Northern Ireland Ambulance Service Health and Social Care Trust

MINUTES OF THE SAFETY, QUALITY, PATIENT EXPERIENCE AND PERFORMANCE COMMITTEE HELD AT 9.30AM ON MONDAY 12 DECEMBER 2022 HELD VIA ZOOM

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 (joined the meeting at 9.40am)
	Ms L Charlton	-	Director of Quality, Safety & Improvement
	Dr N Ruddell	-	Medical Director
	Mr R Sowney	-	Senior Clinical Adviser
	Mrs C Mooney	-	Board Secretary
	Ms R Finn	-	Assistant Director QSI
	Mr N Sinclair	-	Assistant Clinical Director
	Mr J Wilson	-	Boardroom Apprentice
	Mr N Sinclair	-	Assistant Clinical Director (for agenda items 5, 6 & 7 only)
	Ms S Leckey	-	Community Resuscitation Lead (for agenda item 10 only)
APOLOGIES:	Ms R Byrne	-	Director of Operations

1 Apologies & Opening Remarks

Apologies were noted from Ms Byrne.

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 (SC12/12/22/01)**

The minutes of the previous meeting on 8 September 2022 were **APPROVED** by members.

4 **Matters Arising (SC12/12/22/02)**

Members **NOTED** the action list.

Ms Charlton referred to the information provided by Mr Frank Rafferty in relation to duplicate calls.

The Chair welcomed the update on the CAD and believed that the use of auto-texting/advanced caller management would be positive. He noted the significant number of routine calls and said that this would impact on the availability of call takers.

Ms Charlton agreed that this would be the case. She pointed to the percentage difference between 2021 and 2022 and the gap in terms of A&E and routine RRV calls which reflected the reduction in routine calls coming into the Control Room.

Dr Ruddell alluded to his e-mail in November to update Safety Committee members on Card 36. He reminded them that it had been agreed nationally that the Card 36 protocol should be removed and that all patients would be managed through existing AMPDS triage processes. Dr Ruddell advised that a caveat remained whereby patients with medical conditions who had a measured blood oxygen saturation level would still be coded through a small number of Card 36 determinants as this measurement provided a very helpful guide to the severity of the patient's condition when in respiratory difficulty and was not captured anywhere else in the AMPDS protocols.

Ms Charlton believed that further work was required around strengthening assurance to the Board in line with some of the audited processes in England.

Referring to the previous discussion on independent sector management, Ms Charlton confirmed that, at the end of the audit, the action plan was shared with the independent provider. She explained that the plan provided a description of what the action was; who created it; who it had been shared with; vehicle detail; to whom it had been assigned and the level of risk it presented. She added that the wider action details alluded to the timeframe for the action to be completed. Ms Charlton also pointed out that, when appropriate, photographic evidence would be attached to the action plan.

The Chair asked whether these processes in place had led to an improvement in compliance levels.

Ms Charlton invited Ms Finn to respond on this point as she had been absent during the last round of inspections. However, she explained that through Docswork, members of the audit team would be able to check the results and the aggregrated figure.

Ms Finn explained that each provider was inspected once every six months and all were compliant. She pointed out that, during the most recent tranche of inspections, a number of minor issues had been identified in respect of one provider. Ms Finn said that the issues identified did not necessitate taking a vehicle off the road and said that cumulatively the issues had resulted in a lower compliance level.

Continuing, Ms Finn advised that the independent providers had been very engaged in the process and had addressed any issues identified. She explained that, on those occasions where non-compliance had been identified, reports were submitted with photographic evidence. She said that indicated that further work would be needed to refine the process and the Trust would like to introduce spot-checks into the auditing process.

Mr Sowney referred to the previous meeting where there had been discussion in relation to derogation lists which would allow crews to hand over patients and respond to other calls.

Dr Ruddell explained that a process had been agreed which would allow an oncoming crew to replace a crew at ED rather than respond to emergency calls in the community. He acknowledged

the clinical risk involved but explained that the action had the aim of increasing overall levels of emergency cover through reduction of compensatory rest as well as assisting crews in terms of their welfare.

Continuing, Dr Ruddell advised that such calls were reviewed on a fortnightly basis and said there were no reports of any untoward incidents or SAIs caused as a result of calls being held. He clarified that there was a separate process for children but calls suitable for holding were identified on the basis of AMPDS codes. He pointed out that the NIAS had taken the step to introduce this derogation list independently and added that this was not a UK-wide process.

Dr Ruddell commented on the work in the UK around Cat 2 calls and believed that operating a derogation list was not dissimilar in terms of prioritising Cat 2 calls as serious/time sensitive and those which could wait for a response. He acknowledged that some of the work undertaken by the NIAS linked to the national work. He pointed out that the practice of derogation continued within the Trust and was available to crews working in the morning and evening shifts. Dr Ruddell acknowledged that using the derogation list proved more difficult during the evening as there was a smaller number of crews in the morning finishing night shift with larger numbers of crews reporting for day shift.

5 **Standing Items:**

(i) Strategic Review of Clinical Education Update (SC12/12/22/03)

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

He said that he had undertaken to share with the Committee the feedback from the Ulster University following a survey of those students participating on the EV and PCS courses.

The Chair asked whether the loss of staff from within the Education Team had been mitigated by the success of the recent recruitment exercise and whether a delay in the start date confirmation of the Consultant Paramedic for Clinical Education and Clinical Standards Manager posts would have an impact. The Chair also enquired if there were contingency arrangements in place in the event that the

Trust was not successful in appointing a Practice Based Learning Lead post, given that previous recruitment had not been successful. He also sought an update in relation to the issue around emergency driving.

Responding, Dr Ruddell pointed out that only one of the four senior posts within the Team was not yet in place.

Mr Sinclair commented that key for him was a clear understanding of the issues to be addressed and he acknowledged that a challenge was the resources to address and take forward the actions identified. He acknowledged that the issue of emergency driving should ease over the coming weeks as there was an understanding of the causes which were now being addressed. He undertook to keep the Committee updated on progress.

Mr Haslett commended the progress made and welcomed the fact that no section of the progress report had been RAG rated as red.

Dr Ruddell reminded colleagues that, prior to having a team in place, the approach adopted had been to address issues as they had arisen. However, he said he now looked forward to having the full team in place to formally address the findings of the review.

Mr Sowney commented that delivery of Workstream 1 had completed.

Dr Ruddell said the team had been keen to tie in with the wider culture work being taken forward in the Trust and referred to the positive feedback from those students undertaking the courses and clinical attachments with the Trust. He acknowledged there was still work to be done in this regard and reminded the meeting that the new paramedic job description clearly alluded to the provision of mentorship and education to students.

Mr Sowney acknowledged the very positive formal feedback from students but emphasised the importance of NIAS being sensitive to informal feedback as well, particularly where it relates to NIAS staff. He mentioned that some students felt undermined by NIAS operational staff and acknowledged that some students had not had as positive an experience as others. Some had also expressed concern that, while on placement at care homes, care home staff had not necessarily understood the students' learning objectives.

He also referred to the Foundation Degree students and asked what clinical support would be put in place when the students completed their course in December/January.

Mr Sowney said he had learned through informal feedback that some students had been unable to undertake certain clinical skills while on placement and the students expressed concern that they might require further training in these areas after they graduated in 2023. He queried whether this point could be discussed informally with Ulster University colleagues.

Dr Ruddell said that every effort was being made to ensure students were able to provide feedback and he agreed to raise the issues identified by Mr Sowney with the Ulster University. He expressed disappointment that students felt undermined by NIAS staff while on placement and acknowledged that this had not been reflected in the feedback received by the Trust.

Mr Sinclair referred to Mr Sowney's point re staff completing their course and the importance of providing support to them and believed that this was an important point. He acknowledged the short timeframe between the completion of AAP training and the start of the Foundation Degree and explained that traditionally there would have been a gap to allow staff to gain some operational experience. However, with the narrower timeframe, this was no longer possible.

Mr Sinclair advised that a support framework had been developed for those clinicians who had been trained through a University route and would be classified as 'newly qualified paramedics' for 18-24 months. This framework was in line with other UK Trusts and required the paramedic to complete a portfolio and have regular meetings with a supervisor. Mr Sinclair added that the paramedic would operate at a Band 5 level until completion of the portfolio. He said he would be happy to present further detail to the Committee.

Continuing, Mr Sinclair referred to Mr Sowney's comment in relation to clinical skills and alluded to the increasing training matrix. He said it would be important to ensure that students were comfortable with being signed-off and added that this was also addressed during an individual's induction period. Mr Sinclair indicated that an individual would also progress through the ongoing clinical

supervision model during their period as a newly qualified paramedic.

Mr Sowney suggested that one of the best ways in which Clinical Safety Officers could support students was to support existing NIAS staff to ensure professional standards were being maintained and staff clearly understood their professional obligations in relation to HCPC standards and professional responsibilities to students on clinical placements.

Mr Sinclair agreed that clinical staff had a professional responsibility to maintain and supervise students and reminded the meeting that this was part of the Band 6 pay settlement for paramedics reached in 2019. However, he indicated that these responsibilities were now outlined in the paramedic job description which had been updated within the last number of months.

Mr Sinclair said that the remit of Clinical Safety Officers had been stretched during the pandemic in terms of being redeployed to frontline duties and said it would be important to ensure they reverted to supervising students and qualified staff. Mr Sinclair said discussions were ongoing with DoH colleagues around increasing the pool of Clinical Safety Officers to look after BSc students and how that element of the service might need to be commissioned.

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 **Cardiac Arrest Improvement Plan (SC12/12/22/04)**

At the Chair's invitation, Mr Sinclair presented the Cardiac Arrest Improvement Plan in detail. He explained that the size of the Trust was beneficial in that it would be possible to influence and change clinical practice in a relatively short timescale. Mr Sinclair referred to the recognised international model led by the Global Resuscitation Alliance 10-Step to improving cardiac arrest outcomes to support the improvement of outcomes and patient survival and said that the model had been successfully implemented

in a number of ambulance services across the world, including the Scottish Ambulance Service.

Continuing, Mr Sinclair explained that the Trust had developed the action plan which covered the elements outlined in the 10-step programme and the Scottish Ambulance Service had agreed to provide support and guidance as required.

Mr Sinclair reminded members that the Committee had received a presentation from Ms Boylan at its September meeting and concern had been expressed at the poor cardiac arrest outcomes in NI compared to other areas in the UK.

He advised that the Trust had applied to the Chest, Heart and Stroke Association for funding to allow a paramedic examine the data relating to cardiac arrests. Mr Sinclair indicated that an Out of Hospital Cardiac Arrest (OHCA) masterclass was held on 16 November.

The Chair alluded to discussion at the September Committee when concern had been expressed at the benchmarking of the NIAS against other ambulance services in respect of cardiac arrest outcomes and welcomed the progress made.

Mr Sowney said it was reassuring to have sight of the action plan and believed that the issue presented a significant risk to the Trust. He alluded to the positive feedback from staff around the OHCA masterclass, not just in terms of the masterclass itself but the fact that staff had come together and had felt valued in terms of the training and education element. He asked if there were plans to hold further masterclasses.

Responding, Mr Sinclair said that, while he hoped there would be more frequent masterclasses, the intention was to hold a masterclass on an annual basis at least. He agreed with Mr Sowney's point around the value of bringing staff together and said that there had been general consensus that the masterclass had proved to be a valuable learning tool and could be arranged around, for example, trauma patients, alternative care pathways or obstetrics.

Mr Sowney suggested that it would be helpful to identify clear timescales for having such masterclasses. Otherwise, he said, there was a risk that the focus was lost.

The Chair thanked Mr Sinclair for presenting the Cardiac Arrest Action Plan which was **NOTED** by the Committee.

7 **Clinical Support Desk (SC12/12/22/05)**

Mr Sinclair described the framework in place to allow the Trust understand the current position in relation to multiple clinical conditions and said that data would be presented to the Safety Committee on a regular basis.

He indicated that information around CSD Clinicians' performance around 'Hear and Treat' and 'See and Treat' would now be included in the Performance Report presented to Trust Board.

Mr Sinclair also alluded to the earlier presentation around the Cardiac Arrest Improvement Plan and described the data collection exercise. He said that the aim would be to collect 95% of all NIAS cardiac arrest Patient Referral Forms (PRFs)

In Ms Byrne's absence, Ms Charlton provided an update in relation to recruitment to the CSD roles and confirmed that two members of staff had recently been recruited with interviews being held in December for a further four posts. Ms Charlton added that the recruitment process for the Clinical Support Manager, ie the Clinical Navigator, role had also commenced.

Mr Bloomfield welcomed the interest shown by other Trusts around 'Hear and Treat' and 'See and Treat' initiatives and noted the attempts by the Trust to expand CSD recruitment to include nurses. He referred to the challenges experienced by the Control Room during the past weekend and said that the Duty Control Manager had paid particular tribute to the CSD nurses and how they had reduced the number of Cat 3 calls waiting. Mr Bloomfield said that work continued to encourage nurses to apply for the CSD roles and was of the view that there might be greater uptake of such roles if secondment opportunities were available. He indicated that the feedback to date had been positive.

Mr Sowney asked whether there was any indication as to why nurses were not keen on the roles. He said that it was his understanding that nurses wished to continue to maintain their clinical skills within EDs and believed this would remain an issue in terms of recruitment unless CSD posts for nurses could reflect this. This would be of use in a CSD role in terms of ensuring updated knowledge and experience. He asked if it would be possible to employ nurses on a banking basis and ensure they received the necessary training in relation to the CSD role. He believed that, once they had experience of CSD and the ambulance service, nurses might be encouraged to make a career change. Mr Sowney said that a number of other ambulance services had nurses and mental health nurses on their CSD.

Mr Bloomfield agreed with Mr Sowney's comments. He indicated that the feedback he had received from nurses who had decided not to take up the CSD posts related more to moving from an organisation which employed a significant number of nurses to one which did not and they viewed this as a risk. Mr Bloomfield agreed with Mr Sowney's suggestion that using nurses on a banking arrangement would provide an opportunity for nurses to trial the role on an interim basis.

Continuing, Mr Bloomfield suggested that a better approach would be to offer nurses work on sessional bases. He pointed out that those issues which applied to nurses also applied to paramedic staff in that it was challenging to attract paramedics already employed by the Trust to the CSD role and the significant retraining involved. He acknowledged the high turnover in the roles and said that currently those undertaking the CSD role would work 1:4 on operational shifts. Mr Bloomfield said that feedback had suggested that a 50/50 split would be more attractive and might potentially encourage individuals to remain in the role.

Ms Charlton stressed the importance of ensuring nurses did not feel vulnerable and she referred to nurses coming from an ED environment to the CSD role which was very autonomous. She also emphasised the need to ensure those nurses undertaking the CSD role were professionally supported and there was a robust framework in this regard. Ms Charlton pointed out that the NIAS was the only ambulance service in the UK without mental health partners in the Control Room.

Dr Ruddell acknowledged that, while the concept of having staff on bank was attractive, there was an element of risk involved with remote clinical advice and assessment and making clinical judgements without the traditional face-to-face assessments. Dr Ruddell referred to the clinical audit programme which reviewed a significant number of calls each month and the continuous monitoring to ensure the advice being provided was safe and effective.

The Chair thanked Mr Sinclair and Ms Charlton for their updates which were **NOTED** by the Committee.

Mr Sinclair withdrew from the meeting at this point.

8 **Position report on NIAS Safeguarding (SC12/12/22/06)**

Referring to the RQIA Improvement Plan update, Ms Charlton reported that there had been a significant improvement in the Trust's baseline with regard to safeguarding. She confirmed that, while one action had been RAG rated as green in terms of reviewing and updating the Trust's Safeguarding Policy, work continued on the remaining actions. She reminded the meeting that Mr Abraham was the Trust's Non-Executive Champion for Safeguarding.

Ms Charlton referred to the work underway with other Trusts to establish a welfare pathway and said it was hoped that this would be completed early by the end of January.

Referring to staff training, Ms Charlton reported that 'The Intercollegiate Documents for Safeguarding Roles and Competencies for Health Care Staff' (2018) stated that paramedics should be trained to safeguarding level 3; call takers at level 2 & non-clinical staff level 1. She acknowledged that many UK ambulance services with established training programmes over the years had progressed to level 3 training for all paramedics, although around 50% of services had not yet moved to level 3 training. She indicated that safeguarding training had been mandated within the NIAS and a decision had been taken to introduce at level 2 with plans to progress to level 3 training.

Ms Charlton highlighted that the Trust only had one substantive safeguarding post and she commended Mr Flannagan for the

significant progress which had been made to date. She acknowledged that the Trust was not yet where it needed to be in terms of safeguarding and said that this would not be possible until there was increased infrastructure within the Trust to deliver on the necessary training aspect.

Continuing, Ms Charlton said that the Trust had a good working relationship with the National Ambulance Safeguarding Group. She said that the Trust was currently involved in a peer review process where a safeguarding colleague would visit the NIAS to undertake a peer review. Ms Charlton said she was aware that the report would identify further recommendations for the Trust to take forward.

Ms Charlton acknowledged that the referral rate within the Trust was smaller than other ambulance services and said that she and Mr Flannagan believed this was linked to the level of training within the Trust.

Ms Charlton said that the Trust was also involved in domestic homicide reviews and case management reviews for children and added that the Trust's Head of Safeguarding worked closely with HR and the Trust's Professional Standards Lead to emphasise safeguarding processes and procedures.

The Chair sought clarification around the shift from level 2 to level 3 training and that level 3 involved significant face-to-face training.

Ms Charlton explained that level 2 training could be completed via e-learning whereas level 3 enabled scenario based discussions giving staff opportunity to discuss context and those occasions on which they may have come across safeguarding issues when responding to calls. She acknowledged that there was no opportunity to ask questions through e-learning. Ms Charlton indicated that, due to the fact that the Trust only had one Subject Matter Expert, ie the Head of Safeguarding, it was not possible to move to provide level 3 training currently. She said it was reflective of Mr Flannagan's commitment to training and improving individuals' knowledge that he was attending face-to-face training to ensure the training resonated more with staff.

Ms Charlton referred to the recent safeguarding benchmarking exercise undertaken by the Association of Ambulance Chief

Executives and said it was clear that the NIAS was under-resourced in terms of safeguarding.

Mr Haslett referred to the increased incidence of domestic homicide and potential for the Trust to become overwhelmed through its involvement in such reviews.

Ms Charlton pointed out that domestic homicide reviews had been introduced in Northern Ireland in December 2021 and she emphasised the importance of the Trust being involved in such work as well as the work around sudden unexpected child deaths in terms of shared learning. She agreed with Mr Haslett's point and said it was important for the Trust to be proportionately involved.

Referring to the resources for safeguarding, Mr Bloomfield said that Non-Executive Directors would be aware that safeguarding was one area where the Trust was vulnerable in terms of the absence of safeguarding expertise to train staff and ensure appropriate referrals. He acknowledged the progress which had been made since Mr Flannagan's appointment and believed that this had naturally led to the identification of further areas for improvement and potential risks and acknowledged the significant amount of work yet to be done. Mr Bloomfield said that this also applied to pharmacy in terms of the work identified by the Trust's Lead Pharmacist yet to be taken forward.

Mr Sowney welcomed the significant progress which had been made and asked if level 3 training would also apply to the CSD.

Ms Charlton confirmed that this would be the case and advised that Mr Flannagan had recently spent some time with CSD clinicians on safeguarding. She reminded the meeting the CSD clinicians were often the first point of contact in terms of delivering care to patients.

Responding to a question from Mr Sowney, Ms Charlton confirmed that EMTs would complete level 2 training while paramedics would complete level 3. She reiterated Mr Flannagan's preference for face-to-face training as that provided real value to staff to discuss experiences.

Ms Charlton confirmed that, in relation to the independent ambulance service (IAS), the Non-Emergency Framework required IAS providers to provide their own safeguarding training and said

that the Trust would support providers in terms of sharing guidance about what needed to be delivered in accordance with the non-emergency specification.

Ms Charlton explained that Mr Flannagan had attended a quarterly meeting with IAS providers to share learning based on NIAS scenarios and had also shared NIAS policies and procedures. However she said it would be important to clarify that Mr Flannagan was not accountable or responsible for providing training to IAS staff.

Mr Sowney sought further detail as to the monitoring applied.

Ms Charlton confirmed that this formed part of the independent audits carried out. She advised that the Trust did not have capacity to quality assure the training provided by the IAS but, as part of its monitoring, the provider completed an assurance template regarding training and, on unannounced inspections, staff were asked if they had received safeguarding training with feedback then being subsequently provided to the IAS provider.

The Committee Chair **NOTED** the Position Report on Safeguarding as presented by Ms Charlton.

9 **Emergency Preparedness & Response Annual Report 2021-22 (SC12/12/22/07)**

Introducing this agenda item, Dr Ruddell explained that the report reflected the activity of the Trust's emergency preparedness and response for the year 2021-22. He highlighted that there had been a decrease in the number of incidents responded to in the last reported year 2018-19.

Dr Ruddell welcomed the review of the Trust's emergency planning arrangements being undertaken by the Association of Ambulance Chief Executives (AACE). He explained that absence within the Emergency Planning Team had necessitated a temporary reconfiguration of the Team and said this had allowed a fresh examination of issues internally.

Continuing, Dr Ruddell said that members would be aware that the report from the Manchester Arena Inquiry had recently been

published and added that there were a number of recommendations concerning ambulance services in general.

Dr Ruddell acknowledged that the Trust had work to do in terms of strengthening its emergency preparedness, particularly the on-call arrangements and ensuring that the Trust would be able to respond to major incidents in a robust and effective manner. He referred to the need for a 24/7 presence and explained that, in the past, the Trust had relied on the willingness of a small number of staff carrying out this role. He said that work was now being progressed to put in place a formal rota to ensure cover. Dr Ruddell said he had no doubt that AACE would put forward a number of recommendations, including the need for the Trust to have 24/7 cover.

Mr Bloomfield indicated that the Trust had asked the AACE to undertake the review and believed that it was timely in that the review could take account of the recommendations arising from the Manchester Arena Inquiry Report. He said that, in a recent meeting with AACE colleagues, he had been advised that there were two issues which required immediate attention and which would be important to bring to the Committee's attention. The first, he said, related to the need for immediate refresher training for a large number of Operational staff and he confirmed that this training was being planned. The second issue highlighted by AACE colleagues related to the need for 24/7 Operational manager cover. Mr Bloomfield pointed out that no other ambulance service would respond to a major incident out-of-hours on the basis of an on-call arrangement. He indicated that the Trust had planned to address this element within the CRM business case.

Continuing, Mr Bloomfield said that AACE colleagues had commended the work being done by the NIAS Emergency Planning team and, while concerned at the amount of work to be progressed, believed the NIAS team was capable of ensuring the work was taken forward.

Mr Bloomfield referred to the delays which had been experienced in securing approval of the CRM business case and said that, given the current financial climate, he would be minded to extract the 24/7 operational management cover from the CRM business case with a view to developing a separate business case for funding.

Mr Bloomfield said that, given the significant risks associated with this, he intended to raise this issue at the forthcoming Accountability Review meeting with DoH colleagues to make them aware.

The Chair agreed with this and said he was aware that this risk appeared on the Corporate Risk Register.

Mr Bloomfield said that, with the significant gap in finances, the DoH had asked Trusts to bring forward savings proposals and he believed it would be important for the Trust to highlight the need for 24/7 operational management cover as a significant risk in terms of the Trust's response to major incidents.

The Chair suggested there might be a need to revisit the risk within the Corporate Risk Register.

Mr Sowney sought further details as to the timescale for completion of the AACE review.

Mr Bloomfield explained that AACE colleagues had indicated they wished to undertake further interviews with staff and said he hoped that the report would be finalised by January.

At Mr Bloomfield's request, Mrs Mooney undertook to share the 2022 Major Incident Plan with Committee members.

Referring to the work to be done, Mr Bloomfield explained that this included, for example, the updating of policies and procedures; Standard Operating Procedures, training and exercises.

Mr Sowney said he appreciated the risk had been included on the Trust's Corporate Risk Register. However, he believed there would be a greater risk if the risk was allowed to continue without action being taken to address it.

He referred to the recent major incident declared by the NHSCT and sought further detail as to the NIAS involvement in this and whether a debrief, either organised by the NHSCT or by NIAS, had taken place. He alluded to the crews waiting at EDs with patients and asked if there was a plan in place in the event of a major incident to release these crews to attend.

Responding, Mr Bloomfield said that the incident referred to by Mr Sowney highlighted the need to use the same terminology. He clarified that a major incident had been called by the NHSCT because their ED at Antrim Hospital was at capacity. He said that the NHSCT effectively closed the ED for a six-hour period on the Saturday night. Mr Bloomfield confirmed that the NIAS had contributed to the review undertaken by the DoH and said it was his understanding that the review of the major incident would be completed by the end of November but that he had not had sight of any report to date. He said that a significant point made by the NIAS related to the fact that it had not been part of any decision-making process but had been advised that the NHSCT had closed its ED and, as a result, the NIAS had to put the necessary arrangements in place.

Mr Bloomfield said that, moving forward, it would be important that the wider impact across the HSC system was taken into account as part of the decision-making process. He said that the NIAS had also recommended use of different terminology in circumstances when a Trust came under pressure and needed assistance.

Mr Bloomfield indicated that the terminology used for major incidents, for example a gas explosion or a terrorist incident, should be protected. He said it was his understanding that the Regional Escalation Plan would be updated as a result.

Responding to Mr Sowney's question re the release of crews from EDs to attend a major incident, Mr Bloomfield confirmed that arrangements were in place to release crews. He advised that, if crews were queueing at EDs, arrangements were also in place to release them to respond to Cat 1 calls.

He acknowledged that, while this practice had worked well initially, there had been some difficulties recently in ensuring crews were released to respond to Cat 1 calls. However, he said that Trusts had renewed their commitment to releasing crews to respond to Cat 1 calls and that, if this did not happen, an escalation process was in place.

The Chair referred to previous discussions around Risk 357 and was of the view that this linked to that issue.

Mr Bloomfield clarified that declaring a major incident and closing the ED had allowed the NHSCT to clear those patients waiting. He suggested that the declaration of a major incident would result in the clearing of ED, wards and theatres, for example, in order to deal with a large number of patients presenting. He believed it was unhelpful for the terminology to be used interchangeably.

The Committee **NOTED** the Emergency Preparedness and Response Report 2021-22.

10 **Community First Responder Volunteers (SC12/12/22/08)**

The Chair welcomed Ms Stephanie Leckey to the meeting. At the Chair's invitation, Ms Leckey provided a detailed overview of the Community First Responder (CFR) Scheme.

The Committee learned that the Community Resuscitation Team was established in early 2018. At that time, there had been 12 schemes with approximately 170 volunteer responders across the 12 schemes. Now, there were 21 schemes in operation with over 300 volunteers available. Ms Leckey explained that, initially Schemes were reviewed on a six monthly basis but that Schemes were now recertified on an annual basis in line with other Schemes in the UK and RoI.

Ms Leckey reminded the meeting that the CFR Scheme had been stood down between March – October 2020 due to the pandemic. She pointed out that the DoH had previously agreed to provide indemnity to CFRs but not public liability insurance and added that correspondence had now been received confirming the DoH position.

The Chair welcomed the growth in the number of CFRs and acknowledged the challenges that accompanied that growth. He sought further detail on the plans to address the issue of public liability insurance.

Mr Bloomfield advised that the Trust had only recently received the DoH correspondence and he had not yet had an opportunity to discuss it with colleagues. He reminded members of the intention to go live with the GoodSam initiative and the hope that this could potentially identify further volunteers across communities to respond to cardiac incidents.

Mr Bloomfield commended all those involved in the CFR Schemes and believed the volunteers were enthusiastic and positive and the Trust should support them in whatever ways possible. He also commended the significant contribution made by the Community Resuscitation Team around the establishment of Schemes and to ensure the volunteers received the necessary training. He added that the Trust would be keen to explore the potential for CFRs to respond to other types of appropriate calls. However he stressed the need for careful consideration as there were clear guidelines around the status of volunteers versus Trust employees.

Mr Haslett thanked Ms Leckey for her presentation and said he had found it an encouraging and positive update. He was of the view that the lack of funding for the CFR Scheme was similar to the funding difficulties being experienced across the public sector and believed it would be important to consider funding for what was a successful area of work in order to ensure further growth.

Ms Leckey acknowledged that further funding would be necessary if consideration was to be given to expanding the types of calls CFR volunteers would respond to. She indicated that a number of Schemes would be keen to respond to paediatric calls but that this would clearly require specific training. Ms Leckey believed that it would be important to demonstrate the CFR volunteers were valued and she pointed out that CFR volunteers in England received travelling expenses, for example, while volunteers in NI did not.

She advised that the Team planned to hold a CFR conference on 29 April where it was intended to present an award for 'Outstanding Contribution to Volunteering' in memory of a CFR volunteer who had sadly passed away. Ms Leckey said that the Resuscitation Council had agreed to co-sponsor the conference.

Mr Sowney believed that Ms Leckey's presentation captured the significant and positive work being carried out by a small team and acknowledged the challenges in moving forward. He referred to the recertification process and sought further detail.

Ms Leckey explained that other CFR Schemes were recertifying on an annual basis so a similar process had been adopted. She said that the Schemes were strongly encouraged to meet on a monthly basis as well as carrying out monthly training in order to build

'muscle memory' and added that more training was now undertaken than ever before. Ms Leckey advised that there was a Management Committee within each Scheme but acknowledged the difficulty in getting individuals to take on roles within the Committee. She pointed out that, with the new Schemes coming on board, these expectations were clarified at the outset.

The Chair thanked Ms Leckey for her presentation and asked her to convey the deep appreciation of the Trust to the volunteers. He added that he looked forward to hearing that the issue of public liability insurance had been resolved.

The Committee **NOTED** the CFR update as presented by Ms Leckey who then withdrew from the meeting.

11 **Infection Prevention and Control: Key Performance Indicators: Hygiene and Cleanliness: 1 August – 30 September 2022 (SC12/12/22/09)**

Ms Finn drew the Committee's attention to the report which summarised the Trust's performance in relation to agreed Key Performance Indicators for the following areas:

- Hand Hygiene
- Personal Protective Equipment (PPE)
- IPC e-learning
- IPC face-to-face training
- ANTT

Ms Finn noted that good practice was in place in relation to hand hygiene techniques when undertaken and most staff had been audited as compliant. She advised that staff had responded positively when challenged about their hand hygiene by individuals undertaking the audit and auditors had taken the opportunity to promote the importance of effective hand hygiene.

Ms Finn reminded the meeting that an additional KPI for PPE compliance had been introduced following an Internal Audit recommendation and she pointed out that similar processes were used for auditing PPE as were used for hand hygiene.

Ms Finn clarified the levels of IPC e-learning and explained that Level 1 was for those staff who worked within the Trust but who did

not provide patient care. These staff would be required to undertake Level 1 training once every three years. However, Level 2 was for staff within the Trust who did provide patient care and these staff would be required to undertake training once every two years. Ms Finn drew members' attention to the numbers of staff who had undertaken the training since January 2018.

Ms Finn reported that IPC face-to-face training had been delivered for 22 NIAS staff between April and September 2022.

She advised that the IPC team was working alongside the Information Governance and the Learning and Development teams to develop a dashboard for statutory/mandatory training. Ms Finn explained that a dashboard and database had been developed to allow managers access to training records on an individual basis; a team basis, for example a station; on a Divisional and organisational basis.

The Chair welcomed the progress in relation to hand hygiene and said he hoped it would continue to improve, given the removal of personal hand sanitisers. He queried whether any other trends had been identified.

Responding, Ms Finn said that, through ongoing engagement with staff, it had been highlighted that the Trust's Dress Code policy was at variance with the IPC Hand Hygiene policy. She advised that work was being undertaken to ensure both were congruent and the necessary updates would be taken through SMT.

The Chair thanked Ms Finn for presenting the report which was **NOTED** by the Committee.

12 **Patient Care Services (PCS) (including Voluntary Car Services) - update**

In Ms Byrne's absence, Ms Charlton provided the following summarised update:

Patient Care Services

- The PCS Project Board, which had been established, reports through to the Trust's Strategic Implementation Group and ultimately to SMT and Trust Board;

- The balanced scorecard and PCS specific Key Performance Indicators (KPIs) now approved. All aspects of the work being taken forward have been divided into 'sprints'. The current sprint is focussing on finalising distribution and access list for performance monitoring purposes.
- A highlight report will be included in Trust Board Performance Report under the Operational Performance section from 31/12/22.
- Compliance against valid timestamps is a PCS KPI and will be monitored across PCS and Independent Ambulance Services (IAS) on a monthly basis and included as agenda item at quarterly meetings with IAS.
- A stocktake of available and required MDTs completed November 2022. Roll-out expected to be completed in line with expected completion of PCS Improvement Project
- 'Perfect Day – Planning & scheduling live testing' has now been evaluated. As a result, there are now new planning procedures for NEAC to maximise efficiency and improve productivity. The results were very encouraging and the new procedures were approved for further roll-out. An action plan is currently under development with a view of commencing implementation by late January/early February.
- A web-based booking system functionality has been procured with a plan to install this in December 2022 with a view to commencing testing in January 2023. This will support the adoption of web- based booking as the preferred option for outpatients & scheduled appointments in PCS.

Voluntary Car Services (VCS)

- A VCS and Taxi Task and Finish Group has been established. This is a subgroup of the PCS Improvement Group and will explore proposals to maintain and consider increasing use of VCS under appropriate arrangements.
- The Group has met with VCS colleagues in dedicated short forum workshops on two occasions, most recently on 3 December 2022, to discuss issues under three main themes which will shape the service moving forward :
  - Reasonable volunteering expenses
  - PPE & Equipment
  - Training, Governance & Support
- These Forums were all well attended with good engagement from VCS. Feedback from most recent forum from VCS to the

Task and Finish Group is anticipated by 14 December to agree next steps.

The Chair thanked Ms Charlton for presenting the update and welcomed the web-based booking system.

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

13 **Public & Personal Involvement (PPI) Action Plan – update (SC12/12/22/10)**

Ms Charlton drew the members' attention to the PPI Action Plan and noted the request made at the September meeting to have clear timescales. She confirmed that these would be clear in future papers.

Ms Charlton took the opportunity to convey her thanks to Ms Demi McKay for her significant contribution in progressing PPI within the Trust. She advised that Ms McKay had since moved to take up another post in the HSC.

Ms Charlton referred in particular to Section 3 of the Action Plan. She explained that a set of five standards had been developed to set out what was expected of HSC organisations and staff. She said it was intended that the standards would assist in ensuring consistency of practice and support progress towards a person-centred system.

Continuing, Ms Charlton alluded to the appointment of Mr Neil Gillan as PPI Lead and reported that significant progress had been made within the Trust. She pointed out that the Trust's baseline had been poor but said that actions were being progressed.

Ms Charlton advised that 496 staff had completed e-learning last year with a further 32 completing the training in the current year. She indicated that work would be taken forward identify a PPI Champion in each Directorate. Ms Charlton advised that Mr Gillan was currently drafting a PPI Annual Report for the Trust which she hoped would be published before the end of the financial year.

The Chair thanked Ms Charlton for this update which was **NOTED** by members.

14 **Serious Adverse Incidents (SAIs): current position and learning outcomes (SC12/12/22/11)**

Ms Charlton advised that, of the 24 SAIs reported to the Strategic Planning and Performance Group (SPPG) from April 2022 to date, 15 had related to a delayed NIAS response outside of the standard and that, on eight of these occasions, the patient had passed away.

She explained that she had not seen an increase in the number of SAIs that one might expect given the current significant pressures on services and the challenges around delayed responses.

Ms Charlton said it would be important for the Committee to appreciate that the Trust could not assure members that it was aware of every incident which should be referred as a SAI. She pointed out that, over a three-month period, 1,600 patients had waited more than 80 minutes for a Cat 2 response and she believed that, given a number of conditions within Cat 2 were time critical, such as myocardial infarction and stroke, there was likely to have been patients where a delayed response had an impact on their outcome which the Trust would not necessarily be aware of.

Mr Sowney welcomed the development of sub-themes for the categorisation of SAIs and said the challenges in terms of ensuring learning was disseminated to staff had already been discussed at previous Committee meetings. He referred to recurring themes and asked whether one could assume the incident had recurred due to the challenges in disseminating learning to staff.

In response, Ms Charlton cited the example of misinterpretation of ECGs and suggested that the actual number of SAIs relating to this was small in comparison to the significant number of calls where ECGs were undertaken. She referred to work being undertaken around recommendations arising from SAIs and the development of a dashboard which would show, by Directorate, the progression of recommendations. Ms Charlton stressed the importance of clinical oversight in the EAC as well as having more clinical audit undertaken. However she alluded to the pressures on the small audit team within EAC and believed there was a need to improve resilience in this area.

Continuing, Ms Charlton said that, in order to alleviate some of the pressure placed on the audit team, some of the Trust's Complaints staff were undertaking AMPDS training. She acknowledged that this had been recommended some time ago but had only been possible now. Ms Charlton said that it was important to ensure there were clear audit trails of the actions taken to progress SAI recommendations.

Ms Charlton assured the Committee that work continued in a number of different areas. She alluded to the earlier presentation by Mr Sinclair and the related work around improving cardiac arrest response rates and said this linked with improvement work around ineffective breathing. She added that work was also ongoing in relation to improving the Trust's response to falls amongst elderly patients.

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

15 **Complaints and Compliments: current position and learning outcomes (SC12/12/22/12)**

Ms Charlton noted the Committee's request to have more detail relating to individual complaints.

She alluded to the significant improvement made by the Complaints team in terms of the timeliness of response. Ms Charlton advised that, during the period, 1 April to 31 October 2022, 139 complaints had been reported to the Trust and 99% of these had been acknowledged within two working days. She pointed out that a review of those complaints not acknowledged within the required timeframe had indicated that this was as a result of determining whether the complaint would be processed through the Complaints procedure.

Ms Charlton pointed out that, during the same period, a total of 203 complaints had been closed and she added that this represented a 55% increase for the same period during the 2020-21 year. She acknowledged that, while work would continue to improve the position, significant improvements were clear and she commended the Complaints team for their work in this regard.

Referring to Care Opinion, Ms Charlton acknowledged that the majority of stories had been positive in relation to the NIAS and, where negative stories were reported, they were largely related to delayed response.

The Chair welcomed the reduction in the number of complaints while Mr Abraham commended the progress which had been made.

Mr Bloomfield said that, while he welcomed the reduction in the number of complaints, he would be concerned that this reflected a public acceptance of the deteriorating state of services, given the current context of service pressures.

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

16 **Date of next meeting**

The Chair apologised for having to reschedule the January meeting and confirmed that the next meeting of the Safety Committee would take place on Tuesday 28 February 2023 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: 28 February 2023