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 8 SEPTEMBER 2022 IN THE BOARDROOM, NIAS HQ

PRESENT:	Mr D Ashford	-	Committee Chair
	Mr W Abraham	-	Non Executive Director
	Mr T Haslett	-	Non Executive Director (joined the meeting at 10.05am)
IN ATTENDANCE:	Mr M Bloomfield	-	Chief Executive
	Ms M Paterson	-	Director of Planning, Performance & Corporate Services
	Dr N Ruddell	-	Medical Director
	Mr R Sowney	-	Senior Clinical Adviser
	Mrs C Mooney	-	Board Secretary
	Ms R Finn	-	Assistant Director QSI
	Dr D Monaghan	-	Clinical Lead HEMS (for agenda item 6)
	Dr R McLaughlin	-	Assistant Medical Director (for agenda items 6 & 7)
	Ms E Boylan	-	Clinical Service Improvement Lead (Acute Care) (for agenda item 7)
	Ms A Murdoch	-	SAI Lead (interim) (for agenda item 14)
APOLOGIES:	Ms R Byrne	-	Director of Operations
	Ms L Charlton	-	Director of Quality, Safety & Improvement
	Mr P Nicholson	-	Interim Director of Finance
	Mr J Wilson	-	Boardroom Apprentice

1 Apologies & Opening Remarks

Apologies were noted as above.

The Chair welcomed everyone to the first face-to-face meeting in some time and extended a particular welcome to Ms Finn who would be representing Ms Charlton in her absence and who had recently been appointed as Assistant Director of Quality, Safety and Improvement.

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 (SC08/09/22/01)

The minutes of the previous meeting on 7 April 2022 had been **APPROVED** by e-mail and presented to the Trust Board meeting on 23 June 2022.

4 Matters Arising (SC08/09/22/02)

Members **NOTED** the action list.

Dr Ruddell referred to the derogation list and explained that, while available for use at evening handover, operational decisions had been made to limit its use to the morning handover period. He advised that a more detailed update would be provided to the November meeting.

Ms Paterson advised that duplicate calls continued to rise in July and explained that, while there had been an increase in call demand, ambulances had been delayed at hospital EDs thereby reducing availability of resources in the community and impacting on NIAS' response times.

She said that the hospital handover times had a direct correlation on Cat 2 calls and call answering and added that this focussed on control performance.

Ms Paterson referred to the update which had been provided by Ms Byrne, in particular the initiatives around the Computer Aided Despatch (CAD) and telephony replacements. She advised that the Trust had recently implemented a network to support the installation of new software which would allow a much closer focus on performance. Ms Paterson said that a module with the new CAD system would allow communication back to the caller to make them aware of a delay in response and give them an estimated time of arrival. Ms Paterson believed that this would mitigate the impact of duplicate calls if callers were given an estimated time of arrival.

Ms Paterson stressed the importance of managing expectations of callers in a proactive way. She indicated that, whilst awaiting the installation of the CAD, there were technologies which would allow the service to send texts to callers in an effort to mitigate duplicate calls.

Mr Bloomfield said that the longer term and interim technological solutions would be important and said it was natural that, at times of distress, callers would call back to confirm that an ambulance had been despatched.

The Chair said that it was clear that duplicate calls were having an impact on call performance. He referred to Mr Sowney's question around whether there had been a reduction in calls following the allocation by NIAS of personal devices to Independent Ambulance providers and encouraging staff to use MDT all the time as opposed to times of high volume.

Responding, Ms Paterson said she would need to check whether there had been any definitive impact on routine calls and acknowledged that the Trust needed to become more sophisticated in term of managing these areas. She noted that the Trust's absence levels had increased in July and added that its call answering performance had been impacted as a result.

Mr Sowney indicated that the use of MDTs at all times as opposed to times when under pressure would ensure that telephone lines were kept clear.

Dr Ruddell pointed out that ideally there should be no duplicate calls if patients were receiving a timely response.

Mr Abraham commented that he could foresee a number of callers with no change in circumstances phoning again to ensure they remained in the queue for a response while other callers call back because conditions have deteriorated.

Mr Bloomfield acknowledged that the Trust's public messaging would advise callers to call back if there was a change in a patient's condition. He said he would be concerned that there may be individuals who did not call back when their condition worsened who needed to be conveyed to hospital.

Mr Sowney expressed his concern with public messaging which aimed to discourage the public from making unnecessary calls. He was of the view that, if individuals felt they had a need to call '999' to be conveyed to hospital, they should not be discouraged from doing so. It was ultimately a clinical decision to be taken either by NIAS staff to convey or not, or for clinical staff in a hospital setting to decide as to whether or not it had been appropriate to convey the patient.

Mr Bloomfield acknowledged the minimal impact of such public messaging and said however that it would be important to let staff know that the Trust was aware of the pressures under which they were operating. He added that some staff had voiced the view that the Trust should be doing more to address this issue.

Mr Sowney accepted this but felt it would be more appropriate for staff to be aware of the Trust's reluctance to promote this type of public messaging. He believed that the impact on staff was more about the long waits they were experiencing at EDs to handover patients.

Mr Bloomfield agreed that appropriate public messaging around making the right choices was an important element of a planned communications programme rather than at times when EDs were extremely busy.

Responding to a query from the Chair as to the effectiveness of the 'phone before you go' initiative in place at Lagan Valley Hospital, Dr

Ruddell said that feedback to date had been positive. He explained that when a patient phoned the ED directly, they were given an appointment time by the hospital staff to attend.

Concluding the discussion, the Chair noted that the Trust might expect to see some improvement in call answering performance with the introduction of the new CAD system. However, he acknowledged that this was some time away.

Ms Paterson reminded the meeting that the Trust was considering interim solutions and undertook to provide an update at the November meeting.

5 **Standing Items:**

(i) Strategic Review of Clinical Education Update (SC08/09/22/03)

At the Chair's invitation, Dr Ruddell provided a detailed update on the Strategic Review of Clinical Education.

Referring to the practice placement co-ordinator post, Mr Sowney sought clarification on whether there would be risk associated with the Trust not being able to have this post in place.

The Chair advised that this had been identified as a risk at the previous meeting.

Dr Ruddell said that the Trust was currently considering the placement of students and ensuring that those students undertaking the BSc course were allocated to practice educators. He said that he had recently received positive feedback from the University as well as from those students undertaking placements. He referred to the fact that, within the Band 6 paramedic job description, there was reference to the mentorship role to be undertaken and he acknowledged that the Trust needed to build on this.

Mr Bloomfield stressed the importance of ensuring students had a positive experience and said he looked forward to seeing the report from the University.

Mr Sowney said the positive feedback from both students and the University made the post of practice placement co-ordinator more

important. He reminded the meeting that the Trust would be measured on the formal feedback received.

Mr Sowney said that reference had previously been made at Trust Board meetings around the need to divert Clinical Support Officers to frontline duties during the pandemic. He commented that it would be important for the Trust to assure itself that training was being delivered in order to provide the standard of care to which the Trust aspired. Mr Sowney acknowledged that an important element of the Clinical Support Officers was around, for example, maintaining standards, providing feedback to staff on their clinical practice and undertaking clinical audits.

With regard to the DoH/UU ten places, Mr Sowney commented that not all of the ten allocated places had been filled by NIAS EMTs and asked if any learning had been identified from this.

Responding, Dr Ruddell advised that more posts had now been filled.

Mr Sowney believed it would be important to provide support to potential applicants and those students entering their second year of study alongside BSc students already established on the course.

Dr Ruddell explained that pastoral support was provided by the University and said he had had the opportunity to meet with the students undertaking their second year.

Mr Abraham asked whether consideration had been given as to how that connection could be strengthened.

Responding, Dr Ruddell pointed out that the BSc was a full-time course and added that, as the Trust continued to remunerate these students, there was potential for students also to undertake shifts. He also pointed out that the students, as employees of NIAS, could still access support systems within NIAS as well as the University's pastoral care.

Dr Ruddell agreed the importance of providing support to students as they progressed through the BSc course and said that this would assist the Trust in ensuring the availability of student places in subsequent years.

Mr Abraham said he was aware of fellowship programmes which supported students through, for example, providing opportunities for camaraderie, reflection, regular meetings and thus ensuring lines of communication were maintained. He added it would also be important to support prospective students through the application process.

Mr Bloomfield said it would be important to encourage those students to take up posts within NIAS upon their graduation in 2024 and provide the necessary career progression.

Dr Ruddell said that the University was keen to explore the potential for joint appointments and said that NIAS staff had been involved in particular aspects of the teaching programme throughout the year.

Mr Sowney welcomed the Trust moving ahead with joint appointments and acknowledged that the University would no doubt very much appreciate the expert input from NIAS staff. He added that the Trust needed to be mindful of the potential to lose NIAS staff to the University.

Mr Sowney referred to the key role played by the Professional Standards Officer Policy and noted that the Trust intended to produce its Professional Standards Policy by November 2022. He also alluded to the staff engagement sessions which had taken place between June and August and sought further detail on the format these sessions had taken.

Dr Ruddell confirmed that the engagement sessions had taken place and were supported by the Trust's Transformation Team. He explained that these had been conducted through small events and surveys and said he looked forward to receiving the feedback.

The Chair highlighted the ongoing challenges around driving instruction and believed these were a 'red flag'. He also alluded to the reference in the update to agreeing an interim arrangement for student indemnity with the University for the first cohort of students that commenced in May 2022.

Dr Ruddell commented on the importance of ensuring indemnity was in place in the event that students from the University working for NIAS were injured or caused injury to patients. He clarified that students should only provide care to patients when under the

direction of a NIAS clinician. He explained that the University required the Trust to sign the indemnity agreement on a regular basis as opposed to having an annual agreement in place.

With regard to driving instruction, Dr Ruddell reminded members that this was not originally part of the review of clinical education but had been identified as the review had progressed. He acknowledged that this presented a significant pressure which would likely increase over time. Dr Ruddell said it was likely that the Trust would follow the rest of the UK ambulance services in having to provide regular refresher training for drivers and he commented that this would require a team to oversee and deliver this work.

Responding to a query from Mr Abraham as to whether this would be requalification or refresher courses in the form of a practical assessment, Dr Ruddell clarified that the expectation would be that those staff trained to drive 'blue light' would receive refresher training every couple of years through practical assessment. He explained that the Trust currently procured driver training through external sources as well as hiring in vehicles. Dr Ruddell pointed out that this would affect all 'blue light' services and would require a considerable business case to be developed for consideration.

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

(ii) Identification of Risk

The Chair noted this agenda item and advised that risks might be identified as discussion progressed.

6 **Delivery of Pre-Hospital Emergency Anaesthesia by the Northern Ireland Helicopter Emergency Medicine Service (HEMS): A 42-month review of practice (SC08/09/22/04)**

The Chair welcomed Dr Darren Monaghan to present the 42-month review of practice of the delivery of pre-hospital emergency anaesthesia by HEMS. Dr Russell McLaughlin attended for this discussion.

Dr Monaghan noted that Pre Hospital Emergency Anaesthesia (PHEA) was one of the key interventions that HEMS provided to critically ill patients. He added that it allowed optimal critical care

provision at the earliest opportunity and should be delivered to patients in the pre-hospital setting to the same standard as provided in hospital. He explained that this was the reason why HEMS was partly staffed by Consultants in Emergency Medicine/Anaesthetics or Intensive care to deliver PHEA as part of a physician/paramedic HEMS team.

Dr Monaghan advised that HEMS was a partnership between NIAS and Air Ambulance NI and had successfully implemented PHEA within a robustly governed system as well as recently publishing a paper on the review of this procedure. He highlighted the key points to the Committee.

Mr Abraham welcomed the report and queried what figure was being used as a benchmark in the absence of a meaningful national figure.

Responding, Dr Monaghan pointed out that the service was using the improvement at scene time and explained that this was the time of procedure to the time of leaving the scene.

Dr McLaughlin commented that the time element was of secondary nature and that the focus should be on patient outcome and ensuring the procedure was correctly carried out.

In response to a comment from Mr Abraham around setting the standard for HEMS and measuring against it, Dr Monaghan clarified that the service had adapted clinical parameters to ensure there were no adverse clinical outcomes.

Mr Bloomfield agreed with Dr McLaughlin's point that the primary focus should be on the patient outcome and said he believed this was more reflective of the service provided.

Dr Monaghan pointed out that HEMS would very often not be aware of the patient outcome when they transferred a patient to an ED.

Dr McLaughlin reminded the meeting that the HEMS was performing a high risk medical procedure out of a hospital setting and the Trust was in a position to report no adverse outcomes through the robust governance procedures in place.

Dr Monaghan pointed out that it was his understanding that hospital settings did not always measure the provision of PHEA. In response to a comment from Mr Sowney, he confirmed that, on average, the HEMS was carrying out two Rapid Sequence Intubation (RSI) per week. Dr Monaghan added that pre-hospital treatment was the most critical intervention provided by the HEMS.

Mr Sowney was of the view that the fact that only two RSIs were being carried out each week underlined the importance of the training element and said that the daily training undertaken was key to the success of the procedure. Mr Sowney suggested that there was learning in this approach for the rest of the organisation.

Mr Sowney referred to the inclusion of 'humanitarian need' as an indicator for performing PHEA and sought further detail on this.

In response, Dr Monaghan explained that this would apply to a patient who had suffered significant and horrific injuries, for example, and HEMS would anaesthetise the patient to relieve them from their pain.

Mr Sowney commended the results of the audits undertaken by the HEMS and asked if it was possible to identify individual clinicians who might need further training.

Dr Monaghan explained that each clinician who performed an intubation would be reviewed by the ICU Consultant at the Royal Victoria Hospital and any further training requirements would be highlighted through this review.

Mr Sowney asked if the paramedics working alongside the consultant would perform intubation or whether they were considered to be the 'trained assistant'.

Responding, Dr Monaghan stressed the importance of paramedic involvement and explained that the paramedic co-ordinated and controlled all aspects at the scene. He highlighted the nature of the partnership working between the paramedic and consultant.

Dr McLaughlin pointed out that the national standard stated that PHEA should not be undertaken in the absence of the trained assistant.

Mr Sowney queried whether there were any other aspects of the services provided by NIAS where PHEA would be performed.

Dr Monaghan clarified that, while some BASICS doctors (British Association for Immediate Care Schemes) were trained to perform PHEA, not all BASICS doctors would perform this procedure. He suggested that it would be timely to look at this approach and determine whether those BASICS doctors performing the procedure were doing so to the national standard and in the absence of a trained assistant. Dr Monaghan referred to the trained assistant and said that this individual was integral to the procedure. He pointed out that the HEMS would not perform a PHEA at scene in the absence of the trained assistant.

Responding to a question from Mr Sowney as to how BASICS doctors compared to the national standard, Dr Ruddell explained that a number of BASICS doctors were also HEMS doctors and undertook the same training as HEMS doctors. However, he said, not all BASICS doctors would perform a PHEA procedure. Dr Ruddell advised that an element of BASICS training was an introduction to acting as an intubation assistant and how to assist colleagues performing a PHEA. Dr Ruddell said that the topic of PHEA had been discussed at recent meeting of the BASICS Clinical Governance Group and it had been determined that, unless a trained assistant was present, BASICS doctors would not perform PHEA.

Mr Sowney asked whether this posed a risk.

In response, Dr Ruddell reiterated the view that, unless an assistant was present, BASICS doctors would not perform PHEA. He acknowledged that the likelihood of the procedure going wrong was small but the consequences could be catastrophic. Dr Ruddell said, when performed correctly, the benefit to patients from PHEA was significant and, as a result of withdrawing this option from BASICS doctors, there was the potential for some patients with challenging airways to miss out on an intervention which might significantly improve their outcome.

Dr Monaghan pointed out that BASICS doctors could not be criticised by a representative body for not performing the procedure and that NIAS could follow the example of Scotland where BASICS doctors could still respond to incidents but did not deliver PHEA.

Mr Sowney acknowledged that the number of patients treated by BASICS doctors who required this procedure was low and therefore the risk associated with BASICS doctors carrying out this procedure would be higher.

Dr McLaughlin pointed out that, when acting on behalf of the Trust, clinicians were expected to use only those drugs supplied by NIAS. Likewise, he said, if clinicians were using anaesthesia drugs, such drugs should only be used within the Trust's framework. He confirmed that this had been communicated to BASICS doctors within the last week.

Mr Sowney believed that, as the Trust's Safety Committee, the Committee should endorse and support the same level of governance being applied to BASICS doctors. He added that, if this were not possible, then the procedure should not be performed because the risk would be too high. Mr Sowney emphasised the need for the Trust to ensure clinicians were practising safely in every area governed by the Trust.

Mr Abraham asked what numbers of patients would be impacted by the decision for BASIC doctors not to perform intubation.

The Chair suggested that, as the number of BASICS doctors performing the procedure was low, the numbers of patients impacted would also be low.

Dr Ruddell said that he would like to recognise the quality of the presentation and the work of the HEMS team which, he believed, was an example of what could be achieved by a team who had sufficient free time to practice procedures and analyse performance on a daily basis.

Mr Bloomfield acknowledged the significant input by Dr Monaghan and Mr O'Rourke as medical and operational leaders. He said that Dr Monaghan was always keen to highlight the partnership and role of the paramedic and NIAS in the work of the HEMS.

The Chair thanked Dr Monaghan for his presentation and commended the exemplary work carried out by the HEMS. He said that he looked forward to receiving further updates.

The Committee **NOTED** the update provided by Dr Monaghan who then withdrew from the meeting.

7 Cardiac Arrest Outcomes Update (SC08/09/22/05)

The Chair welcomed Ms Emma Boylan to the meeting and invited her to update the Committee on cardiac arrest outcomes, including benchmarking against a number of other UK ambulance services over the last number of years and the associated challenges.

Following Ms Boylan's presentation, Dr Ruddell pointed out that focus was needed on this area in order to improve outcomes for patients. He acknowledged that the Trust appeared to be lagging behind other UK ambulance services but indicated that there had been some improvement in recent years. Dr Ruddell referred to the cardiac arrest comparison figures for Scotland and said that it was the intention that the NIAS should adopt a 10-point approach used by its Scottish counterparts.

Continuing, Dr Ruddell acknowledged the current challenges in NI in terms of ambulance response and stressed the importance of CPR being commenced as soon as possible until the emergency services would arrive on scene. Dr Ruddell pointed out that approximately 4,000 people in Northern Ireland had completed CPR in a recognised first aid course and had volunteered to become GoodSam responders. He explained that these volunteers were in essence members of the public who had been trained in CPR and who may be close to an individual suffering a cardiac arrest and able to perform CPR until the ambulance arrives.

Dr Ruddell advised that governance is provided through the GoodSam organisation who sign individuals off following receipt of evidence of qualifications.

Dr Ruddell referred to the systems in place within NIAS to provide support to staff following a traumatic incident and advised the NIAS Community Resuscitation Team had expressed concern as to how support would be provided to GoodSam volunteers following an incident. He explained that the GoodSam system maintained records of volunteers who had been deployed to calls and acknowledged the challenge in terms of providing pastoral care to volunteers. He explained that there were also challenges within the NIAS Control Room in supporting the wider roll-out of GoodSam.

He alluded again to the fact that there were approximately 4,000 volunteers throughout Northern Ireland who had the skills and ability to perform CPR and was of the view that there should be further focus on training individuals throughout the health service and the general public.

Mr Bloomfield acknowledged that, when this presentation was given to the Senior Management Team a few weeks previously, concern had been expressed at the Trust's performance against other UK ambulance services. He said it was clear it was necessary to improve that position and believed this point represented the start of the journey to do so. Mr Bloomfield agreed with Dr Ruddell's point around making use of those 4,000 GoodSam volunteers and referred to the need to include the HSC workforce. He said there was a need for a joined up approach across Trusts to encourage individuals already trained to sign up as well as encouraging others to undertake training.

Ms Paterson alluded to the assistance REACH and electronic data would provide and said she would follow up with Ms Boylan in terms of data collation from Informatics. She commented that a member of the Informatics Team had been released to assist with data collation.

Dr McLaughlin advised that the service was not seeing sufficient return of circulation in patients and he acknowledged that this was a clinical concern. He advised that he and Ms Boylan had arranged a number of focus groups with Divisional Training Officers and Clinical Support Officers to share data with them and discuss the findings of this work.

Dr McLaughlin referred to the need to ensure all NIAS staff were highly trained and assessed in Basic Life Support (BLS) and said he was not sure if this was currently the case. He said it was his view that, upon arrival on scene, clinicians perhaps tended to be focussed on more advanced procedures when they should be focussing on performing the simpler elements of CPR to a very high standard.

Dr Ruddell commented that, when treating a patient suffering from cardiac arrest, the emphasis should be on good quality CPR and early defibrillation.

Mr Abraham alluded to the reference within the presentation that there was potential for up to 70 additional patients to survive annually and expressed concern that he was not aware that the Trust had been lagging behind in cardiac arrest outcomes. He commented that, had this issue been identified earlier, it might have been identified as a priority for the Trust to progress. Mr Abraham acknowledged that, while it was not now possible to rectify this, the priority must be to move forward at a pace and determine what was needed to bring the Trust's performance up to standard.

Mr Sowney acknowledged that NIAS was at the start of its journey to improve standards and pointed out that other services had had similar experiences. He suggested that it was for the Trust to reflect why the journey was only commencing now. Mr Sowney referred to the earlier presentation by Dr Monaghan around safe intubation and was of the view that this was much more concerning and alluded to the potential for up to 70 additional patients to survive.

Mr Sowney said that one could argue that the challenges being experienced in terms of ambulance handovers, the rural geography of Northern Ireland contributed towards NIAS' performance in this area. However, he pointed out that other regions across the UK were experiencing similar challenges and that the issues to be considered were the delivery of care and the return of spontaneous circulation (ROSC).

Continuing, Mr Sowney suggested that this could potentially link to training and the wider review of clinical education. He questioned the practice of crews who had worked together for considerable time and who were perhaps not prepared to question a colleague's clinical practice and acknowledged that this was very much a culture issue within NIAS and indeed other ambulance services. Mr Sowney said there was a need to focus on the standards which the Trust could manage and control and suggested there was a need for an action plan to be developed for the Committee's consideration.

Ms Paterson commented that the Trust had focussed on its response times to Cat 1 calls but suggested that if the patient outcome was not positive, then this focus and effort had been irrelevant.

The Chair said that the presentation had identified a significant issue and he expressed concern that the intention was to bring a more detailed presentation to the January meeting.

Responding, Dr Ruddell explained that there was already an action plan in development. He commented that NIAS was quicker than other services in instructing callers to commence CPR and said that he would be keen to commence the GoodSam initiative and have this rolled out as well as early access to public defibrillators. However, he pointed out that emergency despatch and response performance would remain challenges. He once again highlighted the importance of frontline clinical audit which was normally undertaken by the tier of Clinical Support Officers. Dr Ruddell indicated that cardiac arrest patients remained the Trust's highest priority and believed there was a need to focus internally on the quality of treatment provided upon arrival at scene. He pointed out that the Trust's approach should be that an individual with shockable rhythms was an individual who could be saved.

Mr Bloomfield referred to Mr Sowney's points around working practices and acknowledged that this was an issue which the Trust needed to consider in more detail.

Mr Haslett suggested a public campaign to increase the number of GoodSam volunteers.

Mr Sowney reiterated his view that the main issue of concern related to the standard of care and ensuring positive outcomes. He acknowledged that CPR provided the patient with time until the emergency services were on scene.

Continuing, Mr Sowney suggested that the work to be taken forward to improve the cardiac arrest outcomes by focussing on the standards of care should be a catalyst for other standards of care being provided.

The Chair sought further detail on the action plan referred to by Dr Ruddell and said that the Committee would be keen to see how the Trust intended to address the gap identified through the presentation. He also suggested that consideration should be given to this issue being included on the Corporate Risk Register.

Mr Bloomfield advised that this was a high priority stand-alone piece of work and agreed that it would be important for the Committee to have sight of the action plan.

Concluding the discussion, the Chair thanked Ms Boylan for her presentation which was **NOTED** by the Committee and Ms Boylan withdrew from the meeting.

8 **Card 36 – verbal update**

Dr Ruddell reminded the meeting that the Card 36 protocol had been introduced at the start of the Covid-19 pandemic and had been used to triage patients presenting with Covid-19 symptoms. He advised that there a few advantages to the protocol in that it allowed for alternative pathways for some patients.

Dr Ruddell said that it was likely that, with reducing numbers of Covid-19 patients, the Card 36 protocol would soon be removed altogether and he agreed to keep the Committee apprised.

The Committee **NOTED** this update.

9 **Safeguarding (SC08/09/22/07)**

It was noted that the update on safeguarding would be presented to the November meeting.

10 **Hygiene, Cleanliness and Infection Prevention and Control: Key Performance Indicators: 1 April 2022 - 31 July 2022 (SC08/09/22/08)**

At the Chair's invitation, Ms Finn highlighted the key points in relation to the Trust's performance against the agreed Key Performance Indicators (KPIs) for:

- Hand Hygiene (HH)
- Personal Protective Equipment (PPE)
- Environmental Cleanliness
- Vehicle Cleanliness
- IPC E-Learning (April 2021 to March 2022)
- IPC face to face training (April 2021 to March 2022)
- ANTT key performance indicators (April 2021 to March 2022)

Ms Finn acknowledged that the Trust had not achieved the standard in relation to Hand Hygiene. She advised that, following a review of IPC by the Association of Ambulance Chief Executives (AACE), it had been recommended that the audit standard of assessing whether a staff member had personal issue hand sanitiser on their person should be removed as it was felt that this was beyond what other services were measuring and may be presenting NIAS performance at a lower level than other services who were not auditing this element. However, Ms Finn said, in order to ensure consistency of reporting and benchmarking with other Ambulance Services, it was felt that the standards which should be monitored should be:

- Bare below the elbow
- Seven step technique
- 5 moments for HH

Ms Finn indicated that, while this would be consistent with what was audited across all of NI HSC, the Trust would remain non-compliant with this standard. She pointed out that arrangements were being made to locate IPC practitioners in EDs to undertake face-to-face engagement with NIAS staff.

Continuing, Ms Finn advised that an additional KPI for the monitoring of Personal Protective Equipment (PPE) had been introduced as an action arising from BSO Internal Audit on Clinical Audit and Whistleblowing.

Ms Finn advised that the NIAS Environmental and Vehicle Cleanliness (EVC) team now had two Environmental Cleanliness Supervisors in place and the Trust was commencing recruitment of a further Supervisor. She added that, in light of this enhanced capacity, a proposal had been made to change the current station audit format which would result in the NIAS being more closely aligned to the 'National Standards of Healthcare Standards 2021' which would improve the number of audits completed and reduce variation.

Continuing, Ms Finn advised that the frequency of audit would be reduced to once every three months with NIAS EVC Supervisors carrying out audits and providing stronger assurance as they will be more independent. Ms Finn indicated that this would also reduce

the pressure on operational staff having to undertake cleanliness audits.

The Chair commented on the fact, that despite the removal of the requirement for staff to have personal issue hand sanitiser, improvement continued to be required around Hand Hygiene.

Responding to a question from Mr Sowney as to the feedback from the AACE following the peer review, Ms Finn advised that it had generally been positive and said she hoped to be in a position to share the report at the next Safety Committee.

Mr Abraham referred to the change in auditing arrangements and suggested that it would be helpful to have a comparison report showing the monthly audits against the first quarter report to ensure that standards did not slip. Ms Finn agreed to consider this.

Mr Abraham proposed the Committee **APPROVE** the proposal to change the audit elements of the current NIAS Hand Hygiene audit tool as well as the process of environmental cleanliness auditing within NIAS. This proposal was seconded by the Chair.

11 **Independent Sector Management (SC08/09/22/09)**

Ms Finn drew the Committee's attention to this paper which provided an update on the development of the Non-Emergency Independent Ambulance inspection process and governance arrangements which commenced in April 2021.

Ms Finn gave the Committee a brief overview of a number of common themes for improvement.

Responding to a question from the Chair around a number of audit findings, Ms Finn explained that, where possible, organisations ensured action was taken on the day of the audit to address findings. She explained that the results of the audit process were shared with the organisation and action plans drawn up. She added that all actions required were proportionate to the risk identified and said that all actions plans also had associated timeframes.

Continuing, Ms Finn advised that the action plans were jointly agreed with NIAS and the Independent Ambulance Service (IAS). She pointed out that, where minor issues had been identified, the

IAS updated the action plan with photographic evidence of improvement and said that a re-audit would be undertaken when serious findings had been identified. Ms Finn advised that the action plans were also discussed with each provider at every quarterly IAS meeting.

Mr Sowney noted that all those vehicles inspected had passed the audit. However, he referred to some rips and tears which had been found in seating/stretcher mattresses and sought clarification on how such findings had not resulted in an audit failure. He asked for further detail on how the audits were conducted.

Responding, Ms Finn explained that the audits undertaken were based on a scoring system and said that the score to pass the audit had been set at 85%. With regard to the audits, Ms Finn advised that these were undertaken on an unannounced basis with a view to being independent. She acknowledged that the only co-ordination required was around being aware of where services were located throughout the day.

Ms Finn pointed out that the audits were undertaken by Vehicle Supervisors and said that, while not possible currently, her preference would be to put in place an additional layer of assurance around this.

Mr Sowney suggested it would be helpful for members to have sight of a sample action plan with associated timescales. Ms Finn undertook to take this forward.

Mr Abraham queried whether rips and tears which might have been identified in a vehicle which had scored 90% in the audit would be addressed by the provider.

Ms Finn explained that such a circumstance would still be identified as an action and said that providers would submit photographic evidence that the finding had been rectified.

The Committee **NOTED** the Independent Sector Management update.

12 **Control Room Performance (SC08/09/22/10)**

Discussion under agenda item 4 also refers.

13 **Update on the PHA's PPI Action Plan (SC08/09/22/11)**

The Chair suggested that the Committee revisit this paper at a future meeting and said it would be helpful for members to have some information around the timescales for actions and, where appropriate, the reason for delay.

He suggested that this approach should be adopted for similar papers to be presented to the Committee.

The Chair also proposed that it would be helpful to have a standard house style for papers to be presented to Committees. Mrs Mooney undertook to look at this.

14 **Serious Adverse Incidents: current position and learning outcomes (SC08/09/22/12)**

The Chair welcomed Ms Audrey Murdoch, Interim SAI Lead, to the meeting and invited her to highlight the salient points of the report.

Ms Murdoch advised that, in the fiscal year to date, 18 SAIs had been reported to the Strategic Planning and Performance Group (SPPG). She pointed out that 13 SAIs had been notified in the last quarter with four where the outcome was death.

Referring to family engagement, Ms Murdoch advised that the chart in the paper did not reflect an accurate picture and confirmed that, apart from those SAIs which were currently open, all family engagement had now been completed.

Ms Murdoch referred to a pilot currently underway where a specialised team of up to 12 operational staff would complete level 1 SAI reviews as required to ensure reviews were undertaken in a meaningful and timely manner. She said that this team approach would provide a consistent, standardised approach to all level 1 SAI reviews reducing the current variation in how review meetings were conducted, report writing and the learning that had been identified. Ms Murdoch added that the approach would also improve how staff and families were supported through the process.

Mr Sowney acknowledged the challenges associated with ensuring improvement was embedded. He referred to the potential for

recurring themes to be identified and suggested that this would suggest learning had not been embedded.

Ms Murdoch was of the view that a recurring theme did not necessarily point towards lack of improvement. She explained that, while the learning from SAIs was shared throughout the Trust via the Trust's Sharepoint; practice updates; Vital Signs Newsletter and continuous clinical education days, there were challenges associated with the Trust demonstrating improvement in practice had been embedded as the audit processes for the impact of shared learning identified through SAIs had not yet been fully developed. Ms Murdoch said that work was being progressed within individual Directorates around outstanding recommendations. She added that it was difficult to quantify these as a number would not be 'resolved overnight'.

Mr Sowney referred to those SAIs which had clinical or standards of care elements and asked how the Trust would evidence this and determine that learning had been embedded within the Trust to ensure themes did not recur.

He alluded to the Learning Outcomes Group and the issue of learning letters and said his experience from speaking to staff was that not all staff received the information. Mr Sowney was of the view that, unless it was certain that all staff received the learning letters, themes would recur.

Ms Finn believed that the points made by Mr Sowney related to the earlier discussion around the importance of having Clinical Support Officers revert to their roles and said these roles were pivotal in providing assurance. She said that engagement with staff was key.

Mr Sowney indicated that the ultimate measurement would be a decrease in the number of SAIs, particularly those with recurring themes.

Ms Murdoch advised that, of those SAIs recently notified to the SPPG, only one was of a clinical nature while the remaining SAIs had centred on delayed responses.

Dr Ruddell pointed out that the other route for communicating with staff was through the JRCALC app which linked to NIAS clinical protocols, referral pathways protocols. He advised that the

JRCALC app had the ability to forward information to staff who then had to acknowledge receipt. Dr Ruddell said that the app reliably provided evidence as to those staff who had accessed the information. However he acknowledged that the challenge remained in terms of ensuring staff acted on the information received.

In response to a query from Mr Sowney on whether staff were required to download the JRCALC app, Dr Ruddell confirmed that it was recommended to frontline staff and indeed the vast majority of staff already had access but he reiterated the importance of acting on the information received through the app.

Mr Abraham commented that he had found the process of sharing with Non-Executive Directors those SAIs where the outcome was death helpful and suggested that it might also be helpful to include further anonymised detail.

The Chair reiterated the usefulness of the JRCALC and the fact that it provided assurance in terms of those staff who had accessed. He suggested that relevant documentation could be stored in the reference section of Decision Time.

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

The Chair thanked Ms Murdoch for her attendance and she withdrew from the meeting.

15 **Complaints Annual Report 2021-22 (SC08/09/22/13)**

Ms Finn drew the Committee's attention to the Complaints Annual Report for 2021-22 and highlighted a number of key points, including:

- 266 complaints had been received (75% increase on previous year). This represents a complaint rate of 0.08% of all (326,300) emergency and non-emergency ambulance attendances.
- 17% of complaints were responded to within 20 working days (3% decrease on previous year). The challenges of investigating complaints during REAP 4, along with a backlog of complaints from the previous year, significantly impacted the timeliness of resolving these complaints.
- 265 complaints were closed (93% increase on previous year).

- The top three issues of complaint remain the same: 1) Transport, Late or Non-Arrival/Journey Time; 2) Staff Attitude/Behaviour; and, 3) Quality of Treatment & Care.
- 375 compliments were received (74% increase on previous year).

Mr Sowney said that he had referred to 'compassion fatigue' at previous meetings in relation to staff attitudes and behaviour and believed this was an issue not just within NIAS but across the HSC. He stressed the importance of NIAS recognising this was an issue and being in a position to explain what was being done to address this.

Mr Sowney referred to the high compliance of complaints awareness training amongst staff and indicated that, despite this, complaints were increasing. He questioned how much staff were learning from the online training and suggested that face-to-face training dealing with various scenarios might be more beneficial.

Mr Bloomfield said there was a need to focus on the informal response to complaints and suggested that, in many cases, a phone call to apologise would be welcome as opposed to a full complaints investigation.

Ms Finn pointed out that, as well as the online training, there was additional training for the investigation of complaints which might de-escalate the matter before it would reach the formal complaints process stage. However she indicated that this would training would not address staff behaviours.

The Chair welcomed the 93% increase in the closure of complaints and said it was important to note this.

Ms Paterson referred to the importance of ensuring staff felt valued and she alluded to the practice of sharing complaints and compliments with staff. However she suggested that it might be helpful to anonymise complaints information and share this with staff generally to show how staff attitudes and behaviour impacted on patients and made them feel.

The Committee agreed that it would be helpful to have sight of a sample of compliments at Committee level. Ms Finn agreed to consider this.

Mr Abraham congratulated the team in clearing the significant complaints backlog.

The Committee **APPROVED** the Complaints Annual Report 2021-22 on a proposal from Mr Abraham. This proposal was seconded by Mr Haslett.

16 **Date of next meeting**

The next meeting of the Safety Committee will take place on Thursday 10 November 2022 at 9.30am (arrangements to be confirmed).

17 **Any Other Business**

There were no items of Any Other Business.

THIS BEING ALL THE BUSINESS, THE CHAIR DECLARED THE MEETING CLOSED AT 1PM.

SIGNED: _____

DATE: 12 December 2022