Northern Ireland Ambulance Service
Health and Social Care Trust

MINUTES OF THE SAFETY, QUALITY, PATIENT EXPERIENCE AND PERFORMANCE COMMITTEE HELD AT 9.30AM ON THURSDAY 7 APRIL 2022 (VIA ZOOM DUE TO COVID-19)

PRESENT:	Mr D Ashford	-	Committee Chair
	Mr W Abraham	-	Non Executive Director
	Mr T Haslett	-	Non Executive Director
IN ATTENDANCE:	Mr M Bloomfield	-	Chief Executive
	Ms R Byrne	-	Director of Operations (joined the meeting at 9.50am)
	Ms L Charlton	-	Director of Quality, Safety & Improvement
	Ms M Paterson	-	Director of Planning, Performance & Corporate Services
	Dr N Ruddell	-	Medical Director
	Mr R Sowney	-	Senior Clinical Adviser
	Mrs S Beggs	-	Office Manager, Chair & Chief Executive's Office
	Ms R Finn	-	Asst Director QSI (Interim)
	Mr F Rafferty	-	EAC Continuous Improvement Manager (for agenda item 12)
	Mr C McCracken	-	Quality & Service Improvement Lead
	Ms C Hanna	-	NIAS Pharmacist (for agenda item 9)
APOLOGIES:	Mr P Nicholson	-	Interim Director of Finance
	Mr C Carlin	-	Boardroom Apprentice

1 **Apologies & Opening Remarks**

Apologies were noted as above.

The Chair welcomed those present to the meeting and explained that, in Mrs Mooney's absence, the meeting would be recorded to

allow the minutes to be drafted, after which the recording would then be destroyed.

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 (SC07/04/22/01)

The minutes of the previous meeting on 27 January 2022 had been **APPROVED** by e-mail and presented to the Trust Board meeting on 24 March 2022.

4 Matters Arising (SC07/04/21/02)

Members **NOTED** the action list.

The Chair referred to an action seeking clarification on whether the number of staff calls had reduced following the introduction of a new script and invited Mr Sowney to comment.

Mr Sowney referred to the target to reduce routine call volume by 50% and sought further detail on what proportion of the target had been achieved. He asked whether the target was unrealistic or too ambitious and suggested there may have been an opportunity to reset a more realistic target.

Ms Charlton advised that Ms Byrne would be in a position to offer further explanation when she joined the meeting.

The Chair explained that, while he had been unable to meet with other Committee members in relation to the agenda format, they

had had the opportunity to speak by phone to confirm the new format.

The Chair noted that Ms Byrne had joined the meeting and invited her to respond to Mr Sowney's earlier query.

Responding, Ms Byrne advised that she had recently appointed a new temporary Assistant Director within the Control Room and that would be one of the objectives to be set for the year. She indicated that work was being taken forward, in conjunction with Business Intelligence colleagues, in relation to performance, the number of duplicate calls and how these are being managed.

Ms Byrne acknowledged that the 50% target was ambitious and was unsure as to what would be achievable as it would be important to base the target on performance data. She advised that a further meeting had been planned for the coming week to agree the improvement trajectory and said undertook to provide an update at the next meeting.

Mr Sowney advised that he had a number of further queries and would be happy for Ms Byrne to respond to him following the meeting, allowing her the opportunity to gather the information.

The first, he said, related to the allocation by NIAS of Personal Devices to Independent Ambulance providers allowing for calls to be passed electronically throughout the shift, similar to a Digital Trunk Radio (DTR) on a NIAS vehicle and he sought further information around the reduction in the number of calls.

Mr Sowney referred to the Mobile Data Terminal (MDT) which was used on an ad hoc basis during high volume calls and suggested that this might send mixed messages to staff. He suggested that, while staff may experience pressures operationally, they may not necessarily be aware of the pressures being experienced within the Control Room and he queried whether staff could be encouraged to use MDT continuously.

Ms Byrne undertook to respond to Mr Sowney separately on the points he had raised.

The Chair sought further explanation as to why staff should not use MDTs continuously as opposed to only at times of high volume calls.

Ms Byrne acknowledged that there was an education piece to be undertaken with staff to encourage the use of MDT rather than phone lines.

The Chair referred to the new agenda format and said that it now reflected a plan for the year so members would be aware of what would be coming to various meetings. He acknowledged that there would also be scope for other agenda items to be included when required and the new agenda format would provide assurance that the Committee was addressing issues within its remit. The Chair extended his thanks to those involved.

5 **Standing Items:**

(i) Strategic Review of Clinical Education Update (SC07/04/21/03)

At the Chair's invitation, Dr Ruddell provided an update on the Strategic Review of Clinical Education. He acknowledged the challenges associated with resourcing the various workstreams but said that progress was still being made. Dr Ruddell explained that there were areas of work which would require permanent appointments. He advised of the new structure for the Education Team and said that job descriptions for key posts within the structure were going through the necessary HR processes for final agreement and recruitment.

Continuing, Dr Ruddell referred to the challenges within the team in terms of delivering training on a day-to-day basis whilst low in numbers.

Dr Ruddell alluded to the formal feedback from AACE on a number of courses run by the Training Team and added that over 700 comments had been received from staff during the recent engagement process. He advised that the Trust had recently received further feedback from an external assessor of the Foundation Degree programme. Dr Ruddell acknowledged that the Trust was already aware of a number of issues, for example ensuring consistency in terms of training, examining and marking

and said that, whilst these had been highlighted in the external assessor's report, the external assessor had also indicated that significant progress had been made in this regard.

Dr Ruddell indicated that there had also been positive feedback from students on recent courses and said that the Chief Executive had also received positive feedback from students. He said that it was clear that culture change and the strategic review were inextricably linked and that a change was starting to permeate through the organisation. Dr Ruddell said he had been encouraged by the positive feedback from courses and the approach of the trainers to students.

Continuing, Dr Ruddell said that, in terms of resourcing, the Trust was at risk of losing people to other posts, for example the Ulster University and other hospitals had been recruiting lecturers and practice placement co-ordinators and were drawing from the NIAS pool of staff in terms of recruitment. He expressed his frustration that hospital Trusts had received funding for these posts while NIAS had not received any funding.

He was of the view that there was a mistaken belief that NIAS had staff to dedicate to the BSc programme in the future when in reality the Trust had only received temporary funding for the Degree courses.

Dr Ruddell reminded the meeting that one of the aims of the project was to be able to recruit Newly Qualified Paramedics (NQPs) and a recruitment exercise was currently underway. He added that these were qualified paramedics who had undertaken their training elsewhere. Dr Ruddell advised that the Trust would not be able to take all applicants as it would not be in a position to mentor them all within current resources. He welcomed the fact that there had been such positive interest in joining NIAS.

Dr Ruddell commented on the direct entry to the BSc programme from the EMT cohort and said he expected the recruitment exercise to commence in the coming weeks. He explained that successful applicants would be allowed to join the second year of the BSc programme currently underway, to have their course fees paid as well as continuing to receive NIAS remuneration. Dr Ruddell advised that, as it was a University course, the Ulster University was operating the selection process with interviews taking place around

the start of May. He added that NIAS would also be represented in the selection process.

Concluding his update, Dr Ruddell pointed out that, while the approach to the Strategic Review had included managing some issues on a 'fix it as you find it' basis, the most significant challenge remained one of capacity to address the longer term plans. He acknowledged that having permanent resources would assist significantly.

The Chair thanked Dr Ruddell for his update. He alluded to the risk identified around the driving instructors and said that the mitigation was unclear. A further issue raised by the Chair related to the potential for EMTs to join the second year of the BSc programme and the possibility that this would leave the Trust with a shortfall in EMTs.

Responding to the issues raised by the Chair, Dr Ruddell clarified that it had not been intended to include driving within the original remit of the Education Review but that the need to do so had been identified in the early stages of the Review. He acknowledged the importance of ensuring the appropriate driver training structures were in place.

Dr Ruddell also alluded to the scheduling of this type of training and to the potential introduction of legislation already introduced in the rest of the UK relating to emergency driving requirements and the need to ensure skills were valid and updated on an ongoing basis. Dr Ruddell was of the view that this would become a significant piece of work in its own right which would likely require a significant business case to be developed and implemented. He added that the Trust had already engaged with AACE to progress this work.

Responding to the Chair's query around a potential shortfall of EMTs due to moving to the BSc programme, Dr Ruddell advised that only ten places were available. He said it would be important for staff to have this route of development and welcomed this gateway for EMTs to train to become paramedics. He clarified that ten places were available to EMTs to join the existing 40 students on the second year of the current BSc course and said that funding for this had been developed with the DoH to allow it to be ongoing. Dr Ruddell acknowledged that there would be a need to backfill the ten successful EMT posts.

The Chair invited other questions from attendees.

Mr Sowney thanked Dr Ruddell for the additional information which had been shared with the Committee and said he had found this helpful.

Mr Sowney commented on the positive and helpful responses to the stakeholder survey which, he believed, would assist in identifying the issues as well as assisting in steering the review.

Mr Sowney asked whether any target start dates or completion dates had been identified in relation to Workstreams 1 and 2.

In response, Dr Ruddell clarified that changes had already been made in terms of the feedback received from recent courses in terms of, for example, consistency between different people delivering sessions and the assessment.

Dr Ruddell said it was intended that the feedback would be examined in detail with a view to distilling this into themes, thus allowing a comprehensive analysis of the comments received. He accepted that it would take time and resources to deliver on all. He cited the example of the Digital Co-ordinator who would be responsible for managing all the digital training materials which will be used to make the training more accessible and said that this post was funded on a temporary basis.

Dr Ruddell said that, in recent meetings with the Trust's Finance Team, it had been possible to identify funding which would allow this work to commence but acknowledged that, until the team structure had been put in place, challenges would continue.

Mr Sowney referred to the objective to formalise an action plan and commence delivery and acknowledged that, while aspects of the review could be commenced, there was no date identified for the formalisation of a plan.

Dr Ruddell confirmed that there was an action plan which was challenging to deliver upon in light of the lack of resources. He undertook to bring this to the next meeting and forward it to members in the interim. He said that he had been encouraged that the feedback had not differed significantly from the changes that the

Trust had wished to make in terms of the accessibility of training and the consistency of training for example.

Mr Sowney referred to the Practice Placement Co-ordinator post and asked whether the post had been filled. He also sought clarification around the linkages with this role and the Practice Educators in each of the five Trusts.

Responding, Dr Ruddell confirmed that the Trust had a temporary Practice Placement Co-ordinator. He referred to the potential for other Trusts or the University to attract NIAS staff to the Practice Educator posts. He reminded the meeting that, with the exception of NIAS, Trusts had received funding to put in place Practice Placement Co-ordinators and he expressed his frustration at the fact that NIAS had not received any funding.

Dr Ruddell said that it had been made clear in recent meetings with the DoH that the NIAS Training Team was temporarily funded and was dedicated to the Degree programmes. He pointed out that it would be important for the Clinical Safety Officers (CSOs) to revert to their original duties.

The Chair acknowledged Dr Ruddell's frustration and asked whether there were any steps the Trust could take to resolve this matter.

Dr Ruddell referred to discussions with DoH representatives and said he had taken the opportunity to challenge the misconception that NIAS had a huge team of staff to support this area of work. He said that Mr Sinclair, Assistant Clinical Director, had also continued to meet with DoH and AHP representatives to discuss the matter. Dr Ruddell added that Mr Bloomfield had also offered to raise the issue with the DoH Chief Nursing Officer.

Mr Bloomfield pointed out that the Chief Nursing Officer had only recently taken up post and he was of the view that she would rely on the views of those DoH officials with whom Dr Ruddell and Mr Sinclair were currently liaising. However, he said that he still intended to write to the Chief Nursing Officer to set out the NIAS position on this matter.

Continuing, Mr Bloomfield referred to the meeting with the Permanent Secretary and said that, while Directors had identified a

number of issues for discussion, the future of the workforce and the training of the workforce were very much linked to the issue of CRM funding and an issue which warranted discussion with the Permanent Secretary.

Mr Bloomfield referred to the risk to the Trust in not being able to deliver the practice placements to the level of quality required and said that that could potentially threaten the BSc programme which would be unacceptable. He said he imagined the DoH response would focus on the fact that there was no funding available and believed that the onus would be on NIAS to identify a pragmatic solution.

Dr Ruddell commented that the Trust was due to have the first students joining PCS in May and he clarified that students would not be on emergency ambulances until later in the BSc programme but said it would be important to have the processes in place. Dr Ruddell informed the Committee of recent correspondence from the Belfast Trust advising the Ulster University that it intended to appoint a Practice Placement but would not be in a position to do so until September. He acknowledged that, while this was a matter between the Belfast Trust and the University, he again expressed his frustration that funding had been made available to other Trusts for these posts. Dr Ruddell referred to the fact that NIAS would ultimately benefit from these posts and indicated his agreement with Mr Bloomfield's earlier reference to the need for a pragmatic solution.

The Chair explained that he had requested the inclusion of 'identification of risk' as a Standing Item on the agenda as good practice and to ensure that any risks applicable to the work of this Committee were identified. He suggested that the issue of funding for practice placements would be identified as an emerging risk with a view to an update being provided to the next meeting.

Mr Sowney referred to the Section 3 of the update which set out the key risks in relation to inadequate NIAS driver training capacity and suggested that there were a number of issues highlighted there as opposed to mitigations.

Dr Ruddell explained that it would be necessary to explore this area as a completely new project and, as such, work was now ongoing to identify potential mitigations. He outlined the current practice of

hiring in vehicles for driver training and said his preference would be to develop in-house training rather than rely on bringing in external instructors. However, he acknowledged the need for financial resourcing to be able to do so. Dr Ruddell said that some benchmarking work had been carried out with other services in terms of developing an in-house training fleet. He added that there was time now within the training timelines to develop in-house driving instructors and AACE would also provide support and guidance in this regard.

Continuing, Mr Sowney referred to page 5 of the AACE report and asked if the Learning Development Plan had been approved by the Trust.

In response, Dr Ruddell explained that the Learning Development Plan set out the Trust's intention for training over the subsequent year. He advised that Internal Audit had recently reviewed the education element and had considered the Learning Development Plan as well as the training plan for the year. Dr Ruddell said that, while Internal Audit had felt the plans were comprehensive, Internal Audit had been keen to present the plan in a different way in terms of Key Performance Indicators and RAG rating.

Dr Ruddell explained that the Learning Development Plan set out the training intentions around the Foundation Degree, AAP and ACA training. He pointed out that what had been known previously as Post Proficiency Training was now referred to as Continuing Medical Education and meetings of the Education and Learning Team were held on a monthly basis. Dr Ruddell explained that, at these meetings, stakeholders were given the opportunity to put forward what they felt needed to be included within training going forward.

In response to a question from the Chair, Mr Sowney confirmed that he had a few more queries for Dr Ruddell but said that he would be happy to share these with him offline.

The Chair thanked Dr Ruddell for his detailed update.

The Committee **NOTED** the update on the Strategic Review of Clinical Education.

(ii) Identification of Risk

As referred to earlier, the Chair said that he would like to record the funding of practice placement co-ordinators as an emerging risk and reminded the meeting that an update would be provided at the next meeting.

No other risks were identified at this point in the meeting.

6 **Framework Scope and Services Specification Assurances – Quality & Safety Aspects (SC07/04/21/04)**

Ms Charlton said she was delighted to advise that, following an expression of interest process for the post of Assistant Director of Quality, Safety and Improvement, Ms Ruth Finn had been appointed on an interim basis and would take up post in the coming days.

She also introduced Mr Conor McCracken, Quality and Service Improvement Lead, to the Committee and explained that Mr McCracken and Mr Sean Maguire would alternate their attendance at the Committee as part of the Trust's Quality and Safety Team.

Ms Charlton provided the Committee with a detailed update on the actions taken to strengthen Trust assurances taking account of compliance, monitoring and assurance of the quality and safety aspects of the Non-Emergency Framework for Independent Ambulance Services.

Referring to the Framework, Ms Charlton confirmed that it was a regional Framework where all Trusts were clients. She added that the Framework should be reviewed two years from its commencement date, however there was a discretionary extension of 24 months which was now being explored in further detail by the Regional Working Group, on which NIAS was represented, with a view to refreshing the Framework.

Ms Charlton advised that there were seven contractors on the Framework which the Trust could engage with during the duration of the Framework. She said the Trust wished to work with contractors collaboratively and support them and outlined to the Committee the various aspects of the Framework review. These included

performance in relation to KPIs; total value/volume of business transacted; utilisation and cancellations and safety and quality.

Ms Charlton indicated that, while she would focus today on the safety and quality aspects within the remit of the Safety Committee, it was worth noting that there were KPIs which would be reviewed for the next contract or Framework arrangement as well as performance indicators which looked at areas such as volume, utilisation and cancellation and financial aspects looking at areas such as transactions, price and price amendment, invoicing and unpaid invoice. She added that this information would be considered by other Trust Committees.

Continuing, Ms Charlton described the areas which would be examined as part of the regular review meetings held with contractors. She said that these were clearly delineated within the Framework so contractors were aware of what would be expected in terms of monitoring. Ms Charlton explained that the regular review meetings would monitor performance against the Framework as well as discussing what actions and corrective actions might be required.

Ms Charlton pointed out that the Framework also referred to announced and unannounced inspections. She said that the Trust had been able to take significant learning from the Care Quality Commission (CQC) which regulated independent ambulance services in England and which had undertaken a series of 70 inspections.

Continuing, Ms Charlton said that, on the basis of the CQC report, she had requested a meeting with colleagues in the Regulation Quality and Improvement Authority (RQIA) to discuss a perceived regulatory gap. She clarified that the RQIA did not regulate independent ambulance services either in health or outside of health in Northern Ireland due to the legislation that was extant. She advised that RQIA was giving this matter consideration.

Ms Charlton referred to the Internal Audit of the Management of Independent Contractors which had received a limited level of assurance, in particular ‘a lack of assurance processes over Independent Ambulance Service contractors in relation to staff and vehicle compliance to required standards…’.

Ms Charlton said that, through collaborative working across many Trust Directorates, an assurance framework had been developed in response to the IA findings. She advised that there had been extensive engagement with independent ambulance service providers and added that the Framework had been shared with them in detail as well as the monitoring templates which would be used at quarterly meetings and during unannounced inspections. Ms Charlton said that providers had had opportunities to comment on the documentation which was in line with the specification.

Referring to the levels of defence, Ms Charlton explained that the Trust wished to have two levels of defence. One where providers would be asked to complete a quarterly assurance template which would provide sign off and it would be recorded electronically as the provider's assurance that they had met the aspects of the Framework. The second level of defence would take the form of unannounced inspections twice a year when Trust officers would complete the monitoring template in respect of safety and quality as well as health and safety aspects to provide assurance that what was confirmed in the quarterly meetings reflected what was found on an unannounced inspection.

Ms Charlton advised that the quarterly monitoring meetings had commenced in December and had been positive to date. She said that the Trust had also taken time to share with providers areas of good practice as well as sharing any tools which providers might find helpful.

She commented that the Trust had also arranged for Mr Des Flannagan, Head of Safeguarding, speak to providers on the expectations of the specification in relation to safeguarding. However, she said it was important to understand the role of the commissioner and pointed out that each provider organisation should have their own expertise internally.

Ms Charlton explained that, at the quarterly meetings, if the Trust identified learning from any independent ambulance service, the Trust would provide the organisation with a learning letter as well as sharing it with all providers in order to share learning.

Ms Charlton advised that the Trust had undertaken one round of unannounced vehicle audits in mid-January and said the findings had been shared with the provider as well as identifying areas for

improvement and a follow-up meeting had taken in place in February. She pointed out that, in respect of one audit, the Trust had been sufficiently concerned to request the provider to remove the vehicle from operation and to make the improvements required in order to meet the standards of care to patients.

Ms Charlton referred to the corrective action template within the Committee papers which set out the actions to be taken in such circumstances.

Ms Charlton alluded to the RQIA Improvement Notice served on the Trust which referred to the Trust having structures and processes to support, review and action the Trust's governance arrangements and undertaking risk assessments. She said that, in developing the specification and Framework, the Trust had been very mindful of some of the learning from RQIA inspections.

She explained that all audits were uploaded onto DOCWorks which had the functionality to send electronic action plans directly to the service provider as well as storing objective evidence such as photographs. Ms Charlton indicated that the findings were shared with subject experts within NIAS and the team comprising health and safety as well as IPC and NEAC colleagues would undertake the inspections.

Ms Charlton advised that the DOCWorks platform provided a corporate dashboard to allow the Trust strengthen its governance and assurance arrangements. She added that the action plans were reviewed on a quarterly basis or sooner depending on the level of risk and said a further round of unannounced inspections would take place over the coming weeks.

Ms Charlton reported that the Trust had also considered variations to the extant contract and consideration was being given to improvements around wording used. However, she reminded the Committee that this was a regional contract so all clients and Trusts would have to be in agreement with any proposed changes.

She said that it had been helpful to review the processes involved because, as the Trust approached a new contract award process, the wording within the Framework would be explicit so the expectations set out would be very clear.

Ms Charlton clarified that there was the ability within the Framework for independent ambulance providers to sub-contract at times of pressure and staff shortages and said the Trust needed to be very mindful of this. She pointed out that any sub-contracting could only be done with the approval of NIAS or another client so the Trust needed to ensure there were processes in place for providers to seek approval in the first instance.

Ms Charlton said that feedback from providers to date had been positive and she commended Ms Caroline McCabe and Mr Gareth Tumelty who had led on the development of the Framework with assistance from a number of Trust Directorates.

Continuing, Ms Charlton said it would be important to ensure that NIAS was allocated independent ambulance services to calls which were clinically appropriate. She said that she, Dr Ruddell and Ms Audrey Murdoch, SAI Officer, had reviewed an initial sample of the calls being allocated to independent ambulance service providers to ensure there was clinical oversight and acknowledged that further work was needed in this area.

The Chair thanked Ms Charlton for her update and invited questions from members.

The Chair referred to the two levels of defence and the fact that the Trust worked on the 'three levels of defence' and he sought clarification on what the third level might be.

Responding, Ms Charlton explained that ordinarily, the third level of defence would be the regulator. She said it was for this reason that the Trust had met with RQIA to discuss the regulatory gap in Northern Ireland compared to England where the CQC regulated independent ambulance service providers.

The Chair questioned whether Internal Audit could be used in this circumstance.

In response, Ms Charlton pointed out that providers were not a HSC service and therefore would not be covered by Internal Audit. She said that there had been significant learning around independent hospitals and regional frameworks and added that one of the challenges for the independent services was that there would be six clients, ie Trusts.

Ms Charlton indicated that, whilst NIAS was doing what was necessary in terms of assuring quality and safety, other clients using independent ambulance service providers should be doing the same and she was of the view that it would be prudent to adopt a collective approach across the region.

Ms Paterson commented that her colleague Directors of Performance had signposted her to Trust officers who were responsible for the Framework with a view to understanding how the Trusts could collectively optimise and make more effective the overall contract monitoring.

Continuing, she said that Ms Charlton had described the robust approach adopted to the elements of the contract within her remit. She alluded to the aspects of the contract which focussed on clinical safety and said she expected NIAS would triangulate all the various aspects of the contract, including performance and finance, into a more composite approach. Ms Paterson commended the work by Ms Charlton to address the high risk areas in such a short timeframe and stressed the importance of ensuring an organisational approach to the contract and identifying dedication contract management in terms of the third party suppliers.

Mr Sowney thanked Ms Charlton for her comprehensive overview and the information within the papers. He welcomed the quarterly monitoring meetings and unannounced inspections and asked whether they presented a challenges in terms of available resources.

Responding, Ms Charlton acknowledged the learning gained from the first round of inspections. She explained that, due to the comprehensive range of quality and safety aspects, it was considered important to have representation from health and safety, IPC and NEAC involved in the visits and added that a Graduate Intern had also accompanied Mr Tumelty on a number of visits.

She said that, while it was important to ensure the correct expertise within the inspection team, she had taken on board the feedback from providers who felt that the number of those attending the inspection had been extensive. Ms Charlton acknowledged that there were five individuals involved in the last audit and accepted

that this could present challenges as it was not possible to audit every provider in one day.

Ms Charlton advised that NIAS had recently been contacted by the regulator about concerns relating to independent ambulance service providers which had been raised with them and they had asked NIAS to undertake an inspection. She added that this placed additional resource pressures on the Trust and reinforced the regulatory gap as, in normal circumstances, the regulator would carry out an inspection. Ms Charlton said she very much hoped that the process would become more streamlined moving forward and reiterated the fact that DOCWorks allowed the action plan to be developed in an automated way and sent the plan directly to the provider.

Ms Charlton stressed the importance of the quarterly monitoring meetings and said it was likely that further resources would be required.

The Chair welcomed the additional assurances being provided for the Trust through this work.

Mr Sowney asked whether there were any circumstances when Ms Charlton would envisage the Trust agreeing to sub-contracting independent ambulance services.

In response, Ms Charlton confirmed that she was aware of the Trust agreement recently to sub-contracting the service. She acknowledged that one area where the Trust had had to strengthen arrangements was its oversight in ensuring that the sub-contractor met the specification. She explained that, while the specification stated that the contractor who is sub-contracting must ensure the sub-contractor met the specification, she would suggest that the Trust needed to inspect the vehicle/s to be used. Ms Charlton suggested that, on occasions, the organisations being sub-contracted may be much smaller organisations and it would be important to ensure that they had all the arrangements in place.

The Chair thanked Ms Charlton for her update which was **NOTED** by the Committee.

7 **Update on the Patient Care Service (PCS) Review (SC07/04/22/05)**

At the Chair's invitation, Ms Byrne drew the Committee's attention to the update on the implementation of the PCS improvement project which was initiated in early February, following the PCS review.

Ms Byrne acknowledged that there had challenges but said that Mr Charlie Thompson, Head of Strategic Transformation, working alongside Mr Nic Daw from the London Ambulance Service, had made great progress on the improvement project which aimed to deliver the key strategic objectives. She pointed out that the project also addressed a number of Internal Audit recommendations.

Ms Byrne referred to the paper which set out the methodology used and said she believed this had given the work real structure and focus. She alluded to the Gant chart within the papers which set out the various phases that would be progressed between February and December 2022.

Continuing, Ms Byrne advised that one risk had been identified within the work relating to access to operational staff to facilitate the improvement project. She explained that the PCS and NEAC were 'lean' structures in terms of staffing and, working with Mr Thompson and Mr Daw to identify the gaps and what would be best placed to provide that additional support.

Ms Byrne reminded the Committee that NEAC was based in the West and efforts had been made to ensure they felt part of the core business. She acknowledged the fast pace of the work and recognised there were some dependencies, for example, in relation to the ongoing CAD procurement work and the HR improvement programme. Ms Byrne said that the summary paper also set out how the Trust would move forward in relation to communication and engagement.

The Chair thanked Ms Byrne for her update. He alluded to the work initially carried out by Mr Wright and sought clarification on how this had informed the work currently underway. The Chair also asked whether consideration had ever been given to privatising the service and what the rationale might be for not doing so.

In response, Ms Byrne explained that the work taken forward by Mr Wright had formed the foundations for the improvement work to be progressed. She advised that Mr Daw, who was currently supporting the project, had been involved in a similar project in the London Ambulance Service so the Trust had been able to avail of learning from that work.

In relation to the Chair's question about privatising the service, Mr Bloomfield clarified that this had not been considered. He reminded the meeting that the PCS review had come about following his request for Internal Audit to audit the service. Mr Bloomfield pointed out that the decision to cease provision of the PCS was not within NIAS' gift and would require a policy decision from the DoH. He said there had been no appetite from either the DoH or the HSCB to change the status quo and he believed that that continued to be the case.

Continuing, Mr Bloomfield said that the Trust's priority should be to make PCS as effective and efficient as possible. He pointed out that the Trust was funded to deliver PCS and said it was his belief and preference that NIAS should continue to do so. He commented that PCS was an intrinsic part of providing necessary transport to hospital for people with needs.

The Chair said that, while the Chief Executive had articulated the reasons as to why privatisation had not been considered, such an explanation appeared to be missing from the documentation. He suggested it would be prudent to have this included as part of the documentation as it was an issue likely to be raised in the future.

Mr Bloomfield agreed with the Chair's suggestion and Ms Byrne undertook to ensure this was reflected in the paperwork moving forward.

Mr Sowney asked whether the review took account of the current dependency on PCS by the A&E service.

Ms Byrne confirmed that this will be reflected. She acknowledged the support provided by PCS to A&E and said that some of this had already moved back to PCS where demand continued.

Mr Haslett commended the ongoing work. He referred to the expected completion date of December 2022 and asked whether the timescale would satisfy Internal Audit.

Responding, Ms Byrne advised that a significant level of information had been provided to Internal Audit to explain the process and the timelines involved. She acknowledged that, while trying to be ambitious, it was also important to be realistic and said that feedback from Internal Audit had been positive. Ms Byrne said she was unsure as to whether Internal Audit would revise the current level of assurance.

The Chair thanked Ms Byrne for her update which was **NOTED** by the Committee.

8 **Surge Response Late Finishes – Category 2 Calls Derogation List (SC07/04/22/06)**

At the Chair's invitation, Dr Ruddell advised that this was one of measures the Trust was taking to try to mitigate against pressures on our crews, particularly those crews who have to wait considerable periods of time at EDs and working many hours past the end of their shift. Dr Ruddell explained that, as well as these crews being retained beyond their end of shift, they were lost to the service the following day due to the need for compensatory rest, resulting in dropped cover.

Dr Ruddell said that the Trust had examined the calls an oncoming crew might be dispatched to as there were very often calls waiting when crews booked on for shift in the morning to determine what the potential was for crews to relieve their colleagues at ED. He said that he had been clear at Trust Board that there was clinical risk associated with this approach.

In determining this approach, Dr Ruddell pointed out that all Cat 1 calls were protected and that crews would be dispatched to these immediately. However, he said that the Trust had examined all Cat 2 calls to determine whether there were time critical/time sensitive elements and he cited the example of a patient who had suffered a heart attack and needed to be taken to the cath lab within 90 minutes or a patient who had suffered a stroke and needed to receive blood clot busting treatment.

Continuing, Dr Ruddell explained that a protected list of Category 2 calls had been produced for which it would not be possible to delay a response and oncoming crews would be dispatched to these calls and crews at ED would have to wait to be relieved.

Dr Ruddell acknowledged that the situation was not ideal and reiterated his comments made at Trust Board that there was potential for medico legal challenge if a response to a Cat 2 call was delayed knowingly and there was a poor outcome for that patient.

Dr Ruddell acknowledged that the introduction of the derogation list had resulted in better cover and the Trust's overall response to calls had improved as a result, notwithstanding the staff welfare issues.

Dr Ruddell said that, from an assurance perspective, every call to which this process had been applied had been reviewed on a weekly basis. He advised that there had not been any adverse outcomes or effects on patients as a result and added that the numbers involved were not huge with the maximum numbers of calls being subjected to this process being 11 in one week. He said that the call delays had ranged from a few minutes to an excess of an hour.

Dr Ruddell also pointed out that there had been no suggestion of any adverse effect either from the notes of the calls or the computer system nor had any of them been flagged up as an Untoward Incident or a Serious Adverse Incident.

Dr Ruddell expressed his continuing concern at having to use this process and knowingly delaying the response to certain Cat 2 calls. However he said that the process had been introduced with a view to improving the community response.

Continuing, Dr Ruddell advised that other ambulance services in England were experiencing longer delays to Cat 2 calls due to the pressures caused by delays outside EDs.

He said that he hoped he had provided some assurance to the Committee about the management and review of the process with a focus on safety. He advised that, on reflection, the process had been amended to remove the delay in response to calls about children as well as revising very slightly the code set which was used to delay calls.

The Chair welcomed Dr Ruddell's explanation of the process and said he understood why it had been introduced. He sought clarification on whether the Trust was legally obliged to response as quickly as possible to calls.

Dr Ruddell said it was his understanding that the Trust had a statutory duty to respond but that there was nothing legally binding in terms of the timescales involved. However there were national standards for anticipated response times against which the Trust could be measured. He pointed out that those crews delayed at EDs were in reality not on duty as they had gone past their finishing time by four hours and, in some cases, in excess of this.

Dr Ruddell pointed out that the Trust did have the ability to release staff from EDs to respond to Cat 1 calls and worked with other Trusts to ensure this was the case.

Mr Bloomfield said he very much appreciated the concern expressed by Dr Ruddell around the necessity to introduce such a process. He acknowledged the recent media coverage relating to NIAS' delays to calls and said that the Trust currently had delayed responses to Cat 2 on a continuing basis. Mr Bloomfield also acknowledged the potential of medical legal cases in the event a patient did not get the response he/she could have otherwise had.

However, he drew the Committee's attention to page 1 of the paper which alluded to the fact that crews were very often working hours past the end of their shift. He said that this was the overwhelming justification for the introduction of this process in that staff had fulfilled their shift and were entitled to go home. Mr Bloomfield also pointed out that it was important that staff rested after busy shifts as the longer they remained on duty, the greater the risk to patients and themselves. He added that, on a longer term basis, the repeated incidence of delayed shift after shift could have a significant detrimental effect on staff health and wellbeing.

Mr Bloomfield stressed the importance of continuing to review those calls for which there had been a delayed response.

Mr Haslett commented that the general public tended not to distinguish between Cat 1 and Cat 2 calls. He referred to the derogation list and sought clarification around the point at which

Emergency Ambulance Control (EAC) would suggest the need for family to transport a patient directly to hospital rather than wait an ambulance response.

At Dr Ruddell's request, Mr Rafferty reminded the meeting that the call-takers in EAC were non-clinical staff and he explained in the detail the scripts used to prioritise calls. He advised that, at times of demand, there were a number of Medical Director approved scripts to advise the caller that there would be a delay in response and asking whether they could make their own way to hospital. Mr Rafferty advised that the Trust could not insist on a patient making their own way to hospital but could only advise the patient of the Estimated Time of Arrival for the ambulance for the category of call.

Continuing, Mr Rafferty explained that there were clinicians present in the EAC in terms of the Clinical Safety Desk as well as paramedics and hopefully nurses moving forward. He said that these individuals could use their clinical autonomy to advise the patient to make their own way to ED given the non-availability of ambulance resources.

Mr Haslett thanked Mr Rafferty for his explanation and emphasised the complexity involved. He said he was aware of the scripts and algorithms used by the call-takers but added that the allocation of the call also depended very much on the information being given by the caller who were often in panic.

Dr Ruddell said that the service recognised the likelihood that those calling for an ambulance were often upset and explained that huge effort had been made in ensuring the questions posed by the call-takers were straightforward. He clarified that there was a separate process for medical professionals who called. Dr Ruddell commended the call-takers who guided callers through the process to get the right answers to allow them determine the condition of the patient.

Mr Sowney suggested that it would be helpful to compare the amount of compensatory rest 'saved' against the Trust's ability to respond to calls which would assist in setting out the Trust's rationale in introducing the derogation list. He acknowledged Dr Ruddell's position as the Trust's Medical Director and his fundamental desire not to have had to introduce a derogation list in

the first instance. However, he said that he would view the crews delayed at EDs as being replaced by crews on active calls.

Responding to Mr Sowney's suggestion, Dr Ruddell commended the Information Team on the development of a monitoring dashboard for late finishes – Cat 2 Held Calls which he shared with members showing each call that had been subject to the derogation list by Division. He acknowledged that further work was required to refine the information even further.

Mr Sowney sought clarification on whether the derogation had been rolled out to all areas and whether there was scope for further areas to be included on the derogation list.

In response, Dr Ruddell confirmed that, while derogation was operational across all Divisions, it was variable in that some Divisions were more effective in turning ambulances around at EDs. He advised that some Divisions were trialling other initiatives to improve turnaround times such as changing shift change-over times.

Continuing, Dr Ruddell advised that the derogation list was constantly under review. He indicated that the Trust had actually reduced the number of areas where responses would be delayed and said that he did not envisage an expansion of the derogation list.

Mr Bloomfield suggested that it would be helpful for the Committee to see the impact of the derogation list on the number and duration of late finishes for staff and said that the Trust's Information Team might be able to produce this.

The Committee **NOTED** the Surge Response Late Finishes – Category 2 Calls Derogation List as presented by Dr Ruddell.

9 **Medicines Management – Root Cause Analysis (RCA) on NIAS Expired Drug Pack Reporting (SC07/04/22/07)**

Dr Ruddell reminded the Committee of the background to this issue and said that the paper was the Root Cause Analysis the Trust had produced at the request of the DoH Medicines Regulator. He commended Ms Hanna, Lead Pharmacist, on leading this work and

for her work to date in reviewing the Trust's medicines arrangements.

Continuing, Dr Ruddell said that this work had shown that, whilst there were pressures on staff to undertake regular checks and audits, there was a system in place which demonstrated that individual drug packs could be tracked.

Ms Hanna highlighted the key points from the report. She advised that the Trust had a number of expired drug packs in the system and said that this issue had originated from the inability to undertake checks at station level because the Trust was continually at REAP Level 4 as well as station supervisors' time being reduced to allow them undertake frontline operational duties.

She advised the Committee of the Trust's plans to electronically tag all drug packs and the electronic system would flag up any untoward diversions.

Ms Hanna highlighted a risk in that a number of errors had been identified in the drug spreadsheet and acknowledged that further work was required around the management of this spreadsheet in terms of ensuring it was maintained on an ongoing basis.

Ms Hanna confirmed that the DoH had authorised her to be a witness to the destruction of controlled drugs which meant that the Trust could legally destroy drugs if a pack was contaminated. She advised that work was ongoing to put in place procedures around contaminated packs with a view to disseminating these to staff to mitigate against that risk.

Ms Hanna advised that she had also progressed work in relation to establishing a monitoring framework with the Trust's pharmacy provider to monitor the service being received with a view to improvements being made.

The Chair commended Ms Hanna on the comprehensive nature of the report and suggested it would be helpful for any reports coming to the Committee to have numbered paragraphs to assist in the navigation of the documentation.

Mr Bloomfield commended the report and said the detail showed the value of having a Lead Pharmacist in the Trust. He referred to

the proposed actions and sought assurance from Ms Hanna that the pharmacy provider arrangements were sufficiently robust.

Ms Hanna explained that the monitoring arrangements now in place would assist in this regard and the provider would be held to account where necessary. She referred to the Service Level Agreement in place and suggested that this could be revisited should it become necessary.

Ms Charlton extended her thanks to Ms Hanna and said that it was clear from staff on the ground that her work to date was very much appreciated.

Ms Paterson referred to the spreadsheets around the quality and data issues highlighted by Ms Hanna and enquired whether there was any assistance the Trust's Information Team could give in terms of automating the necessary checks around drug packs.

In response, Ms Hanna explained that there would certainly be a role in terms of the paperwork currently used as well as the data collated from REACH as the system moved to a more electronic based system. However she referred to the complexity of the spreadsheets used and the fact that further work was required on the part of the pharmacy provider to ensure they were kept updated. She stressed the importance of looking at a digital solution.

Ms Paterson agreed that there was potential for this work to be supported from a digital and information perspective with a view to making the information more robust from an assurance point of view.

Mr Sowney welcomed Ms Hanna's appointment as Lead Pharmacist and said her appointment had been beneficial to the organisation. He alluded to a number of existing controls, in particular commentary around matching drug records to existing Patient Report Forms (PRFs) and commented that there were occasions on which PRFs could not be located or had been incomplete so it would be prudent not to be assured by this. Mr Sowney also raised an issue relating to handwritten expiry dates.

He said that he had been reassured by the work taken forward by Ms Hanna in relation to establishing a monitoring framework to review the work undertaken by the pharmacy provider and to hold

them to account where necessary through the Service Level Agreement.

Dr Ruddell clarified that the report had been provided to the Medicines Regulator and had been shared with the pharmacy provider. He indicated that the report had identified a number of areas for improvement within the Trust as well as setting out the Trust's plans for improvement.

Referring to the point raised by Mr Sowney in relation to PRFs, Dr Ruddell alluded to the REACH system and said that the move to electronic bag tracking would remove the potential for human error. He said that he looked forward to the full implementation of REACH and indicated that he was keen to move to the technological solution for tracking bags. Dr Ruddell said that Mr Sean Moore, Medical Devices Manager, had had previous experience in this area in terms of asset tracking which potentially had benefits for not just drugs but for equipment across the service.

The Chair welcomed the progress which had been made to date and thanked Ms Hanna for her attendance.

The report was **NOTED** by the Committee.

10 **Serious Adverse Incidents: current position and learning outcomes (SC07/04/22/08)**

Ms Charlton drew the Committee's attention to the SAI report and advised that the position regarding the SAI submission dates had improved slightly with a number of reports now awaiting Director approval before submission to the HSCB within the next week.

Ms Charlton acknowledged the challenges as a result of the continued REAP 4 status and the ability of staff to provide the report and to engage appropriately with families and colleagues.

Ms Charlton referred to Mr Bloomfield and Dr Ruddell's appearance on the Nolan Show on 6 April and said they had articulated very well the challenges being experienced by the service.

The Committee noted that, since April 2021, 29 incidents had been identified as SAIs and notified to the HSCB.

Ms Charlton's presentation provided an overview of the performance against HSCB timelines as well as a summary of deaths associated with SAIs including key causal and contributory factors. She outlined the processes followed within the Trust in the consideration of incidents to determine whether they met the SAI criteria. Ms Charlton explained that consideration was also given as to whether incidents met the criteria for Early Alert. She advised that the purpose of an Early Alert notification was to ensure the DoH (and thus the Minister) received prompt and timely details of events which may include potential SAIs which may require urgent attention or possible action by the DoH including those of media interest.

She took the Committee through the details of a number of SAIs and the learning identified through the review.

Continuing, Ms Charlton highlighted the key findings of the AACE report – Delayed Hospital Handover and Impact Assessment – and said that the Trust was working on an improvement project around the learning and actions related to escalation of the deteriorating patient at EDs.

Ms Charlton referred to work being undertaken with colleagues in EDs around a standardised approach to identifying the most clinically urgent patients on arrival/handover at ED as well as undertaking some work with NIAS staff around the early identification and reporting of the deteriorating patient. This work would also look at the development of a robust standardised process around the escalation processes.

Mr Sowney sought clarification on whether there were any recurring patterns within the SAI themes identified.

In response, Ms Charlton confirmed that there were and explained that further work was planned by the QSI and Risk teams to better understand that was being done around those clinical areas was making a difference. She also pointed out that consideration was being given to how to measure those instances and commented that, while they were few in number, it was clear that there was a theme.

Ms Charlton added that improvements had been made to the reporting processes to the Education and Learning Development Group chaired by Dr Ruddell to better summarise the key themes and where training should focus.

Mr Bloomfield advised that, following the Nolan Show, the DoH had sought confirmation that the Trust Board was aware of the SAIs. He said that he intended to advise the DoH that the Trust's Safety Committee regularly received updates on SAIs and on those SAIs where the outcome is death. He asked if the Committee would be content that such a response would be agreeable.

Committee members agreed to the Chief Executive's proposed response.

Ms Charlton pointed out that, following the IHRD recommendations, Board members would receive a copy of the notification where there is a death associated with a SAI.

The Committee **NOTED** the report.

11 **Complaints and Compliments: current position and learning outcomes (SC07/04/22/09)**

Ms Charlton noted that, while improvements had been made, work remained to be done.

She advised the Committee of the 78% increase in the number of complaints received by the Trust and said that, during the period April 2020-March 2021, 148 complaints had been reported to the Trust while 263 complaints had been received during the same period in 2021-2022.

Ms Charlton indicated that, although there had been an improvement in the number of complaints closed (96% increase for the same period during 2020/21), the Trust continued to experience challenges with performance (25%) against the regional KPI of closure within 20 working days in the context of sustained REAP 4. She reported that the top three themes, as reported to the Committee and Trust Board, remained unchanged and she advised that these were (1) delayed response, (2) staff attitude and behaviour and (3) quality of treatment and care. A 77% increase of recorded compliment for the same period of

2020/21 was noted.

Mr Sowney referred to staff learning from complaints and acknowledged the challenges for such learning to be disseminated given the fact that Clinical Training Officers were supporting frontline operations. He asked if there was any potential for mitigation.

Responding, Ms Charlton advised that, despite the REAP 4 context, the dissemination of learning continued to take place but the issue was around the timeliness of how that took place. She alluded to the anxiety felt by staff during the investigation and review of complaints and SAIs. Ms Charlton alluded to the appointment of Mr Johnny Noble as Head of Professional Standards and was of the view that this role would be invaluable in moving forward.

Ms Charlton advised that, given the sustained REAP Level 4, Directorates were currently reviewing the REAP action cards. She said that while REAP 4 dictated that all focus should be placed on the operational response, the Trust had not received any dispensation from the DoH or the HSCB around complaints and SAIs.

Ms Charlton said that, while it was important to bear this in mind, what was more important was the need to engage sooner with families. She indicated that the Trust was going to explore this further to ensure engagement was taking place in a more timely way with a view to having thorough and robust family engagement while supporting staff at the same time.

Dr Ruddell said that he wished to recognise the work carried out by Ms Charlton and staff from both her Directorate and the Operations Directorate in relation to family engagement.

The Committee **NOTED** the report.

12 **Control Room Performance – Cat 1 and Cat 2 Improvement Group (SC07/04/22/10)**

At the Chair's invitation, Mr Rafferty provided a comprehensive update around the work being progressed to improve Cat 1 and Cat 2 performance.

Mr Sowney referred to the increase in calls and sought clarification on how much of that increase was due to multiple calls in relation to the same call. He pointed out that the increase in calls was not necessarily transferring in an increase in conveyance to EDs as the activity at EDs from an ambulance perspective had not increased.

Mr Rafferty advised that duplicate calls received by the EAC accounted for approximately one third of the total calls in any given day and he acknowledged the need that, when cancelling duplicate calls, the call back to cancel the call was also counted. He clarified that account was also taken of those calls received to advise EAC that the patient was making their own way to ED.

Mr Sowney said it appeared that the South Eastern Division was the worst performing in terms of Cat 1 and Cat 2 performance and he queried how much of this was due to high levels of sickness and absenteeism which then translated into poor cover or whether it related to the delays experienced at the Ulster Hospital. He noted that the West had the best coverage despite its rurality.

Mr Rafferty said that the West was nearly in line with the ORH projections. He pointed out that cover in the West was generally at 100% or above and advised that this correlated directly to response times in that Division.

Ms Byrne referred to the coterminous pressures between the South Eastern and Belfast Divisions. She advised of a number of work-life balance arrangements which had been put in place on a permanent basis and said that these, alongside the dropped cover, contributed to the challenges cover in the SE Division presented. Ms Byrne emphasised that the Trust did wish to be an employer of choice and said that the focus of work currently being taken forward was to triangulate with a view to ensuring additional resources for that Division.

The Committee **NOTED** the update on Cat 1 and Cat 2 Improvement Group.

13 **Hygiene, Cleanliness and Infection Prevention and Control – Key Performance Indicators: Environmental and Vehicle: 1/4/21 – 28/2/22 (SC07/04/22/11)**

The Committee noted the most recent report as well as the arrangements being put in place for strengthening assurances.

Ms Finn said there was a need to look at aspects of the environmental and vehicle cleanliness in terms of how the Trust wished to deliver this service moving forward. She advised that the Trust was currently developing an Options Appraisal to consider these areas of work.

Ms Finn pointed out that, following approval by the Senior Management Team, work was underway to move the facilities management aspect of work in-house and she referred to the significant complexity of this work which would form part of the overarching Options Appraisal.

The Chair acknowledged that there was still work to do, significant progress had been made in relation to IPC since he had joined the Board.

Ms Charlton referred to the Trust's intention to strengthen the assurance arrangements in this area. She noted the high aggregated compliance levels but said that, when one looked at this at individual station levels, it was clear that further work was required to ensure individual stations met the required compliance levels. Ms Charlton also advised of the intention to introduce independent audit whereby it strengthens the assurance of the audit carried out within individual stations.

Mr Sowney alluded to the reference within the report to the difficulties around the completion of audits in the SE Division and was of the view that there was a trend developing.

Mr Haslett commended the progress made in the area of IPC.

The Committee **NOTED** the Hygiene, Cleanliness and Infection Prevention and Control – Key Performance Indicators: Environmental and Vehicle: 1/4/21 – 28/2/22.

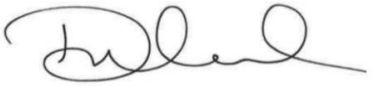
14 **Date of next meeting**

The next meeting of the Safety Committee will take place on Thursday 9 June 2022 at 9.30am (arrangements to be confirmed).

15 **Any Other Business**

There were no items of Any Other Business.

THIS BEING ALL THE BUSINESS, THE CHAIR DECLARED THE MEETING CLOSED AT 12.45PM.



SIGNED: _____

DATE: 28 May 2022