# Northern Ireland Ambulance Service
Health and Social Care Trust

# annual**report** 2010/11

HSC Northern Ireland Ambulance Service
Health and Social Care Trust

## MISSION

*"To deliver effective and efficient care to people in need and improve the health and well-being of the community through the delivery of high quality ambulance services. "*

## VISION

*"An Ambulance Service contributing to a safer community and a better quality of life in Northern Ireland through first class "out of hospital" emergency, non-emergency and disaster services."*

## COMMITMENT TO EQUALITY

The Northern Ireland Ambulance Service is committed to the promotion of equality of opportunity and good relations in fulfilment of its duties under Section 75 of the Northern Ireland Act 1998 and other equality legislation.

## CORE VALUES

### Quality
We will work to the highest possible standards in all our endeavours, evaluating and monitoring, to maximise effectiveness and basing decisions on the best available research and benchmarking information.

### Respect
We will always treat people with dignity and consideration and expect our staff to be treated in a similar way.

### Integrity
We will be reliable and honest in the way we deliver our service.

### Accessibility
We will provide service based on clinical priority, where it is needed, to those who need it, when they need it.

### Confidentiality
We will be open in all our dealings while ensuring that absolute confidentiality of patients' clinical information is maintained.

### Service Excellence
We will be responsive to the changing needs of our patients through teamwork, communication and collaboration.

### Collaboration
We will work closely with other providers of health and social care in both statutory and voluntary sectors and establish effective co-ordination of work with other emergency services.

### Governance
We will adhere to the principles of accountability and probity, which underpin public service

# Northern Ireland spends less than 10p per person per day on its Ambulance Service!



## The Ambulance Service touches lives at times of basic human need when care and compassion are what matter most.

# Contents

# Chairman's Preface

In my preface to last year's annual report I forecast that the challenges facing the Northern Ireland Ambulance Service Trust would be tougher in 2010-11 and on into the foreseeable future. This has certainly proved to be the case. Demand for ambulance services and, in particular emergency 999 calls, has continued to increase significantly while budgets have been further reduced. During 2010-11 we completed the 3rd year of planned efficiency savings and, on top of this, an additional budget reduction was imposed. Despite this the Trust has achieved a financial break-even position, which represents a very consistent and creditable performance within very stringent financial constraints.

Performance on response times to emergency calls slipped a little during the year. This was principally due to December being a very difficult month which carried over into the early part of the new year. December saw a prolonged period of snow and ice, particularly over the holiday period, which made driving conditions in all areas extremely hazardous. At this point I must give credit to front-line staff, control room operators and back-up operations and administration staff who collectively ensured that we continued to provide the best possible service in extreme weather conditions.

I am also pleased to report that much effort has gone into making up for the lost ground during mid-winter and that service levels towards the year-end in March had improved to the highest levels for the year. It is an on-going process which requires much effort from all staff to continually review how best to improve service levels for emergency, urgent and patient care transport systems in order to meet ever increasing demand with increasingly limited resources.

The review of the governance arrangements for the service was completed during the year. This saw the merger of the Clinical Governance and Risk Management Committees into a single Assurance Committee, which dovetails with the Audit Committee to provide the necessary pillars of financial and non-financial assurance to the Trust Board. In December we welcomed two new Non Executive Directors to the Board. Miss Angela Paisley replaced Mr Frank Hughes and Mr Sean McKeever replaced Mr Seamus Mullan. I am very grateful for the service provided by the two retiring members who had each completed two terms and also chaired the Risk Management and Audit Committees respectively. My best wishes go to the new members, both bringing wide experience over many years within health and social care.

I had the privilege of attending two Long Service Medal ceremonies during the year. In total one hundred staff received awards for completing twenty years service or more and they were presented with their medals by Dame Mary Peters, Her Majesty's Lord Lieutenant for Belfast. It was a delight to have the opportunity to speak to highly dedicated staff who have provided such long service and in particular to meet the wives, husbands and partners who have an equally important role to play in facilitating staff who often have to work late at night, at weekends and during holiday periods, to cover the round-the-clock service we provide.

Finally, a word of thanks and appreciation to all staff in the Trust who collectively provide vital and professional services for the people of Northern Ireland.

**Paul Archer**
**27 June 2011**

# NIAS Organisational Overview

The Northern Ireland Ambulance Service (NIAS) was established by the Northern Ireland Ambulance Service Health and Social Services Trust (Establishment) Order (Northern Ireland) 1995 as amended by the Health and Social Services Trusts (Establishment) (Amendment ) Order (Northern Ireland ) 2008 and the section 1 of the Health and Social Care (Reform) Act (Northern Ireland ) 2009.

NIAS responds to the needs of a population in Northern Ireland in excess of 1.7 million people in the pre-hospital environment. It directly employs over 1,100 staff, across 57 ambulance stations/deployment points, two Ambulance Control Centres (Emergency and Non-Emergency), a Regional Training Centre and Headquarters. NIAS has an operational area of approximately 5,450 square miles, serviced by a fleet of over 300 ambulance vehicles. We provide ambulance care, treatment and transportation services to the people of Northern Ireland twenty four hours per day, seven days per week, and three hundred and sixty five days per year.

## *The ambulance services we provide are:*

- Emergency response to patients with sudden illness and injury;
- Non-emergency patient care and transportation. The journeys undertaken cover admissions, hospital outpatient appointments, discharges and inter-hospital transfers;
- Specialised health transport services;
- Education and training of ambulance professionals;
- Planning for and co-ordination of major events, mass casualty incidents and disasters;
- Support for community based first responder services; and
- Community education.

# Trust Board

The Trust Board is made up of six Non-Executive Directors, and five Executive Directors. The Trust Board meets bi-monthly (usually on a Thursday) in public venues across Northern Ireland and an annual general meeting is held in September. Arrangements for public meetings are published in the local press and Trust website to encourage public attendance and the agenda is widely circulated.

## *The Trust Board members are:*

### *Non-Executive Directors*

| | |
|---|---|
| Mr Paul Archer | Chairman |
| Mr Frank Hughes | Non-Executive Director (to Nov 2010) |
| Mr Seamus Mullan | Non-Executive Director (to Jul 2010) |
| Professor Mary Hanratty, CBE | Non-Executive Director |
| Mr Seamus Shields | Non-Executive Director |
| Mr Norman McKinley | Non-Executive Director |
| Ms Angela Paisley | Non-Executive Director (from Dec 2010) |
| Mr Sean Mc Keever | Non-Executive Director (from Dec 2010) |

### *Executive Directors*

| | |
|---|---|
| Mr Liam McIvor | Chief Executive |
| Mr Brian McNeill | Director of Operations |
| Doctor David McManus | Medical Director |
| Mrs Sharon McCue | Director of Finance and Information Communications Technology |
| Ms Roisin O'Hara | Director of Human Resources & Corporate Services |

Non-Executive Directors form the membership of the three Trust Board Committees:

### *The Remuneration Committee*

This committee makes recommendations to the Trust Board on remuneration, terms and conditions of service of the Chief Executive and Directors.

### *The Audit Committee*

This committee provides assurance of effective internal financial controls including the management of associated risks.

### *The Assurance Committee*

This committee provides assurance of effective controls in non-financial matters including the management of associated risks.

## *Membership and attendance is summarised below:*

TRUST BOARD

| Non-Executive Board Members | 29/04/10 | 27/05/10 | 01/07/10 | 23/09/10 | 25/011/10 | 20/01/11 | 24/03/11 |
|---|---|---|---|---|---|---|---|
| MR P ARCHER | √ | √ | √ | √ | √ | √ | √ |
| PROF M HANRATTY | √ | √ | √ | √ | Apol | √ | √ |
| MR S MULLAN | √ | √ | √ | Term Ended | | | |
| MR F HUGHES | √ | √ | √ | √ | √ | Term Ended | |
| MR N McKINLEY | √ | √ | √ | √ | √ | Apol | √ |
| MR S SHIELDS | √ | √ | √ | √ | √ | √ | √ |
| MS A PAISLEY (from 1 December 2010) | | | | | | √ | √ |
| MR S McKEEVER (from 1 December 2010) | | | | | | √ | √ |

EXECUTIVE BOARD MEMBERS

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| MR L McIVOR | √ | √ | √ | √ | √ | √ | √ |
| MS R O'HARA | √ | √ | Apol | √ | √ | √ | √ |
| MRS S McCUE | √ | √ | √ | √ | √ | √ | √ |
| DR D McMANUS | √ | √ | Apol | √ | √ | √ | √ |
| MR B McNEILL | √ | √ | Apol | √ | √ | √ | √ |

REMUNERATION COMMITTEE

| Non-Executive Board Members | 12/10/10 | 30/03/11 |
|---|---|---|
| MR P ARCHER | √ | √ |
| MR S SHIELDS | √ | √ |
| MR N McKINLEY (to 1 July 2010) | √ | Term Ended |
| MR F HUGHES | √ | Term Ended |
| MS A PAISLEY (From 1 December 2010) | | √ |

ASSURANCE COMMITTEE

| Non-Executive Board Members | 20/05/10 | 22/09/10 | 28/01/11 |
|---|---|---|---|
| PROF M HANRATTY | √ | √ | √ |
| MR F HUGHES | √ | √ | Term Ended |
| MR S MULLAN | Apol | Term Ended | |
| MR N MCKINLEY (from 1 July 2010) | | √ | √ |
| MS A PAISLEY (from 1 December 2010) | | | √ |
| MR S MCKEEVER(from 1 December 2010) | | | Apol |

AUDIT COMMITTEE

| Non-Executive Board Members | 20/05/10 | 16/06/10 | 22/09/10 | 28/01/11 | 21/03/11 |
|---|---|---|---|---|---|
| MR S MULLAN | √ | √ | Term Ended | | |
| PROF M HANRATTY | | √ | √ | √ | √ |
| MR N MCKINLEY | Apol | √ | √ | √ | √ |
| MR S SHIELDS | √ | √ | √ | √ | √ |
| MR S MCKEEVER (from 1 December 2010 | | | | Apol | √ |

## *Audit & Assurance*

A declaration of board members interests has been completed and is available on request from the Chief Executive's Office, Northern Ireland Ambulance Service, Knockbracken Healthcare Park, Saintfield Road, Belfast, BT8 8SG.

The responsibility for audit of the Trust rests with the Northern Ireland Audit Office and was delivered by KPMG. The accounts include a non-cash charge of £20,094 for the statutory audit of the 2010/11 annual accounts (Public and Charitable Funds). During the year, an additional amount of £2,184 was paid to Northern Ireland Audit Office for work carried out on the National Fraud Initiative. This is reflected within miscellaneous expenditure in note 4.1 to the accounts. No other audit or non audit services were provided in 2010/11.

All directors have confirmed that, to the best of their knowledge,

- There is no relevant audit information of which the Trust's auditors are unaware.
- They have taken steps as directors in order to make themselves aware of any relevant audit information and to ensure that auditors are aware of that information.
- The Chief Executive and relevant committees have confirmed that the Trust's auditors have been made aware of any relevant audit information available.

The Trust is not aware of any significant personal data related incidents during 2010/11.

A full Statement on Internal Control (SIC) is included as part of the full accounts which are also available on request from the Director of Finance at The Northern Ireland Ambulance Service, Knockbracken Healthcare Park, Saintfield Road, Belfast, BT8 8SG. The full accounts will also be made available on the Trust website (www.niamb.co.uk.)

## *Equality & Good Relations*

The Northern Ireland Ambulance Service is committed to the promotion of equality of opportunity and good relations in fulfilment of its duties under Section 75 of the Northern Ireland Act 1998 and other equality legislation.

In compliance with Section 49A of the Disability Discrimination Act 1995 (DDA 1995) (as amended by Article 5 of the Disability Discrimination (Northern Ireland) Order 2006) the Northern Ireland Ambulance Service's Disability Action Plan outlines the Trusts plans to:

- Promote positive attitudes to disabled people and
- Involve disabled people in public life

The Trust is involved with regional work streams with other HSC Trusts and representative groups from the disability sector to implement these duties and continues to engage with these and the Equality Commission in respect of the further development of work in this area. In addition the Trust is fully committed to complying with its duties under the Disability Discrimination Act to make reasonable adjustments as appropriate for employees who have a disability.


*"My parents and I greatly appreciate the professionalism which made our horrific ordeal a little less chaotic."*

# Chief Executive's Report

The first section of this report sets out the mission, vision and values of the Northern Ireland Ambulance Service. These are very important and powerful statements which direct our actions and intentions. However at its core is a simple and straight forward message...

"NIAS seeks to provide safe, high quality ambulance services that meet the need and expectations of the people of Northern Ireland within the limited resources available".

We have made very clear in this report the financial constraints within which we operate – we spend less than ten pence per person per day on our ambulance service in Northern Ireland. While this clearly does not reflect the value which the Northern Ireland community place on their ambulance service, it is one indication of the priority placed on our collective health and well-being. As we move deeper into a difficult financial environment, we will have even more cause to consider the value we place on our ambulance service and the investment we wish to make in pre-hospital care.

The report which follows describes what we have done this year to achieve our aims. Key themes come to the fore - safe, high quality services; value for money and probity; investing in the present to secure the future; and dealing with the unexpected as well as the norm. We remind ourselves throughout the report of the positive difference we can make and the value attached to our efforts by patients and carers, by sharing their compliments and experiences in their own words. The comments have been highlighted by including them alongside the ten pence coin image which also emphasises the value for money provided. Each compliment received is acknowledged with a letter of thanks to the author and the ambulance personnel involved. We acknowledge also the complaints which illustrate that we may not always get it right, but we do always seek to learn from and put right our mistakes to prevent us from repeating them.

Within the Ambulance Service, it is the people providing the service who define that service. It is they who go out in all weathers, in all conditions, anytime day or night to provide ambulance care and transportation to the people of Northern Ireland. Through this report I pay tribute to their commitment and dedication and their application of clinical and non-clinical skills to meet the needs and expectations of their patients.

I hope, you, the reader, will be better able to judge our performance as an ambulance service through this report. I hope also that you will approve of and appreciate our efforts to provide safe, high quality ambulance services to meet the needs and expectations of the people of Northern Ireland.

**Liam McIvor**
**27 June 2011**

# Management Commentary

## *Ambulance Response to Unscheduled and Scheduled Demand*

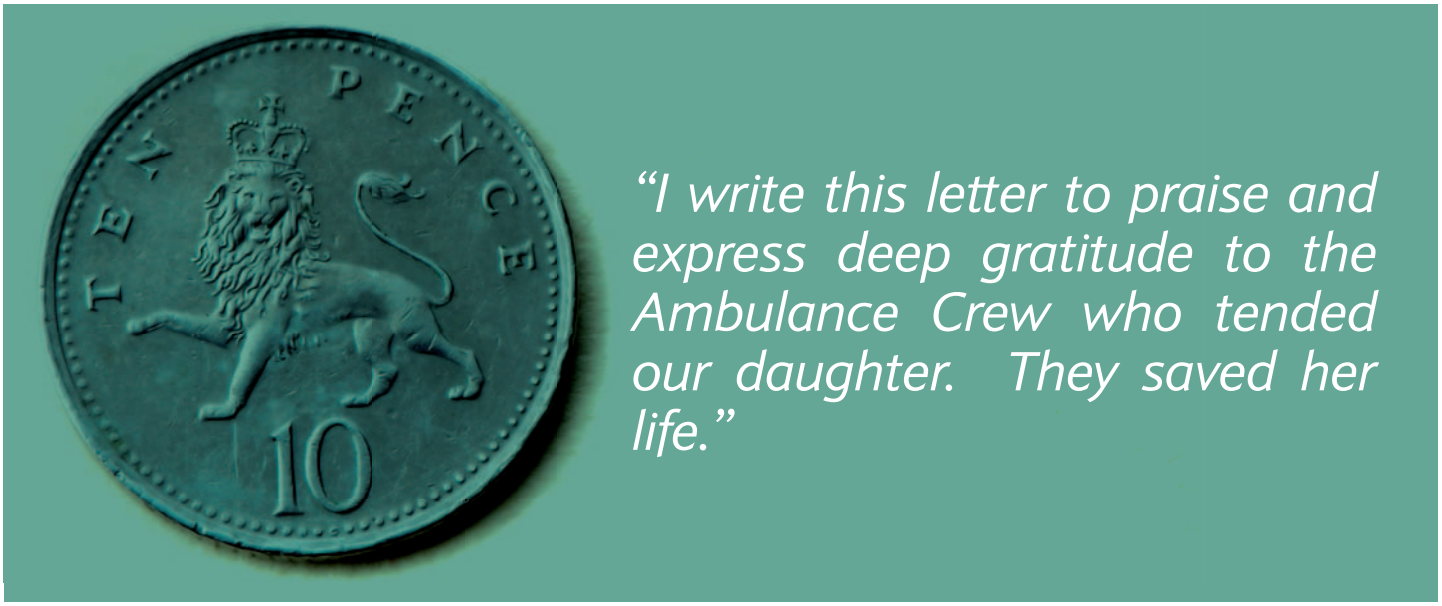
For some time the speed of response particularly to Category A, potentially life threatening calls, has been used as a proxy for quality of ambulance response in the absence of discrete clinical measures of performance as a means of assessing the quality of the service delivered. Speed or timeliness of ambulance response is an important measure of performance, not least in relation to meeting the expectations of the caller. However it is not enough in itself and taken out of context can be damaging and disruptive. One thing is clear, however, no one has ever complained to the ambulance service that the ambulance arrived too quickly!

A key goal for any ambulance service therefore must be to provide a timely response to those who request assistance. However we all know and recognise that of all the 999 calls received only a proportion are actually clinically urgent. Our challenge therefore is to quickly identify those calls which are potentially life threatening and afford them the highest priority in terms of speed of response while also giving due consideration and priority to a timely and appropriate response to the rest of the calls which are not life threatening. To this end we differentiate between 999 calls which are potentially life-threatening (Category A) and those which are not (Category B & C).

NIAS response performance to Category A, potentially life-threatening 999 calls is subject to scrutiny against targets established by the Health Minister. NIAS performance against targets in Northern Ireland, measured and reported at Local Commissioning Group (LCG) level, is illustrated in the table below.

| Response Performance<br>Category A "potentially life-threatening" 999 calls with a sub-8 minute response | | | | | | |
|---|---|---|---|---|---|---|
| **Location** | March 2011 | | Cumulative 2010-11 | | 2009-10 | 2008-09 |
| | Target | Actual | Target | Actual | Actual | Actual |
| **N Ireland** | 75.0% | 73.6% | 72.5% | 69.7% | 71.5% | 67.5% |
| **Belfast** | 67.5% | 88.2% | 65.0% | 83.6% | 85.6% | 83.9% |
| **North** | 67.5% | 66.0% | 65.0% | 62.2% | 62.7% | 56.8% |
| **South East** | 67.5% | 69.5% | 65.0% | 68.2% | 68.7% | 65.3% |
| **South** | 67.5% | 66.4% | 65.0% | 62.8% | 65.3% | 59.1% |
| **West** | 67.5% | 71.2% | 65.0% | 64.9% | 68.7% | 63.6% |

Category A ambulance response performance fell this year compared to last and targets set were, unfortunately, not achieved in all areas. Peak performance targets set for the month of March 2011 were achieved in three of the five LCG areas.




*"I write this letter to praise and express deep gratitude to the Ambulance Crew who tended our daughter. They saved her life."*

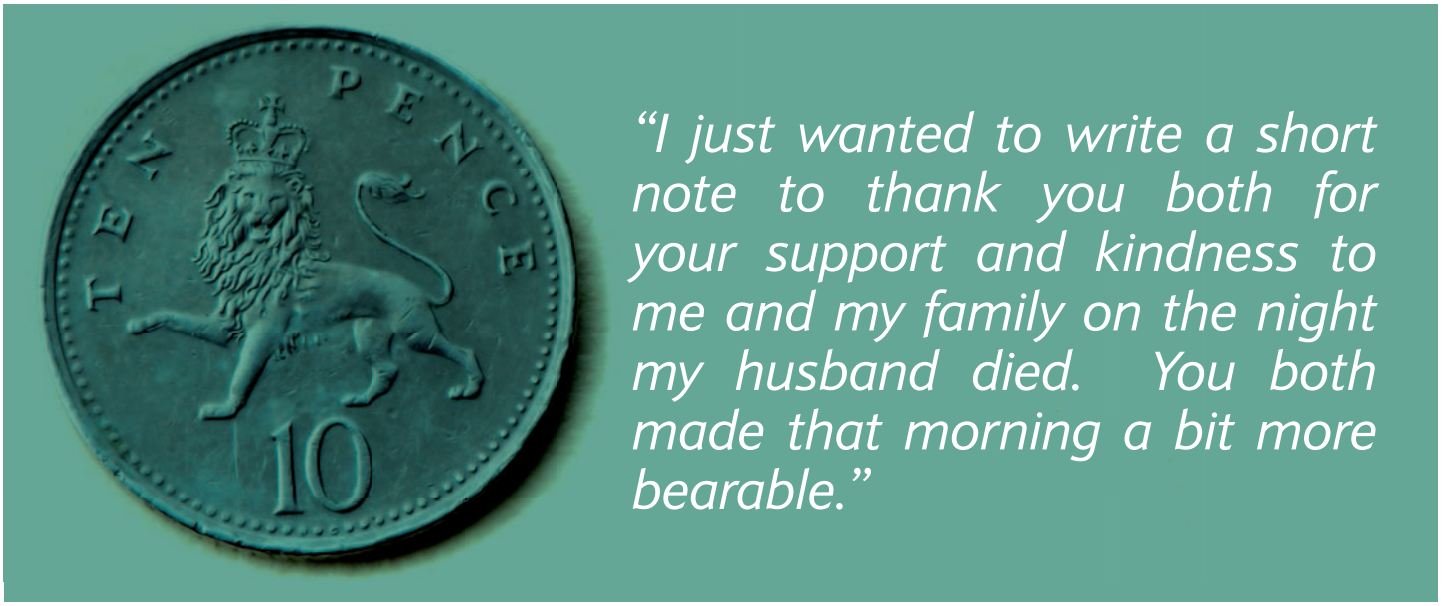
There are a number of reasons why we were unable to achieve the targets set. One key factor was demand for ambulance services which continues to grow year after year. To set the performance in context there has been a 4.5% increase in the volume of 999 calls responded to, which amounts to 5,376 extra calls per year – 15 extra 999 responses on average each day.

Another key factor influencing ambulance capacity was the impact of increased demand and service pressures in our acute hospitals. During 2010/11 we saw increased numbers of patients waiting longer than before for admission to Accident & Emergency (A&E) units. This delayed the handover of ambulance patients to hospital staff which, in turn, led to queuing of ambulance personnel in A&E with their patients. We recognise and accept that not all ambulance patients who are taken to hospital have a high clinical priority in the A&E department and other patients may have more urgent clinical needs. However, a further consideration to take into account is that an ambulance waiting at an A&E department is not available to respond to the next 999 call in the community.

Regrettably 2010/11 also saw an upsurge in dissident terrorist activity which impacted on our service in a number of ways, not least by delaying ambulances as they travel to and from calls when roads, including arterial routes such as the M1, were closed by suspect devices. We were also unable to operate one of the main ambulance stations in Belfast for 5 days due to civil unrest in the area and ambulances had to be deployed to other centres. It is important that we note and recognise the wider impact of such activity on our society and community.

However the most significant factor contributing to poor performance against targets set was the harsh, enduring, winter weather which impacted on all aspects of life in Northern Ireland over an extended period in 2010/11. The weather delayed ambulance response but did not prevent us from attending all 999 calls – sometimes with help and assistance from people within the community, from voluntary ambulance services to local farmers with tractors etc. Resources available to respond to calls were depleted as our staff struggled to get to work. The resources available to us were assigned to priority activity – providing 999 response to a growing number of emergency callers. December 2010 saw our 999 calls increase by almost 1,000 over December 2009.

Through it all we maintained a focus on providing the best possible response to those who need it most. The performance management regime established in previous years was maintained and we continue to review our practice to identify measures to continually improve performance in all areas (not simply timeliness of response). A range of measures have been introduced in the final quarter of the year, principally in February and March, which contributed to improved performance in March and which we hope will be sustained as we go into 2011/12.




*"I just wanted to write a short note to thank you both for your support and kindness to me and my family on the night my husband died. You both made that morning a bit more bearable."*

In spite of the challenges faced and met, NIAS still managed to get to more 999 calls more quickly than ever before. This in itself is a commendable performance which reflects the hard work, dedication and commitment of the whole ambulance team and an over-riding desire to get to those who need our services as quickly as possible and provide quality care.

## Managing Demand

It is well recognised that the Ambulance Service is demand led. We respond promptly to requests for assistance. We differentiate between requests based on information secured from the caller to prioritise and categorise calls based on clinical urgency and perceived need. We respond most quickly to those in greatest need. We also offer alternatives to those who may not require either ambulance attendance or transportation to hospital.

During 2010/11 NIAS experienced a 4.6% increase in emergency calls received, resulting in our dealing with an average of 375 emergency 999 calls per day. Overall there was an increase of 1.1% in ambulance journeys undertaken as we transported 347,511 patients – equivalent to one person in five of the population of Northern Ireland. The changes to the configuration of acute services over the years, with the closure of emergency units and the changes to location of some specialist services means that these patients are also spending more time in ambulances in the care of ambulance professionals as a direct result of the longer journeys required.

While we are a demand led service, we seek to manage that demand. Last year we introduced doctors into our emergency control room to identify and offer alternatives to patients as outlined above. This initiative has been successfully consolidated and further developed in the current year, and feedback from patients has been positive.

Our primary focus in this initiative is to offer and provide an appropriate alternative to patients whose 999 call was neither life threatening nor urgent. This year we have increased from 3,680 to 5,870 the number of 999 callers who are provided with an alternative which allows them to remain at home – a 60% increase. In addition callers provided with an alternative, after the arrival of an ambulance has increased from 258 to 637 – almost 150% improvement over the previous year.

## Developing and Improving Clinical Services

We have signalled in previous reports that the ambulance service is much more than a patient transport service. NIAS has a statutory duty of quality in respect of the services we deliver. We have invested heavily in our staff and our equipment to provide quality, clinical assessment, care and intervention to Northern Ireland. We will continue to develop the skills and scope of practice of ambulance staff to enable them to meet the growing and developing needs of patients. One example of this, worthy of mention, is our contribution to the management of stroke patients in Northern Ireland. A key element in the effective management of stroke is early detection and alerting the hospital team to prepare for rapid diagnostic investigation and in-hospital treatment.


Patient outcomes are directly linked to the speed of diagnosis and early intervention. Ambulance personnel have a key role to play:-

- Call takers instruct the caller in the use of the FAST test (Face, Arms, Speech, Time to call 999) to identify potential stroke patients and pre-alert responding emergency ambulance crews
- Responding ambulance crews perform a further FAST test on arrival with the patient and, if positive, prepare the patient for rapid transportation to the nearest hospital with facilities to manage the stroke patient effectively. Hospital staff are pre-alerted to prepare for the patient's arrival.
- Hospital staff use in-hospital diagnostic tools such as CAT scans to confirm stroke diagnosis and administer thrombolysis if appropriate.

Having worked hard over the last 3 years to introduce paramedic thrombolysis for cardiac patients to the whole of Northern Ireland, we are developing our treatment options further. All NIAS paramedics are trained and equipped to administer thrombolytic drugs to patients having a heart attack which break up the blood clots in the heart and improve the chance of survival and reduce damage to the heart. Patients throughout the region have benefitted from paramedic cardiac thrombolysis administration before they got to hospital during 2010/11.

During this year we have worked with the cardiologists at the Royal Victoria Hospital and Craigavon Area Hospital to directly admit patients to the cardiac catheterisation labs for immediate invasive cardiac procedures for suitable patients who have suffered a heart attack in the catchment area of those hospitals. The hospitals are alerted by paramedics to the patient's condition, and if the hospital resources are available the patient is taken by ambulance staff directly to the cardiac catheterisation laboratory where they can get emergency cardiac angioplasty and stent insertion. This represented a very effective intervention for specific patients. Clinical outcomes to date have been very positive and we will continue to work with our healthcare colleagues to develop the service further.

Another very important and valuable development in patient care has been the extended use of our computer systems to improve care to the chronically ill in the community. We have worked with hospital based clinicians and their patients to identify and record on our ambulance control systems, the individual patients' needs and wishes. These are then sent electronically to responding ambulance personnel to ensure they are as well prepared as possible to meet the patient's needs. This has been particularly important for end of life care, and also improving our care for patients with specific oxygen therapy requirements and postoperative laryngectomy patients. We are keen to continue to work with other healthcare professionals, patients and carers in this type of development


to make better use of the knowledge and information we hold collectively to help patients influence their own care and treatment. We often hear people complain that they have to repeat themselves far too often in the health service. This is one initiative by the ambulance service to make the technology work more effectively and not only prevent the patient from having to repeat themselves, but enable clinical professionals to work far more effectively through a collaborative tool which uses technology to the full.

## *Education Training and Clinical Supervision*

We are rightly proud of the clinical advances we have made and the positive impact they are having on patient outcomes. The ongoing investment in education, training and clinical supervision of our ambulance staff is a corner stone for effective delivery of safe, high quality care. During 2010/11 we have continued to recruit new ambulance personnel to support and sustain our service bringing in 14 ambulance care attendants and 36 student paramedics.

We have also developed a clinical skills workbook for issue to staff supported by annual assessment and demonstration of proficiency of front line staff in core clinical skills. This represents a positive development in the means by which we educate and train our staff. It also represents a significant shift away from direct one to one training to the greater emphasis in education.

In support of this we will also continue to enhance our clinical supervision with the recruitment and development of Clinical Support Officers (CSOs). The CSOs have benefited from a programme providing clinical supervision which has been delivered in conjunction with the University of Plymouth and South Western Ambulance Service. Our CSOs have also been trained in instruction and methods consistent with the standards of the Institution of Healthcare Development. A further enhancement of our supervision capacity has been in the provision of mentorship programmes to our paramedic supervisors facilitated through Queen's University Belfast.

## *Maintaining and Enhancing Infrastructure*

If education, training and clinical supervision are one pillar of safe, high-quality service delivery, then another is investment in the equipment and facilities which staff use to deliver that care day to day. We were pleased to secure full approval of the business case for further replacement of the ambulance fleet during 2010/11. We had been working on this for many years and the approval covers 2010/11, 2011/12 and 2012/13. The challenge now is to build on the successful pattern of investment over

recent years to maintain our ambulance services.

This will require continued investment, not only in our fleet, but in our communication and information systems which are vital to maintaining a 999 response. We also need to continue to invest in our ambulance estate and clinical equipment to ensure that our personnel operate from facilities that are safe, suitable and secure.

We have outlined elsewhere in the report the clinical application of information and information systems to empower patients, carers and clinicians to enable and to support them to deliver better care, particularly to those living in the community with chronic conditions. We have therefore invested in training and raising the awareness of all our staff to ensure they clearly understand and respect the importance of confidentiality and information security. We have sought to deal openly and transparently with requests for information and have reviewed our systems, policies and procedures to ensure strong information governance and data protection. We have not identified any significant information related breaches, nor have any been brought to our attention.

## *Engaging with our Workforce*

A significant amount of staff engagement undertaken in 2009/10 supported the relatively smooth introduction of new rotas for emergency staff reflecting the impact of the Comprehensive Spending Review (CSR) Year 3 Savings. We continue to consolidate staffing rotas for rapid response paramedics and as a matter of course adjust operational cover to match supply and demand. During 2010/11 we rolled out our Global Roster System (GRS) to improve the management of shifts and operational cover. This has increased both consistency and levels of cover and released highly qualified and experienced front line ambulance personnel from administrative tasks to provide emergency care. We will continue to develop this system extending to other areas such as ambulance control and non-emergency patient care services. We will also use this system to engage with staff in developing new and more innovative approaches to providing cover which are more flexible for staff while also providing confidence and assurance of cover for managers and the community.

Another way in which we have sought to enhance operational ambulance cover is by ensuring the most effective management of absence. Regrettably the overall percentage of absence rose slightly from 6.72% in 2009/10 to 6.87% in 2010/11. During 2010/11 absence management has been incorporated as a formal item into the regular monthly operational performance management meetings which underpin the Trust's performance management regime. In addition, the absence management policy and procedure has been reviewed with Trade Unions to ensure that it remains fit for purpose. The current policy continues to be rigorously applied by managers. In addition we have invested to secure early access to occupational health and physiotherapy for ambulance personnel to support an early return to work and decisions on capacity to continue to work in an ambulance role. The absence management process and initiatives to enhance capability and management are informed by ongoing benchmarking of performance and reference to national best practice information.

Regular and ongoing use of formal disciplinary, grievance and harassment procedures within an organisation is an indication that staff are aware of the means by which they can raise concerns and also that managers are identifying issues and matters of concern and investigating and addressing them through the appropriate procedures. The


assurance framework presented at each public board meeting for scrutiny by Trust Board, and available on our website, provides evidence of the application of these various procedures and processes. During 2010/11 NIAS initiated formal disciplinary procedures on 14 occasions (representing approximately 1% of the workforce), suspending 8 staff and referring 5 paramedics to the Health Professions Council. During the same period staff filed 24 grievances and 3 harassment cases, 13 of which were resolved informally or withdrawn. There were no industrial tribunal cases naming NIAS as the defendant during the year.

## *Listening to and Learning from the Community*

Complaints and compliments represent extremely valuable feedback to the ambulance service and to our managers and staff on the delivery of health care to patients. It is very important that we welcome and acknowledge both complaints and compliments and have processes in place to learn from them and apply that learning positively to improve future performance. Trust Board has a key role in the scrutiny of this particular feedback from those who receive our services. The assurance framework provides Board members with relevant performance information and trend data, but crucially Board members are also provided with a synopsis of every complaint and compliment describing incident, outcome and action taken. This supports a greater level of scrutiny by the Board and the public and provides an opportunity to test outcomes and the application of learning to prevent recurrence of the incidents and circumstances underlying complaints.

During 2010/11 NIAS received 85 complaints, a reduction of 13 on the previous year. In the same period we received 112 compliments, an increase of 25 in the previous year. (Further details are available in Trust Board papers through the NIAS Assurance Framework 2010/11.) We have received positive feedback from Health and Social Care Board staff in relation to the quality and thoroughness of the complaints investigation process and our responses to complainants, and in particular our low ratios of complaints being reopened. However we acknowledge difficulties in providing a prompt and timely response to complainants due to the time spent on investigation of the complaint and we have commenced reassessment of processes and the development of escalation procedures to address this weakness.

We have also engaged with the public directly in assessing our services and receiving their assessment of our performance through patient surveys conducted by hospital-based colleagues for patients arriving by ambulance. This has been part of our Personal and Public Involvement (PPI) strategy which has also included engaging with the Patient and Client Council plus issuing our strategy for consultation, and developing and introducing observation of practice in the ambulance environment. One striking example of the positive impact of such engagement has

been the work undertaken to develop a Northern Ireland wide policy and procedure for positive, sensitive and effective engagement with patients/clients with assistance dogs. When raised with NIAS, we quickly realised this was more than a transportation issue, but involved all healthcare trusts in Northern Ireland with regard to a lack of consistency in handling the infrequent instances where a patient/client presented with an assistance dog. Working directly with the patient and Guide Dogs for the Blind Association, NIAS has joined with the Belfast Trust (acting on behalf of the other acute trusts) to develop the policies and procedures to be introduced across Northern Ireland during 2011/12.

In addition we have met with public representatives and interest groups throughout Northern Ireland over the year, explaining how we operate and the constraints within which we provide services, and seeking to identify ways to meet the aspirations and expectations of the communities they represent.

## *Managing Unexpected Events*

NIAS provides services 24/7 which have been outlined elsewhere in this report and which challenge our staff to respond promptly and effectively to demand and expectations. In addition however, we are often called upon to deal with the unexpected. This can range from chemical incidents, major transport incidents, natural disasters, and, unfortunately in our world, terrorist incidents.

While we have plans and processes in place to deal with such unexpected incidents, we do not maintain separate discreet or distinct resources to respond solely to those incidents while we continue to deal with the ongoing demand for ambulances for clinical response. Rather we redistribute existing resources and supplement them with operational managers to direct, manage and co-ordinate the ambulance response and liaise with other emergency services and hospitals.

During 2010/11 our plans have been tested on a number of occasions and the response from ambulance personnel has been second to none. Further detail is available in our assurance framework report. One of the most striking was the tragic and fatal helicopter accidents in the Mournes which tested the resolve and the plans of all involved. I would again commend and pay tribute to those who responded and their colleagues who maintained service provision to the rest of the Northern Ireland community while the incident was ongoing, while also offering our

condolences to the families of those who lost their lives.

It is important that we invest to maintain capacity to deal with existing and emerging threats. In response to this we participated in 25 multi-agency emergency planning exercises over the year. We also continued to invest in the development of a Hazardous Area Response Team (HART) capacity for Northern Ireland. This has been achieved by training ambulance rapid response paramedics and operational managers in additional skills and equipping them to deal with incidents such as rope rescue, hot zone working with Northern Ireland Fire & Rescue Service colleagues, chemical incidents, radiation incidents, and urban search and rescue. We will continue to invest in this area to maintain and develop our response capacity with the funds available to us.

Business continuity, and the capacity of an organisation to establish and maintain it, is key to any service. Put simply, it is about putting plans and processes in place to maintain services when some elements of the service fail and re-establish full service provision as soon as possible.

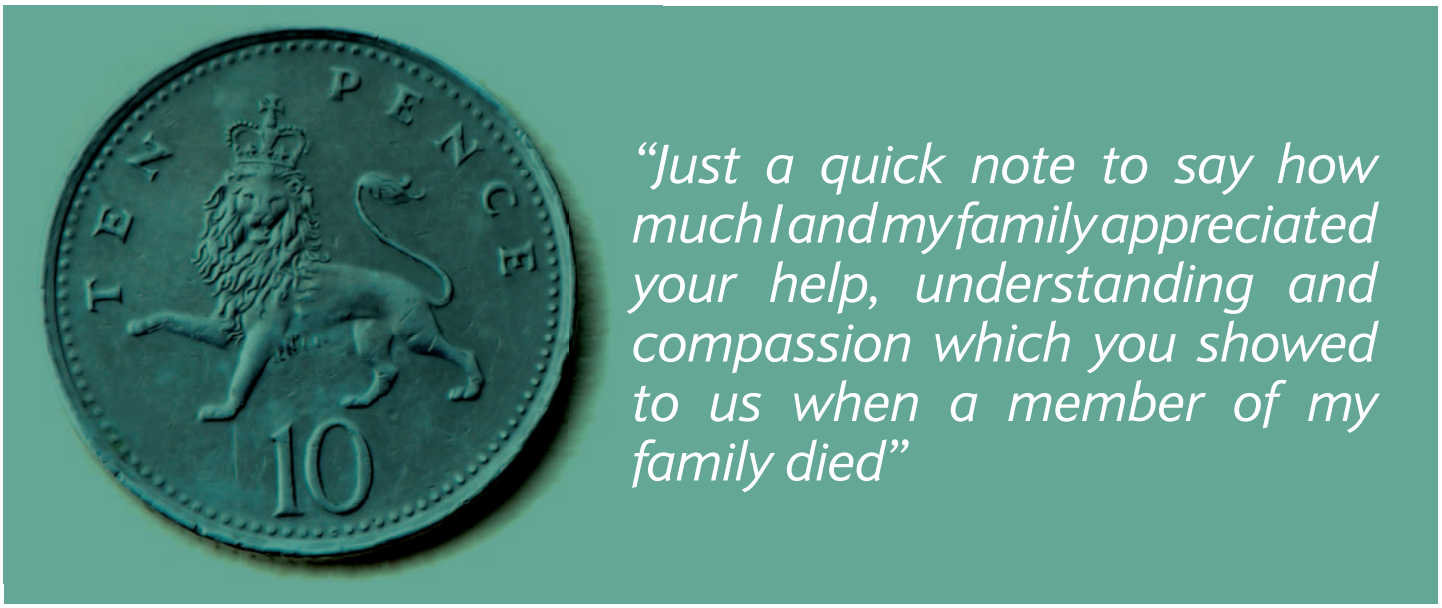
During 2010/11 we engaged in UK ambulance service reviews of business continuity arrangements, where our plans were reviewed by other services and we in turn reviewed theirs. Plans are being revised to reflect and take account of recommendations made. In the interim however we were tested on nine separate occasions on specific business continuity arrangements, including our emergency ambulance control. We also supported the maintenance of business continuity for the Scottish Ambulance Service in May 2010 by taking 999 calls on their behalf when they suffered a temporary telephony failure. Pandemic flu plans were reviewed and reassessed in winter 2010.

## *Controls Assurance*

Controls assurance is a process designed to provide assurance that Health and Social Care (HSC) organisations are doing their reasonable best to manage themselves, so that objectives to protect patients, staff, the public, equipment and assets, against risks of all kinds are met.

There are a total of 22 Controls Assurance Standards which have been developed by the Department of Health Social Services and Public Safety for Northern Ireland to support the embedding of governance and risk management throughout the organisation. Each standard requires a narrative, a compliance score and an action plan along with evidence to substantiate this information.

An integral part of the controls assurance process is an annual report of compliance covering each of the 22 standards, which is made in support of the annual Statement on Internal Control. The 2010/11 controls assurance process indicates that the Trust has met the required level of substantive compliance against all 18 standards applicable to the ambulance service. This reflects the extensive ongoing work throughout the organisation to embed processes covered by these standards. The Trust continues to develop systems and processes to ensure compliance with controls assurance standards.




*"Just a quick note to say how much I and my family appreciated your help, understanding and compassion which you showed to us when a member of my family died"*

## *Principle Risks and Uncertainties*

Principal risks relating to corporate performance are managed in line with our risk strategy which complies with DHSSPS guidance and assurance of the identification and management of risks is delivered through the Audit and Assurance Committees reporting to NIAS Trust Board.

2010/2011 was the final year of the 2008-2011 Comprehensive Spending Review (CSR) period and as such presented a challenge for organisations to consolidate their efficiency savings and deliver them on a recurrent basis. NIAS was required to demonstrate recurring savings at £4.5 million against its baseline 2008/09 budget position. This clearly represented a key risk to the organisation, in common with all other HSC Trusts. Preparatory work undertaken in 2009/2010 allowed NIAS to enter 2010/2011 with clear operational plans which delivered all CSR efficiency savings required on a recurrent basis over the whole financial year. Investment in new and additional resources to improve operational response and clinical performance supported the change to the service delivery model required by the CSR efficiency savings and mitigated against any potential negative impact in performance.

The operating environment was further complicated by ongoing changes in the provision of acute hospital services throughout Northern Ireland in areas such as Mid-Ulster and Down. Changes in clinical practice also impacted upon the provision of ambulance services necessitating a pro-active response on our part to changes elsewhere. NIAS has engaged fully with the architects of acute service change supporting agreed proposals with innovative and highly responsive solutions to manage the change in a way which maintains provision of safe, high quality services to patients.

The Trust continues with the agreed process of Agenda for Change in partnership with Trade Unions. However, there remain uncertainties over the outcome of the process and the Trust cannot predict what the final outcome will be or when the process will be completed. The Trust will continue to fulfil its obligations under the agreed Agenda for Change process.

The future remains uncertain, particularly in relation to available resources and configuration of services. We are fully engaged with the DHSSPS and the HSCB and will continue to work with them in order to manage the risk in this area as it is identified.

## *Environment, Sustainability and Corporate Responsibility*

The Trust is aware of its responsibilities in respect of sustainability and the environment. The planned replacement of ambulances through the year has enabled the Trust to avail of the most modern technologies to improve the efficiency of the fleet and reduce emissions. Where available, the service looks to utilise renewable energy sources, such as wind, to provide electricity.

We are also developing systems to reduce waste and increase recycling, for example with the secure and safe disposal of computer equipment and consumables. The Trust also operates a Cycle to Work scheme as part of the Government's Green Transport Plan which not only aims to reduce environmental pollution and promote healthier lifestyles but also make cycling to work a cost-effective option for employees.

The Trust is a member of Business in the Community with whom it regularly engages in the implementation of its Corporate Responsibility agenda. The Director of Human Resources and Corporate Services has been identified as a Board level champion of Corporate Responsibility.

A Corporate Responsibility Action Plan is in place which reflects key priorities, linked to the Trusts strategic objectives, under themes of Corporate, Sustainability, Workplace, Community and Communications. In addition progress is included in reporting to Trust Board through the Assurance Framework. Examples of work undertaken under this agenda has included participation in Business in the Community schemes such as Silver Surfers and Cares.

## *Financial Performance*

One of the most difficult tasks which we face as an integral part of the Health and Social Care System is to manage our expenditure with reducing resources while dealing with increasing demand for our services. NIAS, like other public sector bodies, had to deliver cash efficiency savings of 9% over the years 2008/09 to 2010/11 as part of the

Comprehensive Spending Review. This represented a reduction in our funding of £4.5 million by 2010/11 whilst we responded to an extra 4.5% of 999 calls during 2010/11. In addition our costs rose during the year in particular the cost of fuel for our vehicles, rent and rates and pharmacy supplies. Against a backdrop of these pressures with a focus on management of our budget and a commitment to securing value for money across the Trust, NIAS is able to report a balanced financial position at 31st March 2011 (we returned a small surplus of £11,000). Balancing our books i.e. spending no more or no less than the money provided to the Trust, is an important achievement which is likely to become more difficult as public sector funds come under increasing pressure.

The Trust spent over £54 million in 2010/11 - the vast majority of this money being provided by the Health and Social Care Board who commission our services. For a population of 1.7 million this represents less than 10p per person per day spent on NIAS. The vast majority of our money (75%) is spent on our workforce – £41 million this year. The remainder is used to pay for the running costs of the vehicles, equipment, accommodation and training which enables them to carry out their role whether they are front line patient care or support as finance, human resources, IT or other operational staff.

The Trust also invests each year in the vehicles, estate and equipment. This is the first year that the Trust has secured approval for an ongoing fleet replacement programme. This will enable NIAS to plan for regular replacement of around £3 million each year leading to a fleet of younger and more modern vehicles. In 2010/11 NIAS received just over £4.6 million which, in addition to vehicles, allowed the Trust to secure IT infrastructure to enhance its disaster recovery plans. The Trust is provided with a Capital Resource Limit which represents the limit of its available funds for this capital expenditure programme. With careful management of these funds NIAS achieved this wide range of capital projects within budget.

Health and Social Care Trusts, in common with other public sector bodies, draw down cash directly from the Department to cover both revenue and capital expenditure. Cash held by the Trust is minimised and any interest earned is repaid to the Department. As such, there are no effects of interest costs on the outturn and no potential impact of interest rate changes.

There are no post balance sheet events which have a material effect on the accounts.

With respect to the treatment of pension liabilities, refer to accounting policy note 1.21 to the annual accounts and the information given on pages 25 and 27 in this annual report (remuneration report).

The summary financial statements have been prepared in compliance with new accounting directions and taking account of those International Financial Accounting Standards which have been adopted by the public sector during the year.

# Summary Financial Statements

| STATEMENT OF COMPREHENSIVE NET EXPENDITURE | 2011 £000 | Restated 2010 £000 |
|---|---|---|
| Expenditure | (54,624) | (59,486) |
| Income | 1,657 | 1,659 |
| Net Expenditure | (52,967) | (57,827) |
| Revenue Resource Limit | 52,978 | 57,832 |
| Surplus against RRL | 11 | 5 |

| STATEMENT OF FINANCIAL POSITION | £000 | £000 |
|---|---|---|
| Non Current Assets | 24,595 | 23,193 |
| Current Assets | 747 | 2,090 |
| Payables due within one year | (9,506) | (12,499) |
| Total Assets less Current Liabilities | 15,836 | 12,784 |
| Payables due after one year | (2,261) | (2,261) |
| Provisions for Liabilities / Charges | (3,523) | (3,155) |
| Capital and Reserves | 10,052 | 7,368 |

| STATEMENT OF CASHFLOWS | £000 | £000 |
|---|---|---|
| Net Cash Outflow from Operating Activities | (53,135) | (51,478) |
| Net Cash Outflow from Investing Activities | (2,087) | (6,939) |
| Net Financing | 55,224 | 58,412 |
| Net Increase (Decrease) in Cash & Cash Equivalents in the period | 2 | (5) |
| Cash & Cash Equivalents at the beginning of the period | 96 | 101 |
| Cash & Cash Equivalents at the end of the period | 98 | 96 |

The notional cost of the audit for the year ended 31 March 2011, which pertained solely to the audit of the accounts was £20,094. An additional amount of £2,184 was paid to the Audit Office in respect of work carried out on the National Fraud Initiative. This is reflected within miscellaneous expenditure in Note 4.1 to the annual accounts. No other audit or non-audit services were provided in 2010/11.

## *The trust performance against statutory financial targets for the year is:*

| TARGET | ACHIEVED |
|---|---|
| Breakeven annually on income and expenditure | Income exceeded Expenditure by £11,000 |
| Remain within the Capital Resource Limit | Expenditure equalled CRL |

## *RELATED PARTY TRANSACTIONS*

None of the directors of the Trust hold company directorships with companies that are likely to do business with the HSC.

During the year, none of the board members, members of the key management staff or other related parties has undertaken any material transactions with the Northern Ireland Ambulance Service HSC Trust.

The Northern Ireland Ambulance Service HSC Trust is an arms length body of the Department of Health, Social Services and Public Safety and as such the Department is a related party and the ultimate controlling parent with which the Trust has had various material transactions during the year. During the year the Northern Ireland Ambulance Service HSC Trust has had a number of material transactions with other entities for which the Department is regarded as the ultimate controlling parent. These entities include the Health and Social Care Board, the five HSC Trusts and the Business Services Organisation.

| TRUST MANAGEMENT COSTS | 2011 £000 | Restated 2010 £000 |
|---|---|---|
| Trust Management Costs | 3,766 | 3,745 |
| Total Income | 53,872 | 59,045 |
| % of Total Income | 6.99% | 6.34% |

The above information is based on the Audit Commission's definition "M2" Trust management costs, as detailed in HSS (THR) 2/99.

As detailed in the departmental circular HSC (F) 08/2011 there were three changes in accounting policy during the year, which are explained in detail in Note 1.28. This has required the prior year figures to be restated to reflect the changes and the effect of this is to decrease total income and as income is the denominator in the calculation of management costs, the headline management cost as a percentage of total income will increase. Prior to this change, the headline management figure as a percentage of total income was 6.35% (2009/10 6.31%)

## *PUBLIC SECTOR PAYMENT POLICY - MEASURES OF COMPLIANCE*

The Department requires that Trusts pay their non HSC trade creditors in accordance with the CBI Prompt Payment Code and Government Accounting Rules. The Trust's payment policy is consistent with the CBI prompt payment codes and Government Accounting rules and its measure of compliance is:

| | 2011 | | 2010 | |
|---|---|---|---|---|
| | Number | £000 | Number | £000 |
| Total bills paid | 15,137 | 13,128 | 14,360 | 17,707 |
| Total bills paid within 30 day target or under agreed payment terms | 14,764 | 12,838 | 13,919 | 17,340 |
| % of bills paid within 30 day target or under agreed payment terms | 97.5% | 97.8% | 96.9% | 97.9% |

As required by HSC (F) 04/2011 'Prompt Payment Compliance', the Trust has updated its measurement whereby prompt payment is defined as invoices paid under standard HSC conditions of contract or under other specific terms agreed with suppliers for the purchase of goods and services.

## *ANALYSIS OF NET EXPENDITURE BY SEGMENT*

As the Trust Board of the Northern Ireland Ambulance Service in its capacity as the 'Chief Operating Decision Maker' receives financial information for the Trust as a whole and makes decisions based on the provision of an ambulance service for the whole of Northern Ireland, it is appropriate that the Trust reports on a one operational segment basis.

This Summary Financial Statement does not contain sufficient information for a full understanding of the activities and performance of the Trust. For further information the full Annual Accounts and Auditor's Report for the year ended 31 March 2011 should be consulted. These accounts have been prepared in accordance with Article 90(2)(a) 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, in a form directed by the Department of Health, Social Services and Public Safety.

Copies of the full accounts are available from myself at the following address: Northern Ireland Ambulance Service, Knockbracken Healthcare Park, Saintfield Road, Belfast BT8 8SG, and will also be made available on the Trust's website (www.niamb.co.uk).

**Mrs S McCue**
**Director of Finance**

**Mr L McIvor**
**Chief Executive**

**Mr P Archer**
**Chairman**

**27 June 2011**

# Remuneration Report For The Year Ended 31 March 2011

## *Scope of the report*

Article 242B and Schedule 7A of the Companies (Northern Ireland) Order 1986, as interpreted for the public sector requires HSC bodies to prepare a Remuneration Report containing information about director's remuneration. The Remuneration Report summarises the remuneration policy of The Northern Ireland Ambulance Service Health and Social Care Trust and particularly its application in connection with senior managers. The reports must also describe how the Trust applies principles of good corporate governance in relation to senior managers' remuneration.

Senior managers include the Chief Executive and the four Executive Directors who operate at Board level and are listed on page 7 of this report and also overleaf. The tables on pages 28 and 29 outlining senior employees remuneration are part of the remuneration report.

## *Remuneration Committee*

The membership the Remuneration Committee is comprised of non-executive directors as outlined previously in this report and the committee is chaired by the chair of Trust Board. Executive director attendance is restricted to Chief Executive and Director of Human Resources and Corporate Services who absent themselves at appropriate points in the meeting to prevent any conflict of interest.

## *Remuneration Policy*

The policy on the Remuneration of Directors and Senior Managers for current and future periods is governed and administered on the basis of the DHSSPS Departmental Directives and Circulars on HSC Senior Executive Salaries. NIAS applies the Senior Executive Performance Management Scheme as set out within Departmental Circular HSS(SM) 1/2003 'Senior Executives Performance Management Scheme'.

The circular sets out the following requirements which are applied within the Trust.

- The Board determines the strategic and operational corporate objectives of the Trust for the year ahead taking into account the parameters established by the Department and to incorporate them within its Service or Trust Delivery Plan.
- The Remuneration Committee oversees the performance management process.
- The Chairman agrees the Chief Executive's performance objectives and undertakes review of performance and objectives and completes final report.
- The Chief Executive agrees individual performance objectives of Executive Directors and undertakes review of performance and objectives and completes final report.
- Senior Executives agree performance objectives with the Chief Executive participate in reviews and take responsibility for personal development.
- Performance objectives are linked to Trust Delivery Plan and Strategic Plans. Performance objectives are clearly defined and measurable.
- Director's performance is reviewed by the Chief Executive on an annual basis. The approach adopted is based on the Executive Director's contribution towards the achievement of key targets included in the Trust's Strategic and Trus Delivery Plan. A similar approach is used by the Chairman for the Chief Executive. Performance pay would be considered within the total pay limit determined by the DHSSPS.

## Service Contracts

The Trust Medical Director is employed under a contract issued in accordance with HSC Medical Consultant Terms and Conditions of Service (Northern Ireland) 2004. All other Senior Executives in the year 2010/11 were on the new the DHSSPS Senior Executive Contract. The contractual provisions applied are those detailed and contained within Circulars HSS (SM) 2/2001

With the exception of the Trust Medical Director, all Executive Directors within the NIAS are on contract provisions issued by the Department and effective from 1 April 2002. Directors total remuneration package is performance related.

## Directors

## Non-Executive Directors

| | |
|---|---|
| Mr Paul Archer | Chairman appointed on 16 October 2010 for a period of four years. |
| Mr Frank Hughes | Non-Executive Director appointed on 1 December 2001. End of term 30 November 2010. |
| Mr Seamus Mullan | Non-Executive Director appointed on 22 July 2002. End of term 21 July 2010. |
| Professor Mary Hanratty, CBE | Non-Executive Director appointed on 1 August 2007 for a period of four years. |
| Mr Seamus Shields | Non-Executive Director appointed on 1 May 2009 for a period of four years. |
| Mr Norman McKinley | Non-Executive Director appointed on 1 May 2009 for a period of four years. |
| Ms Angela Paisley | Non-Executive Director appointed on 1 December 2010 for a period of four years. |
| Mr Sean Mc Keever | Non-Executive Director appointed on 1 December 2010 for a period of four years. |

## Executive Directors

| | |
|---|---|
| Mr Liam McIvor | Chief Executive appointed on 1 October 2004 |
| Mr Brian McNeill | Director of Operations appointed 1 June 2005 |
| Doctor David McManus | Medical Director appointed 1 May 2003 |
| Mrs Sharon McCue | Director of Finance and Information Communications Technology appointed 4 March 2002 |
| Ms Roisin O'Hara | Director of Human Resources & Corporate Services appointed 1 March 2002 |

## Duration of Contract

Permanent Contracts of Employment with continuation subject to satisfactory performance.

## Notice Periods

A three-month's notice period is to be provided by either party except in the event of summary dismissal. There is nothing to prevent either party waiving the right to notice or from accepting payment in lieu of notice.

## Termination Payments

Statutory provisions only as detailed in contract. There were no payments made to directors in respect of compensation for loss of office during 2010/11.

## *Retirement Age*

Currently, employees are required to retire at age 65 years; occupational pensions are normally effective from age 60 years. With effect from 1 October 2006 with the introduction of the Equality (Age) Regulations (Northern Ireland) 2006, employees can ask to work beyond age 65 years.

## *Retirement Benefits Cost*

The Trust participates in the HSC Superannuation Scheme. Under this multi-employer defined benefit scheme both the Trust and employees pay specified percentages of pay into the scheme and the liability to pay benefit falls to the DHSSPS. The Trust is unable to identify its share of the underlying assets and liabilities in the scheme on a consistent and reliable basis. Further information regarding the HSC Superannuation Scheme can be found in the HSC Superannuation Scheme Statement in the Departmental Resource Account for the Department of Health, Social Services and Public Safety.

The costs of early retirements are met by the Trust and charged to the Statement of Comprehensive Net Expenditure at the time the Trust commits itself to the retirement.

In respect of Directors, there are no provisions for the cost of early retirement included in the 2010/11 accounts.

As per the requirements of the Financial Reporting Manual (FReM), full actuarial valuations by a professionally qualified actuary are required at intervals not exceeding four years. The actuary reviews the most recent actuarial valuation at the Statement of Financial Position date and updates it to reflect current conditions. The most recent valuation as at 31 March 2008 will be used in the 2010/11 accounts.

## *Premature Retirement Costs*

Section 16 of the Agenda for Change Terms and Conditions Handbook (issued on 14 February 2007 under cover of the Department's Guidance Circular HSS (AfC) (4) 2007) sets out the arrangements for early retirement on the grounds of redundancy and in the interest of the service. Further Circulars were issued by the Department HSS (AfC) (6) 2007 and HSS (AfC) (5) 2008 setting out changes to the timescale for the operation of the transitional protection under these arrangements.

Under the terms of Section 16 of the Agenda for Change Terms and Conditions Handbook individuals who were members of the HPSS Superannuation Scheme prior to 1 October 2006, are over 50 years of age and have at least 5 years membership of the HPSS Superannuation Scheme qualify for transitional protection. Staff who qualify for transitional protection are entitled to receive what they would have received by way of pension and redundancy payment had they taken redundancy retirement on 30 September 2006. This includes enhancement of up to 10 years additional service (reduced by the number of years between September 2006 and the actual date of retirement) and a lump sum redundancy payment of up to 30 weeks' pay (reduced by 30% for each year of additional service over 6 2/3 years).

Alternatively, staff made redundant who are members of the HPSS Pension Scheme, have at least two years' continuous service and two years' qualifying membership and have reached the minimum pension age currently 50 years can opt to retire early without a reduction in their pension as an alternative to a lump sum redundancy payment of up to 24 months' pay. In this case the cost of the early payment of the pension is paid from the lump sum redundancy payment however if the redundancy payment is not sufficient to meet the early payment of pension cost the employer is required to meet the additional cost.

In respect of Directors, there are no provisions for the cost of premature retirement included in the 2010/11 accounts.

**Mr Liam McIvor**
**Chief Executive**
**27 June 2011**

## *Senior Employees' Remuneration (Audited)*

The salary, pension entitlements and the value of any taxable benefits in kind of the most senior members of the Trust were as follows:

| | 2010-11 | | | | 2009-10 | | | | 2010-11 | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Name | Salary £000s | Bonus / Performance pay £000 | Benefits in Kind (Rounded to nearest £100) | Total £000 | Salary £000s | Bonus / Performance pay £000 | Benefits in Kind (Rounded to nearest £100) | Total £000 | Real increase in pension and related lump sum at age 60 £000s | Total accrued pension at age 60 and related lump sum £000s | CETV at 31/03/10 £000s | CETV at 31/03/11 £000s | Real increase in CETV £000s |
| **Non-Executive Members** | | | | | | | | | | | | | |
| P Archer | 20 - 25 | - | - | 20 - 25 | 20-25 | - | - | 20-25 | - | - | - | - | - |
| M Greer (until 17 May 2009) | - | - | - | | 0 - 5 (5-10*) | - | - | 0 - 5 (5-10*) | - | - | - | - | - |
| M Hanratty | 5 - 10 | - | - | 5 - 10 | 5 - 10 | - | - | 5 - 10 | - | - | - | - | - |
| F Hughes (until 30 November 2010) | 0 - 5 (5-10*) | - | - | 0 - 5 (5-10*) | 5 - 10 | - | - | 5 - 10 | - | - | - | - | - |
| S Mullan (until 21 July 2010) | 0 - 5 (5-10*) | - | - | 0 - 5 (5-10*) | 5 - 10 | - | - | 5 - 10 | - | - | - | - | - |
| N McKinley (appointed 01 May 2009) | 5 - 10 | - | - | 5 - 10 | 5 - 10 (5 - 10*) | - | - | 5 - 10 (5 - 10*) | - | - | - | - | - |
| S Shields (appointed 01 May 2009) | 5 - 10 | - | - | 5 - 10 | 5 - 10 (5 - 10*) | - | - | 5 - 10 (5 - 10*) | - | - | - | - | - |

* denotes full-year salary. See also notes on page 30

| | 2010-11 | | | | 2009-10 | | | | 2010-11 | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Name | Salary £000s | Bonus / Performance pay £000 | Benefits in Kind (Rounded to nearest £100) | Total £000 | Salary £000s | Bonus / Performance pay £000 | Benefits in Kind (Rounded to nearest £100) | Total £000 | Real increase in pension and related lump sum at age 60 £000s | Total accrued pension at age 60 and related lump sum £000s | CETV at 31/03/10 £000s | CETV at 31/03/11 £000s | Real increase in CETV £000s |
| A Paisley (appointed 01 December 2010) | 0 - 5 (5-10*) | - | - | 0 - 5 (5-10*) | - | - | - | - | - | - | - | - | - |
| S McKeever (appointed 01 December 2010) | 0 - 5 (5-10*) | - | - | 0 - 5 (5-10*) | - | - | - | - | - | - | - | - | - |
| Executive Members | | | | | | | | | | | | | |
| L McIvor | 75 - 80 | 0 - 5 | - | 75 - 80 | 70 - 75 | 0 - 5 | - | 75 - 80 | 0 - 2.5 + lump sum of 0 - 2.5 | 20 - 25 + lump sum of 60 - 65 | 367 | 341 | (26) |
| S McCue | 60 - 65 | 0 - 5 | - | 60 - 65 | 55 - 60 | 0 - 5 | - | 60 - 65 | 0 - 2.5 + lump sum of 0 - 2.5 | 5 - 10 + lump sum of 20 - 25 | 133 | 137 | 4 |
| R O'Hara | 60 - 65 | 0 - 5 | - | 60 - 65 | 55 - 60 | 0 - 5 | - | 60 - 65 | 0 - 2.5 + lump sum of 0 - 2.5 | 15 - 20 + lump sum of 50 - 55 | 265 | 240 | (25) |
| D McManus | 100 - 105 | - | - | 100 - 105 | 95 - 100 | - | - | 95 - 100 | 0 - 2.5 + lump sum of 0 - 2.5 | 45 - 50 + lump sum of 135 - 140 | 893 | 855 | (38) |
| B McNeill | 55 – 60 | 0 - 5 | - | 60 - 65 | 55 - 60 | 0 - 5 | - | 55 - 60 | (0 - 2.5) + lump sum of (0 - 2.5) | 15 - 20 + lump sum of 55 - 60 | 358 | 333 | (25) |

* denotes full-year salary . See also notes on page 30

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the HPSS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost.

CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV - This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

## NI AMBULANCE SERVICE HEALTH AND SOCIAL CARE TRUST

## STATEMENT OF THE COMPTROLLER AND AUDITOR GENERAL TO THE NORTHERN IRELAND ASSEMBLY

I have examined the summary financial statement for the year ended 31 March 2011 set out on pages 22 to 24.

**Respective responsibilities of the NI Ambulance Service HSC Trust, Chief Executive and Auditor**

The NI Ambulance Service HSC Trust and Chief Executive are responsible for preparing the summary financial statement.

My responsibility is to report to you my opinion on the consistency of the summary financial statement within the Annual Report with the full annual financial statements, and its compliance with the relevant requirements of the Health and Personal Social Services (Northern Ireland) Order 1972, as amended, and Department of Health, Social Services and Public Safety directions made thereunder.

In addition I read all the financial and non-financial information in the Annual Report to identify material inconsistencies with the audited financial statements. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my certificate.

**Basis of audit opinions**

I conducted my work in accordance with Bulletin 2008/03 'The auditors' statement on the summary financial statement in the United Kingdom' issued by the Auditing Practices Board. My report on the NI Ambulance Service HSC Trust full annual financial statements describes the basis of my audit opinions on those financial statements and the part of the Remuneration Report to be audited.

**Opinion**

In my opinion, the summary financial statement is consistent with the full annual financial statements of the NI Ambulance Service HSC Trust for the year ended 31 March 2011 and complies with the applicable requirements of the Health and Personal Social Services (Northern Ireland) Order 1972, as amended, and Department of Health, Social Services and Public Safety directions made thereunder.

**KJ Donnelly**
**Comptroller and Auditor General**
**Northern Ireland Audit Office**
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**28th June 2011**

# Northern Ireland Ambulance Service

Health and Social Care Trust

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