for all staff;~~ ~~• adverse incidents and complaints with a clinical component;~~

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	• infection prevention and control arrangements; • clinical research and development activity; • Personal and Public Involvement (PPI) arrangements and activities;
DELEGATED TO:	**AUTHORITIES / DUTIES DELEGATED:**
	• corporate social responsibility. • emergency planning and business continuity; • information governance; • compliance with the replacement processes for controls assurance and associated action plans. 3. Review the Trust's Assurance Framework and the Trust's Risk Register and to make recommendations to Trust Board for action as required to ensure high quality patient care. 4. Report and review the outcome of Serious Adverse Incidents (SAI) including Serious Clinical Adverse Incidents in line with DoH guidance and to ensure that appropriate remedial action has been taken including measures to prevent recurrence. 5. Receive reports from other Committees and Working Groups in relation to areas of risk and

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	~~governance.~~ ~~6. Provide Trust Board with regular reports on the management of risk and quality of patient care and an annual report on clinical governance.~~ ~~7. Review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation.~~ ~~8. Report to the Board annually on its work in support of the Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the organisation, the integration of governance arrangements and the appropriateness of the self-assessment processes against relevant standards.~~
People, Finance and Organisational Development Committee	The Committee will be responsible for assuring the NIAS Board that effective and regularly reviewed arrangements are in place to support Human Resources, Finance and Organisational Development functions within the Trust. ~~6.1~~
Trust Board	HSC Trust Boards must comply with legislation and guidance issued by the DoH on behalf of the Minister for Health, respect agreements entered into by themselves or on their behalf and establish terms and conditions of service that are fair to the staff and represent good value for taxpayers' money.

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1.4 SCHEME OF DELEGATION DERIVED FROM THE ACCOUNTING OFFICER MEMORANDUM

DELEGATED TO:	AUTHORITIES / DUTIES DELEGATED:
Chief Executive	Accountable through HSC Accounting Officer to Parliament / NI Assembly for stewardship of Trust resources.
Chief Executive	Ensure the accounts of the Trust are prepared under principles and in a format directed by the DoH. Accounts must disclose a true and fair view of the Trust's income and expenditure and its state of affairs. Sign the accounts on behalf of the Trust Board.
Chief Executive	Sign a statement in the accounts outlining responsibilities as the Accounting Officer. Sign a statement in the accounts outlining responsibilities in respect of Internal Control.
Chief Executive	Ensure effective management systems that safeguard public funds and assist the Trust Chair to implement requirements of corporate governance including ensuring managers: • "have a clear view of their objectives and the means to assess achievements in relation to those objectives • be assigned well defined responsibilities for making best use of resources having the information, training and access to the expert advice they need to exercise their

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	responsibilities effectively."
Chief Executive	Implement requirements of corporate governance.
Director of Finance	Achieve value for money from the resources available to the Trust and avoid waste and extravagance in the organisation's activities. Follow through the implementation of any recommendations affecting good practice as set out on reports from the Northern Ireland Audit Office (NIAO).
Director of Finance	Operational responsibility for effective and sound financial management and information.

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DELEGATED TO:	AUTHORITIES / DUTIES DELEGATED:
Chief Executive	Primary duty to ensure that Director of Finance discharges the function of providing effective and sound financial management and information.
Chief Executive	Ensuring that expenditure by the Trust complies with Parliamentary—/—NI Assembly requirements.
Chief Executive	Chief Executive, supported by Director of Finance, to ensure appropriate advice is given to the Board on all matters of probity, regularity, prudent and economical administration, efficiency and effectiveness.
Chief Executive	If the Chief Executive considers that the Board or Chair is doing something that might infringe probity or regularity, he–/–she should set this out in writing to the Chair and the Board. If the matter is unresolved, he–/–she should ask the Audit and Risk Assurance Committee to einquire and if necessary the DoH.
Chief	If the Board is contemplating a course of action that raises an issue not of formal propriety or regularity but affects the Chief Executive's responsibility for value for money, the Chief

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Executive	Executive should draw the relevant factors to the attention of the Board. If the outcome is that he–/–she are overruled it is normally sufficient to ensure that his / her advice and the overruling of it are clearly apparent from the papers. Exceptionally, the Chief Executive should inform the DoH. In such cases, the Chief Executive should as a member of the Board vote against the course of action rather than merely abstain from voting.

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1.5 SCHEME OF DELEGATION FROM STANDING ORDERS

DELEGATED TO	AUTHORITIES / DUTIES DELEGATED:
Chair	Final authority in interpretation of Standing Orders.
Trust Board	Appointment of Member acting as Chair
Chair	Call meetings.
Chair	Chair all Board meetings and associated responsibilities.
Chair	Give final ruling in questions of order, relevancy and regularity of meetings.
Chair	Having a second or casting vote
Chair	Suspension of Standing Orders
Audit and Risk Assurance Committee	Audit and Risk Assurance Committee to review every decision to suspend Standing Orders (power to suspend Standing Orders is reserved to the Board)
Trust Board	Variation or amendment of Standing Orders
Trust Board	Formal delegation of powers to Ssub- Ccommittees or Jjoint Ccommittees and approval of

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DELEGATED TO	AUTHORITIES / DUTIES DELEGATED:
	their constitution and terms of reference. (Constitution and terms of reference of Ssub Ceommittees may be approved by the Chief Executive.)
Chair & Chief Executive	The powers which the Board has retained to itself within these Standing Orders may in emergency be exercised by the Chair and Chief Executive after having consulted at least two Non-Executive members.
Chief Executive	The Chief Executive shall prepare a Scheme of Delegation identifying his-/-her proposals that shall be considered and approved by the Board, subject to any amendment agreed during the discussion.
Trust Board	Disclosure of non-compliance with Standing Orders to the Chief Executive as soon as possible.
Trust Board & Officers	Declare relevant and material interests.
Director of Finance	Maintain Register(s) of Interests.
All	Comply with the guidance contained in the Trust's Policy on Standards of Business Conduct for HSC Staff.
All	Disclose relationships between self and candidates for staff appointment. (Chief Executive to report the disclosure to the Board.)

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DELEGATED TO	AUTHORITIES / DUTIES DELEGATED:
Director of Finance	Keep seal in safe place and maintain a register of sealing.
Chief Executive	Approve and sign all documents which will be necessary in legal proceedings.

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Northern Ireland Ambulance Service
Health and Social Care Trust

Audit and Risk Assurance Committee

Title:			
Author(s):			
Ownership:			
Date of Committee Approval:		**Date of Trust Board Approval:**	
Operational Date:		**Review Date:**	
Version No:		**Supersedes:**	
Key Words:			
Links to Other Policies / Procedures:			

Version Control:			
Date:	**Version:**	**Author:**	**Comments:**

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Northern Ireland Ambulance Service
Health and Social Care Trust

Audit and Risk Assurance Committee

TERMS OF REFERENCE

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Northern Ireland Ambulance Service
Health and Social Care Trust

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1. CONSTITUTION

1.1 The Trust Board (The Board) hereby resolves to establish a Committee of the Board to be known as the Audit and Risk Assurance Committee (The Committee).

1.2 The Committee is a non-executive Committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference or as may be delegated by the Board on an ad hoc basis.

1.3 All procedural matters in respect of the conduct of the meetings of the Committee shall be in accordance with the Trust's Standing Orders.

1.4 The Committee will regularly review and reflect on best practice and adopt new learning as part of a commitment to continuous improvement.

2. MEMBERSHIP OF THE COMMITTEE

2.1 Trust Non-Executive Directors that are to be included as members of this Committee will be nominated by the Trust Board Chair and the Committee shall consist of not less than three members.

2.2 One of the members of the Committee will be appointed Chair of the Committee by the Chair of the Trust Board.

2.3 The Chair of the Trust Board shall not be a member of the Committee.

2.4 None of these members should be members of the Remuneration Committee.

2.5 One member of the Committee shall be the Chair of the Safety, Quality, Patient Experience and Performance Committee.

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2.6 In the absence of the Committee Chair, another Non-Executive Member may be temporarily appointed to that role by agreement of the Non-Executive Directors.

2.7 One member of the Committee must have significant, recent and relevant financial experience.

2.8 A quorum shall be two non-Executive members including the Committee Chair.

3. ATTENDANCE

3.1 The Director of Finance, Director of Planning, Performance and Corporate Services and appropriate Internal and External Audit representatives shall normally attend meetings. However, at least once a year, the Committee should meet privately with the External and Internal Auditors.

3.2 The Chief Executive, Executive Directors and other Officers of the Trust may be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that Director or Officer. The Trust Board Chair may attend by invitation as an observer.

3.3 The Chief Executive should be invited to attend at least twice annually, to discuss with the Committee the process for assurance that supports the Mid-Year Assurance Statement and the Governance Statement.

3.4 A representative from the Sponsor Department (Department of Health) will be invited and may attend meetings of the Committee as an observer.

3.5 The Board Secretary shall attend to take minutes of the meeting and provide appropriate support to the Chair and committee members.

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4. FREQUENCY OF MEETINGS

4.1 Meetings shall be held not less than three times a year and where necessary can be conducted remotely using such as teleconference/video conferencing.

4.2 The Chair of the Committee may convene additional meetings as is deemed necessary.

4.3 The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

5. AUTHORITY

5.1 The Audit and Risk Assurance Committee's primary role is to independently contribute to the Board's overall process for ensuring that an effective internal financial control system is maintained.

5.2 The Board will always retain responsibility for such control and will act after taking account of the recommendations and assurances of the Committee. The Committee, therefore, does not have the executive authority of the Board, but does have sufficient membership, authority and resources to perform its role independently and effectively.

5.3 The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee.

5.4 The Committee is authorised by the Board to obtain external legal, clinical or other independent professional advice and to secure the attendance of individuals with relevant experience and expertise if it considers this necessary.

6. DUTIES

The duties of the Committee can be categorised as follows:

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Governance, Risk Management and Internal Control

6.1 The Committee shall contribute to the establishment, review and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisation's objectives.

6.2 In particular the Committee will review:

- The adequacy of all risk and control related disclosure statements (in particular the Mid-Year Assurance Statement and the Governance Statement), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board;
- The adequacy of the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;
- The adequacy of the policies for ensuring compliance with relevant regularity, legal and code of conduct requirements, including the Trust's Standing Orders and Standing Financial Instructions;
- The adequacy of the policies and procedures for all work related to fraud and corruption as required by the Department of Health (DoH) and the Business Services Organisation's (BSO) Counter Fraud and Probity Service (CFPS);
- The annual schedule of losses and compensation payments;
- The register of Direct Award Contracts;
- Health and Safety;
- Information Governance, Performance and Compliance – UK GDPR;
- NIAS ICT Performance and Cyber Security;
- Procurement and Logistics including NIAS Stores operation.

6.3 In carrying out its work, the Committee will primarily utilise the work of Internal Audit, External Audit, and other assurance

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functions where appropriate, but will not be limited to these functions.

6.4 The Committee will also seek reports and assurances from other Trust Committees through their respective Chairs, Directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

6.5 This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

Internal Audit

6.6 The Committee shall seek to ensure that there is an effective internal audit function established by management that meets the Public Sector Internal Audit Standards and provides appropriate independent assurance to the Audit and Risk Assurance Committee, Chief Executive and Board. This will be achieved by:

- Consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal;
- Review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework;
- Consideration of the Head of Internal Audit's annual report, major findings of internal audit work (and management's response), and ensure co-ordination between the Internal and External Auditors to optimise audit resources;
- Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation;
- Annual review of the effectiveness of internal audit.

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External Audit

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6.7 The Committee shall review the work and findings of the External Auditor appointed by the Northern Ireland Audit Office and consider the implications of, and management's responses to, their work. This will be achieved by:

- Consideration of the performance of the External Auditor;
- Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Audit Strategy;
- Discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust;
- Review of all External Audit reports, including consideration of the annual Report to Those Charged with Governance before submission to the Board and any work carried out outside the Annual Audit Strategy, together with the appropriateness of management responses.

Other Assurance Functions

6.8 The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation.

6.9 These may include, but will not be limited to, any reports issued by the Comptroller and Auditor General or Public Accounts Committee, reviews by DoH commissioned bodies, the Regulation and Quality Improvement Authority (RQIA) or professional and regulatory bodies with responsibility for the performance of staff or functions (e.g. Joint Royal Colleges Ambulance Liaison Committee (JRCALC), Health Care Professions Council (HCPC), Royal Colleges, accreditation bodies, etc.).

Financial Reporting

6.10 The Committee shall review the Trust's Annual Report and Accounts as well as the Charitable Trust Funds Annual Report and Accounts before submission to the Board, focusing particularly on:

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- The wording in the Governance Statement and other disclosures relevant to the Terms of Reference of the Committee;
- Changes in, and compliance with, accounting policies and practices
- Unadjusted mis-statements in the financial statements;
- Major judgemental areas;
- Significant adjustments resulting from the audit;
- The Committee should also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided to the Board.
- Banking and Treasury Management including Charitable Trust Funds

Value for Money

6.11 The Committee shall oversee the adequacy of the Trust's arrangements for ensuring that Value for Money (VFM) is obtained in the expenditure of all public funds entrusted to its care. This will include a review of the findings from, and management's response to, all value for money audit reports issued to the Trust as part of the regional VFM programme sponsored by DoH.

6.12 Consider and approve relevant policies.

7. REPORTING

7.1 The minutes of Committee meetings shall be formally recorded and submitted to the Board following approval by the Committee. After each meeting, the Chair of the Committee shall make a written report to the next Trust Board meeting. At any point, the Chair shall draw to the attention of the Board any issues that require disclosure to the full Board or require executive action.

7.2 The Committee will report to the Board annually on its work in support of the Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk

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management in the organisation, the integration of governance arrangements and the appropriateness of the self-assessment against quality and assurance standards.

7.3 The Chair shall liaise with the Chairs of other Committees on any issues or matter which may be relevant to their areas of responsibility.

8. REVIEW

8.1 The Terms of Reference should be reviewed annually.

9. OTHER MATTERS

9.1 The Agenda will be sent to members at least five working days before the meeting and supporting papers, wherever possible, shall accompany the agenda, but will be dispatched no later than three working days before the meeting, save in an emergency.

9.2 An explanatory cover note will be provided for each agenda item.

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Northern Ireland Ambulance Service
Health and Social Care Trust

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People, Finance and Organisational Development Committee

Title:			
Author(s):			
Ownership:			
Date of Committee Approval:		**Date of Trust Board Approval:**	
Operational Date:		**Review Date:**	
Version No:		**Supersedes:**	
Key Words:			
Links to Other Policies / Procedures:			

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Date:	**Version:**	**Author:**	**Comments:**

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Northern Ireland Ambulance Service
Health and Social Care Trust

People, Finance and Organisational Development Committee

TERMS OF REFERENCE

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1 CONSTITUTION

1.1 The Trust Board (The Board) hereby resolves to establish a Committee of the Board to be known as the People, Finance & Organisational Development Committee (The Committee).

1.2 The Committee is a Non-Executive Committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference or as may be delegated by the Board on an ad hoc basis.

1.3 All procedural matters in respect of conduct of meetings of the Committee shall be in accordance with the Trust's Standing Orders.

1.4 The Committee will regularly review and reflect on best practice and adopt new learning as part of a commitment to continuous improvement.

2 MEMBERSHIP OF THE COMMITTEE

2.1 Trust Non-Executive Directors that are to be included as members of this Committee will be nominated by the Trust Board Chair.

2.2 Two Non-Executive Members of the Committee will be appointed as Co-Chairs of the Committee by the Trust Board Chair. One Co-Chair shall have responsibility for all matters relating to People and Organisational Development and one Co-Chair shall have responsibility for all matters relating to Finance.

2.3 In the absence of the Committee Co-Chairs, another Non-Executive Member may be temporarily appointed to that role by agreement of the Non-Executive Directors.

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2.5 A quorum shall be two Non-Executive members.

3 ATTENDANCE AT MEETINGS

3.1 The Director of Human Resources and the Director of Finance shall normally attend meetings.

3.2 The Chief Executive, all Directors, Assistant Directors and senior managers with responsibility for workforce and finance related functions will be invited to attend as appropriate.

3.3 The Board Secretary shall attend to the minutes of the meeting and provide appropriate support to the Committee Co-Chairs and Committee members.

4 FREQUENCY OF MEETINGS

4.1 Meetings shall be held not less than three times a year, and where necessary can be conducted remotely using such as teleconference/video conferencing.

5 AUTHORITY

5.1 The Committee will be responsible for assuring the NIAS Board that effective and regularly reviewed arrangements are in place to support Human Resources, Finance and Organisational Development functions within the Trust.

5.2 The Board will always retain responsibility for such control and will act after taking account of the recommendations and assurances of the Committee. The Committee, therefore, does not have the executive authority of the Board, but does have sufficient membership, authority and resources to perform its role independently and effectively.

5.3 The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all

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employees are directed to co-operate with any request made by the Committee.

5.4 The Committee is authorised by the Board to obtain external legal, clinical or other independent professional advice and to secure the attendance of individuals with relevant experience and expertise if it considers this necessary.

6 DUTIES

The duties of the Committee can be categorised as follows:

6.1 Provide assurance to Trust Board in relation to all strategic issues relating to Human Resources, workforce and organisational development to deliver the Trust's Strategy, Plans and standards as determined by Trust Board.

These include those related to:

- Health and Wellbeing
- Learning and Development
- Employment Law
- Workforce Planning
- Recruitment and Retention
- Equality and Diversity
- Whistleblowing
- Pay and Conditions
- Culture

This list is not exhaustive and focus will evolve as the work of the Committee develops.

6.2 Provide assurance on the quality and effectiveness of targeted plans to support the organisation in delivering a positive patient centred culture, embedding the values and behaviours that the Trust aspires to demonstrate, including collective and compassionate leadership.

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6.3 Provide assurance on the development and implementation of the Workforce Planning, Estates and Fleet strategies.

6.4 Ensure consideration of an evidence-based approach to workforce and organisational development work streams to include quantitative and qualitative information.

6.5 To independently contribute to the Board's overall process for ensuring that the Trust Board delivers its statutory responsibility to break even. This includes:

- To review in detail the financial strategy, so as to be able to confirm to the Trust Board the basis of acceptance.

- To review the financial monitoring information in sufficient detail to advise the Trust Board, with confidence, concerning the financial performance of the Trust.
- To keep Directors up-to-date regarding the financial outlook for the Trust, and to review the key financial assumptions used in estimating the projected position.
- To review achievement of cost improvements and income generation activities in line with the Trust Delivery Plan.
- To receive regular updates on actions taken by the Director of Finance to ensure the provision of effective and sound financial management and information.
- To ensure the Director of Finance provides assurance that adequate training is delivered on an on-going basis to budget holders to enable them to manage their responsibilities.
- To assist and recommend training for SMT and Board, as appropriate.

6.6 Consider and approve relevant policies.

7 REPORTING

7.1 The Minutes of Committee meetings shall be formally recorded and submitted to the Board following approval by the

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Committee. After each meeting, the relevant Co-Chair of the Committee shall make a written report to the next Trust Board meeting. At any point, the Co-Chair shall draw to the attention of the Board any issues that require disclosure to the full Board or require executive action.

7.2 The Committee will report to the Board annually on its work in support of the Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the organisation, the integration of governance arrangements and the appropriateness of the self-assessment against quality and assurance standards.

7.3 The Co-Chairs shall liaise with the Chairs of other Committees on any issues or matter which may be relevant to their areas of responsibility.

8 REVIEW

8.1 The Terms of Reference should be reviewed annually.

9 OTHER MATTERS

9.1 The agenda will be sent to members at least five working days before the meeting and supporting papers, wherever possible, shall accompany the agenda, but will be dispatched no later than three working days before the meeting, save in an emergency.

9.2 An explanatory cover note will be provided for each agenda item.

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Northern Ireland Ambulance Service
Health and Social Care Trust

Remuneration and Terms of Service Committee

Title:			
Author(s):			
Ownership:			
Date of Committee Approval:		**Date of Trust Board Approval:**	
Operational Date:		**Review Date:**	
Version No:		**Supersedes:**	
Key Words:			
Links to Other Policies / Procedures:			

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Date:	**Version:**	**Author:**	**Comments:**

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Northern Ireland Ambulance Service
Health and Social Care Trust

Remuneration and Terms of Service Committee

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1. CONSTITUTION

1.1 The Trust Board (The Board) hereby resolves to establish a Committee of the Board to be known as the Remuneration Committee (The Committee)

1.2 The Committee is a Non-Executive Committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference or as may be delegated by the Board on an ad hoc basis.

1.3 All procedural matters in respect of the conduct of the meetings of the Committee shall be in accordance with the Trust's Standing Orders.

1.4 The Committee will regularly review and reflect on best practice and adopt new learning as part of a commitment to continuous improvement.

2 MEMBERSHIP OF THE COMMITTEE

2.1 Trust Non-Executive Directors that are to be included as members of this Committee will be nominated by the Trust Board Chair and the Committee shall consist of not less than three members.

2.2 The Chair of the organisation shall be Chair of the Committee.

2.3 None of these members should be members of the Audit and Risk Assurance Committee.

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2.4 In the absence of the Committee Chair, another Non-Executive Member may be temporarily appointed to that role by agreement of the Non-Executive Directors.

2.5 A quorum shall be two members including the Committee Chair.

3 ATTENDANCE

3.1 The Trust Board Chair, Chief Executive and Director of Human Resources shall normally attend meetings.

3.2 The Board Secretary shall attend to take minutes of the meeting and provide appropriate support to the Chair and Committee members.

4 FREQUENCY OF MEETINGS

4.1 Meetings shall be held not less than two times a year and where necessary can be conducted remotely using such as teleconference/video conferencing.

5 AUTHORITY

5.1 The Committee's primary role is to advise the Board about appropriate remuneration and terms of service for the Chief Executive and all other direct reports to the Chief Executive. Advice to the Board on remuneration should include all aspects of salary (including any performance-related elements/bonuses and any allowances), provisions for other benefits including pensions and cars, as well as arrangements for termination of employment and other contractual terms.

5.2 The Board will always retain responsibility for such control and will act after taking account of the recommendations and assurances of the Committee.

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The Committee, therefore, does not have the executive authority of the Board, but does have sufficient membership, authority and resources to perform its role independently and effectively.

5.3 The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

5.4 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

6 DUTIES

The duties of the Committee can be categorised as follows:

6.1 Recommend to the Board about appropriate remuneration and terms of service for the Chief Executive and Executive Directors employed by the Trust, having proper regard to the Trust's circumstances and performance. Recommendations will also take into account Directions and/or guidance issued by the Department of Health and to the provisions of any national/regional arrangements where appropriate. Matters considered shall include:-

- All aspects of salary (including any performance-related elements/bonuses)
- Provisions for other benefits e.g. Lease cars
- Arrangements for termination of employment and other contractual terms.

6.2 Monitor and evaluate the performance management process in respect of the Chief Executive and Executive

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Directors (and other senior employees where appropriate). This will include:-

- Encouraging effective appraisal of staff
- Scrutinising objectives for:
  - Consistency
  - Robustness
  - Alignment with Government and Departmental priorities and local priorities
- Ensuring robust process has taken place
- Monitoring for consistency of assessment
- Recommending overall banding and award for Senior Executives

6.3 Advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

6.4 Ensure that all provisions regarding disclosure of remuneration, including pensions, are fulfilled.

6.5 Consider and approve relevant policies.

7. REPORTING

8.5 The Minutes of Committee meetings shall be formally recorded and submitted to the Board following approval by the Committee. After each meeting, the Chair of the Committee shall make a written report to the next Trust Board meeting. At any point, the Chair shall draw to the attention of the Board any issues that require disclosure to the full Board or require executive action.

8 REVIEW

9.5 The Terms of Reference should be reviewed annually.

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9 OTHER MATTERS

10.5 The Agenda shall be sent to members at least five working days before the meeting and supporting papers, wherever possible, shall accompany the agenda, but shall be dispatched no later than three working days before the meeting, save in an emergency.

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10.6 An explanatory cover note will be provided for each agenda item.

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Northern Ireland Ambulance Service
Health and Social Care Trust

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Safety, Quality, Patient Experience and Performance Committee

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Author(s):			
Ownership:			
Date of Committee Approval:		**Date of Trust Board Approval:**	
Operational Date:		**Review Date:**	
Version No:		**Supercedes:**	
Key Words:			
Links to Other Policies / Procedures:			

Version Control:			
Date:	**Version:**	**Author:**	**Comments:**

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Northern Ireland Ambulance Service
Health and Social Care Trust

Safety, Quality, Patient Experience and Performance Committee

TERMS OF REFERENCE

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1 CONSTITUTION

1.1 The Trust Board (The Board) hereby resolves to establish a Committee of the Board to be known as the Safety, Quality, Patient Experience and Performance Committee (The Committee).

1.2 The Committee is a Non-Executive Committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference or as may be delegated by the Board on an ad hoc basis.

1.3 All procedural matters in respect of conduct of meetings of the Committee shall be in accordance with the Trust's Standing Orders.

1.4 The Committee will regularly review and reflect on best practice and adopt new learning as part of a commitment to continuous improvement.

2 MEMBERSHIP OF THE COMMITTEE

2.1 Trust Non-Executive Directors that are to be included as members of this Committee will be nominated by the Trust Board Chair.

2.2 A Non-Executive Member of the Committee will be appointed Chair of the Committee by the Trust Board Chair.

2.3 The Trust Board Chair shall not be a member of the Committee but may attend meetings in an ex-officio capacity.

2.4 In the absence of the Committee Chair, another Non-Executive Member may be temporarily appointed to that role by agreement of the Non-Executive Directors.

2.5 One member of the Committee shall be the Chair of the Audit and Risk Assurance Committee.

2.6 Where practicable, one member of the Committee should have a clinical background.

2.7 A quorum shall be two Non-Executive members including the Committee Chair.

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3 ATTENDANCE AT MEETINGS

3.1 All Directors shall normally attend meetings (subject to the issues to be considered on the agenda).

3.2 The Trust Board Chair, Chief Executive and other Officers of the Trust may attend and will be particularly expected to do so when the Committee is discussing areas of risk or operation that are the responsibility of that Officer.

3.3 The Board Secretary shall attend to the minutes of the meeting and provide appropriate support to the Committee Chair and Committee members.

4 FREQUENCY OF MEETINGS

4.1 Meetings shall be held not less than three times a year, and where necessary can be conducted remotely using such as teleconference/video conferencing.

5 AUTHORITY

5.1 The Committee will be responsible for assuring the NIAS Board that effective and regularly reviewed arrangements are in place to support the implementation, maintenance and development of Governance (clinical and non-clinical) and risk management and that such matters are properly considered and communicated to the Board.

5.2 The Board will always retain responsibility for such control and will act after taking account of the recommendations and assurances of the Committee. However, the Committee does have the delegated authority of the Board, through sufficient membership, authority and resources to perform its role independently and effectively.

5.3 The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee.

5.4 The Committee is authorised by the Board to obtain external legal, clinical or other independent professional advice and to secure the attendance of individuals with relevant experience and expertise if it considers this necessary. In particular, the

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Committee must be satisfied that it is able to provide appropriate clinical assurance.

6 DUTIES

The duties of the Committee can be categorised as follows:

6.1 Governance, Risk Management, Internal Control, Safety, Quality, Patient Experience and Performance - The Committee shall contribute to the establishment, review and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisation's objectives with a particular focus on safety, quality, patient experience and performance.

6.2 In particular the Committee will:

6.2.1 Provide assurance that adequate systems and processes are in place to support the achievement of the organisation's objectives and strategically manage clinical and non-clinical risks.

6.2.2 Provide assurance that adequate systems and processes are in place for the delivery of high-quality patient care that is safe, effective and patient focused through the review and monitoring of:

- Clinical and operational activities;
- Operational performance;
- Safeguarding;
- Professional self-regulation;
- Development and implementation of national standards of care and practice;
- Clinical audit activity;
- Professional and clinical performance standards;
- Continuing professional development for all staff;
- Adverse incidents and complaints with a clinical component;
- Infection prevention and control arrangements;

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- Clinical research and development activity;
- Personal and public involvement (PPI) arrangements and activities;
- Corporate social responsibility;
- Emergency planning and business continuity;
- Information governance;
- Compliance with the relevant DoH controls assurance standards and associated action plans.
- Clinical Effectiveness Audit
- Compliments and Complaints
- Quality Assurance and Annual Quality Report
- Complex Case Team
- Medicines Management
- Clinical Practice and Guidance
- Community First Responders
- Control Room Performance
- Clinical Support Desk
- Voluntary Car Service and Independent Sector Management

6.2.3 Review the Trust's Assurance Framework and the Trust's Risk Register and to make recommendations to Trust Board for action as required to ensure high quality patient care. In reporting to the Trust Board the committee will seek to reach consensus in any decisions made. Where consensus cannot be reached, the issue will be referred to the Trust Board for further discussion and if necessary a decision.

6.2.4 Report and review the outcome of Serious Adverse Incidents (SAI) including Serious Clinical Adverse Incidents in line with DoH guidance and to ensure that appropriate remedial action has been taken including measures to prevent recurrence.

6.2.5 Receive reports from other Committees and Working Groups in relation to areas of risk and governance.

6.2.6 Provide Trust Board with regular reports on the management of risk and quality of patient care, an annual report on clinical governance and an annual quality report.

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6.3 [1]In carrying out its work, the Committee will utilise the work of Internal Audit, External Audit, and other assurance functions where appropriate, but will not be limited to these functions. It will also seek reports and assurances from other Trust Committees through their respective Chairs, Directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

6.4 This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

6.5 Other Assurance Functions - The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation.

6.6 These may include, but will not be limited to, any reports issued by the Comptroller and Auditor General or Public Accounts Committee, reviews by DoH commissioned bodies, the Regulation and Quality Improvement Authority (RQIA) or professional and regulatory bodies with responsibility for the performance of staff or functions (e.g. Joint Royal Colleges Ambulance Liaison Committee (JRCALC), Health and Care Professions Council (HCPC), Royal Colleges, accreditation bodies, etc.).

6.7 Governance Statement - The Committee shall review the Governance Statement and other disclosures relevant to the Terms of Reference of the Committee.

6.8 Consider and approve relevant policies.

7 REPORTING

7.1 The minutes of Committee meetings shall be formally recorded and submitted to the Board following approval by the Committee. After each meeting, the Chair of the Committee shall make a written report to the next Trust Board meeting. At any point, the Chair shall draw to the attention of the Board any issues that require disclosure to the full Board or require executive action.

[1] Safety First – A framework for sustainable Improvement in the HPSS (March 2006)
[2] Procedure for reporting and follow up of SAI (April 2010)

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7.2 The Committee will report to the Board annually on its work in support of the Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the organisation, the integration of governance arrangements and the appropriateness of the self-assessment against the Quality Standards and Controls Assurance Standards.

7.3 The Chair shall liaise with the Chairs of other Committees on any issues or matter which may be relevant to their areas of responsibility.

8 REVIEW

8.1 The Terms of Reference should be reviewed annually.

9 OTHER MATTERS

9.1 The Agenda will be sent to members at least five working days before the meeting and supporting papers, wherever possible, shall accompany the agenda, but will be dispatched no later than three working days before the meeting, save in an emergency.

9.2 An explanatory cover note will be provided for each agenda item.

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Return to Agenda

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

PRESENTATION OF PAPER

Date of Trust Board:	21 October 2021
Title of paper:	Medical Devices Policy
Brief summary:	This is a review of an existing Policy. The purpose of this policy is to provide an up-to-date, comprehensive, Trust-wide strategy for the management of Medical Devices, from inception to disposal. This is to ensure compliance with legislation and to establish procedures for the identification, selection, procurement, integration, training, use, maintenance and ultimate replacement and disposal of Medical Devices. The Policy has been designed to protect staff and service users from risk whilst safeguarding the welfare of patients, staff and members of the public.
Recommendation:	**For Approval** ☒ **For Noting** ☐
Previous forum:	Medical Equipment Group - 20 August 2021 SMT – 7 September 2021 Safety Committee – 16 September 2021
Prepared and presented by: **Date:**	Katrina Keating, Risk Manager Sean Moore, Medical Devices Lead Dr Nigel Ruddell, Medical Director 14 October 2021

Northern Ireland Ambulance Service Health and Social Care Trust

Title:	**Medical Device Policy**		
Author(s):	Seán Moore, Medical Device Lead Katrina Keating, Risk Manager		
Ownership:	Dr Nigel Ruddell, Medical Director		
Date of SMT Approval:	07/09/2021	**Date of Trust Board Approval:**	Pending
Operational Date:	Pending	**Review Date:**	Pending
Version No:	8.0	**Supercedes:**	Version 7.0
Key Words:	Medical devices, medical equipment, servicing, maintenance, repair, life cycle, Infection Prevention and Control and decontamination, decommissioning, condemnation and disposal, replacement, medical device alerts, NIAIC, incident reporting, deployment, training, asset management, risk assessment, evaluation.		
Links to Other Policies / Procedures:	Risk Management Policy, Risk Assessment Procedure, Regional Ambulance Clinical Training and Education arrangements, medical gases procedures, NIAS IPC Policy and NIAS Vehicle and Equipment Decontamination Manual, Incident Reporting Procedures, Standard Operating Procedures.		

Version Control:			
Date:	**Version:**	**Author:**	**Comments:**
August 2021	8.0	Medical Device Lead	Complete review
July 2016	7.0	Medical Director	Scheduled review
December 2009	6.0	Medical Director	Scheduled review

1.0 INTRODUCTION:

1.1 Background:

Medical Devices improve health outcomes when used within the context of a robust health system, and which itself, is only as good as the policy, strategies, and action plans that constitute it.

This policy is required to create a framework through which to direct the Trusts valuable resources such as finance, human resources, information, leadership and governance to collectively address the needs of the Trust.

Within the Northern Ireland Ambulance Service Health and Social Care Trust (NIAS), Medical Devices are an essential and integral element of all aspects of pre-hospital care.

By definition, 'Medical Device' means any instrument, apparatus, implement, machine, appliance, implant, reagent for in vitro use, software, material or other similar or related article, intended by the manufacturer to be used, alone or in combination, for human beings, for one or more of the specific medical purpose(s) of diagnosis, prevention, monitoring, treatment, alleviation or compensation for an injury or disease, supporting or sustaining life[1].

The Northern Ireland Ambulance Service Health and Social Care Trust (NIAS) recognises its statutory obligations under The Medical Device Regulations, MDR, and has reviewed and updated the existing policy to reflect both the structural review within NIAS and the updating of the statutory instruments in respect to Medical devices.

1.2 Purpose:

The purpose of this policy is to provide an up-to-date, comprehensive, Trust-wide strategy for the management of Medical Devices, from inception to disposal. This is to ensure compliance with legislation and to establish procedures for the identification, selection, procurement, integration, training, use, maintenance and ultimate replacement and disposal of Medical Devices. The Policy has been designed to protect staff and service users from risk whilst safeguarding the welfare of patients, staff and members of the public.

1.3 Objectives:

This Policy aims to establish a framework for statutory Medical Devices management within NIAS with due regard to the following key objectives:

- *To provide clarity and transparency for the justification and rationale for the selection, use and disposal of Medical Devices.*
- *To ensure that all Medical Devices for the Trust are* identified, risk assessed, selected, procured, used, serviced and calibrated, managed, investigated and

[1] Excerpt from the WHO Medical Device Full Definition

disposed of *in compliance with statutory instruments, standards, approved codes of practice and manufacturers' recommendations.*

- *To detail the corporate responsibility to the safety of staff and patients, and set down the roles and responsibilities of all personnel.*
- *To formally record and detail the information that will be collected, collated and stored to assist in the management of Medical Devices.*

2.0 SCOPE:

2.1 This Policy is applicable to all NIAS staff who are involved in the identification, selection, procurement, use, management, investigation and disposal of Medical Devices.

3.0 ROLES AND RESPONSIBILITIES:

3.1 The Chief Executive is responsible for:

- Ensuring that there are suitable and sufficient arrangements in place for the management of Medical Devices within the Trust, including the necessary resources, monitoring processes and oversight where appropriate.
- Ensuring the full and effective implementation of this Policy, and satisfying the Trust Board of the same.
- Ensuring there are suitable arrangements in place for the review and audit of this policy document to ensure that the policy remains fit for purpose and that full policy compliance is achieved.

3.2 The Medical Director is responsible for:

- Providing the Chief Executive and Trust Board with information and assurance pertaining to the management and use of Medical Devices within the Trust.
- Ensuring that the Trust has a robust system and structure in place for Medical Devices use.
- Ensuring that systems, policies and procedures are developed and implemented on behalf of the Trust including the onward reporting of relevant incidents to external agencies for e.g., Health & Social Care Board (HSCB), Health and Safety Executive for Northern Ireland (HSENI) and the Regulation, Quality Improvement Authority (RQIA). On a daily basis, this function is delegated to the Risk Manager.
- Ensuring that the need for Medical Device familiarisation, management and use is recorded in the job descriptions of the posts concerned and in any associated recruitment documentation.
- Ensuring there is a robust mechanism for the monitoring and validation of the Medical Device training system and that measures are in place to provide statistical data on training outcomes.
- Ensuring the necessary competence and expertise of individuals' assigned specific roles and responsibilities.
- Ensuring that there is oversight and accountability with regards to the Medical Device responsibilities of all staff.

- Ensuring that employees and their representatives are kept informed at all stages of the process, encouraging participation and involvement in the development and delivery of policies and procedures.
- Chairing the Medical Equipment Group (MEG).

3.3 The Assistant Medical Director is responsible for:

- Representing the Trust at Contract Advisory Groups to ensure that the Trust can take advantage of regional contracts for the selection, supply, procurement, service and maintenance of Medical Devices.
- Ensuring that those appointed by the Trust for supplying, servicing and repairing Medical Equipment and Devices are competent to do so and represent the best interests of the Trust in terms of their suitability, capability, technical ability, manufacturer accreditation, quality assurance and safety, ensuring that the interests of user and patient are protected.
- Engaging with Stores and Procurement Department and play an active role in the selection of Medical Devices.
- Providing economic evaluation data to enable the provision of sufficient resources for service and maintenance contracts or where necessary provide adequate facilities and staff to ensure effective and efficient maintenance/repair/ calibration of medical equipment.
- Ensuring that guidance as distributed in relation to the management and use of Medical Equipment, inclusive of but not limited to Memos, Standard Operating Procedures, Safety Alerts etc. is correct and appropriate.
- Engaging with and advising the Medical Equipment Group at the earliest opportunity if there are any changes to national guidance, services or clinical procedures, which involve the use of and which may require the review of Medical Devices.
- Advising the Medical Equipment Group of any emerging risk from the use or misuse of any Medical Equipment or Device.
- Ensuring that robust governance is embedded in all aspects of Medical Device and equipment use from inception to disposal.
- Support the Directorate in the development of clinical standards and governance plans as appropriate and providing expert advice on the application of Medical Devices to meet the clinical needs of the Trust to deliver service improvement.
- Deputise for the Medical Director where required and take a lead role in developing links between the Medical Directorate and the wider Trust in respect of clinical standards and governance.
- Support incident investigations inclusive of but not limited to clinical analysis, reviewing research and national guidelines to improve practice.

3.4 Directors & Assistant Directors are responsible for:

- Ensuring that this policy and any associated procedures are effectively implemented within their areas of responsibility.
- Ensuring arrangements are in place for monitoring and compliance with this Policy.
- Ensuring that there are suitable resources available for the implementation of this Policy.

- Informing the Risk Management Team where there is a significant change in circumstances.
- Ensuring line managers and supervisors have sufficient training and instruction to be competent to carry out risk assessments and to identify training needs in respect to Medical Devices.
- Ensuring that the Trust's procedure on adverse incident reporting and management is widely disseminated, promoted and implemented within their areas of responsibility.
- Ensuring that staff are appropriately trained in the reporting and management of adverse incidents.
- Promoting an open, honest and just reporting culture and ensuring that appropriate reviews are carried out.

3.5 <u>The Medical Equipment Group is responsible for:</u>

- Advising the Board, through the Safety, Quality, Experience & Performance Committee, on the management of Medical Devices, relevant to the agreement of strategic objectives and investment priorities.
- Alerting the Board, through the Safety, Quality, Experience & Performance Committee, to issues associated with the management of Medical Devices, which influence resource allocation.
- Ensure the development, implementation and audit of a Trust-wide policy and strategy for the management of Medical Devices to include procurement; training; risk assessment; maintenance, including maintenance contracts, replacement and disposal contracts.
- Organising, co-ordinating and prioritising risk management issues in relation to Medical Equipment and advising on the level of actions and resources necessary to manage those risks effectively.
- Ensuring appropriate arrangements are in place to facilitate effective cross-partnership working and to interface with other Trusts.
- Ensuring the existence and maintenance of a Trust-wide inventory of Medical Devices.
- Encouraging and fostering awareness of Medical Devices management at all levels of the organisation.
- Recommending proposals for the purchase of Medical Equipment.
- Monitoring and reviewing pharmacy provision and drug-related incidents.
- Oversight of incidents and issues pertaining to Medical Devices within NIAS.
- Ensuring lessons learned from the outcome of Medical Device investigations are used as a means of improving precautions, revising works activities and practices, including the revision of documentation or purchase of additional or alternative Medical Devices in addition to any adverse event outcomes.
- The formulation of any remedial measures that may be required and to assist with the aim of seeking continual improvement of Medical Device related tasks.
- Assessing any training requirements associated with Medical Device roles and responsibilities
- Monitoring, measuring, review and audit measures that may be required to ensure that the roles and responsibilities pertaining to Medical Devices are applied in practice and that they continue to be effective

3.6 The Medical Devices Lead is responsible for:

- Collaborating widely with stakeholders both internally and externally to ensure compliance with regional, national and international guidance, standards and legislation.
- Leading Medical Devices capital programmes, procurement, project and contract management, leading the Trust's actions to manage the life-cycle of medical technology efficiently and within financial limits.
- Ensuring that there are systems in place across the Trust to for planned, preventative maintenance and decontamination of Medical Devices.
- Developing and implementing asset management/ inventory systems for medical devices and equipment across the Trust.
- Developing corporate wide Medical Devices strategies, policies and procedures, including the arrangements for risk management, governance and assurance, health and safety, decontamination and training to ensure the safe and effective management of Medical Devices.
- Developing and provision of a high quality, efficient Medical Device service which is flexible and responsive to the Trust needs and demands, for example emerging risks, immediate maintenance requirements etc.
- Investigating equipment failures, completion of failure reports and when necessary escalate failures to regional or national forums.
- Managing information flows safety alerts involving medical devices and acting as the Trust's Medical Devices Liaison Officer, MDLO, to the NIAIC.
- Promoting the safe use of Medical Devices across the Trust and supporting the implementation of local and national safety initiatives and supporting actions on Field Safety Notices, acting as the Trust's Medical Devices Safety Officer, MDSO.
- Reviewing and interpreting regional, national and international legislation, health service policy, strategy standards and guidance relating to medical devices including their decontamination in-line with the Trusts Infection prevention control policies and procedures, ensuring that the Trust is compliant and informed of any changes and subsequent actions required.
- Interpreting national and regional health service policy and strategy in order to ensure safety and quality in the area of Medical Devices for the organisation.
- Responsible for reviewing and updating existing policy, procedures and developing a more robust system for all aspects of clinical equipment management in conjunction with other senior staff.
- Maintaining current knowledge of the latest scientific/technical developments/ national best practice relating to Medical Devices.
- Reacting to changes in best practice and guidance, to ensure that the Trust is at the forefront of sound Medical Devices management and ensure the safety of its staff and service users.
- Maintaining the careful use and security of all Medical Devices across the organisation.
- Ensuring that at all times the management of the Medical Devices services are patient focused.

3.7 The IPC Group is responsible for:

- Providing expert IPC advice in relation to the procurement of Medical Devices and Equipment.
- Being a resource for advice regarding effective decontamination of Medical Devices and Equipment.
- Advising on storage of medical devices in line with IPC best practice.
- Engaging in the audit of existing facilities and arrangements for routine cleaning and the control of infection for all Trust premises, using audit tools designed in conjunction with the Trust risk assessment process.
- Developing robust monitoring arrangements, to ensure compliance with Trust policies and procedures in relation to infection prevention & control at all times to enhance the safety and welfare of all staff, patients and visitors.
- Reviewing the Trust's policies and procedures on infection prevention & control.
- Producing regular reports to the Assurance Committee highlighting the outcome of audit reports from stations, training and management walk-around inspections, and making appropriate recommendations as required.
- As appropriate, reviewing, implementing and producing policies, procedures and practices, ensuring compliance with the Health and Safety at Work Order and COSHH Regulations making recommendations for change as appropriate.
- Developing educational programmes, delivered by the Trust's Training Department, which are to be agreed and approved by the IPCG.
- Advising on staff education in accordance to infection prevention & control standards.
- Considering emerging threats, to evaluate their relevance and consequence, and to develop and co-ordinate the Trust response as appropriate.

3.8 Training Officers & Clinical Support Officers are responsible for:

- Collating and interpreting training needs analysis for the purpose of developing training plans and providing training and clinical supervision as required in relation to Medical Device and Equipment use.
- Providing training and assessment to ensure staff are competent to use Medical Devices and Equipment.
- Providing advice and support to staff in the use of Medical Devices and Equipment.
- Liaising with the Medical Equipment Group for the provision of Medical Device Documentation, inclusive of but not limited to Original Equipment Manufacturers Manuals, Standard Operating Procedures, Technical Notes etc.
- Adhering to direction as provided by the Medical Device Lead and the content of this Policy, SOPs, Original Equipment Manufacturers' Manuals to ensure consistency of information and Training.

3.9 Line Managers are responsible for:

- Ensuring that this policy and associated procedures are effectively implemented across their area of responsibility.

- Complying fully with and distributing guidance in relation to the management and use of Medical Equipment, inclusive of but not limited to Memos, Standard Operating Procedures, Safety Alerts etc.
- Ensuring that staff using medical devices have received the appropriate training and are competent and authorised to do so.
- Ensuring appropriate support is offered to staff in the use of Medical Devices and Equipment and any training needs are addressed to the EDUCATION, LEARNING AND DEVELOPMENT.
- Maintaining a record of all Medical Devices across their area of responsibility.
- Ensuring that any risk assessments in respect to Medical Devices are carried out in line with the Risk Assessment Procedure and supported by the Risk Management Team.
- Ensuring that any issues or concerns involving Medical Devices that cannot be addressed locally, or deemed beyond their control, are escalated to a more senior manager via line management structures.
- Promoting an open, honest and just reporting culture.
- Ensuring that appropriate reviewing, approving and/ or escalating of incidents, via the Trust Incident Reporting System, is carried out in line with incident reporting procedures.
- Ensuring that any Medical Device or Equipment defective in performance or involved in an incident is immediately withdrawn from service, cleaned, decontaminated, clearly marked to ensure no inadvertent use, withheld, and returned to the Medical Device Lead. The device or equipment shall not be disposed of under any circumstances.
- Ensuring that the all respective incidents on the Trust Incident Reporting System is updated and all incidents are correctly and timeously closed, in line with incident reporting procedures.
- **Challenging any misuse or deliberate over categorisation of Medical Devices and ensuring that any stocks are at appropriate levels to reduce the potential for overstock and that all expired products are removed from stores and responsibly decommissioned, condemned or disposed.**
- Ensuring that the all Vehicular Daily Inspections, VDI, within their remit, are carried out in respect of Medical Devices and Equipment and any adverse incidents are reported via the Trust Incident Reporting System, in line with incident reporting procedures and ensuring that the content of the reports is factual and appropriate.
- Overseeing and supervising the implementation of infection control policies for the routine decontamination of Medical Devices and Equipment within their area of responsibility and to actively participate in the management of infection control related incidents and risks.

3.10 <u>All Staff are responsible for:</u>

- Adherence to this Policy and overarching arrangements.
- Attending any Medical Device training courses provided by NIAS.
- Ensuring the safety of individuals involved, service users, visitors and staff, the environment and equipment.
- Avoiding putting themselves and others in situations of danger.

- Only using medical devices if they have received the appropriate training and are competent and authorised to do so.
- Complying fully with guidance and actions required, as distributed in relation to the management and use of Medical Devices and Equipment, inclusive of but not limited to Memos, Standard Operating Procedures, Safety Alerts etc.
- Fully co-operating with any review and investigative process including the provision of witness statements, if appropriate.
- Immediately reporting Medical Device defects, faults, near misses, or any adverse incidents via the Trust Incident Reporting System, in line with incident reporting procedures, criteria and timescales, and ensuring that the content of the report is factual and appropriate.
- Where applicable, initiating, investigating or reviewing incidents, ensuring that incidents reported are in line with Trust reporting policies and procedures and the content of the report is appropriate, within agreed Trust timeframes, and closing upon completion of this process.
- Participating in adverse event investigation where applicable, the aim of which is to provide appropriate help and support at the earliest opportunity to mitigate the effects of any Medical Device related issue.
- Identifying the medical device involved in incidents, recording the type, model and serial number(s) of the equipment, clearly labelling defective devices and any consumables associated, ensuring they are taken out of use and presented for investigation.
- Ensuring that any medical device or equipment involved in incidents is held, not disposed of, and returned to the Medical Device Lead. Such devices and equipment shall not be disposed of, under any circumstances.
- Ensuring that their line manager and/or person in charge of the area is informed of any incident.
- Co-operating with any control measures implemented to protect their health.

4.0 KEY PRINCIPLES:

4.1 Identification of Need:

The Trust shall take into consideration that as clinical practice and medical technology advances, so too must the Medical Devices and Equipment to support that practice and technology, especially if there are advantages to patients, to staff and to the Service.

From time to time, service developments may require new equipment, or staff may themselves consider that a new item of equipment is likely to benefit patients or the service. Staff may have witnessed the use of new or innovative Devices and Equipment in other Services, at trade fairs conference & exhibition or approached by medical equipment manufacturers / suppliers with a view to adopting new products.

Individual members of staff, Departments or Directorates wishing to identify items of medical equipment for use by NIAS shall submit an Identification of Need to the Medical Equipment Group for consideration. Copies of the Identification of Need will be available from the NIAS Intranet. The Identification of Need shall include, but not be limited to the following:

- Name of item; manufacturer, make, model
- Indications for use
- Clinical benefit or advantage over existing equipment, where applicable
- Clinical evidence to support use
- Approximate cost per item
- Dimensions; size, weight
- Power requirements; battery, vehicle charging
- Amount required e.g. per staff member, per vehicle, per department etc.
- Projected frequency of use e.g. per call, day, month etc.
- Training Requirements
- Potential supplier details, if known
- Details of potential competing products

4.2 Assessment of Need:

Medical Devices and Equipment shall only enter service within the Trust, through approved routes, when it has been established that the devices and equipment have been formally identified, assessed and evaluated as matching the user requirement and specification as set by the Medical Equipment Group. This is to ensure that the devices are approved and safe for use, that arrangements for, training, servicing, maintenance, calibration and decontamination, consumables and spare parts with continued supplier support are adequate and in the best interests of the Trust. New equipment requests, demonstrations or changes will be a standing item on the agenda of the Medical Equipment Group.

- All submissions that have arrived since the previous meeting shall be raised to reach an initial determination as to whether there is any merit in formal consideration.
- If the Group deems that there is no merit in further consideration, then the representative or NIAS staff member who made the submission will be notified of the decision.
- If a decision is made that the item is worthy of further consideration, then an assessment of need shall be requested and undertaken.
- The procedure for the assessment of new equipment will depend on the complexity of new Medical Devices and Equipment and the satisfaction of rationale.

For further information on equipment assessment, please see Appendix 1.

4.3 Governance:

The Trust shall ensure that there is an appropriate governance structure in place at all levels with clearly designated responsibilities for the oversight and management of Medical Device and Equipment.

The Trust has established and regularly reviews terms of reference for groups and committees responsible for such oversight and ensure appropriate representation and attendance.

Internal audit arrangements are in place to review that appropriate policy and procedures are in place to ensure the effective management and review of medical devices in accordance with Controls Assurance Standards (CAS) / replacement process.

Audit is a statutory requirement and the BSO Audit is an independent, objective assurance service that provides the Trust with an objective evaluation, through a systematic, disciplined approach, of the overall adequacy and effectiveness of the Trust's framework of governance, risk management and control to minimise or eliminate risks to patients and staff.

Medical Device and Equipment incident reporting is a key element of audit analysis whereby the management and performance of devices and equipment can be established through analysing the incident data as reported and establishing themes, trends, patterns etc. to provide feedback and support to the Trust, its staff and patients.

The audit shall encompass applicable criteria and key indicators capable of showing improvements in medical devices management and providing early warning of any risk. The audit shall note the criteria, detail the evidence and provide a narrative of self-assessment of compliance, including source evidence.

Any gaps in compliance shall be noted such that a post CAS assessment can be performed, and an action plan can be compiled to enable any gaps in compliance to be addressed and closed.

Any internal audit reports shall be submitted to the appropriate committees / Trust Board as necessary

The Trust shall employ additional 'external' monitoring and audit to inspect the policy and procedures against essential standards of quality and safety for the management of Medical Devices as necessary and any audit reports shall be submitted to the appropriate committees / Trust Board as necessary.

4.4 Device Evaluation:

Where an item of equipment has been approved for further consideration, the Medical Equipment Group shall contact the representative to arrange a demonstration of the item for members of the Group. This shall ideally be undertaken at NIAS Headquarters and will be arranged in keeping with the NIAS policy on hospitality etc. This evaluation will be undertaken by an evaluation team, a minimum of five people to include:

- The Medical Director, Assistant Medical Director, or representative,
- A member of the Regional Ambulance Clinical Training Centre Staff,
- The Stores Manager or their nominated representative,
- An Infection Prevention and Control Practitioner,
- A front-line staff member, Paramedic or Technician, who would potentially use the equipment if it was deployed,

The Director of Finance or nominated representative should ideally attend, but their consideration may be included at a later date. Where the original Identification of Need

submission has been made by a member of staff, then that staff member shall not be involved in the Initial Assessment.

The Medical Equipment Group shall develop a Medical Devices Equipment Evaluation Checklist, based on the assessment of need, to which the Device or Equipment being evaluated can be compared and assessed against.

The evaluation team shall ensure that the user requirement as defined by the Medical Equipment Group is met in the evaluation checklist.

4.5 Risk Assessment:

A Risk Assessment with supporting Method Statement shall be undertaken for all new Medical Devices and Equipment that are considered for implementation. The risk assessment shall take into account any potential hazards to the user, other staff, patients and the service, inclusive of but not limited to the following:

- Manual Handling: weight and orientation of the device and equipment
- Ease of use: functionality, clarity of observations, printouts, audibility
- Infection, Prevention and Control: Cleaning, disinfection, decontamination
- Deployment; impact on service delivery, downtime of vehicles
- Training element: cascading training from Trainer to End User
- Service and maintenance; impact on service delivery, downtime of vehicles

The Risk Assessment shall be carried out as part of any evaluation, with reviews and updates at each stage of the evaluation process.

The Health and Safety Team shall provide guidance and support to individuals carrying out risk assessments and method statements.

4.6 Standardisation:

The Trust is committed to a policy of standardisation of Medical Devices in order to:

- Reduce the range of inventory in terms of consumables held,
- Minimise risk through a common range of equipment,
- Build resiliency through available alternatives in the event of replacement or a withdrawal following the receipt of a Field Safety Notice,
- Improve the continuity of patient care,
- Minimise purchasing cost through competition and purchasing power,
- Minimise maintenance and training costs.

4.7 Procurement:

In the procurement of Medical Devices, be it through purchase, rental, lease, loan or transfer, the Trust shall follow the twelve agreed procurement principles, guiding public procurement in Northern Ireland as listed in Appendix 2.

The Medical Equipment Group, in assessing need, shall establish which method of procurement best suits the needs of the Trust be that outright purchase, rental or

lease, and establish for each option the ownership and responsibility for aspects such as warranty, service, maintenance, calibration, consumables, spares and changeout etc. where applicable.

The procurement of the device may take the form of a regional contract for which a region wide Contract Advisory Group, CAG, through the Centre of Procurement Expertise, COPE, will be established.

The Medical Equipment Group shall define the user requirement, the function that the item is required to perform through the preparation of a specification and the Trust will be represented at the CAG to ensure that the Trust specification can be implemented for the selection, supply, procurement, service, and maintenance of appropriate Medical Devices.

All purchases shall be in line with the Trust's policy and procedure in respect of requisitioning, ordering and receipt of goods and services.

All requisitions for Medical Devices or Equipment in terms of purchase, rental or lease, shall be placed via the electronic Procurement System, also known as eProcurement or eProc, or via the submission of a Memo of Need directly to the Stores and Procurement Department, detailing the justification of need for the new device.

All requisitions placed for Medical Devices or Equipment, shall be open to scrutiny by the Stores Department, in conjunction with the Centre of Procurement Expertise, COPE, to ensure appropriate oversight in terms of stock levels, expenditure and Trust needs.

Any order shall reflect the results of the procurement negotiations and call for delivery to an agreed location.

All requisitioners shall ensure that no requisition or order is placed, or expenditure committed for any item or items for which there is no Line Manager oversight and approval.

All requisitioners shall ensure that no requisition or order is placed, or expenditure committed for any newly approved Medical Devices or Equipment direct to suppliers for which there is no Line managers oversight or authorised by the Director of Finance on behalf of the Chief Executive.

4.8 Loan Equipment:

Medical Devices or Equipment shall not be supplied on loan to the Trust without an Overarching Master Indemnity Agreement being in place, detailing the Supplier, the Devices or Equipment on loan, and signed for by a representative of the Trust.

This Indemnity Agreement shall ensure clarity of responsibility for any problems, which may arise, with the equipment and detail the public liability and product liability insurance covering the Equipment together with any other information provided to the Trust is accurate and will be kept

The Medical Device Lead shall collate the identify any training elements required with the loan equipment and pass these to the Education, Learning and Development Department for implementation.

All Loan equipment shall be clearly identifiable as such, marked with a unique identifier and recorded on a database which allows for storage of loan equipment data such as:

- Type of equipment.
- Its purpose.
- Make.
- Model.
- Serial nos.
- Value.
- Purpose of loan.
- Condition as received.
- Loan period commencement date.
- Premises and location(s) at which the equipment will be kept.
- The final collection date upon return to the supplier.

The loan equipment record should also include data on maintenance, service and breakdown history, original equipment manufacturers manuals etc. and any replacement due date.

Prior to collection and return, all loan equipment shall be appropriately decontaminated, with the corresponding Decontamination Form accompanying the Equipment.

Loan equipment shall be carefully inspected for any damage and the condition recorded.

Suppliers collecting loan equipment at the end of the loan term shall complete a Collection Confirmation Receipt as part of the Indemnity Agreement, at the point of collection.

The Loan Equipment Database shall be updated to reflect the items that have been returned, the return condition and the date upon which they were collected.

Where disposable Equipment is provided to the Trust, this shall be on a transfer basis, with the same information as per loan equipment recorded and stored with the exception that a Purpose of Transfer is recorded along with the means and date of disposal.

In the event of disposal, the Trust will notify the Supplier of the disposal of any medical devices or equipment on transfer and the date upon which this occurred.

4.9 Commissioning & Acceptance Procedure:

All new Medical Devices or Equipment shall upon completion of the evaluation, acceptance and procurement, undergo commissioning and acceptance to ensure that they fulfil the requirements of the Trust in terms that they are:

- Undamaged.
- In Proper Working Order,
- Complete With All Necessary Accessories And User Operating Manuals and decontamination guidance,
- Allocated And Marked With An Asset Code
- Included In The Medical Devices And Equipment Management System.

All new Medical Devices or Equipment shall be delivered to the Stores Department unless otherwise arranged due to complexity, size etc., who with the Medical Equipment Group, shall ensure that they are as procured and receipted in respect of the order raised.

In the case of established Medical Devices or Equipment procured through eProcurement or Memo of Need, it shall be the responsibility of the end user who requisitioned them to inspect, confirm acceptance, and receipt the devices as procured.

4.10 Asset Management:

The Trust is committed to a systematic and planned approach to the management of assets from their inception to their ultimate disposal.

The Trust recognises the extensive range of Medical Devices and Equipment in terms of complexity and sophistication and the mobility that is required to take into account servicing, downtime, vehicle and facility transfer, change out, replacement etc. The Trust shall be a responsible for the management of those assets in terms of their location, use, service and maintenance, from inception to disposal, throughout their lifespan within the Trust.

The Trust shall ensure that it controls the quality and quantity of the information that it generates, can maintain that information in an effective manner and can dispose of the information efficiently when it is no longer required as set out in the Trust's Records Management Policy and Records Management Business Rules.

The Trust shall maintain an inventory of all medical devices held within it and detailed asset lists of all reusable Medical Devices and Equipment. This may be a combination of records held centrally by the Medical Directorate or by individual Departments. Depending on the type of device and the departments in which they are used, the Trust shall appoint a designated Device Manager for each device or group of devices for those departments e.g. HART, HEMS, Fleet, Medical, Education, Learning and Development Department etc. Each device manager shall be appropriately acquainted with this Policy and Procedures and clearly understands their responsibilities in the role in respect that all medical devices and equipment in their

area of responsibility are accounted for and recorded on an inventory. Device managers shall attend the Medical Equipment Group.

In addition to overarching inventory and asset lists, the Trust shall maintain asset lists of Medical Devices and Equipment under Service, Maintenance and Calibration contracts for each respective contract. All asset lists shall be named in accordance with the Trust's Records Management Policy to ensure the dating and clarity of description of each asset list with no ambiguity.

The Medical Device and Equipment asset lists and records may take different forms and formats, be that a database, spreadsheets, contractor reports in portable document formats but there shall be consistency across Device and Equipment Types to enable ease of following and information retrieval.

Medical Device and Equipment asset lists and records shall provide evidence of:

- Type of Device and Equipment,
- Make,
- Model,
- Serial Nos.,
- Unique Device Identification, UDI,
- Valid Trust asset ID tag, where appropriate,
- Deployment location,
- The purchase price of the equipment,
- Date of purchase,
- Purchase Cost,
- Date of reception into the Trust,
- Date of deployment,
- Manufacturer operating instructions and manuals,
- Any Pre-installation checks performed and completed,
- Date of installation,
- Date of installation and commissioning by manufacturer or agent,
- Trust and Contractor Emergency contacts in event of failure,
- Schedule and details of maintenance and repairs,
- Service, maintenance and calibration costs,
- Up to date Service Records,
- Dates of downtime with reasons and any actions taken,
- End-of-life date, if specified,
- Responsible Device Manager,

Medical Device records shall be protected to ensure their accuracy is maintained and that any changes are reflected and do not obscure previously recorded information. Procedures shall include the ability to store securely to enable record retrieval throughout the retention period of records to ensure that equipment is correctly serviced, maintained and calibrated, and any inconsistencies, unreliability or failures evident.

4.11 Training:

Medical Devices or Medical Equipment shall not be implemented into service until the end users have adequate training in its use.

The Trust shall ensure that there is commitment at all levels of management to the achievement of an adequate standard of training is essential.

All training in relation to Medical Devices shall be mandatory and shall be held during normal working hours wherever possible and so far as reasonably practicable. Where staff receive training outside their normal working hours, the Trust will ensure that they suffer no loss as a result.

The Trust shall ensure that Information, Training and Instruction (ITI) for end users be delivered by competent professionals and in a form comprehensible to the end user. The ITI shall enable end users to use the respective device safely and effectively and perform user maintenance as required.

Train the Trainer training shall be provided by the Manufacturer or their agent to members of the Education, Learning and Development Staff at Regional and Divisional level and this training shall be cascaded to end users.

This shall be inclusive of but not limited to any user decontamination, servicing, calibration and maintenance and the action to be taken in the event of a malfunction.

Medical Device documentation shall be available to Education, Learning and Development Staff and end users in the form of Original Equipment Manufacturer User Manuals, Manufacturer's Instructions, Standard Operating Procedures, and Technical Notes etc. to ensure comprehensive learning.

All training provided shall comply with any general provisions of the appropriate statutory instruments, approved codes of practice and manufacturer's instructions.

The Trust shall ensure that records are kept of training of users of medical devices. These records shall show that users:

- Know how to use the device safely.
- Can carry out routine checks, user maintenance and routine decontamination.
- Have been trained and had relevant refresher training.
- Are confident and/or competent to use devices in their areas of work.

All end users shall be assessed for competency on the respective devices with a record of assessment and competency undertaken and subsequently signed by the users that they have received and understood the instruction as provided.

The Education, Learning and Development Department, shall document and maintain records and details of training given to all personnel, inclusive of the dates, personnel trained, personnel providing the training, copies of training documentation, competency assessments and copies of certificates as issued by Training Providers.

It is the responsibility of the end users to identify any training needs that they have in their training and notify their respective line managers such that these can be addressed to the Education, Learning and Development Department and whereby new or refresher training can be provided. It is also the responsibility of the end user to attend training provided for them by line management, the Education, Learning and Development Department and the Trust.

4.12 Deployment:

The Medical Equipment Group shall determine the deployment rationale of Medical Devices for use throughout the Service. Medical Devices and Equipment may be issued to individual End Users, Vehicles, Departments, Stations, Divisions or Service wide. Medical Devices and Equipment may be placed on the eProcurement System or as a direct Stores Item, where they will be deployed to the requisitioner upon receipt of an eProcurement requisition or a Memo of Need.

Line managers shall take cognisance of and responsibility for the requisitioning of Medical Devices and Equipment in their Stations, Departments etc. to ensure that stores are not overstocked to the extent that devices are unnecessarily disposed of if an expiry date is reached. Where Medical Devices are issued in boxes or batches, in quantities greater than required by the requisitioner, line managers, Station Supervisors, Officers etc. shall liaise with each other for the distribution of devices across Stations and Areas so as to prevent overstocking and any unnecessary disposal. It is essential that all staff are aware of the medical device management system and the part that they play within the system to ensure that medical devices are managed correctly.

The management of Medical Devices and Equipment issued on transfer or loan shall transfer either to the individual end user or to the respective Station or Department. Responsibility for each aspect of loan device management, inclusive of the decontamination procedures, service, maintenance, calibration etc. shall be as detailed in the associated indemnity agreement. End users and line managers shall remain accountable for collecting and returning these items when they are no longer required. It is essential that all individuals are aware of the medical device management system and the part that they play within the system to ensure that medical devices are managed correctly.

Directors, Heads of Department, Area Managers, Divisional Officers, Divisional Training Officers / Station Officers shall be responsible for Medical Devices and Equipment in their areas of responsibility. End Users and Line managers shall ensure, as far as reasonably practicable, that each Medical Device or item of Medical Equipment is physically located in its respective recorded location, or list the current location such that when required, it can be easily traced.

4.13 Storage:

All Medical Devices and Equipment shall be stored in accordance with manufacturer's recommendations and in line with best IPC practice for the storage of equipment.
Line managers shall take cognisance of and responsibility for the Medical Devices and Equipment in their Stations, Departments etc. to ensure that they are stored

appropriately, securely, cleanly, and organised, whereby stocks can be readily assessed for type, quantity and Use By dates etc., in the event of product recalls, replacement or actions required as part of Safety Alerts, Field Safety Notices etc.

4.14 Infection Prevention & Control (IPC):

The Medical and Healthcare Products Regulations Agency, MHRA, defines the following terms:

- *Cleaning* 'is a process which physically removes contamination but does not necessarily destroy microorganisms. The reduction of microbial contamination cannot be defined and will depend upon many factors including the efficiency of the cleaning process and the initial bio-burden'.
- *Cleaning*, by removing organic material and reducing the number of microorganisms present, is an essential prerequisite of equipment decontamination to ensure effective disinfection or sterilisation can subsequently be carried out.
- *Disinfection* 'is a process used to reduce the number of viable microorganisms, which may not necessarily inactivate some viruses and bacterial spores. Disinfection will not achieve the same reduction in microbial contamination levels as sterilisation'. Disinfection can be achieved by the use of chemicals and sterilisation by physical methods such as the use of heat.
- *Sterilisation* 'is a process used to render the object free from viable micro-organisms, including spores and viruses'.

The Trust's Guidance and Procedures for Infection Prevention and Control Policy and Strategy sets out the strategic and policy approach to the prevention and control of infection.

The NIAS Vehicle and Patient Equipment Decontamination Manual sets out the principles and process of decontamination utilised within the NIAS. This manual should be read in conjunction with the manufacturers decontamination instruction for specific medical devices.

All line managers are required to oversee and supervise the implementation of the infection control policy and procedures within their area of responsibility and actively participate in the management of infection control related incidents and risks.

The selection and implementation of Medical Devices shall comply with the Trust's Guidance and Procedures for Infection Prevention and Control Policy and Strategy such that all Medical Devices and Equipment receive an infection prevention and control evaluation as part of their assessment of need.

The whole process of decontamination shall begin prior to acquisition to ensure that device decontamination recommended by the manufacturer can be undertaken safely and effectively within the NIAS. Failure to enable effective decontamination of a device in line with accepted NIAS processes may result in a device being deemed not suitable for introduction.

Suppliers and manufacturers shall be responsible for providing information on safe decontamination methods and cleaning, disinfection and decontamination product compatibility.

All Medical Devices and Equipment shall have the ability to be cleaned, disinfected and decontaminated in accordance with the Infection Prevention and Control Policy and Procedures of the Trust. Medical Devices and Equipment that cannot be adequately and safely decontaminated shall not be considered for implementation beyond the evaluation stage.

Thorough cleaning shall always be the first step in the decontamination process.
All reusable Medical Devices and Equipment shall be adequately cleaned and decontaminated in between use and in between patient use.

Decontamination methods shall be chosen according to the risk of infection associated with the use of a particular device or piece of equipment and shall be carried out in accordance with the Trust's guidance and the manufacturers' instructions.

Medical devices may require storage if used intermittently and this shall be undertaken in line with existing NIAS process. This will be dependent on the nature and size of the device. All devices should be decontaminated prior to storage, an indicator that cleaning has occurred should be place on the device, Trigger tape.
The device shall be placed inside a clean transparent plastic bag and sealed for the duration of storage.

Appropriate Personal Protective Equipment, PPE, shall be worn as required during the cleaning, disinfection and decontamination processes.

Single Use Disposable Medical Devices shall be suitable for one use only on an individual patient only and then discarded. They shall not be reprocessed in any way, cleaned, disinfected or sterilised, for further use.

Single Patient Use Medical Devices may be used for more than one episode on one patient only. The manufacturer shall state the number of times the item can be reused prior to disposal. Single Use items will bear the single use logo in the form of a 2 inside a circle with a line through it:

Advice shall be sought from the IPC Team in regard to compliance with the Infection Prevention and Control Policy and Procedures.

In compliance with the MHRA, all Medical Devices and Equipment requiring inspection, repair, service or calibration shall be appropriately decontaminated in order to remove or minimise the risk of infection, by the end user or other appropriately trained staff, before it is sent away.

A Decontamination Certificate must be attached to the equipment on dispatch, which states the method of decontamination used.
Copies of the Decontamination Certificate will be available from the NIAS Intranet.

Area Officers are the designated responsible managers for the routine cleaning and decontamination of equipment within their Area.

The decontamination of equipment to be used for or following use after a patient care episode is the responsibility of the member of staff who will or has used it. This principle applies across all levels of staff within NIAS without exception.

4.15 Implementation:

The Trust shall only implement Medical Devices and Equipment into Service once all measures in training have been completed in accordance with manufacturer's recommendations.

- All end users are appropriately trained and assessed as competent to use the devices and equipment.
- All corresponding support documentation is available to end users e.g. Original Equipment Manufacturers User Manuals, Standard Operating Procedures etc.
- Users are fully aware of servicing, maintenance and calibration procedures, where applicable.
- The Medical Equipment Group shall assign responsibility to an individual or team for the implementation process.
- Where appropriate, a risk assessment shall be developed to ascertain any risks to service provision during implementation are mitigated or controlled.
- No unauthorised Medical Devices may be used within the Trust's activities.
- Only Medical Devices and Equipment as approved by the Medical Equipment Group, implemented and issued by the Trust shall be used within the Trust.

4.16 Service, Maintenance & Calibration:

The Trust shall ensure that where applicable, all non-single use, reusable, Medical Devices and Equipment that can be serviced, are supported by appropriate service and maintenance contracts in compliance with the manufacturers' recommendations.

The Trust shall evaluate and allocate sufficient resources for service and maintenance contracts or where necessary provide adequate facilities and staff to ensure effective and efficient maintenance, repair and calibration of Medical Devices and Equipment.

The Trust shall maintain asset lists of Medical Devices and Equipment under Service, Maintenance and Calibration contracts for each respective contract.

Asset lists of Medical Devices and Equipment shall be named in accordance with the Service, Maintenance and Calibration contracts shall be so written as to allow for the addition and subtraction of devices to take account of expansion of need, replacement or disposal of Medical Devices and Equipment.

Any Medical Devices that are considered for decommissioning, condemnation and disposal and subject to a service, maintenance or calibration contract shall have their details removed from those respective contracts.

Trust attendance and representation at Contract Advisory Groups shall ensure that contracts for the service, maintenance and calibration of Medical Devices and Equipment represent the best interests of the Trust in terms of:

- The technical content of contracts,
- The suitability and competency of contractors,
- Provision of expert advice on the servicing, repair and calibration,
- A scheduled servicing system that takes into account the 24 hour service delivery of the trust
- Minimises impact on service delivery
- Flexibility with work patterns and continuous service provision
- Clear and unambiguous designation of serviced devices and equipment
- Frequency of servicing
- Provision of service schedules
- Provision of service reports and verification of service
- Provision of updated asset lists and inventories per contract
- Authorisation and control of work
- Quality control, assurance and safety
- Ensuring that the safety of users and patients is paramount

All Medical Devices and Equipment being presented for service, maintenance and calibration shall be appropriately cleaned, disinfected and decontaminated The Trust's Guidance and Procedures for Infection Prevention and Control Policy. A Decontamination Certificate shall accompany the equipment on dispatch, stating the method of decontamination used.

Scheduled Servicing shall be in compliance with the Original Equipment Manufacturers' recommendations, statutory instruments and approved codes of practice corresponding to the device and equipment being serviced, inclusive of but not limited to the following:

- Comprehensive inspection;
- Changing of components which require regular replacement;
- Safety checks
- Performance tests as necessary;
- Calibration;
- Final functionality checks;

User servicing shall be restricted to the following:

- Functional checks;
- Careful cleaning and, where necessary, decontamination/ sterilisation,
- Inspection of leads and ancillary devices for damage;
- Other checks as recommended in the manufacturer's User Instruction Manual.

Users shall not carry out any servicing or maintenance which is beyond their knowledge, capability, or training.

The Trust shall ensure that all respective staff are made aware of service schedules affecting Medical Devices and Equipment in their area.

It is the responsibility of all staff to ensure that equipment required for servicing is made available;

The Trust shall ensure that service history records of Medical Devices and Equipment service, maintenance and calibration shall be maintained for the lifetime of that equipment and retained for the periods as required by statutory instruments.

Service records shall detail all relevant information regarding the respective Medical device or item of Medical Equipment inclusive of but not limited to the following:

- Device details such as Make, Model, Serial Number, location;
- Identification and listing of all checks and tests carried out;
- Results of tests and checks with any recommendations;
- What components were replaced, where applicable
- Calibration;
- Verification that the device is compliant and safe for use;

Service records and updated asset lists shall be issued to Device Managers in a format amenable to them and to the Trust.

Records shall be stored where they are both secure and readily accessible to establish servicing, maintenance and calibration status along to ensure that repairs and servicing are carried out regularly and promptly and the remedial actions to be taken in the event of recommendations noted.

Any failure or breakdown of a Medical Device during servicing shall be recorded on the Trust's Incident Reporting System such that all failures and breakdowns can be recorded and used in the evaluation of new or replacement, impacting on future decisions regarding equipment procurement.

The end user and line manager shall notify the Medical Device Lead and ensure that the equipment is withdrawn from service and clearly marked to ensure that it cannot be inadvertently used.

4.17 Incident Reporting:

The Trust Incident Reporting System (Datix) is the prime means of communicating incidents involving Medical Devices and Equipment to the Trust. It is the recognised reporting system for the escalation of incidents to the regional and national regulatory agencies and the means by which, statistical data on the performance, defects or failure can be extrapolated for use in assessments and evaluations of existing equipment and in the selection of new or replacement devices and equipment. Incidents may be shared via Datix both regionally and nationally, and as such this data

will be anonymised for data protection purposes and in a form that can be analysed to identify hazards, risks and opportunities to improve the safety of staff and patient care.

- Any Medical Device or Equipment defective in performance or involved in an incident shall be immediately withdrawn from service, cleaned, decontaminated, clearly marked to ensure no inadvertent use, withheld, and returned to the Medical Device Lead.
- It must not be interfered with or tampered with in any way until any necessary investigation has been completed.
- Any consumables used with the device or equipment in the incident shall be subject to the investigation and shall also be isolated, cleaned, decontaminated and clearly marked to ensure that they cannot be inadvertently used.
- The incident shall be reported and notified using the standard adverse incident Report on the Trust Incident Reporting System, DATIX, in line with Trust reporting policies and procedures, reporting criteria and timescales.
- In the event of identification of a defect in performance or an incident where an issue with a Medical Device has been raised, the respective line manager and the Medical Device Lead shall be included as Additional Investigating Managers, who will have access to an oversight of to this incident.
- Reporters shall make contact and agree roles before adding names to the Additional Investigating Managers part of the incident report form.

The reporter shall complete all fields of the incident report form and record specific details that will enable the identification of the Medical Device involved in the incident, to assist with any investigation, inclusive of but not limited to the following:

- Device Type.
- Model.
- Serial number(s).
- Vehicle Call Sign, if applicable.
- Station or Department, where applicable.
- Factual, clear, concise and appropriate account of the incident with key events leading up to and immediately after the event, including any relevant clinical judgement, key risks, contributory factors or causes of the incident.
- Any action taken, inclusive of logging the equipment on Contractor sites for investigation and or repair and the isolation, labelling and identification of the devices, equipment and any consumables associated for investigation and repair, ensuring they are taken out of use and presented for investigation.

The reporter shall anonymise the description of the incident with no names of patients or staff, avoiding the use of abbreviations and jargon wherever possible so that what happened in the incident is clearly understood.

4.18 Medical Device Alerts:

Medical Devices Alerts (MDAs) are the prime means of communicating safety information to the Trust on Medical Devices and Equipment. MDA's are prepared by the Medicines and Healthcare products Regulatory Agency (MHRA) and are distributed nationally with the same reference, content, and format.

The Northern Ireland Central Alert System (NICAS) provides access to safety alerts and information issued by the Northern Ireland Adverse Incident Centre (NIAIC), on behalf of the Department of Health, to provide safety guidance on the safe use of Medical Devices. NIAIC has direct links with the MHRA, who co-ordinate information across the adverse incident centres in England, Scotland, Wales, and Northern Ireland for issues concerning medical device safety.

NIAIC, operates as a regional centre for the voluntary reporting and investigation of adverse incidents involving medical devices, and for providing relevant safety guidance in relation to these items and alert where action is required to be taken.

NIAIC places high importance on the open reporting of adverse incidents encouraging a shift to a safety culture in the HSC, where open reporting and balanced analysis are encouraged in principle and by example to achieve continual improvement and learning in patient and staff safety.

Medical Device Alerts may be received in a number of forms, from Patient Safety Alerts to Field Safety Notices, end user feedback, incident reported via the Trust Incident Reporting System etc., and from a number of sources, inclusive of but not limited to the following:

- The Medicines and Healthcare products Regulatory Agency (MHRA).
- The National Patient Safety Alerting Committee (NatPSAC).
- The Northern Ireland Adverse Incident Centre (NIAIC).
- The Northern Ireland Central Alert System (NICAS).
- Manufacturers.
- Manufacturers Agents.
- Trust Incident Reporting System.
- Inter-Trust Communication.
- Medical Device User Forums.

The Trust shall maintain a Medical Device Register of Alerts detailing and recording all device alerts as received and applicable to the Trust and any actions undertaken. The Register shall also record all device alerts as raised within the Trust and any adverse incidents involving medical devices as reported to NIAIC, with any responses, actions undertaken and any subsequent alerts where action is required to be taken.

The Medical Device Lead is the nominated MHRA Liaison Officer and is responsible for reporting adverse incidents involving Medical Devices and Equipment to the NIAIC.

The Trust shall ensure that any Medical Device Alerts are properly scrutinised and disseminated throughout the Service appropriately to ensure that as far as reasonably practicable, all required action is taken.

4.19 Replacement:

The Trust shall continuously review the inventory of Medical Devices and Equipment based upon the lifespans and life stages of devices, warranties, contract periods, changes in clinical guidance and procedures etc. to best meet the needs of the Trust.

The Trust shall base any recommendation for replacement upon the priority of need.

The Medical Equipment Group shall have the authority to remove equipment from service when a specified replacement date is approaching or on safety grounds due to the receipt of Safety Alerts, equipment being worn or damaged beyond economic repair, unreliable, clinically or technically obsolete or it is deemed impossible to obtain consumables or spare parts.

The Group shall advise user departments as soon as possible, as far as reasonably practicable, when equipment needs replacing.

Reusable devices may require replacement in the advent of being lost or damaged and as such, the end user or line manager shall complete a Memo of Need, detailing the reason for the replacement e.g. lost at scene, damaged etc. and reporting the incident on the Trust Incident Reporting System, Datix, in line with Trust reporting policies and procedures, reporting criteria and timescales.
This will assist in the evaluation of the device by providing quantifiable statistical data on the performance of Medical Devices and Equipment.

The Trust shall ensure that any replacement strategy utilised shall promote the standardisation of Medical Devices and Equipment such that replacement equipment is compatible with equipment and facilities already in use. It shall also promote the continuity of service.

The recall of a device, be it by manufacturer, agent or regulatory agency shall take precedence over other considerations.

4.20 <u>Decommissioning, Condemnation & Disposal:</u>

Medical Devices shall be considered for decommissioning, condemnation and disposal when they fulfil one or more of the following criteria:

- No longer compliant with respective statutory instruments.
- No longer within their use by or expiration date.
- At the end of a life stage or lifespan.
- Obsolete.
- No longer supported by manufacturer or manufacturer's agent.
- Beyond economic repair.
- Damaged or unsafe for use.

All reusable Medical Devices and Equipment shall be regarded as assets, and when it is decided to dispose of such an asset, the Head of Department or authorised deputy will determine and advise the Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate.

Any Medical Devices that are considered for decommissioning, condemnation and disposal and subject to a service, maintenance or calibration contract shall have their details removed from those respective contracts.

Asset Lists and inventories of reusable Medical Devices and Equipment shall be updated to reflect any disposals or transfers.

Decommissioning shall include the removal of all confidential data from the Medical Device, where applicable.

Any disposal of Medical Devices and Equipment shall be in accordance with the Original Equipment Manufacturers (OEM), instructions and in compliance with respective statutory instruments, policies and guidance for waste management such that devices are disposed of safely, clinically and environmentally.

Manufacturers shall also provide details of the current techniques and processes applicable to their products.

Where applicable, Medical Devices and Equipment shall be decontaminated before disposal and accompanied by a Decontamination Certificate.

Used single use disposable and single patient use Medical Devices shall be treated as clinical waste and shall be disposed of via the local, designated, controlled, secure waste storage area. All sharps, including glass, ampoules, vials, needles, syringes and medicine remnants shall be disposed of into a sharps container.

All unused single use disposable and single patient use Medical Devices shall firstly be assessed for reappropriation or if they can be treated as recyclable waste else, they shall be disposed of via the local, designated, controlled, secure waste storage area.

All electronic Medical Devices and Equipment considered for decommissioning, condemnation and disposal shall be responsibly disposed of in accordance with the Waste Electrical and Electronic Equipment, WEEE, Regulations.

All portable batteries within medical devices and equipment as considered for condemnation shall be recycled in compliance with the Waste Batteries and Accumulators Regulations 2009. Embedded batteries in sealed units shall be returned to the manufacturer or manufacturer's agent for recycling.

The Condemning Officer, and all respective line management, shall satisfy themselves as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance who will take the appropriate action.

The End User or respective Condemning Officer shall complete a Trust Condemn Certificate and a Trust Condemn Spreadsheet whereby the details of the Medical Device or Equipment being condemned are fully recorded, inclusive of but not limited to the following:

- Record the Condemn Certificate number
- Budget Holder
- Location of the item(s) being condemned
- Description of the item or items being condemned.
- Asset No., where applicable

- Reasons for condemnation

The Certificate shall be signed by the user and countersigned by their Line Manager with a copy to be retained, a copy to be sent to the Procurement Department, a copy to be sent to the Finance Department and a scanned copy sent to the Medical Device Lead. Copies of the Condemn Certificate shall be available as necessary.

A Condemn Asset Spreadsheet listing the devices condemned shall accompany the Certificate and shall include the following details:

- Date.
- Device Description.
- Manufacturer.
- Model.
- Serial Number.
- UDI; Unique Device Identifier.
- REF; the Reference number of the device.
- LOT; the manufacturing Lot or Batch number of the product.
- Product Expiry or Use By Date; the date upon which the product must be used.

Copies of the Condemn Asset Spreadsheet shall be available from the NIAS Intranet. The Condemning Officer for reference shall retain a copy of the Condemn Asset Spreadsheet and a scanned copy shall be sent to the Medical Device Lead.

These details are to assist with stock control and to ensure traceability in the event of a Field Safety Notice being issued to the Trust.

Where items can be reappropriated for the purposes of training, the Condemning Officer shall firstly contact the Education, Learning and Development Team to establish capacity within Education, Learning and Development for the respective Devices.

If capacity is confirmed, the Condemning Officer shall complete a Transfer Asset Spreadsheet similar to the Condemn Asset Spreadsheet to list all the devices being transferred.

The Condemning Officer for reference shall retain a copy of the Transfer Asset Spreadsheet and a scanned copy of the Transfer Asset Spreadsheet shall be sent to the Education, Learning and Development Department accompanying the devices, and a scanned copy sent to the Medical Device Lead.

The Medical Device Lead shall notify the Medical Equipment Group of any such disposals and transfers.

5.0 IMPLEMENTATION OF POLICY:

5.1 Dissemination:

With regards to dissemination this Policy will be:

- Issued to all Board Members, Chair, Non-Executive Directors, Chief Executive, Directors and Assistant Directors.
- Disseminated to the required staff by Assistant Directors.
- Made available on the Internet and SharePoint so that all employees and members of the public/ stakeholders can easily have access.
- Discussed during Corporate Induction.
- Discussed during appropriate/ specific/ training sessions

5.2 Resources:

Information contained within this policy will be made available to new employees at the commencement of employment, at employee induction programmes, and via information leaflets.

An electronic copy of this Policy shall be available via the Trust intranet site.

For existing employees, information and training will be available through clinical updates, Clinical Training sessions, Risk Assessment Training sessions and annual mandatory training in accordance with Trust Policies.

Line managers will be responsible for ensuring compliance with the Trust / Organisation training matrix.

5.3 Resources:

There are no staff exempt from the operation of this Policy.

6.0 MONITORING:

It is the responsibility of the Medical Equipment Group to monitor the implementation of and assess the level of compliance with this Policy.

7.0 EVIDENCE BASE/REFERENCES:

There is a statutory requirement to under a number of pieces of legislation including the following:

- The Health and Safety at Work (NI) Order 1978
- The Management of Health and Safety at Work Regulations (NI) 2000
- Provision and Use of Work Equipment Regulations (NI) 1999
- Data Protection Act 2018, the General Data Protection Regulation (GDPR)
- Medical Device Regulations (2017/745) (MDR)
- In Vitro Diagnostic Medical Device Regulations (2017/746) (IVDR)
- The Waste Electrical and Electronic Equipment (Waste Management Licensing) Regulations (Northern Ireland) 2006
- Waste Batteries and Accumulators Regulations 2009
- The Consumer Protection (Northern Ireland) Order 1987

8.0 CONSULTATION PROCESS:

This updated Policy has been developed by the Medical Device Lead.

Consultation took place with the Medical Equipment Group consisting of representatives from Operations, Stores and Procurement, Fleet, Risk, Regional Ambulance Clinical Training Centre, Medical Directorate, Trade Unions, Senior Managers, Assistant Directors and Directors within the organisation. The final content of the document was agreed by the Medical Equipment Group, Senior Management Team, Safety, Quality, Experience and Performance Committee and Trust Board.

9.0 APPENDICES:

Appendix 1 Assessment of Need – Pertinent Questions
Appendix 2 Procurement Principles

10.0 EQUALITY STATEMENT:

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

10.2 The outcome of the equality screening for this Policy undertaken on 27 May 2021 is:

Major impact	
Minor impact	
No impact	✓

11.0 SIGNATORIES:

Katrina Keating **Date: Pending 2021**
Lead Author

Dr Nigel Ruddell **Date: Pending 2021**
Lead Director

APPENDIX 1 ASSESSMENT OF NEED – PERTINENT QUESTIONS:

- How long has the device/ equipment been on the market?
- What similar devices already exist?
- Has a scoping exercise been undertaken to establish what similar products are available on the market, if any, who uses them and in what context?
- Has the scoping exercise been expanded to other Trusts and Services to establish device use and any issues arising from that use that may impact on this Trust?
- Can samples be requested to enable assessment and evaluation?
- Can all similar products be made available for direct comparison?

- Has the user requirement, the function that the item is required to perform, been defined by the Medical Equipment Group?
- Is the equipment easy to use?
- Is the equipment more complex than needed for the task required and should it be avoided?
- Are the staff capable of using the equipment, after provision of training?
- What are the parameters of the devices and equipment in terms of dimensions, weight, portability, charging, servicing, spares and consumables?

- What does the device or equipment cost per unit?
- Are there discounts for bulk quantities?
- Are there consumable costs?
- What are the projected consumable costs over the lifespan of the device?
- What are the service, maintenance and calibration costs, where applicable, per service and for the lifespan of the device?
- Are there costs for call outs?
- What are the shipping costs to and from service contractor?
- Is there an energy cost associated with the device or equipment?
- Are there cleaning, disinfection and decontamination costs?
- Are there any disposal costs?

- Are the devices and equipment supported by appropriate service and maintenance contract?
- Is there a pre-existing service-maintenance contract already in place in Trust or can the devices and Equipment into an existing Trust or Regional contract?
- Where is the contractor located?
- Is there a time element in shipping to and from the contractor?
- Are the contracts compliant with servicing and repair schedules as recommended by the manufacturer?
- Is there satisfactory Supplier and Manufacturer Technical Support?
- Is there satisfactory Supplier User Support?
- Is the contract comprehensive or service and maintenance only?
- How does service and maintenance impact on Trust service delivery?
- Are response times applicable?
- Are loan devices available in the event of failure.
- Do the devices and equipment require supplementary testing e.g., PAT?

- Can the devices and equipment be stored in accordance with manufacturer's recommendations.
- Is there supporting documentation for the Device or Equipment e.g., user, service manual,
- Are User Guides and instructions suitable?
- Does the supporting documentation require additional Standard Operating Procedures?
- Is this equipment on an established PALs Framework Contract?
- Can the device procurement be openly tendered?

- Will a request for Approval of Single Tender Action, STA, as part of a Direct Award Contract, DAC, require completion and submission?
- Do the devices and equipment bear Conformity Assessment Markings?
- Does the device meet all the Trust's essential or desired intended functions?
- Is the device easy to clean, disinfect, decontaminate?
- Are any special facilities needed?
- Does the equipment have any special requirements e.g., power, charging, mounting, assembly, accommodation, connectivity, etc.?

- What are the ICT requirements?
- Can the device and equipment be used in adherence to Trust standards for connectivity to the Trust network and onwards to the Internet?
- Can the device and equipment be used in adherence to the ICT technology standards
- Can the device and equipment be used in adherence to Trust standards for information governance?
- Is there identification of Information Assets Owners?

- Do the Medical Devices and Equipment have the ability to be cleaned, disinfected, and decontaminated in accordance with the Infection Prevention and Control Policy and Procedures of the Trust?
- Do the manufacturer's instructions detail clear methods for the cleaning, disinfection and decontamination in accordance with the Trust's policy?

- Can Train the Trainer training be provided by the manufacturer or their agent?
- How long will training take?
- Is there technical support for staff training?

- Are there consumables associated with the Device or Equipment?
- Is there a consumables and spare parts list?
- What is the availability of consumables and spares?
- How often will consumables be required, per use, week, year?

- Is there compatibility with devices equipment and facilities already in use?
- Can the range of inventory in terms of consumables held be reduced to support a policy of standardisation of Medical Devices?
- Is there an implementation plan schedule?
- Are there any implementation and installation costs?

- Have all costs associated with the device or equipment been assessed for the duration of its economic lifespan, inclusive of device cost, service, maintenance, calibration, consumables, call outs etc?
- Has an Economic Evaluation, be that an Economic Assessment Report or Business Case, been developed, commensurate with the size of the investment, in the format specified by the DHSSPS/ HSCB?
- Has the Finance Directorate been communicated with to determine whether there may be a potential funding stream for acquiring the new equipment?
- Has the Business Case been approved and sufficient resources been allocated for the procurement of the devices and to ensure effective and efficient maintenance, repair, and calibration contracts throughout the lifespan of the Medical Devices and Equipment, within the Trust?

The Medical Equipment Group may decide to provide generic copies of the Assessment of Need and make these available from the NIAS Intranet.

APPENDIX 2 PROCUREMENT PRINCIPLES:

The letting and management of contracts for goods and services, on behalf of the Trust, is carried out by the Business Services Organisation, BSO, Procurement and Logistics Service, PaLS.

PaLS is a recognised Centre of Procurement Expertise, CoPE, established under the Northern Ireland Public Procurement Policy, to comply with the Public Contract Regulations and implement the Procurement Guidance Notes, PGNs, developed by the Procurement Policy Unit in Department of Finance, Construction Procurement Delivery, CPD.

Contracts are arranged to optimise value for money for goods and services, to ensure integrity, probity and to minimise resources used in the contracting process.

In the procurement of Medical Devices, be it through purchase, rental, lease, loan or transfer, the Trust shall follow the twelve agreed procurement principles, guiding public procurement in Northern Ireland as listed below:

1. ***Accountability***; Effective mechanisms shall be in place in order to enable Accounting Officers to discharge their personal responsibility on issues of procurement risk and expenditure.
2. ***Competitive supply***; Procurement shall be carried out by competition unless there are convincing reasons to the contrary.
3. ***Consistency***; Suppliers should, all things being equal, be able to expect the same general procurement policy across the public sector.
4. ***Effectiveness***; The Trust shall meet the commercial, regulatory and socio-economic goals of government in a balanced manner appropriate to the procurement requirement.
5. ***Efficiency***; Procurement processes shall be carried out as cost effectively as possible.
6. ***Fair-dealing***; Suppliers shall be treated fairly and without unfair discrimination, including protection of commercial confidentiality where required. The Trust shall not impose unnecessary burdens or constraints on suppliers or potential suppliers.
7. ***Integration***; The Trust shall pay due regard to the Executive's other economic and social policies, in line with the NI Executive's policy on joined-up government.
8. ***Integrity***; There should be no corruption or collusion with suppliers or others.
9. ***Informed decision-making***; The Trust shall base decisions on accurate information and to monitor requirements to ensure that they are being met.
10. ***Legality***; The Trust shall conform to all appropriate regional, national and international legal requirements.
11. ***Responsiveness***; The Trust shall endeavour to meet the aspirations, expectations and needs of the community served by the procurement.
12. ***Transparency***; The Trust shall ensure that there is openness and clarity on procurement policy and its delivery.

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Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

PRESENTATION OF PAPER

Date of Trust Board:	21 October 2021
Title of paper:	DoH correspondence re: Further Pause Sponsorship and Governance Activities 2021/22
Brief summary:	Members will recall that the DoH issued previous correspondence in relation to pausing Sponsorship/Governance activities. The attached correspondence dated 24 September 2021 from the Permanent Secretary has now been received and is attached for members' information.
Recommendation:	**For Approval** ☐ **For Information** ☒
Previous forum:	n/a
Prepared and presented by: **Date:**	Paul Nicholson, Interim Director of Finance 14 October 2021

From the Permanent Secretary and HSC Chief Executive

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

To: ALB Chairs
ALB Chief Executives

Castle Buildings
Upper Newtownards Road
BELFAST, BT4 3SQ

Tel: 02890520559
Fax: 02890520573

Email: richard.pengelly@health-ni.gov.uk

Our ref: RP5899
SSUB-0422-2021

Date: 24 September 2021

Dear Colleagues,

Further Pause Sponsorship and Governance Activities 2021/22

Further to correspondence of 25 August 2021 from La'Verne Montgomery, Director of Corporate Management which advised of the intention to restart ALB Sponsorship and Governance activities. Due to the on-going pressures across the system as a result of the pandemic, I have decided that a further pause will be placed on Sponsorship and Governance activities for a further three month period until the end of the 2021 calendar year.

Mid-year Assurance Statements
The request for Mid-year assurance statements issued by Governance Unit on 31 August 2021 is now rescinded, these are no longer required to be submitted to the Department. In cases where the MYAs have already been significantly progressed and ALBs wish to submit these assurances to the Department, please forward to governance@health-ni.gov.uk, copied to your Sponsor Branch for information only.

Mid-year Ground Clearing/Accountability Meetings
These meetings will not now be held and any dates arranged by Sponsor Branches can now be cleared from diaries.

Annual Business Plans 2022/23
ALBs are again asked to only conduct a light touch review and roll forward current 2021/22 Business Plans. There will be no formal Departmental approval process, this correspondence confers Departmental approval. ALBs should share revised plans with Sponsor Branches by 31 March 2022 for information.

Corporate Plans 2022-2027
The Department recognises that existing Corporate Plans expire on 31 March 2022 and several ALBs have sought clarity on next steps. The intention will be to align ALB Corporate Plans to the next Assembly mandate (2022-2027). Although it will not be

possible to have agreed plans in place for April 2022, further guidance will issue to commence this process as early as possible in the next Assembly mandate.

Partnership Agreements

Due to this further pause on sponsorship and governance activities replacement of Management Statements/Financial Memorandums (MSFMs) with Partnership Agreements remains on hold. The intention will be to start this process with a DOF facilitated workshop once resources permit.

Accounting Officer responsibilities remain unchanged; Non Executives should continue to provide both support and constructive challenge to their executive colleagues as necessary. In the absence of normal sponsorship arrangements it is imperative that any irregularities or matters of concern should be notified to your Executive Board Member/Sponsor Branch immediately.

If you have any queries, please contact your usual Sponsor Branch contact in the first instance.

Yours sincerely

RICHARD PENGELLY
ACCOUNTING OFFICER

cc: La'Verne Montgomery
DOH Board Members
DARAC Members
ALB Governance Leads
Head Internal Audit
DOH Finance Director
DOH Sponsor Branches
DOH Governance Unit
DOH Press Office

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Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

PRESENTATION OF PAPER

Date of Trust Board:	21 October 2021
Title of paper:	NIAS Charitable Trust Fund - Trustee's Annual Report & Accounts for the year ended 31 March 2021
Brief summary:	The Trust Board is asked to note these final, audited, certified, approved Charitable Trust Fund Annual Report and Accounts for the year ended 31 March 2021. This is the first presentation of these documents in the public domain and they will subsequently be published on the Trust website.
Recommendation:	**For Approval** ☐ **For Noting** ☒
Previous forum:	Audit Committee – 13 May 2021 In Committee Trust Board – 24 June 2021
Prepared and presented by: **Date:**	Paul Nicholson, Interim Director of Finance 14 October 2021

NORTHERN IRELAND AMBULANCE SERVICE
HEALTH AND SOCIAL CARE TRUST

CHARITABLE TRUST FUNDS

TRUSTEE'S ANNUAL REPORT & ACCOUNTS

FOR THE YEAR ENDED 31 MARCH 2021

Northern Ireland Ambulance Service
Health and Social Care Trust

Charitable Trust Funds

Trustee's Annual Report & Accounts

For the year ended 31 March 2021

Laid before the Northern Ireland Assembly
under Article 90(5) of the Health and Personal Social Services (NI) Order 1972
(as amended by the Audit and Accountability Order 2003)
by the Department of Health on

29 September 2021

Any enquiries regarding this document should be addressed to the Director of Finance at the following address: Northern Ireland Ambulance Service HSC Trust, Knockbracken Healthcare Park, Saintfield Road, Belfast BT8 8SG.

This publication is also available for download from our website at www.nias.hscni.net.

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Introduction

Under Article 91 of the Health and Personal Social Services (Northern Ireland) Order 1972 (as amended by Article 6 of the Audit and Accountability (Northern Ireland) Order 2003), the Trust is required to prepare annual accounts in respect of endowments and other property held on trust by it in a form determined by the Department of Health (DoH). This format is in accordance with the requirements of the Charites Statement of recommended Practice (SORP) (FRS 102).

The Charitable Trust Funds (also known as funds held on trust) Annual Report and Accounts for the year from 01 April 2020 to 31 March 2021 include all the separately established funds for which the Northern Ireland Ambulance Service Health and Social Care Trust (NIAS) is the sole beneficiary.

Reference and Administrative Details

Contact Us

Northern Ireland Ambulance Service HSC Trust
NIAS Headquarters - Finance
Knockbracken Healthcare Park
Saintfield Road
Belfast BT8 8SG

Telephone: 028 9040 0750

Email: Finance.Secretary@nias.hscni.net

Web: http://www.nias.hscni.net/

Comments

If you have any comments about this report please use the above contact details.

Trustee Arrangements

Under Article 85 of the Health and Personal Social Services (Northern Ireland) Order 1972 (as amended), a Trust may hold and administer property on trust for purposes relating to any service which it is the Trust's function to make arrangements for, administer or provide.

The Trust Board acts as "corporate trustee" for the Charitable Trust Funds and is responsible for ensuring that these funds are held and managed separately from public funds. The members of the Trust Board during the financial year were as follows:

Non-Executive Directors

Mrs Nicole Lappin, Chair, appointed 1 July 2018 for a period of four years.

The Department for Communities appointed the NIAS Chair, Mrs Nicole Lappin, as the Chief Commissioner to the Board of the Charity Commission for Northern Ireland for a five-year period, from 1 August 2019 to 31 July 2024. During this period, the Chair is not involved in any business relating to the NIAS Charitable Trust Funds and, in line with the Trust's Standing Orders, will withdraw from any parts of Trust Board meetings where Charitable Trust Funds are discussed. In which case, the Chair of the Audit Committee, Mr William Abraham shall then assume the position of Chair in line with the Standing Orders.

Mr William Abraham, Non-Executive Director, initially appointed 18 May 2015 for a period of four years and reappointed 18 May 2019 to a date not later than 17 May 2023.

Mr Trevor Haslett CBE, Non-Executive Director, initially appointed 18 May 2015 for a period of four years and re-appointed 18 May 2019 to a date not later than 17 May 2023.

Mr Alan Cardwell, Non-Executive Director, initially appointed 1 August 2015 for a period of four years and reappointed 1 August 2019 to a date not later than 31 July 2023. Mr Cardwell retired as a Non-Executive Director with effect from 11 February 2021.

Mr Dale Ashford, Non-Executive Director, appointed 16 April 2018 for a period of four years.

Mr Jim Dennison, Non-Executive Director, appointed 1 March 2019 for a period of four years.

Directors

Mr Michael Bloomfield, Chief Executive, appointed 19 March 2018.

Mr Brian McNeill, Director of Operations, appointed 1 June 2005. Mr McNeill took up the role of Programme Director Clinical Response Model on 1 May 2019.

Mr Robert Sowney, Interim Director of Operations, appointed 1 May 2019. Mr Sowney left post on 30 September 2020.

Ms Rosie Byrne, Director of Operations, appointed 7 September 2020.

Dr Nigel Ruddell, Medical Director, appointed 1 November 2018.

Mr Paul Nicholson, Interim Director of Finance, appointed 1 July 2019.

Ms Roisin O'Hara, Director of Human Resources and Corporate Services, appointed 1 March 2002. Ms O'Hara took up the role of Programme Director Strategic Workforce Planning in March 2020.

Ms Michelle Lemon, Interim Director of Human Resources and Corporate Services, appointed 8 January 2020.

Ms Lynne Charlton, Director of Quality, Safety & Improvement, appointed 1 November 2019.

Ms Maxine Paterson, Director of Planning, Performance and Corporate Services, appointed 5 April 2020.

The Trust Board as corporate trustee has delegated responsibility for the ongoing management of funds to the Interim Director of Finance.

Professional Advisors

The Trustee employed the following professional advisors during the year:

Investment Fund
NIHPSS Charities Common Investment Fund
Belfast HSC Trust, 1st Floor Dorothy Gardner Unit,
Knockbracken Healthcare Park, Saintfield Road
Belfast BT8 8BH

Solicitors
Directorate of Legal Services
Business Services Organisation
2 Franklin Street
Belfast BT2 8DQ

Internal Auditors
Business Services Organisation - Internal Audit Service
Ballymena Office, Greenmount House
Woodside Road Industrial Estate
Ballymena BT42 4TP

External Auditors
Northern Ireland Audit Office
106 University Street
Belfast BT7 1EU

Structure, Governance and Management

The Charitable Trust Funds held by NIAS are governed by the Health and Personal Social Services (NI) Order 1972. The Trust Board acts as "corporate trustee" for the Charitable Trust Funds. The Trust Board of NIAS as corporate trustee has delegated responsibility to manage the Charitable Trust Funds to the Director of Finance. The Director of Finance oversees the day to day financial management and accounting for the Charitable Trust Funds during the year.

The Director of Finance has particular responsibility to ensure that:

- Each fund is managed appropriately with regard to its purpose and requirements;
- Spending is in accordance with the purpose of the donations and that the criteria for spending charitable monies are fully met;
- Full accounting records are maintained;
- Annual Accounts are prepared in accordance with DoH guidelines;
- Each fund is periodically reviewed and makes recommendations to the Trust Board regarding the rationalisation of funds within statutory guidelines;
- Each new charitable fund has a clearly identified purpose; and
- Devolved decision making or delegated arrangements are in accordance with the policies and procedures set out by the Board as the corporate trustee.

As required by the Charities Act (Northern Ireland) 2013, an application was submitted to the Charities Commission for Northern Ireland (CCNI) in March 2015 for the NIAS Charitable Trust Funds. However, due to the complexity surrounding the HSC charitable funds the CCNI withdrew all applications for registration by HSCNI Trusts in December 2016 in order to facilitate discussions with the Department of Health and HSCNI Trusts on the way forward. NIAS continues to work with the other HSC Trusts, the Department of Health and CCNI, in order to successfully register the charitable trust funds as a charity.

Within the NIAS Charitable Trust Funds there was one unrestricted fund and two restricted funds in the financial year. The restricted funds relate to specific regional areas and correspond with certain ambulance stations.

Charitable Trust Funds are subject to the same system of internal control as that operating in NIAS. The Annual Governance Statement in the NIAS Annual Report and Accounts reflects the system of internal control that operates throughout the Trust as a whole, which includes funds held on trust.

During the year, none of the members of the NIAS Trust Board or members of the key management staff or parties related to them has undertaken any material transactions with the Charitable Trust Funds.

There are no key management personnel employed by the Charitable Trust Funds and there are no employees. All management and administrative duties are performed by the employees of NIAS and the Charitable Trust Funds are not charged a management fee for their services.

Objectives and Activities

The objectives of NIAS are to ensure that charitable donations received by the Trust were appropriately managed, invested, expended and controlled, in a manner that is consistent with the purposes for which they were given and with the Trust's Standing Financial Instructions, Departmental guidance and legislation.

The unrestricted fund and two restricted funds, which existed in the financial year, were as follows:

- General (unrestricted);
- Newry; and
- Ballymoney.

The overall strategy of the Charitable Trust Funds is to provide support by the following means:

- Patients Expenditure: Purchase of comforts for the benefit of patients;
- Staff Expenditure: Purchase of equipment and facilities for use by ambulance staff;
- Research: Encouragement of research into any aspect of the work of the Trust;
- Capital Equipment: Purchase of additional equipment; and
- Other: Any purpose which the Trustee considers to be for the better provision of care and service for patients.

Whilst respecting the wishes of the donors, the corporate trustee has ultimate discretion to apply the Charitable Trust Funds where it is impractical to maintain the designated fund due to residual balances.

Certain schemes of expenditure are deemed not to be suitable for the application of Charitable Trust Funds, which include the following:

- Supplements to the remuneration of members of staff;
- Payments towards staff meals;
- Cash or other gifts; and
- Capital schemes contrary to Trust policy.

Financial Review, Achievements and Performance

The financial statements have been prepared in accordance with the Charities Statement of Recommended Practice (SORP)(FRS 102) and with relevant guidance issued by the Department of Health.

The Trustee's policy is to seek to balance the use of the Charitable Trust Funds income in a way which maximises the benefits to the Trust and patients.

Income

During the year income totalling £106,400 was received, which is an increase of £101,550 compared to the prior year.

Along with the other five Health Trusts Charitable Funds in Northern Ireland, the NIAS Charitable Trust Funds became a member of the Association of NHS Charities in April 2020. The NIAS Charitable Trust Funds received four grants in total from the NHS Charities Together Covid-19 Urgent Appeal Grant Scheme. The first two grants were received in May 2020 at a combined value of £42,500 as part of the Stage 1 first wave grants. The NIAS Charitable Trust Funds successfully applied for a further grant in the Stage 1 second wave in December 2020 at a value of £50,000. The final grant was received through the Charities Together Covid-19 Urgent Appeal Grant Scheme and was donated by Starbucks in December 2020 with a value of £2,100.

The combined total of these grants is £94,600 and the grants are treated as restricted funds and should be spent on enhancing the well-being of Trust staff, volunteers and patients impacted by Covid-19, as part of the Trust's Covid-19 response.

Unrestricted income of £11,800 was also received, which is an increase of £6,950 compared to the prior year. The Progressive Building Society donated £5,000 and the Gaelic Players Association donated £2,440 with the remainder being from members of the public.

During the year and especially during the first Covid-19 lockdown, NIAS received over two hundred donated gifts in kind such as food and care packages from members of the public and local businesses. On acceptance, these donated gifts were immediately distributed and consumed by staff and as such no value has been accounted for in line with the accounting policy note 1(n).

NIAS received fourteen donated tangible assets at a combined value of £972 which includes a television and eight coffee machines among other items. These donated gifts are accounted for in line with the accounting policy and are included within donations in Note 2.

BP introduced a programme on two occasions to provide free fuel for emergency services in order to support essential services through the pandemic. NIAS vehicles are issued with an Allstar fuel card and were able to fill up without charge at BP's network of retail sites. The total value of the free fuel is £141,618. As this is a material donation, it is accounted for within donations in Note 2 in line with the accounting policy.

Expenditure

There were three purchases during the year totalling £3,717 (2020: £2,068) relating to staff welfare, of which £449 was funded from the General Fund (2020: £664) and £3,268 from restricted funds (2020: £1,404).

Support costs of £2,100 relate to audit fees for 2020-21 (2020: £2,100), and are only notional expenditure as there is no actual charge made to the fund accounts.

The donated tangible assets and free fuel detailed in the income section above are also reflected in Note 7 as expenditure in line with the accounting policy.

Investments

The Charitable Trust Funds which are fully invested in the Common Investment Fund experienced a resurgence in investment performance following last year's decrease as a result of the Covid-19 pandemic. Total funds increased by £73,586 during the year (2020: £19,018 decrease) as a result of the performance of the investments.

Financial Position

The overall balance of the Charitable Trust Funds increased by £176,268 to £457,318 as at 31 March 2021 (2020: £281,050). The General Fund has a balance of £327,803 (2020: £251,383) and restricted funds have a combined balance of £129,515 (2020: £29,667).

The Charitable Trust Funds continue to maintain balances at a level which is suitable to provide continued support as and when required.

Achievements

The main achievement in the year was to successfully register with the NHS Charities Together as a member charity which enabled the receipt of the grants detailed above.

Financial Controls

The members of the NIAS Trust Board are aware of their financial responsibilities for the money that is held on trust. Appropriate policies and procedures are in place to ensure these responsibilities are adequately discharged and these are reviewed on a regular basis.

NIAS utilises an internal audit function (commissioned from the Business Services Organisation), which operates to defined standards and whose work is informed by an analysis of risk to which the Trust is exposed and annual audit plans are based on this analysis.

Internal Audit reviewed the Charitable Trust Funds procedures and controls in 2020-21 and provided a satisfactory level of assurance with no significant findings identified.

Statement of Risk

The management of risk in relation to the Charitable Trust Funds is closely aligned with NIAS's risk management strategy and procedures.

Reserves Policy

The Charitable Trust Funds do not currently enter into future commitments and so has not created any reserves for this. Activities are only authorised when funding is available.

Investment Policy

In order to maximise the total return from investment of the Charitable Trust Funds, the Northern Ireland Health and Social Services Charities Common Investment Fund was established by an Order dated 30 March 1995, made by the Department of Health and Social Services under Section 25 of the Charities Act (Northern Ireland) 1964. The Charitable Trust Funds of NIAS are invested within this Common Investment Fund.

A HSC Committee manages the operation of the Common Investment Fund. During 2020-21, this Committee consisted of the following individuals:

Chair
Mr P McNaney, Belfast HSC Trust, Chair

Committee members
Mrs M Edwards, Belfast HSC Trust, Director of Finance
Mrs F Cotter, Belfast HSC Trust, Co-Director of Accounting & Financial Services
Mrs N McKeagney, Belfast HSC Trust, Non-Executive Director
Mr P Morgan, South Eastern HSC Trust, Interim Director of Finance (to September 2020)
Mrs W Thompson, South Eastern HSC Trust, Director of Finance (from September 2020)
Mrs H Minford, South Eastern HSC Trust, Non-Executive Director

Business Address
NIHPSS Charities Common Investment Fund
Belfast HSC Trust, 1st Floor Dorothy Gardner Unit,
Knockbracken Healthcare Park, Saintfield Road
Belfast BT8 8BH

The Committee employed the following professional advisors during the year:

Solicitors
Directorate of Legal Services
Business Services Organisation
2 Franklin Street
Belfast BT2 8DQ

Investment Managers
Brewin Dolphin Limited
Waterfront Plaza
8 Laganbank Road
Belfast BT1 3LR

Nominees
Brewin Nominees Limited
12 Smithfield Street
London EC1A 9BD

Bankers
Bank of Ireland
Donegall Place
Belfast BT51 5BX

Independent Auditors
PricewaterhouseCoopers LLP
Chartered Accountants and Statutory Auditors
Waterfront Plaza
8 Laganbank Road
Belfast BT1 3LR

NIAS does not maintain a bank account for Charitable Trust Funds, all fund monies are held in the Common Investment Fund. The Trustee does not envisage any change in the NIAS investment policy in the foreseeable future.

Plans for Future Periods

Following the fantastic grant support provided by the NHS Charities Together the NIAS Trust Board as corporate trustee of the NIAS Charitable Trust Funds approved an application in March 2021 to spend over £130k on health and wellbeing resources for the benefit of NIAS staff. This will be funded from the grant monies received from NHS Charities Together and the General fund. These resources will enable the recruitment of a clinical psychologist and other resources, which will make a real impact on the mental health and wellbeing of our staff in our recovery from the Covid-19 pandemic. The work to implement these health and wellbeing improvements will be taken forward in 2021-22.

The NHS Charities Together has now Stage 2 and Stage 3 grant schemes open until December 2021 and NIAS will commence work in order to submit appropriate applications to avail of further grant funding.

The Charitable Trust Funds has now significant fund balances that were not previously available and also has the potential to access further grant funding. NIAS will work to develop further proposals to enhance the service we currently provide for the benefit of both patients and staff and for the Trust as a whole.

NIAS also continues to participate in regional discussions with DoH and CCNI regarding the charity registration process. The Trust will review and seek to consolidate funds (or fully utilise funds with low balances) following which the Trust will seek to commence the process for successful registration with CCNI.

Funds Held as Custodian Trustee on Behalf of Others

The Trust does not act as Custodian Trustee on behalf of others.

A Big Thank You

The support for Health and Social Care across the country was a source of support to our staff throughout the year. From the Clap for Our Carers initiative during the first wave, the gifts and donations to ambulance stations throughout the year and also the financial donations through NHS Charities Together and directly to NIAS.

National headlines were filled with extraordinary fundraising achievements. People stepped up to meet different challenges with determination, ability and character. The Trust has benefitted from this support and the many gifts, donations, grants and inspiration provided by individuals, groups and businesses. The Trust and our staff are very appreciative of this generosity, especially at such an uncertain and difficult time.

pOn behalf of the staff and patients, the Corporate Trustee would like to thank all those who stepped up to support NIAS and Health and Social Care in this most challenging year.

Signed on behalf of the Corporate Trustee by:

Mr Michael Bloomfield
Chief Executive
6 September 2021

NORTHERN IRELAND AMBULANCE SERVICE HEALTH AND SOCIAL CARE TRUST – CHARITABLE TRUST FUNDS

THE CERTIFICATE AND REPORT OF THE COMPTROLLER AND AUDITOR GENERAL TO THE NORTHERN IRELAND ASSEMBLY

Opinion on financial statements

I certify that I have audited the financial statements of the Northern Ireland Ambulance Service Health and Social Care Trust's Charitable Trust Funds for the year ended 31 March 2021 under the Health and Personal Social Services (Northern Ireland) Order 1972, as amended. The financial statements comprise: the Statement of Financial Activities, the Balance Sheet and the related notes including significant accounting policies. The financial reporting framework that has been applied in their preparation is United Kingdom accounting standards including FRS 102, the Financial Reporting Standard applicable in the UK and Republic of Ireland (United Kingdom Generally Accepted Accounting Practice).

In my opinion the financial statements:

- give a true and fair view of the state of the Northern Ireland Ambulance Service Health and Social Care Trust's Charitable Trust Fund's affairs as at 31 March 2021 and of its incoming and expenditure of resources for the year then ended; and
- have been properly prepared in accordance with the Health and Personal Social Services (Northern Ireland) Order 1972, as amended and Department of Health directions issued thereunder.

Opinion on regularity

In my opinion, in all material respects the financial transactions recorded in the financial statements conform to the authorities which govern them.

Basis for opinions

I conducted my audit in accordance with International Standards on Auditing (ISAs) (UK), applicable law and Practice Note 10 'Audit of Financial Statements of Public Sector Entities in the United Kingdom'. My responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of this certificate.

My staff and I are independent of Northern Ireland Ambulance Service Health and Social Care Trust's Charitable Trust Fund in accordance with the ethical requirements of the Financial Reporting Council's Revised Ethical Standard 2019, and have fulfilled our other ethical responsibilities in accordance with these requirements.

I believe that the audit evidence obtained is sufficient and appropriate to provide a basis for my opinions.

Conclusions relating to going concern

In auditing the financial statements, I have concluded that the Northern Ireland Ambulance Service Health and Social Care Trust's Charitable Trust Fund's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the Northern Ireland Ambulance Service Health and Social Care Trust Charitable Trust Fund's work I have performed, I have not disclosed in the financial statements any identified material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt about the Northern Ireland Ambulance Service Health and Social Care Trust's Charitable Trust Fund's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

The going concern basis of accounting for Northern Ireland Ambulance Service Health and Social Care Trust's Charitable Trust Fund's is adopted in consideration of the requirements set out in the Government Reporting Manual, which require entities to adopt the going concern basis of accounting in the preparation of the financial statements where it anticipated that the services which they provide will continue into the future.

My responsibilities and the responsibilities of the Trust and the Accounting Officer with respect to going concern are described in the relevant sections of this report.

Other Information

The other information comprises the information included in the Annual Report other than the financial statements and my audit certificate and report. The Trust and the Accounting Officer are responsible for the other information included in the annual report. My opinion on the financial statements does not cover the other information and I do not express any form of assurance conclusion thereon.

My responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or my knowledge obtained in the audit or otherwise appears to be materially misstated. If I identify such material inconsistencies or apparent material misstatements, I am required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact.

I have nothing to report in this regard.

Opinion on other matters

In my opinion based on the work undertaken in the course of the audit, the information given in the Trustee's Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

In the light of the knowledge and understanding of the Northern Ireland Ambulance Service Health and Social Care Trust's Charitable Trust Funds and its environment obtained in the course of the audit, I have not identified material misstatements in the Trustee's Report.

I have nothing to report in respect of the following matters which I report to you if, in my opinion:

- adequate accounting records have not been kept; or
- the financial statements are not in agreement with the accounting records; or

- I have not received all of the information and explanations I require for my audit.

Responsibilities of the Trust and Accounting Officer for the financial statements

As explained more fully in the Statement of Accounting Officer Responsibilities, the Trust and the Accounting Officer are responsible for the preparation of the financial statements and for:

- the preparation of the financial statements in accordance with the applicable financial reporting framework and for being satisfied that they give a true and fair view;
- such internal controls as the Trust Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud of error;
- assessing the Northern Ireland Ambulance Service Health and Social Care Trust's Charitable Trust Fund's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Trust and Accounting Officer anticipates that the services provided by Northern Ireland Ambulance Service Health and Social Care Trust's Charitable Trust Funds will not continue to be provided in the future.

Auditor's responsibilities for the audit of the financial statements

My responsibility is to audit, certify and report on the financial statements in accordance with the Health and Personal Social Services (Northern Ireland) Order 1972, as amended.

My objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error and to issue a certificate that includes my opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

I design procedures in line with my responsibilities, outlined above, to detect material misstatements in respect of non-compliance with laws and regulation, including fraud.

My procedures included:

- obtaining an understanding of the legal and regulatory framework applicable to the Northern Ireland Ambulance Service Health and Social Care Trust's Charitable Trust Funds through discussion with management and application of extensive public sector accountability knowledge. The key laws and regulations I considered included the Health and Personal Social Services (Northern Ireland) Order 1972 (as amended);
- making enquires of management and those charged with governance on Northern Ireland Ambulance Service Health and Social Care Trust's Charitable Trust Fund's compliance with laws and regulations;
- making enquiries of internal audit, management and those charged with governance as to susceptibility to irregularity and fraud, their assessment of the risk of material misstatement due to fraud and irregularity, and their knowledge of actual, suspected and alleged fraud and irregularity;
- completing risk assessment procedures to assess the susceptibility of Northern Ireland Ambulance Service Health and Social Care Trust's Charitable Trust Fund's financial statements to material misstatement, including how fraud might occur. This included, but was not limited to, an engagement director led engagement team discussion on fraud to identify particular

areas, transaction streams and business practices that may be susceptible to material misstatement due to fraud. As part of this discussion, I identified potential for fraud in the revenue recognition;

- engagement director oversight to ensure the engagement team collectively had the appropriate competence, capabilities and skills to identify or recognise non-compliance with the applicable legal and regulatory framework throughout the audit;
- documenting and evaluating the design and implementation of internal controls in place to mitigate risk of material misstatement due to fraud and non-compliance with laws and regulations;
- designing audit procedures to address specific laws and regulations which the engagement team considered to have a direct material effect on the financial statements in terms of misstatement and irregularity, including fraud. These audit procedures included, but were not limited to, reading board and committee minutes, and agreeing financial statement disclosures to underlying supporting documentation and approvals as appropriate;
- addressing the risk of fraud as a result of management override of controls by:
    - performing analytical procedures to identify unusual or unexpected relationships or movements;
    - testing journal entries to identify potential anomalies, and inappropriate or unauthorised adjustments;
    - assessing whether judgements and other assumptions made in determining accounting estimates were indicative of potential bias; and
    - investigating significant or unusual transactions made outside of the normal course of business.

A further description of my responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website www.frc.org.uk/auditorsresponsibilities. This description forms part of my certificate.

In addition, I am required to obtain evidence sufficient to give reasonable assurance that the financial statements conform to the authorities which govern them.

Report

I have no observations to make on these financial statements.

KJ Donnelly
Comptroller and Auditor General
Northern Ireland Audit Office
1 Bradford Court
Galwally
Belfast
BT8 6RB
24 September 2021

NORTHERN IRELAND AMBULANCE SERVICE HSC TRUST

Statement of Financial Activities for the year ended 31 March 2021

	Note	Unrestricted Funds £000s	Restricted Funds £000s	Endowment Funds £000s	Total Funds 2021 £000s	Total Funds 2020 £000s
Income and Endowments						
Donations and legacies	2	155	0	0	155	5
Charitable activities	3	0	94	0	94	0
Other trading activities		0	0	0	0	0
Investments	4	6	1	0	7	8
Other		0	0	0	0	0
Total Income		**161**	**95**	**0**	**256**	**13**
Expenditure						
Raising funds	5	0	0	0	0	0
Charitable activities	6-8	(146)	(3)	0	(149)	(4)
Other		0	0	0	0	0
Total Expenditure		**(146)**	**(3)**	**0**	**(149)**	**(4)**
Net Income / (Expenditure) before Gains and Losses on Investments		**15**	**92**	**0**	**107**	**9**
Net Gains / (Losses) on Investments	11	**0**	**0**	**0**	**0**	**0**
Net Income / (Expenditure)		**15**	**92**	**0**	**107**	**9**
Transfers between Funds	10	**0**	**0**	**0**	**0**	**0**
Other Recognised Gains / (Losses)						
Gains / (losses) on revaluation of fixed assets	11	60	7	0	67	(27)
Other gains / (losses)		0	0	0	0	0
Net Movement in Funds		**75**	**99**	**0**	**174**	**(18)**
Adjustment to add back notional audit fee	8	2	0	0	2	2
Net Movement in Funds excluding Notional Audit Fee		**77**	**99**	**0**	**176**	**(16)**
Reconciliation of Funds						
Fund balances brought forward at 1 April 2020		251	30	0	281	297
Total funds carried forward at 31 March 2021		**328**	**129**	**0**	**457**	**281**

All gains and losses recognised in the reporting period are included in the Statement of Financial Activities and relate to continuing activities.

There is no material difference between the net incoming / (outgoing) resources for the reporting period stated above and their historical cost equivalents.

The notes on pages 22 to 32 form part of these accounts.

NORTHERN IRELAND AMBULANCE SERVICE HSC TRUST

Balance Sheet as at 31 March 2021

	Note	Total Funds 2021 £000s	Total Funds 2020 £000s
Fixed Assets			
Intangible assets		0	0
Tangible assets		0	0
Heritage assets		0	0
Investments	11	457	283
Total Fixed Assets		**457**	**283**
Current Assets			
Stock		0	0
Debtors		0	0
Investments		0	0
Cash at bank and in hand		0	0
Total Current Assets		**0**	**0**
Current Liabilities			
Creditors: amounts falling due within one year	12	0	(2)
Net Current Assets / (Liabilities)		**0**	**(2)**
Total Assets less Current Liabilities		**457**	**281**
Creditors: Amounts falling due after more than one year	12	0	0
Provisions for liabilities		0	0
Total Net Assets / (Liabilities)		**457**	**281**
Funds of the Charity			
Endowment funds		0	0
Restricted income funds	13	129	30
Unrestricted funds	13	328	251
Revaluation Reserve		0	0
Total Unrestricted Funds		**328**	**251**
Total Charity Funds		**457**	**281**

The notes on pages 22 to 32 form part of these accounts.

The financial statements were approved and authorised for issue by the Corporate Trustee on 6 September 2021 and have been signed on its behalf by:

Mr W Abraham
Chair of Audit Committee*
06 September 2021

Mr M Bloomfield
Chief Executive
06 September 2021

* As detailed in Trustee Arrangements on page 7, in line with the Standing Orders the Chair of the Audit Committee assumes the position of Chair when Charitable Trust Funds are discussed, as the Chair was appointed Chief Commissioner to the Board of the Charity Commission for Northern Ireland.

NORTHERN IRELAND AMBULANCE SERVICE HSC TRUST

Charitable Trust Fund Accounts for the year ended 31 March 2021

Notes to the Accounts

1. Accounting Policies

1(a) Basis of Preparation

The financial statements have been prepared under the historic cost convention, with the exception of investments which are included at market value.

The financial statements have been prepared in accordance with the Charities Statement of Recommended Practice (Charities SORP) (FRS102), and with relevant guidance issued by the Department of Health.

Update Bulletin 1, issued February 2016, amended the Charities SORP and a Statement of Cash Flows is now only required for larger Charities. Larger Charities include those charities with a gross income exceeding £500,000 in the reporting period. The Charitable Trust Funds held by NIAS had a gross income of less than £500,000 during 2020-21 and therefore the Charitable Trust Funds are exempt from the requirement to prepare the statement.

Assets and liabilities are initially recognised at historical cost or transaction value unless otherwise stated in the relevant accounting policy note(s).

The financial statements have been presented in sterling which is also the functional currency of the Charitable Trust Funds.

The Charitable Trust Funds meet the definition of a public benefit entity under FRS 102.

The financial statements have been prepared on a going concern basis.

1(b) Structure of Funds

Where there is a legal restriction on the purpose for which a fund may be used, the fund is classified either as an endowment fund, where the donor has expressly provided that only the income of the fund may be expended, or as a restricted fund, where the donor has provided for the donation to be spent in furtherance of a specified charitable purpose.

The major funds held in each of these categories are disclosed in Note 13.

NORTHERN IRELAND AMBULANCE SERVICE HSC TRUST

Charitable Trust Fund Accounts for the year ended 31 March 2021

Notes to the Accounts

1(c) Incoming Resources

All incoming resources are included in full in the Statement of Financial Activities as soon as the following three factors can be met:

- Entitlement – arises when a particular resource is receivable or the charity's right becomes legally enforceable;
- Probability – where there is reasonable certainty that the incoming resource will be received; and
- Measurement – when the monetary value of the incoming resources can be measured with sufficient reliability.

1(d) Income from Donations and Legacies

This includes all income received by the Charitable Trust Funds that is a gift or bequest made on a voluntary basis, for any purpose (unrestricted funds) or for a particular purpose (restricted funds).

Legacies are recognised when it is probable that they will be received.

1(e) Income from Charitable Activities

This includes income earned both from the supply of goods or services under contractual arrangements and from performance-related grants which have conditions specifying the provision of particular goods or services by the Charitable Trust Funds.

1(f) Other Income

This includes income from groups that have undertaken fundraising activities, income from charity vouchers and any other miscellaneous income.

1(g) Investment Income

This is income earned from holding assets for investment purposes and includes dividends and interest.

1(h) Resources Expended and Irrecoverable VAT

All expenditure is accounted for on an accruals basis and has been classified under headings that aggregate all costs related to the category. All expenditure is recognised once there is a legal or constructive obligation committing the charity to the expenditure. Irrecoverable VAT is charged against the category of resources expended for which it was incurred.

1(i) Expenditure on Raising Funds

This includes all expenditure incurred by a charitable fund to raise funds for its charitable purposes and includes the costs of all fundraising activities and events, non-charitable trading activities and the sale of donated goods.

1(j) Expenditure on Charitable Activities

This includes all expenditure by the Trust Funds in undertaking activities that further its charitable aims for the benefit of its beneficiaries as shown in Note 7.

These costs where not wholly attributable, are apportioned between the categories of charitable expenditure.

1(k) Allocation of Support Costs

Support costs are those functions that assist the work of the charity but do not directly undertake charitable activities. Support costs include management fees, however, NIAS does not charge the Charitable Trust Funds a management fee for provision of clerical and administration support. Support costs also include costs related to the statutory audit (see Note 8).

Support costs have been allocated within expenditure on charitable activities and the bases on which support costs have been allocated are set out in Note 6.

1(l) Fixed Asset Investments

Investments are stated at market value as at the Balance Sheet date. The Statement of Financial Activities includes the net gains and losses arising on revaluations and disposals throughout the year.

Details of movements in fixed asset investments during the year are shown in Note 11.

1(m) Realised Gains and Losses

All gains and losses are taken to the Statement of Financial Activities as they arise. Realised gains and losses on investments are calculated as the difference between sales proceeds and opening market value (purchase date if later). Unrealised gains and losses are those gains or losses arising from increases or decreases in the value of investments that have not been sold (hence unrealised) at the reporting period end. These are calculated as the difference between the carrying value at the year end and opening market value (or purchase date if late). Unrealised gains and losses are allocated across the appropriate funds (that is those funds for which investments are held) according to the closing value of funds at the year end.

1(n) Gifts in Kind

Gifts in kind, such as food and care packages are not accounted for when they are accepted and immediately distributed unless a single donation is material.

Gifts of tangible assets such as microwaves and fridges are recognised as a donation at fair value (market price) on receipt and charitable expenditure when they are distributed.

Where gifts in kind are held before being distributed to beneficiaries, they are recognised at fair value as stock until they are distributed.

Assets given for use by the charity (for example property for its own occupation) are included in the Statement of Financial Activities as incoming resources within Corporate Donations when receivable.

Gifts made in kind but on trust for conversion into cash and subsequent application by the charity are included on the accounting period in which the gift is sold.

1(o) Debtors

Debtors are recognised at the settlement amount due after any trade discount offered. Prepayments are valued at the amount prepaid net of any trade discounts due.

1(p) Creditors

Creditors are recognised where the Charitable Trust Funds have a present obligation resulting from a past event that will probably result in the transfer of monies to a third party and the amount due to settle the obligation can be measured or estimated reliably. Creditors are normally recognised at their settlement amount after allowing for any trade discounts due.

NORTHERN IRELAND AMBULANCE SERVICE HSC TRUST

Charitable Trust Fund Accounts for the year ended 31 March 2021

Notes to the Accounts

1(q) Financial Instruments

The Charitable Trust Funds only have financial assets and liabilities that qualify as basic financial instruments. Basic financial instruments are initially recognised at transaction value and subsequently measured at their settlement value.

1(r) Going Concern

There are no material uncertainties about the Charitable Trust Funds ability to continue as a going concern.

1(s) Key Judgements and Assumptions

The Charitable Trust Funds make estimates and assumptions concerning the future. The resulting accounting estimate will, by definition, seldom equal the related actual results. The most significant areas of uncertainty that affects the carrying value of assets held by the Charitable Trust Funds are the level of investment return and the performance of investment markets.

Notes to the Accounts for the year ending 31 March 2021

Note 2 Analysis of Income from Donations and Legacies

	Unrestricted Funds £000s	Restricted Funds £000s	Total Funds 2021 £000s	Total Funds 2020 £000s
Donations from individuals	7	0	7	5
Corporate donations	148	0	148	0
Legacies	0	0	0	0
Other	0	0	0	0
Total	**155**	**0**	**155**	**5**

Corporate donations includes £1k relating to gifts of tangible assets and £142k of free fuel for emergency vehicles, both of which have been distributed. These gifts are also included as charitable expenditure in Note 7.

Note 3 Analysis of Income from Charitable Activities

	Unrestricted Funds £000s	Restricted Funds £000s	Total Funds 2021 £000s	Total Funds 2020 £000s
Stage 1 first wave grant	0	42	42	0
Stage 1 second wave grant	0	50	50	0
Starbucks grant	0	2	2	0
Other	0	0	0	0
Total	**0**	**94**	**94**	**0**

All of the income received above is through the NHS Charities Together's Covid-19 Urgent Appeal Grant Scheme.

Note 4 Gross Investment Income

	Unrestricted Funds £000s	Restricted Funds £000s	Total Funds 2021 £000s	Total Funds 2020 £000s
Fixed asset equity and similar investments	6	1	7	8
Fixed asset cash on deposit	0	0	0	0
Current asset investments	0	0	0	0
Other	0	0	0	0
Total	**6**	**1**	**7**	**8**

Notes to the Accounts for the year ending 31 March 2021

Note 5 Expenditure on Raising Funds

There is no expenditure on raising funds for Charitable Trust Funds for the year ended 31 March 2021 (2020: £nil).

Note 6 Analysis of Governance and Support Costs Across Expenditure

	Staff Costs £000s	Audit £000s	Total Funds 2021 £000s	Total Funds 2020 £000s
Medical research	0	0	0	0
Purchase of new equipment	0	0	0	0
Building and refurbishment	0	0	0	0
Staff education and welfare	0	2	2	2
Patient education and welfare	0	0	0	0
Other	0	0	0	0
Total	**0**	**2**	**2**	**2**

Support costs and Governance costs are apportioned pro-rata across charitable expenditure. Audit fees are notional expenditure only and there is no actual charge made to the fund accounts (see Note 8).

Note 7 Analysis of Charitable Expenditure

	Grant Funded Activity £000s	Support Costs £000s	Total Funds 2021 £000s	Total Funds 2020 £000s
Medical research	0	0	0	0
Purchase of new equipment	0	0	0	0
Building and refurbishment	0	0	0	0
Staff education and welfare	5	2	7	4
Patient education and welfare	0	0	0	0
Other	142	0	142	0
Total	**147**	**2**	**149**	**4**

Note 8 Auditor's Remuneration

The auditor’s remuneration of £2,100 (2020: £2,100) related solely to the audit with no other additional work undertaken (2020: £nil). This is notional expenditure only and there is no actual charge made to the fund accounts.

Note 9 Trustee Remuneration

The members of the Trust Board which acts as the corporate trustee, received no remuneration or expense reimbursements from the Charitable Trust Funds during the year ended 31 March 2021 (2020: £nil).

Note 10 Transfers between Funds

There have been no transfers between Charitable Trust Funds during the year ended 31 March 2021 (2020: £nil).

Note 11 Analysis of Fixed Asset Investments

11.1 Investments in a Common Investment Fund

	2021 £000s	2020 £000s
Market value at 1 April	283	297
Net cash inflow / (outflow)	100	5
Share of income	7	8
Share of realised gains / (losses)	5	4
Share of unrealised gains / (losses)	62	(31)
Market value at 31 March	**457**	**283**

11.2 Market Value

	Held in UK £000s	Held Outside UK £000s	2021 £000s	2020 £000s
Investment properties	0	0	0	0
Investments listed on Stock Exchange	0	0	0	0
Investments in a Common Investment Fund	457	0	457	283
Investments in a Common Deposit Fund or Investment fund	0	0	0	0
Unlisted securities	0	0	0	0
Cash held as part of the investment portfolio	0	0	0	0
Investments in connected bodies	0	0	0	0
Other investments	0	0	0	0
Total Market Value of Fixed Asset Investments	**457**	**0**	**457**	**283**

Note 12 Analysis of Creditors

12.1 Amounts falling due within one year	2021 £000s	2020 £000s
Trade creditors	0	2
Other creditors	0	0
Accruals	0	0
Total	**0**	**2**

12.2 Amounts falling due after more than one year

The Charitable Trust Funds had no creditor amounts due more than one year after the year ended 31 March 2021 (2020: £nil).

Note 13 Analysis of Charitable Funds

13.1 Analysis of Charitable Funds

Restricted Funds are funds where the donor has placed a legal restriction to either oinly utilise income generated from the donation (endowment) or to only be spent in furtherance of a specific charitable purpose.

	Balance at 1 April 2020 £000s	Incoming Resources £000s	Resources Expended £000s	Transfers £000s	Gains and Losses £000s	Balance at 31 March 2021 £000s
Endowment Funds						
Other	0	0	0	0	0	0
Endowment Funds Total	**0**	**0**	**0**	**0**	**0**	**0**
Restricted Funds						
NHS Charities Together*	0	94	0	0	0	94
Heart*	26	0	0	0	7	33
Ballymoney	1	0	0	0	0	1
Newry	3	0	(3)	0	1	1
Restricted Funds Total	**30**	**94**	**(3)**	**0**	**8**	**129**
Unrestricted and Material Designated Funds						
General	251	155	(144)	0	66	328
Unrestricted and Material Designated Funds Total	**251**	**155**	**(144)**	**0**	**66**	**328**
Grand Total	**281**	**249**	**(147)**	**0**	**74**	**457**

* These donations are currently held within the General Fund for administrative purposes, the donations meet the definition of a restricted donation and as such is noted here and in other statements and notes under restricted funds.

13.2 Analysis of Charitable Funds

	Unrestricted Funds £000s	Restricted Funds £000s	Endowment Funds £000s	Total Funds 2021 £000s	Total Funds 2020 £000s
Fixed asset investments	328	129	0	457	281
Cash at bank and in hand	0	0	0	0	0
Current assets	0	0	0	0	0
Current liabilities	0	0	0	0	0
	328	**129**	**0**	**457**	**281**

Note 14 Commitments

The Charitable Trust Funds have no contingencies or commitments as at 31 March 2021 (2020: £nil).

NORTHERN IRELAND AMBULANCE SERVICE HSC TRUST

Notes to the Accounts for the year ending 31 March 2021

Note 15 Comparative figures for the Statement of Financial Activities

	Unrestricted Funds £000s	Restricted Funds £000s	Endowment Funds £000s	Total Funds 2020 £000s
Income and Endowments				
Donations and legacies	5	0	0	5
Charitable activities	0	0	0	0
Other trading activities	0	0	0	0
Investments	7	1	0	8
Other	0	0	0	0
Total Income	**12**	**1**	**0**	**13**
Expenditure				
Raising funds	0	0	0	0
Charitable activities	(3)	(1)	0	(4)
Other	0	0	0	0
Total Expenditure	**(3)**	**(1)**	**0**	**(4)**
Net Income / (Expenditure) before Gains and Losses on Investments	**9**	**0**	**0**	**9**
Net Gains / (Losses) on Investments	**0**	**0**	**0**	**0**
Net Income / (Expenditure)	**9**	**0**	**0**	**9**
Transfers between Funds	**0**	**0**	**0**	**0**
Other Recognised Gains / (Losses)				
Gains / (losses) on revaluation of fixed assets	(24)	(3)	0	(27)
Other gains / (losses)	0	0	0	0
Net Movement in Funds	**(15)**	**(3)**	**0**	**(18)**
Adjustment to add back notional audit fee	2	0	0	2
Net Movement in Funds excluding Notional Audit Fee	**(13)**	**(3)**	**0**	**(16)**
Reconciliation of Funds				
Fund balances brought forward at 1 April 2019	264	33	0	297
Total funds carried forward at 31 March 2020	**251**	**30**	**0**	**281**

Note 16 Financial Instruments

Other than investments the Charitable Trust Funds did not have any financial instruments during the year ending 31 March 2021 (2020: £nil).

NORTHERN IRELAND AMBULANCE SERVICE HSC TRUST

Notes to the Accounts for the year ending 31 March 2021

Note 17 Financial Guarantees, Indemnities and Letter of Comfort

The Charitable Trust Funds has not entered into any financial guarantees, indemnities or provided letters of comfort during the year ending 31 March 2021 (2020: £nil).

Note 18 Related Party Transactions

The Trust Board acts as "corporate trustee" for the Charitable Trust Funds and is responsible for ensuring that these funds are held and managed separately from public funds. During the year none of the members of the NIAS HSC Trust Board or members of the key management staff or parties related to them has undertaken any material transactions with the Charitable Trust Funds.

Board Members (and other senior staff) take decisions both on Charity and Public Funds matters but endeavour to keep the interests of each discrete and do not seek to benefit personally from such decisions. Declarations of personal interest have been made and are available to be inspected by the public.

The Charitable Trust Funds has not made any revenue or capital payments to the NIAS HSC Trust.

Note 19 Ultimate Holding Organisation and Registered Address

The ultimate controlling party of the Charitable Trust Funds is the Northern Ireland Ambulance Service Health and Social Care Trust. Copies of the 2020-21 Annual Report and Accounts of the NIAS HSC Trust can be obtained by: visiting www.nias.hscni.net; emailing finance.secretary@nias.hscni.net; or by writing to the Director of Finance, NIAS HSC Trust at the address below.

Address of Charity: Northern Ireland Ambulance Service Health and Social Care Trust
Headquarters, Site 30, Knockbracken Healthcare Park
Saintfield Road
Belfast BT8 8SG

Note 20 Post Balance Sheet Events

There have been no material events after the Balance Sheet date which would have a material effect on the accounts.

Date Authorised for Issue

The Accounting Officer authorised these financial statements for issue on 24 September 2021.

Return to Agenda

TB/21/10/2021/10

Return to Agenda

Northern Ireland Ambulance Service Health and Social Care Trust

'SAFETY' COMMITTEE REPORT TO TRUST BOARD 21/10/21

The Safety, Quality, Patient Experience and Performance Committee met on Thursday 16 September 2021. Issues discussed included:

1	Medical Devices Policy The Committee approved this policy which provides an up-to-date, comprehensive, Trust-wide strategy for the management of Medical Devices, from inception to disposal. The policy ensures compliance with legislation and the establishment of procedures for the identification, selection, procurement, integration, training, use, maintenance and ultimate replacement and disposal of Medical Devices. It has been designed to protect staff and service users from risk whilst safeguarding the welfare of patients, staff and members of the public.
2	Updated Policy & Procedures for the Management of Medicines The Committee approved this updated policy and noted that NIAS had at its disposal a range of medicines, which may be administered by appropriately trained staff in the delivery of care to their patients. The Policy's aim is to ensure that the procurement, use, storage, security, and Control of Prescription Only Medicines (POMs) within NIAS complies with all relevant legislation and guidance. The Policy also takes account of the latest changes to the range of medications carried by NIAS staff as well as providing detail of the Local Intelligence Network. It is intended to revisit the Policy after the pharmacist is appointed.
3	Serious Adverse Incidents Position & Learning Outcome Update The Committee noted that improvement efforts and training initiatives in relation to raising awareness regarding recognition and reporting of SAIs have continued with an external SAI training programme provided to staff. Between April – August 2021, nine SAIs had been reported to the HSCB. There was an acknowledgement that the current service pressures have resulted in delays in conducting investigations around SAIs and complaints and that further work in relation to understanding the effectiveness of shared learning was required going forward.
4	HART SAI Update The Committee noted the update in respect of an equipment incident.
5	Controls Assurance Standards (CAS)/Post Control Assurance Standards Arrangements CAS were withdrawn in 2018. However, Trusts must ensure that adequate alternative arrangements were in place to provide assurance. Six of the previous 22 standards require a return to the DoH, namely: Food Hygiene (not required by NIAS); Environmental Cleanliness; Emergency Planning; Medicines Management; Information Governance and Estates standards. Members received an overview of the current arrangements and those areas where further work was required.

6	Medical Devices Incidents & Learning – Annual Report The Committee noted this report which provided an annual update on medical and non-medical device incidents and any associated learning.
7	Complaints Annual Report 2020-21 The Committee approved this report which will now be posted on the Trust website.
8	NIAS Response to NIPSO Consultation of creating complaints handling standards for the Northern Ireland Public Sector The Committee approved the draft response to this consultation which closes on 30 September 2021.
9	Complaints & Compliments: current position The Committee noted overview of the increasing number of complaints with a focus on the number which relate to delayed response, in particular falls, staff attitude and behaviour and quality of care. Anonymised complaints and compliments were shared with the Committee as well as an update on the steps being taken by the Trust to address these issues and specifically the complaints backlog.
10	Hygiene, Cleanliness and Infection Prevention and Control - Key Performance Indicators: 1 April – 31 August 2021 The Committee noted the challenges around ensuring compliance in relation to Hand Hygiene and were advised of the steps which would be taken to improve compliance. They also received an update in relation to the uptake of e-learning in respect of IPC Levels 1 & 2 and Aseptic Non-Touch Technique as well as IPC face-to-face training.
11	Education Review Members received an update. This will become a standing item on the Committee agenda.

Northern Ireland Ambulance Service
Health and Social Care Trust

MINUTES OF THE SAFETY, QUALITY, PATIENT EXPERIENCE AND PERFOMANCE COMMITTEE HELD AT 9.30AM ON THURSDAY 16 SEPTEMBER 2021 (VIA ZOOM DUE TO COVID-19)

PRESENT:	Mr D Ashford	-	Committee Chair
	Mr W Abraham	-	Non Executive Director (left the meeting at 11.15am
IN ATTENDANCE:	Mr M Bloomfield	-	Chief Executive
	Ms L Charlton	-	Director of Quality, Safety & Improvement
	Ms K Keating	-	Risk Manager
	Mr P Nicholson	-	Interim Director of Finance
	Dr N Ruddell	-	Medical Director
	Mr R Sowney	-	Senior Clinical Adviser
	Mrs C Mooney	-	Board Secretary
	Ms E Boylan	-	SAI Lead (Clinical) (for agenda item 7)
	Mr S Moore	-	Medical Devices Lead (for agenda item 10 only)
	Dr R McLaughlin	-	Assistant Medical Director (for agenda item 7 only)
	Ms C McVeigh	-	Complaints Manager (for agenda items 11-13 only)
	Ms R Finn	-	IPC Lead (for agenda item 14 only)
	Mr C Carlin	-	Boardroom Apprentice (left the meeting at 12.30pm
APOLOGIES:	Mr T Haslett	-	Non Executive Director
	Ms R Byrne	-	Director of Operations
	Ms M Lemon	-	Interim Director of Human Resources
	Mr B McNeill	-	Programme Director - CRM
	Ms R O'Hara	-	Programme Director – Strategic Workforce Planning
	Ms M Paterson	-	Director of Planning, Performance & Corporate Services

1 Apologies & Opening Remarks

Mr Ashford thanked those present for attending and welcomed Mr Carlin to his first meeting of the Safety Committee. He explained that he intended to consider those agenda items for approval at the start of the meeting while Mr Abraham was present and the meeting was quorate.

Apologies were noted from Mr Haslett, Ms Byrne, Ms Lemon, Mr McNeill, Ms O'Hara and Ms Paterson.

2 Procedure

2.1 Declaration of Potential Conflicts of Interest

There were no declaration of conflicts of interest.

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 (SC16/09/21/01)

The minutes of the previous meeting on 10 June 2021 had been **APPROVED** by e-mail and presented to the August Trust Board.

4 Matters Arising (SC16/09/21/02)

Members **NOTED** the action list.

The Committee agreed with a suggestion from Mr Bloomfield that, given the importance of the Education Review, it should be included as a standing item on the Committee agenda.

Dr Ruddell advised that the first meeting of the Programme Board would take place on 1 October and added that the internal working group met on a weekly basis to review and progress work. He acknowledged that REAP 4 and Covid-19 had presented challenges

in maintaining progress as staff had been diverted to support operational duties.

Dr Ruddell then provided the Committee with a detailed update on progress to date, covering areas such as the strategic context; team structure; programme and the challenges presented.

Mr Nicholson advised that the Trust continued to work through the funding arrangements for the current year's training programme with the Health and Social Care Board (HSCB). He said that reference had been made at Trust Board meetings of the delay in implementation of a number of programmes and he cited the example of the REACH programme. However, Mr Nicholson highlighted the criticality of maintaining training, particularly around Cohort 4 paramedic training and was of the view that it was about balancing the risk for the remainder of the year.

The Committee Chair noted that the availability of staff was key and asked whether timelines had been revised to take account of these difficulties.

Agreeing with this point, Mr Nicholson referred to the difficulties in releasing staff to undertake training. He pointed out that, while the REACH programme had been rolled out in the West, there had been pressures to release staff from operational duties to undertake the necessary training.

In response to the Committee Chair's query around revised timelines, Dr Ruddell explained that training was taking place and there was a more realistic acceptance of the time required.

Mr Sowney said that it would be important to ensure that the processes were not overly bureaucratic and process-driven. He suggested that discussions should move away from referring to the 'training school' and focus more on an 'education academy/facility'. Mr Sowney welcomed the inclusion of updates on the Education Review as a standing agenda item and suggested that the Committee should continue to receive updates even if progress was slow.

Mr Bloomfield advised that he had recently accompanied Ms Byrne, Dr Ruddell and Mr Sinclair to Magee to meet the 40 BSc students who would graduate in June 2024. He said that he had been struck

by their enthusiasm and ambition and had been very impressed by the facilities available at Magee.

Mr Abraham said that he wished to emphasise the critical importance which Non-Executives attached to this development and echoed the comments which had been made.

The Committee Chair said that he understood the reasons why the update on the PCS review had been deferred to a future meeting but asked if there had been any progress.

Mr Bloomfield explained that the PCS review had undoubtedly been impacted upon by Covid-19. He said that he had met with Ms Byrne to discuss whether the review should be paused until the Trust had returned to business as normal or whether it could be progressed in a different way. Mr Bloomfield indicated that his preference had been to progress the review and said that he would be discussing with Ms Byrne how this could be taken forward. He undertook to update the Committee at its November meeting.

Mr Sowney expressed his support for this approach and believed it was prudent to find an alternative way to progress the review.

Mr Bloomfield reminded the Committee that PCS had been identified as an issue by Internal Audit. He referred to the resources available within PCS which could potentially be used to support emergency services and said it would be critical to examine how these services could be used more effectively. He added that it was important that the PCS review would take cognisance of this.

The Committee Chair thanked those present for their updates.

5 **Medical Devices Policy (SC16/09/21/03)**

The Committee Chair welcomed Mr Sean Moore, Medical Devices Lead, to the meeting and invited Dr Ruddell to introduce this agenda item.

Dr Ruddell explained that the purpose of this policy was to provide an up-to-date, comprehensive, Trust-wide strategy for the management of Medical Devices, from inception to disposal. He said that the policy would ensure compliance with legislation and establish procedures for the identification, selection, procurement,

integration, training, use, maintenance and ultimate replacement and disposal of Medical Devices as well as protecting staff and service users from risk whilst safeguarding the welfare of patients, staff and members of the public.

Ms Keating pointed out that this was a review of an existing policy and mainly covered the use of devices for medical purposes.

Mr Sowney referred to para 3.9 within the policy, in particular reference to Vehicular Daily Inspections (VDI), and asked who was responsible in ensuring such inspections were undertaken, taking account of the potential for ED vehicles to be dispatched to urgent calls before VDIs could be undertaken.

Responding, Dr Ruddell explained that VDIs were an operational responsibility. He acknowledged the challenges facing staff in ensuring these were undertaken and cited the example of crews finishing a shift, only for the ambulance to be immediately despatched to another call. Dr Ruddell advised that there was a separate procedure around rapid VDI and clarified that, while the Medical Directorate developed the standards, it was operational management responsibility to ensure adherence.

Dr Ruddell indicated that the policy also referred to the completion of an Untoward Incident Report (UIR) relating to the inability to carry out a VDI and clarified that this responsibility lay primarily with EAC as time was to be provided to perform VDIs. He said that, on occasions, where it had not been possible to complete a VDI, EAC should ensure there was an opportunities to complete one at a later stage.

Mr Bloomfield was of the view that this highlighted the benefit of having a make-ready depot. He pointed out that there was a similar issue previously in relation to IPC where paramedics and EMTs were required to undertake deep-cleans of vehicles when they should be providing patient care.

Ms Charlton, agreeing with Mr Bloomfield's comments, said that the VDIs and the cleaning of vehicles had implications for the Trust in terms of its response times. However deep cleans were now carried out by vehicle cleans as are a significant number of in-between patient cleans at ED.

Mr Sowney said that he was aware, on occasions, of staff reporting early for shift to undertake the VDI as they felt vulnerable if it was not undertaken. He suggested that this was an issue which could be revisited by Operations in order to protect staff and agreed that a make-ready depot would be beneficial.

Continuing, Mr Sowney referred to the responsibilities placed on staff using medical devices to ensure they received the appropriate training. He sought clarification around what mitigations were in place around the inability to train and instruct staff safely to undertake a risk assessment in the current climate.

Dr Ruddell referred to the delivery of educational practice both within NIAS and also within the Ulster University as well as the regular training provided at station level. He alluded to 'carry chairs' and acknowledged the difficulty in bringing these into service because of the challenges in ensuring staff undertook the necessary training. He said there would be greater emphasis on delivering training on a face-to-face basis. Dr Ruddell said that the 'carry chair' training had been completed and 'stretcher' training was now taking place.

In response to a query from Mr Sowney in relation to an inventory of medical devices, Mr Moore explained that an audit of all medical devices across the service was currently being undertaken. He reminded the meeting that, due to the nature of the service, devices moved around the region depending on operational need and added that consideration was being given to dynamic monitoring procedures. Mr Moore confirmed that, while nothing was currently on loan from the Trust, the Trust could have equipment loaned to it on a trial basis. He clarified that the policy also covered equipment on loan.

Mr Sowney referred to para 4.11 'Training' and sought clarification around the practicality of the statement that 'No Medical Devices or Medical Equipment shall be implemented into service until all potential users have adequate training in its use.'

Mr Moore explained that this statement had also been included in the previous policy, ie no member of staff should use any equipment unless they had been trained in its use. He pointed out that all equipment would have associated Standard Operating Procedures.

The Committee Chair sought further clarification on this point and asked whether training had to be provided to every member of staff before it was brought into use. He agreed with the point made by Mr Moore that staff should not use equipment unless they had undergone the necessary training.

Mr Bloomfield suggested that it would be important to clarify this point within the policy and said that to adopt an approach whereby every member of staff had to receive training before a device was introduced would be counter-productive and result in unnecessary delays.

Dr Ruddell agreed that there were ways in which equipment could be introduced without the need for every single member of staff to have been trained in its use. However he re-emphasised the point that no member of staff should use equipment for which they had not been trained in its use.

Referring to the monitoring of the policy, Mr Sowney sought clarification on how the Medical Equipment Group ensured compliance.

Dr Ruddell explained that the Group met on a regular basis and oversaw the procurement of equipment, its supply through to ensuring the roll-out of the necessary training packages in its use. He added that the Group also considered any updates received in relation to, for example, oxygen cylinders, defibrillators as well as considering any Untoward Incident Reports in terms of any issues that may arise.

The Medical Devices Policy was **APPROVED** on a proposal from the Committee Chair and seconded by Mr Abraham.

The Chair thanked Mr Moore for his contribution.

6 **Updated Policy & Procedures for the Management of Medicines (SC16/09/21/04)**

At the Committee Chair's invitation, Dr Ruddell drew members' attention to the updated Policy and Procedures for the Management of Medicines. He explained that NIAS had at its disposal a range of medicines, which may be administered by appropriately trained staff in the delivery of care to their patients. Dr Ruddell further explained

that the aim of the Policy for the Management of Medicines was to ensure that the procurement, use, storage, security, and Control of Prescription Only Medicines (POMs) within NIAS complied with all relevant legislation and guidance. He said that, as well as being a scheduled review, this update took account of the latest changes to the range of medications carried by NIAS staff as well as providing detail of the Local Intelligence Network.

Dr Ruddell said that, while the Trust had recently appointed a pharmacist who would revisit the policy and procedures, it would be important to ensure the policy and procedures were updated in the interim. He proceeded to take the Committee through the detail.

The Committee Chair commented that he had found the policy and procedures challenging and complex to understand and acknowledged that this was due to the subject matter. He sought clarification around the reference within the documentation that the Chief Executive was able to supply and possess diazepam and morphine sulphate and sought further clarification around the monitoring processes in place. The Committee Chair questioned whether there was an easier way to present the information as the complex nature of the information made it difficult for members to approve.

Responding, Dr Ruddell explained that the Chief Executive was the Accounting Officer for the Trust in terms of Controlled Drugs documentation but that this responsibility had been devolved to him as Medical Director. He said that he was conscious of the legislation around the supply and administration of Prescription Only Medicines (POMS) and this had contributed towards the complexity of the papers. Dr Ruddell indicated that, given the significant value of the Controlled Drugs medicines stock, there was legislation setting out how its use should be monitored and tracked. He said the Trust was exploring ways to minimise and reduce the paperwork around this and was considering the introduction of electronic tracking of drugs. Dr Ruddell added that the pharmacy working with the Trust had put forward a number of proposals for consideration.

Referring to his role as Accountable Officer, Mr Bloomfield suggested that it might be helpful to provide clarification within the policy around the responsibility for the function and the fact that this function had been devolved to the Medical Director.

Dr Ruddell advised that NIAS crews carried a standard set of drugs recognisable to any UK ambulance service. He clarified that the Helicopter Emergency Service (HEMS) could, for example, use specialist drugs and advised that there were national and regional plans for the Hazardous Area Response Team (HART) to stock antidotes as well as having the ability to distribute specialist drugs.

Mr Sowney agreed with the Committee Chair's comments around the complexity of the issue in view of the fact that approval was being sought to both the policy and procedures. He acknowledged the challenges in understanding the content unless an individual was a subject matter expert or had clinical knowledge. Mr Sowney suggested that it might be helpful to revisit the requirement around approval of policies and procedures.

Mr Sowney referred to the refusal of consent around drugs and asked whether it was sufficient for the crew to note a patient's refusal as opposed to asking patients to sign the Patient Record Form (PRF).

Dr Ruddell confirmed that there was a section on the PRF to record the patient's withdrawal of consent. He agreed with the point made by Mr Sowney that it was sufficient for the crew to record the withdrawal of consent on the PRF rather than require a patient signature. Dr Ruddell advised that training was provided to staff on this issue.

Mr Sowney asked whether there were formal agreements with voluntary ambulance services around the provision of drugs.

Responding, Dr Ruddell cited the example of St John's Ambulance and explained that only those St John's Ambulance volunteers who were employed by NIAS were permitted to withdraw drug packs from NIAS, assuming that stocks were available. He pointed out that St John's Ambulance volunteers followed the same monitoring process as NIAS staff and added that, if drugs were used, then the Trust would recoup the funding.

In response to a further question from Mr Sowney as to the steps taken to ensure withdrawal of drug packs by St John's Ambulance, for example, did not present operational challenges, Dr Ruddell explained that drug packs were only withdrawn subject to availability and agreement with the Station Officer. He added that a register

was maintained around the withdrawal of packs and St John's Ambulance provided a list of authorised personnel.

Mr Sowney asked whether the Safety Committee was assured that there were sufficient monitoring arrangements in place to mitigate any risk for the Trust.

Dr Ruddell advised that the current Memorandum of Understanding in place with St John's Ambulance reflected NIAS existing procedures and said he was of the view that it did not pose any risk to the Trust. Continuing, Dr Ruddell pointed out that the Trust was required to report every incident of loss or potential loss of Controlled Drugs to the Local Intelligence Network. He confirmed that the Trust had not suffered any losses or misdirection of morphine. Dr Ruddell acknowledged that, while no service was completely fool proof, the Trust processes around the monitoring and tracking of drugs were robust for those involved.

The Committee Chair asked if any steps could be taken to make the documentation more user-friendly.

Dr Ruddell again acknowledged its complexity and said that it was his intention when the pharmacist took up post to revisit the documentation.

Mr Sowney welcomed the appointment of the pharmacist and said the appointment would be an excellent addition to the Trust.

Following this discussion, the Committee **APPROVED** the Updated Policy & Procedures for the Management of Medicines.

7 **Complaints Annual Report 2020-21 (SC16/09/21/09)**

The Committee Chair welcomed Ms Clare McVeigh, Complaints Manager, to the meeting.

By way of introduction, Ms Charlton advised that it was a requirement from the DoH to publish a Complaints Annual Report and added that, if approved at today's meeting, the Report would be posted on the Trust's website.

Ms McVeigh highlighted the salient points of the report, including the recent increase in monthly complaints which highlighted themes

of delayed responses, in particular falls, and staff attitude and behaviour.

Mr Sowney referred to the increase in complaints around staff attitude and behaviour and quality of care and acknowledged that it was likely that a significant number could be linked to an increase in pressures arising from Covid-19 and asked what steps were being taken in this regard.

Ms Charlton said that it was clear from a number of complaints that comments made by staff reflected their frustration at the use of resources and added that, while their frustrations on occasions were genuine, such comments were inappropriate and had a negative effect on families. She pointed out that a process had now been put in place whereby when a complaint was received around the clinical care or attitude and behaviour of a member of staff, cognisance was also taken of whether there had been any previous complaints over the last three year period. Ms Charlton said it would be important to understand whether helpful discussion or further development in a particular area was required or whether there had already been interventions and that, despite these, the poor attitude had continued in which case in keeping with a 'just' culture approach should be managed appropriately.

Continuing, Ms Charlton noted that there had been discussions around compassion fatigue, meal breaks, late finishes and the impact such could have on staff. She acknowledged that, while crews advised that many of these comments were unintentional, they were perceived by families as uncompassionate.

Mr Sowney emphasised the importance of Area Managers and Station Officers being aware of the increase in complaints due to compassion fatigue and ensuring they were supportive. He pointed out that the situation was not unique to NIAS and was occurring across the HSC.

Ms Charlton advised that, while a look-back exercise was undertaken in respect of complaints received regarding a member of staff, a similar look-back was also undertaken in relation to compliments. She indicated that it was important not to focus on the negative aspects alone but to acknowledge compliments received. Ms Charlton reminded the meeting that compliments were recorded and the Chief Executive forwarded a note of thanks

to each staff member. She referred to the policy around Supporting Staff Involved in Incidents, Complaints, Claims & Coroner's Inquests and alluded to Mr Ashford's comments at the Safety Committee in relation to the importance of supporting staff in a just culture and holding them to account where necessary.

Mr Sowney acknowledged that there was potential within every organisation for complaints to be received about the same staff member. However he pointed out that, when complaints were received in relation to members of staff who had never had a complaint made against them previously, it highlighted the issue of compassion fatigue. Mr Sowney enquired whether there were different levels of complaints training available to staff.

Responding, Ms Charlton advised that the same general HSC complaints e-learning was offered to all staff and added that those staff undertaking investigations received additional enhanced training in the organisation previously. She acknowledged that the complaint investigation process was frightening for some staff and she referred to the checklist at the back of the Supporting Staff Policy which attempted to achieve a balance between supporting staff whilst ensuring a proportionate and appropriate investigation was carried out.

In response to a question from Mr Sowney around whether there had been progress in ensuring compliments received at local station level were forwarded to HQ for processing, Ms Charlton said that, whilst some improvements had taken place, further work was required.

The Complaints Annual Report 2020-21 was **APPROVED** on a proposal from Mr Abraham and seconded by Mr Ashford.

8 **NIAS Response to NIPSO Consultation of creating complaints handling standards for the Northern Ireland Public Sector (SC16/09/21/10)**

Ms McVeigh remained for this discussion and took members through the detail of the proposed response to the NI Public Service Ombudsman (NIPSO) consultation around creating complaints handling standards for the NI public sector.

The draft response was **APPROVED** on a proposal by Mr Ashford and seconded by Mr Abraham.

Mr Abraham left the meeting at this point.

9 **Serious Adverse Incidents Position & Learning Outcome Update (SC16/09/21/05)**

The Committee Chair welcomed Ms Emma Boylan, SAI Lead (Clinical) to the meeting.

Ms Boylan provided the Committee with an overview of those SAIs notified to the HSCB and she advised that 9 SAIs has been reported between April – August 2021. She said that a number of SAIs were overdue in terms of their submission to the HSCB and added that improvement plans were in place for each of these.

Ms Boylan advised that complaints and incidents reported in NIAS, as well as incidents reported from other HSC Trusts, continued to be considered at the weekly Rapid Review Group meeting to determine if they met SAI criteria. She added that every SAI was coded to a NIAS or regional SAI theme.

Ms Boylan acknowledged that the continued REAP 4 level had presented challenges to information gathering and said that she had engaged with family members to make them aware of the difficulties. She noted that a number of SAI reports were currently with families for consideration and it was hoped that they would be in a position to provide feedback on these in the coming weeks.

With regard to learning from SAIs, Ms Boylan pointed out that this was discussed at the Trust's Learning Outcomes Group meeting. She acknowledged that the Trust was not yet in a sufficiently robust position to audit the implementation of the learning but said that this remained the intention. Ms Boylan alluded to work to be undertaken around ECG recognition and added that the current REAP level had resulted in CSOs being unable to undertake the necessary audits of PRFs.

Mr Bloomfield referred to the increase in NIAS reported incidents in 2019/20 followed by a sharp reduction in 2020/21 and asked if there was any explanation as to why this may have happened.

Ms Boylan suggested that the increase may have come about as a result of work undertaken around the importance of reporting incidents through Datix and an increased focus on using that reporting system.

Ms Keating pointed out that the Datix system had been overhauled at that time and staff had received training on its use. She added that the Trust had also introduced policy and procedures around SAIs at that time and suggested that these factors may have contributed to the increase in reported incidents.

Agreeing with these points, Dr Ruddell was of the view that there were more robust arrangements in place to ensure greater staff understanding of the SAI process. He referred to the weekly Rapid Review Group meetings and said that a collective decision was now made as to whether a complaint/incident met the SAI criteria rather than such decisions being considered by an individual.

The Committee Chair asked whether the Learning Outcomes Group had been impacted by Covid-19.

Responding, Ms Boylan confirmed that the Group continued to meet and said that, where necessary, actions had been taken.

Mr Bloomfield explained that the Rapid Review Group also considered key pieces of work and the immediacy of actions while the Learning Outcomes Group considered actions on more of a long-term basis.

Mr Sowney commended the robust arrangements which had been put in place. He asked how the Trust could measure the learning which had taken place and the improvements made as a result. He also alluded to Ms Boylan's earlier reference to the resources required to progress learning and suggested it would be important for the Trust Board and Committee to be assured that learning from complaints and SAIs was routinely identified and taken forward with a view to reducing SAIs and any harm coming to patients. Mr Sowney said that this was not clear and suggested that, if the issue related to resources, the Trust should address this in order to provide the relevant assurance to the Trust Board and Committee.

Mr Sowney referred to the reliance on Patient Report Forms (PFRs) when investigating SAIs. He commented that, in the past, there had

been a significant percentage of incomplete PRFs and asked if this position had improved and what arrangements had been put in place at station level.

Mr Sowney also referred to the continued REAP 4 level and the difficulty for staff in accessing e-mail during pressured shifts. He sought clarification on what steps had been taken to ensure information was disseminated to and accessed by staff. Mr Sowney commended Ms Boylan on arranging to meet with managers on a weekly basis and acknowledged the challenges this presented given the current pressures.

Ms Boylan acknowledged the difficulty in collating the necessary information to present at the weekly Rapid Review Group meetings and said she had arranged to meet with the Duty Control Manager on a weekly basis to discuss the information.

Mr Sowney said it would be important to prioritise this work irrespective of REAP 4 and the associated pressures.

Mr Bloomfield indicated that the Rapid Review Group had been effective in making early decisions around the de-escalation of SAIs and said that it was likely, given the recent response times, that there would be further SAIs within the service. However he emphasised the importance of pursuing the learning arising from SAIs.

Referring to the gaps in timelines, Ms Keating advised that the Trust would receive incidents for investigation from the PSNI, NIPSO, RQIA, coroners, elected members and other Trusts and added that, on occasions, these were not received in a timely manner leading to delays in progressing the investigation.

In relation to Mr Sowney's point about incomplete PRFs, Ms Boylan said she hoped the position had improved and said that the non-completion of PRFs would be rare but acknowledged the importance of undertaking an audit to confirm this was the case. Continuing, Ms Boylan accepted that staff did not always have an opportunity to check e-mails and she alluded to the use of the staff WhatsApp group.

Dr Ruddell explained that CSOs had previously undertaken audits of PRFs on a regular basis but that Covid-19 and recent pressures

had resulted in CSOs being returned to frontline duties and focussing attention on management of students. He acknowledged that the REACH project would significantly assist in the governance around the completion of PRFs.

Mr Sowney agreed with the comments made by Dr Ruddell and accepted that actions needed to be taken to address these gaps and provide assurance to the Committee. He suggested that Station Officers could play a bigger role in ensuring the completion of PRFs and asked if Ms Byrne could assist in this regard in ensuring that the necessary arrangements were in place.

Concluding the discussion, Ms Charlton updated the Committee on a SAI completed in relation to a young person.

The Committee Chair thanked Ms Boylan for her attendance and she withdrew from the meeting.

10 **HART SAI Update (SC16/09/21/06)**

Dr Ruddell provided an update in relation to the SAI within the HART team and shared a copy of correspondence which clarified the position. He also outlined the process which would be followed during future equipment inspections.

The Committee **NOTED** the update.

11 **Controls Assurance Standards/Post Control Assurance Standards Arrangements (SC16/09/21/07)**

At the Committee Chair's invitation, Ms Keating explained that the purpose of the report was to update Committee members on the arrangements for assurance across the Trust. She reminded the meeting that the Permanent Secretary had advised Trusts of the withdrawal of Controls Assurance Standards (CAS) in 2018. However, Trusts had been asked to ensure adequate alternative arrangements were in place for assurance.

The Committee Chair queried how this report sat within the Trust's overall Assurance Framework. Ms Keating advised that she and Ms Paterson had commenced work to ensure that the post Control Assurance Standard arrangements dovetailed with the Framework.

The Committee **NOTED** the Controls Assurance Standards/Post Control Assurance Standards Arrangements.

12 **Medical Devices Incidents & Learning – Annual Report (SC16/09/21/08)**

Ms Keating and Mr Moore advised that the report, which was split into two distinct areas, medical devices and non-medical devices, provided an annual update on medical and non-medical device incidents and any associated learning. They highlighted the salient points of the report and indicated that, during the financial year 2020/21, a total of 429 medical device incidents were reported via DATIX (incident reporting system). The meeting noted that medical device incidents remained one of the top ten reported incidents in the Trust.

Mr Sowney referred to the fact that the number of thermometer incidents increased during the reporting period and that, during quarter four, a total of 14 thermometer incidents had been reported and, whilst not wanting to underestimate these incidents, he would be more concerned about, although smaller in number, incidents concerning ventilators, oxygen and suction units. He asked whether the Trust was aware or measured if harm came to patients as a result of equipment failures.

Mr Sowney asked, given the number of issues over time with Corpuls, whether NIAS was content and assured with the contractual arrangements.

Responding, Dr Ruddell confirmed that he was content. He further explained that if patients were harmed as a result of equipment failure, it would be reported as a Serious Adverse Incident. He noted that, in the previous year, there had been a number of incidents when defibrillators had failed to shock patients and added that there had also been occasions when Corpuls had failed. However he pointed out that, in the last quarter of the year, there had been few reports. Dr Ruddell believed that this reflected the emphasis that had been placed by Mr Moore on the servicing and monitoring of equipment.

Mr Sowney alluded to non-medical device incidents and sought clarification on whether this included the ability to undertake a VDI.

Dr Ruddell clarified that, when staff were unable to carry out a VDI, it was normal practice to record this.

The Medical Devices Incidents & Learning – Annual Report was **NOTED**.

The Committee Chair thanked Mr Moore for his attendance and he withdrew from the meeting.

13 **Complaints & Compliments: current position (SMT16/09/21/11)**

Ms Clare McVeigh, Complaints Manager, had remained for this discussion.

At the Committee Chair's invitation, Ms Charlton advised that this report focussed more on the human elements of the complaints received and reinforced the fact that behind each complaint/compliment was an individual. She also referred to the commitment given to BSO Internal Audit to resolve and close down those remaining complaints received before 2020 by the end of September.

Continuing, Ms Charlton reported that, at the June meeting of the Safety Committee, 44 complaints remained open from before 2020. She added that this had reduced to currently 20 complaints and said it was hoped that, despite the current challenges facing operational staff in terms of carrying out investigations and drafting the investigation report, this number would reduce even further. Ms Charlton said it was her hope that the work done to date would result in the outstanding IA recommendations being fully implemented.

Ms Charlton said that the Trust awaited the decision around what regional position would be adopted in relation to complaints and SAIs given the current pressures across the HSC. She cautioned against a further backlog developing and added that SMT had recently discussed contingency arrangements to avoid such a backlog recurring.

Ms McVeigh provided the Committee with a detailed overview of complaints as well as anonymised individual complaints in relation to falls, stroke and chest pain.

Mr Sowney thanked Ms McVeigh for her presentation and sought clarification whether, in relation to patients who had fallen, the standard advice had remained the same, ie not to move the patient or give them anything to eat or drink. Mr Sowney also queried whether the Clinical Support Desk (CSD) would be used to assess patients. He said that Mr Bloomfield had made reference earlier in the meeting to the fact that a significant number of PCS crews were not being utilised and he asked how the Trust could be assured that every single available resource was being utilised. Mr Sowney questioned whether there was the potential for PCS crews to be dispatched to a patient who had fallen in order to assist moving the patient to safety and reporting back as necessary. He said it would be important to provide the Committee with the assurances that everything was being done to explore the various options.

Mr Bloomfield clarified that significant numbers of VAS/PAS crews were not being utilised to their potential rather than PCS.

Responding to the points made by Mr Sowney, Ms Charlton advised that the Trust had established an internal Quality Improvement Group to explore falls responses and how this could be improved. She pointed that its membership had been drawn from Operations, Information, PPI and PCS staff. Ms Charlton said that work was also underway to explore how other ambulance services had responded to falls calls and added that other services had dedicated falls response vehicles. However, progress had been impacted by the REAP 4 context.

Ms Charlton referred to the Falls Governance Framework published by the Association of Ambulance Chief Executives (AACE) which focussed on ensuring the right treatment at the right time as well as focussing on a non-conveyance/prevention element. She said there was a recognition within the Trust that steps needed to be taken to address the Trust's response to falls.

Ms Charlton referred to November meeting of the Committee when she had shared a service user's experiences when her father had fallen and had laid on the floor for a significant period of time before an ambulance had arrived. She said that issues such as dignity and respect were fundamental and alluded to the deep impact on families when their loved ones were taken to hospital following a fall.

Continuing, Ms Charlton advised that a number of options were currently being explored including the use of Ambulance Care Attendant (ACA) staff and providing enhanced training in specialised equipment as well as using PCS staff to respond to calls within certain timescales. She acknowledged that further training would be required and said that work was being undertaken to determine whether PCS staff would only respond to a call where there was no suspected injury.

Ms Charlton acknowledged the breadth of information available around falls and indicated that for Category 3 responses to over 65 year olds who had fallen, 84% of calls received a response within the target time of 120 minutes. She advised that performance varied across the region and it was clear that those patients who waited for a response, waited significantly longer than the target. Ms Charlton said that the Trust would be engaging with Trade Union colleagues on this issue and said that PCS colleagues had expressed an interest in undertaking enhanced training to respond to a suitable cohort of patients. Ms Charlton said that the Trust was also keen to explore some collaborative work with the NIFRS and discussions were at an early stage.

Speaking as NIAS Chair, Ms Lappin said that she welcomed this development.

Mr Bloomfield indicated that SMT received a report on complaints/ compliments at its weekly meeting and discussed this in detail. He acknowledged that the extended waits experienced by elderly patients who had fallen were unacceptable.

Continuing, he referred to the pressures throughout the HSC system not least the delays in ED handover where crews were waiting 2-4 hours to handover patients. He cited the example of one crew working a 19-hour shift and said that the pressures on the system were manifesting in ambulance response times with the resultant impact on patients in the community.

Mr Bloomfield assured the Committee that he continued to share the detail of these impacts with DoH colleagues and other Trust Chief Executives as well as the Permanent Secretary and Minister who had recently attended a Trust Chief Executive meeting.

Ms Charlton emphasised the importance of being able to identify available resources outside of Division and referred to a new software system which identified all available resources and which had been recently implemented in the EAC.

Responding to an earlier question posed by Mr Sowney in relation to the advice re patients who had fallen and who remained on the floor, Dr Ruddell advised that some changes had recently been made to the advice provided. He acknowledged that the clinical aspects relied on CSD advice and said that tools were available to determine whether it was reasonable to move a patient from the floor. Dr Ruddell alluded to the 'I Stumble' tool in use. He also referred to changes which had been made in relation to letting a patient drink/eat/take medication while waiting for a response. Dr Ruddell added that some of the NIAS recommendations regarding a safe approach to this issue had been adopted nationally through the NASMED group.

Mr Sowney suggested, while the numbers would continue to suggest that too many elderly patients experienced prolonged waits for an ambulance response, it might be helpful to capture this information, ie that the changes made around CSD assessment, PCS staff assisting patients and ensuring patient received food/drink, had gone some way to reducing the impact on patients.

Ms Charlton acknowledged the challenges around CSD capacity. She said that the number of welfare checks to be undertaken was significant and placed major pressure on staff and this presented an issue with timeliness of calls.

The Committee Chair stressed the importance of looking after patients and staff and said that, as an organisation, he hoped that everything possible was being done to mitigate the effects. He referred to the welfare hubs in place at EDs and said he hoped staff found these helpful.

The Committee Chair thanked those present for their comments and the report was **NOTED**.

He thanked Ms McVeigh for her attendance and she withdrew from the meeting.

14 **Hygiene, Cleanliness and Infection Prevention and Control – Key Performance Indicators: 1 April – 31 August 2021 (SC16/09/21/12)**

The Committee Chair welcomed Ms Ruth Finn, IPC Lead, to the meeting.

By way of a presentation, Ms Finn highlighted the key points of the paper which summarised Hand Hygiene (HH), IPC E-Learning, IPC face-to-face training and Aseptic Non-Touch Techniques (ANTT) key performance indicators from 1 April to 31 August 2021.

Ms Finn explained that this particular data would be presented twice per year to the Committee for assurance and that this data would be alternated with presentation of data relating to Environmental and Vehicle Cleanliness which would be presented twice per year on an alternating basis.

Referring to the HH audit which was below the compliance standard, Mr Sowney referred to the fact that community nurses routinely carried hand sanitiser to clients' home and asked if there was any learning from this which could be used within NIAS. He asked if there was any indication that compliance rates were better amongst community nursing services.

Ms Finn advised that she and Ms Charlton had spoken to colleagues across other ambulance services to find out what steps other services were taking to improve HH compliance. She acknowledged that compliance rates had been significantly impacted by the element of 'wearing of hand sanitiser' and added that, when audit scores had been re-examined with and without this element, there had been a difference improvement in compliance levels. Ms Finn indicated that she would not be aware of compliance rates for community nursing services.

The Committee Chair noted the reduction in the numbers undertaking e-learning. In response, Ms Finn pointed out that significant numbers of staff had undertaken e-learning in year two and she acknowledged that the presentation of information did not reflect the three yearly compliance accurately.

Ms Charlton said that she would like to acknowledge Ms Finn's expertise and significant contribution and said that members would

be aware of the changes she had brought about in relation to environmental cleanliness and Infection Prevention and Control. Ms Charlton emphasised that Ms Finn's approach had been to ensure that views of staff on the ground were taken into account in progressing this work.

The Committee **NOTED** the Hygiene, Cleanliness and Infection Prevention and Control – Key Performance Indicators: 1 April – 31 August 2021.

15 **Date of next meeting**

The next meeting of the Safety Committee will take place on Thursday 25 November 2021 at 9.30am (arrangements to be confirmed).

16 **Any Other Business**

Mr Bloomfield said that references had been made throughout the meeting to the pressures within health and social care and added that the recent months had proved to be the most difficult period for the Trust since the pandemic began. He reminded members that REAP 4 had been in place since early July and that it was likely to continue for the foreseeable future.

Continuing, Mr Bloomfield noted that demand continued to increase as well as the numbers of staff having to self-isolate. He was of the view that the easing of restrictions would result in additional pressures on health and social care and expressed concern that the HSC system would likely experience a level of pressure not previously experienced.

Mr Bloomfield said it was important to highlight this to the Committee and emphasised the importance of staff health and wellbeing and staff being fit to report to work.

Speaking from a Non-Executive Director perspective, the Committee Chair said that he and his Non-Executive Director colleagues acknowledged the significant challenges facing the Trust and would be happy to support staff as best they could.

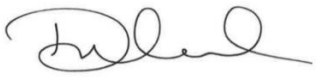
Dr Ruddell referred to the Scottish First Minister's recent comments about the Scottish Ambulance Service and the Scottish

Government's agreement to consider what assistance could be offered by the military. He said that similar discussions were ongoing locally and various options were currently being explored.

Ms Lappin advised that she would be meeting with the Chief Executive to discuss the level of input required from Directors and others to the Trust's governance arrangements and how this could be revisited in the current context.

Responding to a question from the Committee Chair about the work being taken forward on Standing Orders, Ms Lappin advised that she hoped this would come to the October Trust Board for consideration.

THIS BEING ALL THE BUSINESS, THE CHAIR DECLARED THE MEETING CLOSED AT 1PM.

SIGNED: 

DATE: 30 September 2021

Northern Ireland Ambulance Service
Health and Social Care Trust

ACTION - SAFETY COMMITTEE – 16 SEPTEMBER 2021

		INDIVIDUAL ACTIONING	UPDATE
1	Education Review – to be included as a standing item on future agenda	CM	Actioned
2	Updated Policy & Procedures on the Management of Medicines: • clarification to be provided within the policy around the Accounting Officer having responsibility for the function which had been devolved to the Medical Director; • policy to be revisited once pharmacist has been appointed	NR	
3	SAI report – examine what measures could be put in place by Station Officers to ensure completion of PRFs	RB	
4	PCS review – Committee to receive update on how PCS review would be progressed	MB	
5	Medical Devices policy: - Operations to consider how crews could be assured of time to undertake VDIs; - Provide further clarification around the statement in para 4.11 - 'Training - No Medical Devices or Medical Equipment shall be implemented into service	RB KK/SM	Updated policy to October Trust Board

	until all potential users have adequate training in its use.’		
6	Complaints/Compliments: - Capture information to demonstrate impact on patients as a result of CSD assessment; enabling patients to eat/drink/take medication	LC	

Northern Ireland Ambulance Service
Health and Social Care Trust

MINUTES OF THE PEOPLE, FINANCE AND ORGANISATIONAL DEVELOPMENT COMMITTEE HELD AT 9.30AM ON THURSDAY 8 JULY 2021 (VIA ZOOM DUE TO COVID-19)

PRESENT:	Mr J Dennison	-	Committee Chair
	Mr T Haslett	-	Non Executive Director
APOLOGIES:	Ms N Lappin	-	Non Executive Director
IN ATTENDANCE:	Mr M Bloomfield	-	Chief Executive
	Ms M Lemon	-	Interim Director of Human Resources
	Mr P Nicholson	-	Interim Director of Finance (left the meeting at 10am)
	Ms A Quirk	-	Boardroom Apprentice
	Mrs C Mooney	-	Board Secretary
	Ms R O'Hara	-	Programme Director – Workforce Planning (for agenda item 5 only)
	Mr G Plant	-	Senior HR Business Partner – Workforce Planning (for agenda item 5 only)
	Ms L Gardner	-	Assistant Director of HR (for agenda item 7 only)
	Ms A Pepper	-	Business Performance Manager (for agenda item 8 only)
	Mr J Kearney	-	Equality & PPI Officer (for agenda item 9 only)

1 Apologies & Opening Remarks

The Chair noted apologies had been received from Ms Lappin and thanked members for facilitating the rescheduled date.

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 (PC08/07/21/01)

The minutes of the previous meeting held on 22 April 2021 had been agreed by e-mail and **APPROVED** on a proposal from Mr Dennison and seconded by Mr Haslett.

4 Matters Arising (PC08/07/21/02)

The Chair referred to the actions from the previous meeting and acknowledged that a number of these were ongoing.

Ms Lemon referred the Committee to the HR Directorate Strategic Plan and described in detail how each objective within the Plan linked to the Trust's 'Strategy to Transform'. She acknowledged that, while the paper focussed on those deliverables within a one-year horizon, it also focussed on what could be delivered within a similar timeline to that of the Strategy.

Ms Lemon commented that some of the more substantive deliverables included transformation of culture; revision of Occupational Health Service (OHS); focus to reduce sickness absence on which members would receive updates during today's meeting.

She advised that, as well as progressing issues within the Trust, a number of colleagues were significantly involved in HSC workstreams which had been tasked with progressing issues on a

regional basis. Ms Lemon said that, although the Trust benefitted greatly from this involvement, officers were also required to make significant contributions to this work.

The Chair commended the detail of the Plan and said it was clear that significant work had been involved in its development. He asked whether consideration had been given to how the Trust would know if the Plan had been successful and what outcomes might be available for the Committee to consider.

Ms Lemon acknowledged that such issues were being discussed with the Planning team and said that achievement of the Key Performance Indicators (KPIs) would act as an indicator that objectives had been delivered. She undertook to bring a paper to a future meeting outlining the KPIs. Ms Lemon explained that ultimately her intention was to deliver a new model of HR which met the organisation's needs.

Continuing she acknowledged the need to undertake further work in relation to establishing a baseline as well as looking at an analytic approach. She referred to Ms Avery's presentation to a recent Trust Board meeting around business intelligence and said that consideration was being given to what a HR performance dashboard might look like. Ms Lemon suggested that such a dashboard might include, for example, information on levels of disciplinary/grievances within the Trust; indicators of leadership approach; number of complaints in relation to bullying and said that such issues were indicators of the organisational culture and potential engagement levels amongst staff. She indicated that information in relation to these areas had previously not been reported within the Trust.

Ms Lemon alluded to the engagement scores around staff surveys and said that these had not been reported until recently.

Agreeing with the points made by Ms Lemon, Mr Bloomfield reminded members that the findings of the most recent survey had made difficult reading. He suggested that it would be important to have indicators which could initially demonstrate that the direction of travel was correct. Mr Bloomfield was of the view that this would be key to getting a sense of the overall organisational culture.

Ms Lemon said it would be important to strike a balance between being able to achieve objectives in-year as well as monitoring the progression of those to be achieved in the longer term.

Ms Lemon was of the view that the process to transform organisational culture and increase levels of staff engagement would take time to achieve. She pointed out that all staff within the Trust had a responsibility towards ensuring a positive organisational culture. Ms Lemon believed that the fundamental aspect of improvement was how staff felt within the organisation and she accepted that, while staff surveys were indicators, they were not measures.

Referring to the objectives to be achieved within the short-term, the Chair asked Ms Lemon for her view on what these might be.

In response, Ms Lemon emphasised the importance of making a real difference to staff on the ground. She alluded to the leadership visits being undertaken by Directors and said that staff had raised a number of issues during these including long waits at ED and the need to continue wearing PPE as well as the need for staff to be hydrated and fed. Ms Lemon said that, as a result, arrangements had been made for vehicles or hubs to be available to staff where they could remove PPE for a short period of time and avail of water/food. She added that such actions were more tangible to staff.

Ms Lemon referred to peer support and advised that this would be further developed with the addition of a clinical psychologist and the adoption of a trauma-informed approach. She indicated that it was also important to communicate with staff and said that more effort was being made to undertake engagement through short videos, visits to stations and Zoom engagement sessions rather than issue paper directions. Ms Lemon also said that the Trust had introduced a horticultural programme which had been received positively by staff.

Mr Bloomfield commended the work which had been undertaken to date and was of the view that such initiatives would only make a difference to staff when those staff saw changes within the organisation.

Ms Lemon referred to the trauma-informed approach and suggested that the Committee might find it helpful to hear from the Clinical Psychologist about the impact such an approach has not only on the individual but also the organisation.

Mr Haslett agreed that the 'quick wins' would clearly demonstrate to staff the Trust's intention. He said that he looked forward to further updates on the culture programme and the review of OHS which, he believed, were two key elements in transforming an organisation as well as ensuring increasing safety levels.

5 **Consultation on the Personal Development Performance Review (PDPR) Policy and Procedure and to seek feedback on the proposal (PC08/07/21/03)**

The Chair welcomed Ms O'Hara, Programme Director – Workforce Planning, and Mr Plant, Senior HR Business Partner – Workforce Planning, to the meeting.

Ms O'Hara advised that, in the Trust's Strategy To Transform 2020-2026, the Trust had committed to 'providing meaningful and constructive feedback through structured appraisal and development conversations so that staff feel valued and included in the organisation's vision…'

She advised that, following agreement at SMT, the new PDPR policy and procedure proposal had been presented at JCNC on 26 May. Ms O'Hara indicated that, having elected and agreed a new staff side Knowledge and Skills Framework lead, the Trust had recently issued the documentation for consultation to seek feedback on the proposal. She indicated that engagement sessions to date around the development of the Personal Development Performance Review policy and procedure had been positive.

Ms O'Hara said it was intended to run a pilot in the autumn with a view to collating feedback on this before the system would go live in early 2022. She stressed the importance of staff knowing that any feedback had been taken into consideration and said that some documentation had already changed as a result of feedback.

Ms O'Hara explained that, following a positive meeting with Branch Secretaries, it had been agreed to proceed using critical success

factors for posts to negate the need to review and renew over 100 job descriptions.

Ms O'Hara alluded to the fact that there was an absence of a formal Organisational Development (OD) function within the HR Directorate and commented that the other Trusts against which NIAS had benchmarked had existing OD functions within their respective HR Directorates. She was of the view that this was a valuable function in terms of credibility and one which the Trust would continue to evaluate.

Continuing, Ms O'Hara said that, when running the pilot and at the point of implementation, it would be important to take account of the need for frontline staff to prepare for their appraisals. She indicated that consideration was currently being given to how best to work through this with Operational managers. Ms O'Hara said if preparatory time was not possible, it would be important to fully explain to staff the reasons behind such a decision. Ms O'Hara said that the Trust was working closely with the Yorkshire Ambulance Service which, in the context of Covid-19, had changed its appraisal system to consist of three questions. She acknowledged that the future was unclear in terms of how Covid-19 might impact upon the service and subsequently the timeframes for the pilot and implementation of the Scheme could also be impacted.

The Chair commented that it was clear that both the KSF and the PDPR were inextricably linked and noted the absence of this on the flowchart contained within the documentation. He sought clarification on why this was the case.

Mr Plant explained that the KSF was within the PDPR project plan. He clarified that Trade Union colleagues were of the view that it should be an integral part of the process. He advised that, as a result of the collaboration between the Trust and Trade Unions, it had been agreed that a streamlined version could be used. Mr Plant said that, through networking with other Trusts, NIAS had obtained a template which was the equivalent to approximately ten post outlines. He added that this template would help in simplifying the process and would be used for the pilot.

Ms O'Hara explained that, following positive discussions with Trade Union colleagues, KSF was now an integral part of the appraisal system. However, she emphasised the importance of staff having a

positive experience when progressing through the appraisal system and said it would be important that staff did not focus on the KSF element.

Mr Haslett referred to the staff perspective of the scheme and sought clarification on how it was presented to staff.

Responding, Ms O'Hara said that, in the past, appraisals tended to be used for staff to seek agreement to undertake development programmes. She referred for the need for Personal Development Plans (PDPs) to be realistic and acknowledged that it was likely that there will be aspirations from staff in relation to their development. Ms O'Hara indicated that, if it was not possible to meet staff aspirations, it would be important to provide the reasons as to why.

Ms O'Hara said she hoped that the introduction of the PDPR programme would assist in bringing about cultural change throughout the organisation. She clarified that KSF focussed on staff providing evidence to their line manager on how they performed their job while the appraisal discussion focussed more on providing support to staff and managers to ensure they performed to the optimum level.

Mr Bloomfield pointed out that both the Committee Chair and Mr Haslett were currently members of the Remuneration Committee and said that the appraisal process in place for Directors was much more robust than for other staff. He stressed the importance of staff viewing the appraisal system as a valuable opportunity for them to raise any concerns they may have as well as providing managers with the opportunity to give feedback on performance.

Ms Lemon acknowledged that the action of managers meeting with staff to undertake the appraisal would be a significant cultural shift within the Trust and would be hugely important from that perspective.

The Chair referred to the consultation process and sought clarification around the timescales involved.

In response, Ms O'Hara welcomed any comments members may have on the documentation. She advised that the consultation had commenced in June and would close in July with a view to commencing the pilot in the autumn. However she said that a

decision would be taken in July on whether there was a need to extend the consultation period. She added that work was also ongoing in relation to a communications strategy.

The Committee **NOTED** the Consultation on the Personal Development Performance Review (PDPR) Policy and Procedure.

Before they withdrew from the meeting, the Chair thanked Ms O'Hara and Mr Plant for their presentation and said he looked forward to further updates.

6 **Financial Update**

Mr Nicholson advised that he planned to provide a verbal update today following on from the detail provided at the last People Committee and the subsequent Trust Board meetings.

He reminded the meeting that the Trust's Financial Plan had been presented to People, Finance and Organisational Development Committee on 22 April 2021 and approved by Trust Board on 24 June 2021. He advised that there had been minimal formal Revenue Resource Limit (RRL) adjustments received since then and said that the Trust continued to engage with HSCB, in particular in relation to the business case process that was required in order for the funds to be released.

Continuing, Mr Nicholson indicated that of note in the discussions to date was that the original savings requirements of £2.6 million may be reduced marginally. However, he said, other significant areas remained in relation to Covid-19, Agenda for Change (AfC), regrading, pay pressures and Community Paramedics.

Mr Nicholson explained that financial reporting was minimal for the first two months of the year as the focus was on the completion of the Annual Report and Accounts. He indicated that the Trust was currently working on producing the Month 3 Trust Monitoring Returns and associated Management Accounts Information.

Mr Nicholson reported that the operational pressure had continued in 2021-22 and had continued to translate into expenditure. He added that the reliance on Independent Ambulance Providers remained significant as did reliance and expenditure on overtime.

Mr Haslett acknowledged the financial pressures across the public sector and sought clarification in relation to the general view on available budgets and finance.

Mr Bloomfield advised that the focus of recent regional meetings had been on finance, in particular how best to release additional monies to undertake various pieces of work. He alluded to the work being progressed through No More Silos and which members had been briefed on and said that bids totalling £27 million had been received against available funding of £13.5 million.

Mr Bloomfield advised that Trusts were currently considering how to address their respective in-year positions with underlying deficits. He reminded the meeting that the Trust was required to identify savings of £2.6 million and added that other Trusts' savings requirements were more significant because their budgets were larger. Mr Bloomfield indicated that the allocation of additional funding was a matter for the NI Executive.

Mr Haslett agreed that the need for additional funding was a significant issue across the public sector.

Mr Bloomfield said that it was his understanding that, moving forward, Committee meetings would alternate between finance and human resources.

The Chair was of the view that it would be important to identify the Committee's priorities in the first instance as well as agreeing what financial information needed to be brought to the Committee. He added that this might necessitate a change in the Committee schedule.

It was agreed that Committee members as well as Mr Bloomfield, Mr Nicholson and Ms Lemon, would discuss this further.

Mr Haslett confirmed that he had been asked to chair the Committee when it met to consider finance and added that his preference would be to focus on the current schedule.

The Chair thanked Mr Nicholson for his update which was **NOTED** by the Committee.

Mr Nicholson left the meeting at this point.

7 **Attendance Management – June 2021 Update (PC08/07/21/04)**

By way of introduction, Ms Lemon reminded the meeting that a key objective of the Trust was to reduce sickness absence and said that Ms Gardner would outline a number of steps being taken by the Trust in this regard. Ms Lemon emphasised that work had commenced on developing better analytics and baseline information highlighting the importance of this in demonstrating outcomes.

The Chair invited Ms Lorraine Gardner, Assistant Director HR, to provide her update to the Committee.

Ms Gardner commenced by providing a context to the 2020-21 reporting year, specifically referencing management of the Trust's response to Covid-19 and Covid-related absences. She then highlighted the salient points of the report which provided information on current sickness absence levels and comparative figures within the Trust for 2019-20 and 2020-21 as well as figures for comparison purposes within the HSC. Ms Gardner detailed the measures which had been put in place to deliver improvements in attendance levels; detailed the impact of such measures on the Trust's attendance management figures and outlined priorities for 2021-22 including the introduction of a revised HSC Framework for the Management of Attendance which would introduce a focus on prevention and sustaining attendance at work. Ms Gardner said she would welcome the Committee's view on what information it would like to see at future meetings.

The Chair welcomed the proactive approach adopted by the Trust as well as the support offered to staff. He referred to the fact that the cumulative absence figure in 2019-20 was 10.49% and said this had reduced to 8% in 2020-21, resulting in a reduction of 2.49%. The Chair indicated that this had not included Covid-19 figures and asked whether this had skewed the figures.

Ms Gardner acknowledged that the Trust had started to examine this in detail and said that evidence, at this stage, would suggest that those staff off work due to Covid-19 were usually those who would not be off long-term. Therefore the reduction achieved may not be significantly skewed. She indicated that further analysis should provide better certainty in this regard.

The Chair enquired if there was any analysis around how those staff returning to work had felt the Trust had supported them.

Responding, Ms Gardner acknowledged that, while there was no current analysis, the intention was to undertake measures to improve the 'employee experience' in the workplan moving forward and to bring a focus on supporting staff to remain in work following a return.

Ms Lemon referred to the significant amount of work ongoing in this area. She said she recognised that very often those staff absent from work felt vulnerable and said that the Trust was giving consideration to the content of letters issued to those on sickness absence to ensure a compassionate approach.

The Chair reminded members of Ms Gardner's request for members to give consideration to the types of information the Committee might wish to see.

Mr Haslett commended the comprehensive nature of the information provided within the paper and agreed with the Chair's point around the importance of return to work interviews. He said he was uncertain whether the exclusion of Covid-19 figures had portrayed a more positive representation than was the case and thought that absences would have been significant during the pandemic.

Ms Gardner accepted that further detailed examination was needed.

The Chair queried whether the figures covered frontline staff only and suggested that, when examining absence figures, it might prove interesting to consider roles and geographical locations as well.

The Chair welcomed the progress and detail within the report and thanked Ms Gardner for her presentation which was **NOTED** by the Committee.

8 **Occupational Health Improvement Plan (PC08/07/21/05)**

The Chair welcomed Ms Amy Pepper, Business Performance Manager, to the meeting.

By way of introduction, Ms Lemon reminded members that the HR Strategic Plan and the Trust's Strategic Plan had both referenced the need for the Trust to review its occupational health service.

Ms Pepper drew the Committee's attention to the paper providing an update and outlined for the Committee the recommended steps for action, namely:

a) To secure assurance of continuation of service delivery beyond 31 March 2021;
b) To commission OHS services within Contract regulation requirements:
    i. Establishment of NIAS policy & procedure for commissioning of services
c) To monitor delivery, evidence need and outcome impact of service commissioned;
d) To establish a Key stakeholder group to informed service development and ongoing management;
e) To communicate with staff and points of referral OH services and support available

Ms Pepper advised that a phased approach would be adopted to progress this work. She outlined the timescales for each element and described the progress made to date, including the establishment of monthly finance reports and monitoring returns around the OHS being provided; commencement of monthly 1:1 monitoring meetings with OHS providers; the development of an information/data gathering dashboard in-house as well as building relationships with the OHS providers. Ms Pepper advised that a draft Memorandum of Understanding was currently with the BHSCT for consideration and if the Trust was in agreement with its content, it was hoped that this would be signed off in the coming months. She added that this would also allow the BHSCT to be included within the procurement process.

Referring to the financial aspects of the work, Ms Pepper cautioned that the review of OHS may not necessarily reduce expenditure on OHS but there would be absolute clarity in terms of where the resources were being allocated and ensuring that the Trust received value for money against its expenditure. Ms Pepper explained that current practice meant that all providers were on an equal footing in terms of providing OHS. She explained that any referrals for OHS should be directed to the BHSCT in the first instance and if the Trust

was unable to provide the service in a timely manner, then the Trust could look to alternative providers.

Responding to a query from the Chair around the timescales for the procurement of OHS, Ms Pepper said it was hoped that this would be concluded by April 2022.

Ms Lemon advised that a number of aspects of the review of OHS could be progressed in-year while other aspects would be achieved on a more longer-term basis.

Mr Haslett referred to page 5 of the report and sought clarification on a number of points.

In response, Ms Pepper reminded the meeting that the Trust did not have any in-house services and confirmed that the current average monthly spend represented expenditure with other OHS providers. She explained that the providers listed in the tabled were independent providers with whom NIAS had commissioned services on an ad hoc basis since November 2019.

Mr Haslett sought clarification on the likelihood that costs would increase as a result of progressing the action plan.

Ms Pepper confirmed that it was not clear, at this point, whether expenditure would increase and explained that work was ongoing to develop a needs analysis. She indicated that the focus of OHS should be to maintain a healthy workforce.

Responding to a request from Mr Haslett to identify any impediments which might prevent the Trust from achieving the Gold standard to which it aspired, Ms Pepper suggested that a significant impediment might be resources.

Mr Bloomfield said it was his understanding that the only funding identified in the Trust baseline was £98,000 to the BHSCT and said that Mr Nicholson had identified substantial additional funding over the last number of years to meet the need. Mr Bloomfield clarified that the Trust currently spent approximately £300,000 on OHS services and said he had no doubt that further resources would be required in addition to those already identified in the Trust baseline. He said that he hoped the Trust would be able to put a better value for money contract in place for such funding.

The Committee **NOTED** the update on the Occupational Health Improvement Plan.

The Chair thanked Ms Pepper for her update and attendance and she withdrew from the meeting.

9 **NIAS Culture Programme - #Proud to work for NIAS (PC08/07/21/06)**

At the outset, Mr Kearney expressed his personal thanks to Ms Lemon, Ms O'Hara and Mr Bloomfield for leading by example in terms of engagement, compassion and focussing on outcomes. He conveyed his appreciation that the Trust Board had supported the focus of the culture work and said it was important to focus on realities. Mr Kearney referred to the £2.6 million efficiency savings to be achieved by the Trust. He mentioned the 2,700 staff contacts with peer support, 29% of which were following assaults on staff. He said that, while the Trust could provide the support to staff at such times, it could not stop the assaults taking place.

Mr Kearney outlined the programme being undertaken and explained that it had three distinct phases, namely:

- Discovery – diagnosis to discover the culture of the organisation;
- Design – development of a programme to chance the workplace culture entitled 'Proud to work for NIAS' and
- Delivery – implementation of 'Proud to work for NIAS' culture programme.

Mr Kearney drew the Committee's attention to the action plan which had evolved from documentation and the staff engagement process and said that the plan focussed on what had to be done in order to make a difference. He advised that a number of changes had already been implemented as a result of staff engagement undertaken and he briefly described these to the meeting.

Continuing, Mr Kearney said that a key driver within the organisation in terms of health and wellbeing had been the engagement partnership between NIAS and UNISON launched a few years previously. He was of the view that, when considering measurements of change, it would be important to look at qualitative as well as quantitative matrices. Mr Kearney said it would be

important that members would view the prospective changes as an evolving process, for example, considering progress through focus groups and how it progressed through qualitative assessments of work.

Ms Lemon emphasised the importance of Mr Kearney's comments and referred to the consistent 'thread' that permeated today's Committee agenda in terms of the culture, compassionate leadership and recognising and valuing the workforce. She acknowledged that the review of the Operational management structure and the Education Review being led by Ms Byrne and Dr Ruddell respectively would be helpful in ensuring that culture was embedded in the organisation. Ms Lemon accepted that further work was needed and she referred to the culture dashboard which was based on the culture assessment tool and which provided the basis from which to progress this work.

Mr Bloomfield stressed the importance of this programme of work and was of the view that, until significant progress had been made in this area, other programmes of work would only have a marginal impact. He referred to peer support which had started as a reasonably small service and one which was very much valued by staff. Mr Bloomfield acknowledged the complexity of the work undertaken by peer support and said that the Trust's focus on ensuring the continuation of this service had helped signal to staff the importance of its workforce.

He said that he would be keen for the Committee to focus on this programme of work and provide challenge to ensure that the work was progressed.

The Chair sought clarification around what the outcomes might look like and acknowledged that the nature of the work did not lend itself to quantitative analysis.

In response, Mr Kearney referred to the action plan which had been developed as a result of the methodology and engagement approach and said that this should result in the delivery of the objectives having a positive impact, based on the existing science behind culture and OD transformation. In terms of measurement, Mr Kearney acknowledged that this was very much ongoing and suggested that, rather than set narrow targets, the change in culture should potentially be felt and measured across the organisation in

terms of, for example, attendance management, health and wellbeing, feedback from those staff on leadership courses.

Ms Lemon said it would be important to accept that organisational culture would take time to embed. She indicated that the culture dashboard represented the baseline based on the staff survey and the cultural assessment tool and that, over the next number of years, the scale would begin to look different.

The Chair thanked Mr Kearney for his attendance and said that, while he appreciated this was work in progress, he looked forward to receiving further updates.

The Committee **NOTED** the update on the NIAS Culture Programme. Mr Kearney withdrew from the meeting at this point.

10 **Date of next meeting**

The next meeting of the People Committee will take place on Thursday 30 September 2021 at 10am (arrangements to be confirmed).

Consideration would be given to face-to-face meetings if permitted.

11 **Any Other Business**

Closing the meeting, the Chair confirmed that there were no items of Any Other Business. He commented that it was clear there was a significant amount of work being progressed with a great sense of commitment and enthusiasm. He acknowledged that, while further work remained to be done, the fundamentals were already there to build upon. Commending all involved, the Chair welcomed the positive updates provided to the Committee and said he looked forward to receiving further updates.

THIS BEING ALL THE BUSINESS, THE CHAIR DECLARED THE MEETING CLOSED AT 12.00PM.

SIGNED: 

DATE: 20 September 2021

Northern Ireland Ambulance Service
Health and Social Care Trust

‘PEOPLE’ COMMITTEE REPORT TO TRUST BOARD 21/10/21

The People, Finance and Organisational Development Committee met on Thursday 30 September 2021.

The focus of the Committee at this meeting was on financial matters.

Issues discussed included:

1	• Financial reporting The Committee discussed in detail the structure and format of future financial reporting both to the Committee and to Trust Board.
2	• Financial updates The Committee received updates on the following areas: - Financial Plan 2021-22 - Use of Voluntary & Private Ambulance Providers - Use of HSC Leadership Centre Associates - Use of Staff Substitution - Use of Overtime - Capital programme 2021-22

Northern Ireland Ambulance Service
Health and Social Care Trust

AUDIT COMMITTEE REPORT TO TRUST BOARD

The Audit Committee met on Thursday 7 October and I would like to bring the following issues to the attention of the Board in advance of the formal minutes.

1.	**<u>Outstanding Internal Audit Recommendations</u>** In light of a year-end Limited Assurance received from the Head of Internal Audit for 2020/21 a decision was made by the Committee to put in place regular meetings between management and Internal Audit and including myself as Chair of the Committee to advance the implementation of the outstanding Internal Audit recommendations. I can advise that a number of meetings have been held and good progress is being made despite on-going pressures on the service. In order to sustain focus on this area the Committee decided at its meeting on 7 October 2021 to schedule an extraordinary meeting in early December to receive further updates from the relevant Directors on the Internal Audit recommendations which are still outstanding. The Chair of the Board has also been invited to attend this meeting. The Head of Internal Audit gave a mid-year update on the implementation of outstanding Internal Audit recommendations. It was reported that 68% (135 recommendations) have been 'Implemented' or are regarded as 'No Longer Applicable'. It was reported that 32% (63 recommendations) are deemed as being 'Partially Implemented'. It should be noted that no recommendations have been classified as being 'Not Implemented'. The Committee noted that the assessment of the Head of Internal Audit was based at times on verbal assurances rather than evidence presented. This aspect will be further explored at the extraordinary Audit Committee meeting planned for December.
2.	**<u>Direct Award Contracts</u>** The DAC Register was presented and reviewed by the Committee.
3.	**<u>Fraud Update</u>** The Committee was given a verbal fraud update and advised that the Business Services Organisation will assume the lead role in preliminary investigations relating to fraud.

4.	**Internal Audit Progress Report** Internal Audit reported on an audit undertaken in relation to Fire Safety and advised the Committee that they were giving a Satisfactory level of assurance in this area. It was noted that this is the first time that Internal Audit have reviewed this area and that the audit highlighted 5 key findings (all Priority 2s). Internal Audit also advised on an audit relating to Accounts Payable Shared Services, which had received a Satisfactory level of assurance.
5.	**Internal Audit General Report 2020/21** The Head of Internal Audit presented the Internal Audit General Report for 2020/21 to the Committee.
6.	**Report to Those Charged with Governance 2020/21** The Report to Those Charged with Governance issued to NIAS by the NI Audit Office on 30 September 2021 was noted. I would highlight that the Public Funds received a qualified audit opinion on the accounts with the Charitable Trust Funds receiving an unqualified audit opinion.
7.	**Standing Orders and Scheme of Reservation and Delegation** Amended Standing Orders and Scheme of Reservation and Delegation were presented to the Committee for review and recommendation of approval to the Board. A number of changes were brought to the attention of the Committee and I would highlight the following: • **Page 42 – Section 4.8 Committees Established by the Trust Board –** *This section documents the review of the Committee structure of the Board and the Terms of Reference for each Committee is included at Section D of the document.* • The Audit Committee will assume an increased role in relation to risk assurance and will be known as the Audit and Risk Assurance Committee. • **Page 50 – Section 6.1 Policy Statements: General Principles – The Trust Board will determine an appropriate mechanism for the formal approval of policies and procedures**. *It is intended that the approval of Policies will rest with the relevant Committee of the Board and recorded appropriately in the minutes. A Policies Register will be established and presented to the Board on an annual basis. The relevant Committee may at any time decide to escalate the approval of a policy to the Board for appropriate reasons. It was noted that there may still be a need for regional policies to be approved by the Board.* **The Committee recommend approval by the Board of the Standing Orders and Scheme of Reservation and Delegation subject to a number of minor changes.** It should be noted that the Standing Orders and Scheme of Reservation and Delegation will be reviewed after one year to take into consideration any further changes in context.

8.	**<u>DoH Correspondence dated 24 September 2021</u>** The Committee noted DoH correspondence dated 24 September 2021 advising the Trust of a further pause on sponsorship and governance activities due to on-going pressures across the system.

Submitted By:

William Abraham
Chair of Audit Committee

Northern Ireland Ambulance Service Health and Social Care Trust

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