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 27 JANUARY 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 (joined at 9.40am)
IN ATTENDANCE:	Mr M Bloomfield	-	Chief Executive
	Ms R Byrne	-	Director of Operations
	Ms L Charlton	-	Director of Quality, Safety & Improvement
	Mr P Nicholson	-	Interim Director of Finance
	Dr N Ruddell	-	Medical Director
	Mr R Sowney	-	Senior Clinical Adviser
	Mrs C Mooney	-	Board Secretary
	Mr C Carlin	-	Boardroom Apprentice
	Mr N Sinclair	-	Asst Clinical Director
	Mr N Walker	-	Head of Planning & Performance
	Mr S Maguire	-	Quality & Service Improvement Lead

1 Apologies & Opening Remarks

No apologies were noted.

The Chair welcomed those present to the meeting and explained that, as well as providing an update on the strategic review of clinical education, the agenda would focus on safety concerns arising from the current pressures and the mitigations put in place by the Trust.

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 (SC27/01/22/01)

The minutes of the previous meeting on 25 November 2021 were **APPROVED** on a proposal from Mr Abraham and seconded by Mr Ashford.

4 Matters Arising (SC27/01/21/02)

Members **NOTED** the action list.

Mr Bloomfield advised that, despite the challenges presented by Covid-19 and the recent service pressures, there had been progress in relation to the PCS review.

Mr Sowney welcomed the additional narrative on the action list and said this served as an update as well as a record as to why certain issues had been deferred to future meetings.

5 Standing Item: Strategic Review of Clinical Education Update (SC27/01/21/03)

Dr Ruddell advised that the update had been included for the Committee to note. He said that members would be aware that, while some transformation projects had been paused due to Covid-19 pressures, it had been possible to progress elements of the strategic review and he stressed the need to maintain the momentum.

Dr Ruddell commented that stakeholder engagement and staff surveys had been completed with approximately 250 returns through the staff survey and over 550 comments received through the staff engagement sessions. He said that all feedback was currently being analysed in terms of staff experience, expectations and suggestions from members of staff as to how to improve this area.

Dr Ruddell said that an external review of the materials and practices within the Education Team had recently been completed by a colleague from the Association of Ambulance Chief Executives (AACE) and their report was currently being analysed with a view to bringing it to the next Education Review Programme Board and to a future meeting of the Committee for consideration.

He said that the report had identified a number of issues which had already been identified such as ensuring consistency amongst trainers, instructors and lecturers and the manner in which they delivered the training. Dr Ruddell advised that work was being taken forward to develop a national quality assurance policy with a view to addressing the issues of consistency.

Continuing, Dr Ruddell advised that the Trust had progressed the ability to offer NIAS staff a place on the BSc course being run by the Ulster University. He pointed out that Advanced Ambulance Practitioners (AAPs) would be able to enter the degree course at year two and said that the DoH had provided financial support and terms and conditions to allow ten NIAS staff to undertake the BSc course. Dr Ruddell added that the Ulster University and the Trust would undertake a joint selection process. He stressed the importance of ensuring those applying were clear in terms of the expectations of the course and said that, to this end, the Trust would be holding sessions for interested individuals.

Dr Ruddell advised that the Trust had also finalised job descriptions for newly qualified paramedics (NQPs) applying to join NIAS from other ambulance services and said it was hoped the recruitment exercise would commence in the coming weeks with a view to finalising recruitment by the start of the new financial year.

Dr Ruddell also pointed out that a plan for the restructuring of the Education Team had also been developed with two main focuses, namely the education and training provided outside of the University

courses as well as the support provided to University students and improving the quality of the education services provided.

Mr Nicholson welcomed the DoH's sponsorship of the BSc places for NIAS staff and commented that this was a significant expenditure. He said that members would be aware of the Trust's planning for funding for the training programme in the current year and beyond and added that the wider restructuring and review would be included within this.

Mr Sowney referred to Workstream 2 and the seven high level recommendations therein and asked if it would be possible to have sight of the detail behind this.

Dr Ruddell undertook to share this with the Committee and explained that the data had been shared with the Programme Board. He advised that some of the training staff had attained International Quality Assurance status so were able to quality assure work and acknowledged that this needed to be extended to other members of staff.

Referring to the issue of consistency, Dr Ruddell explained that all the core education materials were placed on the Canvas system which is accessible by any of the training team required to deliver them. He advised that, should it become necessary to make changes to any training material, a review of documentation would be undertaken. Dr Ruddell pointed out that staff undertaking assessments would receive training on standard setting so as to ensure a consistent approach.

Responding to a question around the progress of the NQP recruitment, Mr Sinclair advised that the advertisement would be placed in HSC Recruit in the coming weeks. He indicated that the Trust had received a number of expressions of interest from qualified paramedics wishing to return to NI to work. Mr Sinclair said that a support package had been developed to support those clinicians over the first 24 months and added that the package had been benchmarked against other UK Trusts. He explained that the benchmarks would allow NIAS to assess an individual's portfolio upon joining the Trust.

Mr Sowney asked whether there were plans to offer support to the cohort of students currently undertaking the Foundation programme

when they complete and for the next cohort who were currently undertaking the bridging programme.

Mr Sinclair clarified that the NQP programme would include support for the current and next cohort of students.

Responding to a question from Mr Sowney as to the current status of the CRM business case, Mr Bloomfield advised that the business case had been submitted to the DoH in early December and said it was his understanding that the business case remained a priority for the DoH. He indicated that, while he continued to be hopeful that the Trust would secure additional funding for CRM, he was uncertain as to whether the Trust would receive the totality.

In terms of funding for training, Mr Bloomfield clarified that the cohort of students currently undertaking the bridging programme would be the fourth and final cohort of students to undertake the foundation degree. He indicated that each foundation degree programme cost £5 million because of the backfill required. Mr Bloomfield pointed out that the majority of the funding needed for next year's training programme had not yet been secured. He advised that the Trust intended to proceed with the programme in order to ensure the supply of paramedics needed by June 2024 and would make it clear to the DoH and HSCB that it would be doing so at financial risk.

The Chair referred to Dr Ruddell's earlier emphasis on the need for consistency and sought further detail.

By way of explanation, Dr Ruddell advised that, because of practice changes such as new guidelines, the course material was reviewed on a regular basis as well as ensuring the education team had adapted training to take account of any changes.

Continuing, Dr Ruddell advised that the Trust had a temporary post in place to oversee the management of digital training and who acted as the 'guardian' of the training material. He explained that any changes proposed to course materials were considered and agreed by the Education Group and uploaded accordingly onto the Canvas system. Dr Ruddell acknowledged that there would always be regional tweaks to the training materials based on new guidance.

The Chair acknowledged the progress which had been made to date and said he looked forward to further updates at the April meeting.

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

6 **Safety Concerns arising from current pressures and associated mitigations (SC27/01/21/04)**

Introducing this agenda item, the Chair explained that it would be important that members left the meeting with a full and clear understanding of the pressures facing the service currently.

At the Chair's invitation, Ms Charlton provided a detailed presentation on the key safety concerns arising from the current pressures and the associated mitigations put in place by the Trust.

Mr Bloomfield believed it was helpful to have the national comparisons and said the Trust would continue to develop these. Referring to the presentation, he said it was clear that NIAS compared to other Trusts in terms of the pressures impacting on service delivery. Mr Bloomfield added that, like as his Director colleagues, he participated in regular calls with his counterparts in other ambulance services and had been struck by how challenging and similar the position was in other parts of the UK.

Continuing, Mr Bloomfield indicated that, as had been predicted, Omicron had had a greater impact on staff absences compared to hospital admissions and he reported that, at the start of January 2022, the Trust had over 20% of its staff not available for work. He said that the Trust had faced its most challenging period over the last 4-6 weeks since the start of the pandemic but the position was beginning to improve.

Mr Bloomfield highlighted the positive collaborative work between the NIAS and the NIFRS around cardiac arrest and falls and said that an update would be provided to the February Trust Board. He clarified that the joint working with NIFRS focussed on how both services would co-respond moving forward.

Mr Bloomfield alluded to the improvements which had been made around late finishes and reminded the meeting that this was an area

of work which the Trust was determined to address. He explained that, rather an issue an instruction, the approach adopted had been to encourage local teams at Area Manager level to work with their staff to identify ways to address this issue. Mr Bloomfield said that a range of solutions and priorities had been proposed and shared across Divisions. He added that feedback from staff had been positive and said it was clear that staff were beginning to see the impact of the measures put in place.

The Chair sought clarification if the predicted peak in infections had now passed.

In response, Mr Bloomfield said that, while there certainly had been slight improvements in January in terms of indicators around hospital admissions/ICU beds and a reduction in staff absent as a result of Covid-19, community infection rates remained high. He said he hoped the position would be clearer at the time of the February Trust Board and undertook to keep members apprised.

Ms Charlton reminded the meeting that, as health care workers, NIAS staff were still required to have PCR tests. She advised that the number of staff testing positive varied on a weekly basis but indicated that, in the last week, over 30 members of staff had tested positive with as many as 49 members of staff testing positive in one week.

Mr Abraham referred to the 'ripple' effect of the pandemic in terms of cancellations in elective care surgery, patients not being able to access review appointments and experiencing delays in treatment. He asked if the Trust had examined the break-down of calls to determine how many had been received because patients had deteriorated due to their inability to access hospital services, how many were actual Covid-19, Covid-19 related and how many were duplicate calls. He asked for a breakdown of this with as much granularity as possible.

Ms Charlton confirmed that the Trust did record duplicate calls and explained that a sub-group examined these to understand the true demand. She believed duplicate calls were an indicator of the pressures within EAC and delayed response because of system-wide pressures.

She said that Mr Abraham had made a valid point in relation to the categorisation of patients requesting an ambulance and suggested that, while AMPDS could not determine whether a patient was awaiting a hospital procedure, the chief complaint could be determined through AMPDS. As such, it would be difficult for NIAS to give the level of detail Mr Abraham had requested.

Continuing, Ms Charlton suggested that it also might be helpful to analyse the overall demand for conveying patients to hospital and clearly understanding that, should a patient experience significant delays on elective care, they would potentially present at an ED having been conveyed by ambulance.

Ms Byrne advised that it was clear from regional discussions that work was ongoing to look this in more detail, for example, access to GPs in and out-of-hours and understand whether that had resulted in an increase in ED attendance as well as considering elective activity and determining whether patients had been conveyed to hospital by ambulance.

Dr Ruddell said there had been much discussion regard increased complications of chronic conditions as a result of delayed treatment and investigation and said that this view would be shared by GP and ambulance colleagues. He agreed with Ms Charlton's earlier point that AMPDS identified the priority of need at a particular time and would not give an explanation as to how a patient reached that point.

Continuing, Dr Ruddell explained that Card 36 protocol was designed to address those individuals presenting with a likely diagnosis of Covid-19. He pointed out that, in a pre-hospital setting, one would never be aware of the final diagnosis.

Mr Haslett referred to 'Hear and Treat' and commented that NIAS was an outlier when compared to other UK ambulance services.

The Chair alluded to the Trust asking people to convey themselves to hospital in certain situation and sought further detail in relation to this.

Responding to Mr Haslett's reference to 'Hear and Treat', Mr Sinclair commented that the incidence of Hear and Treat continued to increase. He commended the work carried out by the staff on the

Clinical Support Desk (CSD) and said that there were currently between 15-18 staff working on CSD. Mr Sinclair explained that the CSD would contact those patients experiencing prolonged waits on an ambulance response to check on the patient as well as scoping all available options in terms of response. He indicated that the service would ask patients at times of pressures to make their own way to hospital but only in circumstances when it was safe and appropriate to do so.

Dr Ruddell agreed with the points made by Mr Sinclair and said 'Hear and Treat' would only be successful when there were other places to which to transfer patients. He said that ambulance services in England had the benefit of the 111 service which was very often co-located in Control Rooms, thus making the transfer to other services more accessible. Dr Ruddell said that NIAS' ability to pass calls to primary care was limited particularly at a time when the primary care structure was stretched.

Ms Byrne acknowledged that recruitment to the CSD had been challenging. She advised that the recruitment pool had been opened to nurses and confirmed that there had been a positive response. Ms Byrne advised that consideration was also being given to the introduction of a Clinical Navigator role, thus providing an additional layer of support to EAC.

Mr Walker alluded to the request from the Trust for patients to convey themselves to hospital where it was appropriate to do so. He advised that, as part of the work emanating from its surge planning, the Trust had been examining alternative methods of conveyance. Mr Walker said it was intended to conduct a pilot in the South East Division over the next few months to provide the Clinical Safety Desk (CSD) with the ability to organise alternative means of transport to convey patients to hospital in order to free up A&E resources which could then be targeted at higher acuity patients.

Mr Maguire asked whether this would only apply to patients being conveyed to hospital or whether consideration had been given to the transport required to discharge patients.

Mr Walker clarified that the trial would focus on supporting A&E crews.

Responding to a question from Mr Sowney around the Clinical Navigator role and whether it would be in addition to the Control Ambulance Liaison Officer (CALO) role, Ms Byrne confirmed that it would. She further explained that the CALO role was one of co-ordination between NEAC and EAC to ensure the optimum use of vehicles.

Mr Sowney referred to the impact multiple calls were having on the increase in call volume and asked if any work was being done to try to reduce these calls.

In response, Ms Byrne advised that some work had been proposed through the National Directors of Operations Group (NDOG) to be taken forward on a regional basis. She explained that a new script had been designed for use by call takers whereby one question asked whether the caller was calling back to check on the estimated time of arrival of an ambulance. If that was the case, a different algorithm was followed. Ms Byrne explained that this had only been in place for a number of weeks until it had been paused due to concerns expressed by BT.

Mr Sowney sought clarification around whether staff calls into EAC had reduced. Ms Byrne acknowledged that the feeling in the room was that the number of calls had reduced and she undertook to obtain further detail on this.

Ms Charlton clarified that the amber/red script had wording to discourage people from calling again unless their medical condition had changed. She added that there also had been a number of communications on social media along these lines in an effort to try to reduce duplicate calls in this context.

Mr Sowney said that he had had sight of information relating to 146 deaths related to patient safety issues across ambulance services nationally and added that this had represented a 62% increase on the previous year. He asked whether the Trust had identified any patient safety issues around its inability to respond or the emergency response arriving too late.

Ms Charlton clarified that any incident relating to a delayed response which was recorded on DATIX was discussed at the weekly Rapid Review Group (RRG) meetings. She referred to the presentation and said that, since December 2020, there had been

14 Serious Adverse Incidents (SAIs) relating to delayed response, including a number where the patient had sadly passed away before the emergency response had arrived.

Ms Charlton said that Committee members would be aware of the AACE report in relation to patients coming to harm waiting in the back of ambulances at EDs. She explained that incidents relating to patients waiting in the back of an ambulance or where a patient was waiting too long which was recorded on DATIX was reviewed to determine whether it would potentially meet the threshold for a SAI.

Ms Charlton indicated that, due to the volume, it was not possible to refer every single incident where a patient waited too long and therefore a decision had been taken to determine whether there had been any care process issues.

Dr Ruddell said that there were several pieces of research on this topic. He alluded to the AACE report around the extent of hospital handover delays which was supported by the Royal College of Emergency Medicine and mentioned that the Emergency Medical Journal had recently published some clear evidence showing that patients will wait longer for admission post arrival at hospital. He undertook to share the research with members.

Mr Sowney expressed his surprise that there had not been more media coverage in relation to the AACE report. He indicated that mortality and morbidity increased the longer patients waited in EDs and said it was clear that long waits in the back of ambulances were less conducive to quality clinical care. Mr Sowney noted that ambulance services across the UK had been clear in stating the fact that patients were coming to harm while waiting in the back of ambulances and he encouraged colleagues to continue to do so.

Mr Sowney sought an update in relation to ambulance handover zones and turnaround times. He was of the view that there was more capacity in the five acute Trusts post-pandemic due to less patients being conveyed by ambulance to hospital and the cancellation of elective surgery. Mr Sowney said that, despite this, turnaround times remained extremely challenging and he expressed concern that this was becoming normalised as an acceptable position to Trusts. He referred to audits looking at 100 A&E records to see if patients might have been directed to alternative care pathways. He encouraged the Trust to continue to emphasise the

unacceptable nature of long waits outside EDs in discussions with HSCB, Trust and DoH colleagues.

Mr Bloomfield said he agreed with the points put forward by Mr Sowney and added that he regularly emphasised the dangers of long waits outside EDs. However, he said it would be important to strike a balance and not interfere in terms of how other Trusts were managing the challenges. He referred to issues in the community in terms of capacity around domiciliary care and said that Trust colleagues would refer to this as impacting on their ability to discharge patients.

Continuing, Mr Bloomfield said that Trust Chief Executives met with the HSCB Chief Executive on a regular basis to discuss unscheduled care in detail. He added that it was clear that the HSCB had taken a more focussed performance management approach and said that Ms Byrne was accompanying HSCB colleagues in undertaking visits to Trusts to view their ambulance handover zones. He reminded the meeting that the establishment of the ambulance handover zones was an action from No More Silos, an action plan which built upon learning from the review of urgent and emergency care.

Mr Bloomfield indicated that Trusts had been given funding to develop the zones and he acknowledged that a greater focus was required by Trusts around this work. Mr Bloomfield said that he expected the HSCB to hold Trusts to account for progress and said that NIAS' role was to facilitate any discussions on the matter. He indicated that the Trust had received a number of Assembly Questions around the long waits at EDs and in response, had clearly set out the number of operational hours lost by crews waiting at EDs; the impact on those patients waiting in the back of ambulances; the impact of lost shifts as well as the impact on response times in the community. He said that he had also shared the research from the Emergency Medical Journal with the HSCB Chief Executive and had emphasised the fact that, if there was a high rate of mortality in EDs with extended waiting times, that rate would be significantly increased for those patients waiting in the back of ambulances.

Ms Byrne said that she also met with her colleague Trust Directors of Operations on a regular basis and she agreed that there needed to be significant acceleration on the part of Trusts to progress

ambulance handover zones. She said that, in discussions, she had articulated the actions being taken by NIAS to mitigate against the lack of progress but stressed that responsibility clearly lay with acute Trusts.

Mr Sowney referred to the comparison with national figures around response Categories 1-3. He commented that NIAS Category 1 responses appeared to be outliers and asked whether the Trust had compared like with like.

In response, Ms Charlton reminded the meeting that the national standard mean response time for Category 1 calls was seven minutes and NIAS CRM had an eight minutes mean response time standard in respect of Category 1 calls. She confirmed that the comparison basis was the same. Ms Charlton alluded to the Category 1 Improvement Group and said that progress had been made with improvements in Category 1 responses since December despite the recent significant challenges facing the service. She acknowledged that Categories 2 and 3 were significantly prolonged and pointed out that this reflected a national picture with NIAS February 2021 position being less prolonged than the national average.

Continuing, Ms Charlton explained that the Improvement Group examined the whole process, for example from the pre-triage sieve, nature of the call, the allocation time, time to go mobile. She added that the Trust was also looking at where it sat in comparison to other ambulance services in terms of these measures.

Mr Sowney referred to the independent ambulance providers used by NIAS and asked if the Trust was content there were robust governance arrangements in place.

Ms Charlton confirmed that the Trust used independent ambulance providers in terms of its non-emergency specification. She advised that the Trust had recently carried out significant work in relation to strengthening its assurance around the quality and safety aspects of the specification. Ms Charlton explained that a template had been designed for use at quarterly monitoring meetings and significant engagement had taken place with providers to define the areas on which the Trust would seek assurance. She said that these arrangements would be further strengthened by undertaking unannounced inspections on vehicles and advised that the first of

these had taken place the previous week. Ms Charlton indicated that the Trust used an electronic auditing system where those undertaking the inspections could upload photographs, for example, for objective evidence.

Continuing, Ms Charlton reminded the meeting that, in the rest of the UK, the Care Quality Commission (CQC) would regulate the independent ambulance sector. However this was not the case in Northern Ireland. She indicated that the Trust had met with the Regulation, Quality and Improvement Authority (RQIA) to discuss potential regulatory gaps. She was of the view that the Trust had made significant progress over the last six months and added that this work had resulted in increased awareness and learning.

Mr Sowney commended the progress which had been made. He believed that the arrangements put in place were comprehensive and would provide the necessary assurance, particularly when there was no NI regulatory body to hold organisations to account.

Mr Sowney also commended the Trust on the work being taken forward to address late finishes and said that he was aware that this had been a significant concern for staff.

Mr Walker said that this work had been a focus for Operational teams and added that, in his view, another positive result had been the determination of everyone involved to work together to ensure the issue of late finishes was addressed.

Mr Nicholson referred to the significant improvements which had been made in the governance arrangements around the management of independent ambulance providers and advised that this was part of the audit plan for the current year. He clarified that the Internal Audit fieldwork had been carried out in summer 2021 and the draft Internal Audit was currently with management for consideration before being submitted to the Audit and Risk Assurance Committee.

Mr Bloomfield advised that the Trust had come very close to putting alternative escalation measures in place over the Christmas/New Year period when it had proved extremely difficult to be able to respond to calls as nearly all operational ambulances were waiting outside EDs. He advised that consideration had been given to erecting tents outside EDs to enable crews to transfer patients and

continue to respond to calls. However he said Trusts had managed to put arrangements in place to allow ambulances to be turned around and released to respond to calls in the community.

Mr Sowney cautioned against erecting tents, even as a last resort. He pointed out that such tents were designed for major incident use for a finite time only and questioned the staffing for such circumstances. Mr Sowney also emphasised that evidence showed that patients were safer inside a hospital as opposed to being looked after in a tent or carpark.

The Chair referred to the evolving CMO guidance around returning staff to work and asked if this had assisted the Trust in obtaining increased staffing levels.

Responding, Ms Charlton confirmed that the Trust had been using the guidance and had been able to return a number of staff to work particularly over the New Year period when staffing had been challenging. However she acknowledged that implementation of the CMO guidance had not resulted in as many staff as had been envisaged returning to work. She advised that over 260 cases had been considered for return to work with between 70-80 staff confirmed as being able to return. She referred to the governance arrangements required and said that significant efforts were required to administer the guidance and ensure it was applied in a safe way.

Mr Nicholson agreed with Ms Charlton's comments around the administration task involved and said that the guidance had been welcomed by staff who had been keen to return to work.

The Chair said he wished to place on record his deep appreciation to all NIAS staff and said he never failed to be impressed by their dedication and significant contributions during such challenging times. He commended the Senior Management Team and thanked them for their efforts and added that he very much hoped the worst of the pandemic had now passed.

The Chair thanked all those involved in the presentation to the Committee.

7 **Date of next meeting**

The next meeting of the Safety Committee will take place on Thursday 7 April 2022 at 9.30am (arrangements to be confirmed).

8 **Any Other Business**

(i) Agenda Structure

The Chair suggested that it would be helpful to meet with other Committee members to discuss the future structure of Committee agendas.

THIS BEING ALL THE BUSINESS, THE CHAIR DECLARED THE MEETING CLOSED AT 11.30AM.

SIGNED: _____

DATE: 7 March 2022