NORTHERN IRELAND AMBULANCE SERVICE TRUST

TRUST BOARD - THURSDAY 9 FEBRUARY AT 11AM

LAGAN ROOM, THE MOUNT CONFERENCE CENTRE, 2 WOODSTOCK LINK, BELFAST BT6 8DD

Agenda

1 Welcome, Apologies & Declarations of Conflict of Interest

For Information

2 Minutes of the previous meeting held on 15 December 2022

For Approval

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3 Matters Arising

For Noting

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4 Chair's Update

For Noting

5 Chief Executive's Update

For Noting

6 MP - Approach to productivity/efficiency

For Noting

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7 NR - Overview of Manchester Arena Inquiry Report and Recommendations

For Noting

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8 LC - Overview of Serious Adverse Incidents

For Noting

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9 ML - Draft Equality Action Plan and Disability Action Plan 2023-28

For Approval

9 - 01 - Draft EAP & DAP Jan 23 cover.pdf ***Page 31***

10 MP - Review of NIAS Standing Orders

For Approval

11 MP - Board Governance Self-Assessment Tool

For Approval

12 MP - Performance Report - January 2023

For Noting

13 PN - Finance Report (Month 9)

For Noting

14 Committee Business:

- Safety Cttee - report from meeting on 12 December 2022

For Information

- Audit & Risk Assurance Committee - minutes of the meeting on 8 December 2022 and report of meeting on 19 January 2023

For Information

15 Date & venue of next meeting: Thursday 23 March 2023 at 10am. Arrangements to be confirmed.

16 Any Other Business

Northern Ireland Ambulance Service Health and Social Care Trust

Minutes of NIAS Trust Board held on Thursday 15 December 2022 at 10am via Zoom

Present:	Mrs N Lappin	Chair
	Mr W Abraham	Non Executive Director
	Mr D Ashford	Non Executive Director
	Mr J Dennison	Non Executive Director
	Mr T Haslett	Non Executive Director (joined the meeting at 11.30am)
	Mr M Bloomfield	Chief Executive
	Ms R Byrne	Director of Operations (left the meeting at 10.55am)
	Ms M Lemon	Director of HR & OD
	Mr P Nicholson	Director of Finance, Procurement, Fleet & Estates
	Dr N Ruddell	Medical Director
In Attendance:	Ms L Charlton	Director of Quality, Safety & Improvement
	Mr B McNeill	Programme Director - Clinical Response Model (CRM)
	Ms M Paterson	Director of Performance, Planning & Corporate Services
	Mrs C Mooney	Board Secretary
	Mr N Sinclair	Asst Clinical Director (for agenda item 7 only)
	Mr J Wilson	Boardroom Apprentice

1 Welcome, Introduction & Apologies

The Chair welcomed members to the meeting and explained that, due to the industrial action, she had agreed to today's meeting being held virtually thereby allowing Directors to focus on planning and managing the NIAS response. She acknowledged that, while today's industrial action was being taken by the RCN, there could be potential impact on NIAS staff.

The Chair welcomed back Ms Charlton and Ms Byrne on their return to work following an extended period of absence and noted that Ms Byrne would have to leave the meeting at 11am to join a meeting with other Trusts regarding industrial action.

The Chair acknowledged that today would be Mr McNeill's last Trust Board meeting and said she would return to this point at the end of the meeting.

Referring to today's agenda, the Chair noted that, as papers had been made available to members in advance of the meeting, she intended to allow discussion on a 'by exception' basis. However, she acknowledged there were a number of items on the agenda which may require more detailed discussion.

The Chair reminded those present that they should declare any conflicts of interest at the outset or as the meeting progressed.

The meeting was declared as quorate.

2 **Previous Minutes (TB15/12/2022/01)**

The minutes of the previous meeting held on 11 October 2022 were **APPROVED** on a proposal from Mr Dennison and seconded by Mr Bloomfield.

3 **Matters Arising (TB15/12/2022/02)**

Members **NOTED** that the actions arising from the previous meeting had been actioned.

4 **Chair's Update**

The Chair reminded members that, at the October meeting, she had referred to the fact that she would be requesting a meeting with the Permanent Secretary to discuss the CRM business case and the delays in its progression. She reported that she and Mr Bloomfield had since met with the Permanent Secretary and other DoH colleagues where they acknowledged the delays and the frustrations felt by Board members.

Continuing, the Chair said she had impressed upon them the need to progress the business case with some timeliness as well as

seeking a clear timeline as to when the Trust might expect further correspondence from the DoH. She added that she was given an assurance that the Trust would be kept informed. The Chair said that colleagues would be aware that the first section of the business case was re-submitted to the DoH at the end of November and added it was her understanding that the Trust was on track to submit the remaining sections when feedback on the first section was received from the DoH. The Chair noted that she had confirmed her understanding in writing to the Permanent Secretary.

Mr McNeill advised that he had not yet received feedback from the DoH and suggested it would be prudent to await the feedback on section one of the strategic case which might influence the remaining sections. He confirmed that work had commenced on the economic and commercial case.

The Chair sought clarification on whether it was Mr McNeill's intention to submit the subsequent sections regardless of whether feedback had been received.

In response, Mr McNeill said it had been made clear that no further sections were to be submitted until feedback had been provided. He assured members that the Trust would be ready to address any comments received and amend section one accordingly.

The Chair agreed to share a draft of her intended e-mail to the DoH with Mr McNeill for his comments.

Continuing her update, the Chair advised that Trust Chairs and Chief Executives recently met to discuss various issues arising out of the major incident which had been declared by the NHSCT at Antrim Hospital. She said that a further meeting of HSC Chairs was also being scheduled to discuss issues such as funding and the absence of a Minister and she undertook to update members at the February Board meeting.

The Chair noted that the Permanent Secretary intended to join members at the February Board meeting and said arrangements were currently being finalised for Mr May's attendance.

The Chair reported that she had attended the launch and associated discussion at a joint event hosted by the Chief Executives Forum and Public Sector Chairs Forum of the NOUS

Group reports entitled 'The Chair in Government – profiling the Chair of an Arm's Length Body'. She commended the report both to Non-Executive and Executive Directors as well as Director colleagues and said that discussion around the report 'The CEO in Government – Leading ALBs well' had also taken place.

Continuing, the Chair reported that she had recently attended a meeting to discuss how work on the Partnership Agreement could be recommenced. She acknowledged that lack of progress and said that other parts of the public sector had Partnership Agreements in draft format. The Chair advised the working group proposed to take the recommendations to the NI Civil Service Board with a view to ensuring that momentum was garnered to develop partnership working.

The Chair advised that the competition for her successor closed on Friday 9 December with a view to holding interviews in February.

Concluding her update, the Chair advised that she had recently met with Mr Wilson, Boardroom Apprentice, to discuss areas where he might make a contribution, as previous Apprentices had done, to the work of the Trust.

Members **NOTED** the Chair's update.

5 **Chief Executive's Update**

Mr Bloomfield said that he intended to focus on three current significant issues.

The first related to industrial action which the Chair had alluded to in her opening remarks and he noted that Ms Lemon had updated members via e-mail. Mr Bloomfield noted that, from 5 December, three Trade Unions were taking continuous action short of strike action. However, on 12 December Trade Unions had taken strike action over a 24-hour period.

Mr Bloomfield advised that huge effort had gone into the planning in the weeks leading up to the strike and the Trust had worked constructively with Trade Union colleagues. He acknowledged that their focus had been on what needed to done to facilitate their members to take strike action but also protect services. Mr

Bloomfield said it had been clear that their dispute was not with the NIAS as an employer but against the Government's pay policy.

Continuing, Mr Bloomfield explained that the Trust and Trade Unions had agreed derogations involving those staff taking strike action with Trade Union colleagues ensuring that all Cat 1 and 2 calls were responded to as normal. He added that those Cat 3 and 4 calls which had been assessed as being time critical were also responded to and he explained the Trade Unions had a member of staff in the Control Room to oversee this assessment.

Mr Bloomfield advised that, in terms of Patient Care Services, derogations had been agreed for cancer, renal and paediatric transfers. However, it had been necessary to cancel 66 patient journeys which had been booked for Monday 12 December. He pointed out that, from an operational perspective, approximately half of the operational staff did not take strike action while those staff who did strike followed the agreed derogations and responded to calls from the picket lines.

Mr Bloomfield said that there had been a number of checkpoints throughout the day with Trade Union colleagues and he commended all involved. He referred to the excellent work by Tactical Command Group which had been established in the weeks leading up to the planned strike action. Mr Bloomfield extended his thanks to Ms Byrne as Gold Commander for leading the Tactical Command Group and believed the Trust's proactive approach and working together with Trade Union colleagues had benefitted all concerned.

Mr Bloomfield confirmed that the action short of strike had continued and said that the Trust had subsequently planned for the RCN day of action taking place today. He acknowledged that, while none of the NIAS staff were directly involved in the RCN strike, the Trust expected a significant impact on its service delivery as the rest of the HSC system came under pressure in terms of flow through the hospitals being effected and thereby impacting on hospital handovers.

He advised that the Tactical Command Group had been re-established and Ms Byrne would attend the first regional meeting later that morning to ensure any impact on the NIAS was reflected and fed back.

Mr Bloomfield clarified that NI Trade Unions were not participating in the further ambulances strikes planned for 21 and 28 December in England and Wales. He said that if no resolution was forthcoming, he would envisage further industrial action being planned for the New Year.

Moving to the second issue, Mr Bloomfield referred to delayed handovers and said there had been significant focus on this issue since the October Board meeting as well as considerable discussion at the December ARAC meeting.

He said that delayed ambulance handovers had been the focus of discussion at the recent unscheduled care summit which had taken place on 9 November. He added that NIAS officers had presented figures in terms of the lost capacity, SAIs as well as highlighting the cases of patients who had come to harm as a result of the lack of resources available to NIAS and there had been discussion around the actions needed to address this.

Mr Bloomfield said that the subsequent correspondence dated 11 November 2022 from the Permanent Secretary had asked all Trusts to agree how to address this and to consider whether corridor cohorting of ambulance patients could commence at the start of December. Mr Bloomfield said it was unfortunate that, as at 30 November, no Trusts had confirmed the commencement of corridor cohorting due to the lack of physical space at EDs.

Mr Bloomfield advised that there had been detailed discussion at the Performance Transformation Executive Board, following which the Permanent Secretary wrote to Trusts to requesting focused discussion on what could be done before Christmas regarding handover delays and hospital flow and asking Trusts to commit to a maximum three hour ambulance handover. Mr Bloomfield reminded that the correspondence and associated e-mail from the Permanent Secretary had been shared with members.

Continuing, Mr Bloomfield advised that there had been a mixed reaction from Trusts with some Trusts indicating they would be unable to commit to a three hour handover until other issues within the system were resolved which would improve flow and hospital discharge.

Mr Bloomfield acknowledged that there were some initial concerns about the risk of unintended consequences and noted that the three hour maximum handover would only benefit individual patients and crews. He pointed out that approximately 10% of the NIAS' lost operational hours were accounted for by handovers in excess of three hours. He also acknowledged the concern that if the focus was on a three hour handover that this may be considered acceptable. Mr Bloomfield stressed that the handover standard remained 15 minutes and the three hour handover was an interim backstop in an effort to reduce from the regular 10-12 hour delayed handovers.

Mr Bloomfield said that the NIAS was willing to commit to the three hours' handover provided there were robust monitoring arrangements. He referred to meetings which he had attended with Dr Ruddell, Ms Charlton and Ms Byrne to discuss the detail and acknowledged that Trusts had expressed concern not in relation to the implementation of the three hour handover but in relation to the associated risks. Mr Bloomfield said that agreement had been reached and all Trusts had committed to the three hour handover which would commence on 19 December. He stressed again that this was an initial backstop and further efforts would be needed to reduce handovers further once the impact of the three hour handover was understood as well as the arrangements required to ensure the current handover times did not deteriorate any further. Monitoring would be undertaken by the SPPG.

Continuing, Mr Bloomfield advised that the SPPG would visit all EDs to identify where areas might be used to corridor cohort patients. He added that the other actions to be taken were around stabilising risk across the system and pointed out that the overall approach of trying to do the best for the most was to address the greatest risk, ie those patients in the community waiting for an emergency response.

Mr Bloomfield referred to a meeting being held the following day involving DoH and Trust professional officers to agree principles to give Trust staff reassurance that the actions were being taken as part of a system-wide risk.

Mr Bloomfield indicated that the Permanent Secretary was taking a keen interest in this matter and was supportive of the overall approach agreed amongst Trusts. He said that it was recognised that there may not immediate improvement from 19 December as it

would take some time to embed the new practice as well as recognising the industrial action being taken. Mr Bloomfield said that the NIAS teams would work to explore the impact from an operational perspective and ensure there were smooth handovers at EDs. He said that the arrangements would require daily monitoring and escalation if progress was not evident. He said that the Chair and he would take the opportunity at the Trust's Accountability Review meeting to raise any concerns as well as stress the need for continued improvement.

Continuing his update, Mr Bloomfield advised that the Manchester Arena Inquiry Report had been published at the start of December. He said that Trust officers were reviewing the report to identify any learning and a more detailed update would be provided to a future Board meeting.

Mr Bloomfield said that the Trust's internal focus would be on those specific findings and recommendations relating to ambulance services. He referred to the work currently being undertaken by the Association of Ambulance Chief Executives (AACE) to review the Trust's emergency planning arrangements. Mr Bloomfield acknowledged that a number of recommendations within the Inquiry Report focussed on working across emergency services and the importance of effective co-ordination between them. He said that he had recently met with colleagues from the NIFRS and PSNI under the auspices of the Blue Light Forum where it had been agreed that, using existing emergency planning structures, a gap analysis would be undertaken of the multi-agency issues identified in the Inquiry Report. Mr Bloomfield said he would keep Board members apprised of the outcomes in due course.

Ms Lemon advised that the Trust was currently awaiting the most recent pay circulars. She indicated that recommendations of the NHS Pay Review Body had been implemented in England and Wales and she reminded the meeting that the recommendations had not been implemented in NI due to the political situation. Ms Lemon said that, following the move by the UK government to bring in a draft budget for NI, there would be an uplift to salaries in NI. She acknowledged the view from Trade Unions that the uplift had fallen short of what they had asked for and would not resolve the dispute.

Mr Ashford said it appeared that industrial action would continue and asked whether Directors had any sense of whether there would be a potential escalation to actions being taken. He alluded in particular to the derogation list and said he expected to see this reduce. Mr Ashford asked whether, from a legal perspective, ambulance crews were permitted to strike and whether there was potential for the army to be used as had been the case in England.

Continuing, Mr Ashford said that, while he welcomed the focus on handover delays, he was unsure as to what the outcome would be. He acknowledged the introduction of the three hour handover but believed that very little had changed. He questioned why corridor cohorting could not be implemented immediately and asked what steps were being taken which would make a difference. Mr Ashford said he shared the concerns expressed that the three hour handover would become the norm and agreed that continued monitoring of the situation would be important.

Responding to Mr Ashford's queries, Mr Bloomfield acknowledged that the continuation of industrial action could result in a reduced derogation list. He said that, following consideration, the Trust had indicated that it did not need to employ the use of the army at this time. Mr Bloomfield indicated that Trade Union colleagues had been keen to protect services as much as possible and he expected this to continue. However, he acknowledged that the position would be kept under review.

Mr Bloomfield stressed that it was legal for all health care workers to take strike action and said the last strike action in 2019 had been successful and believed that much of this had been down to the Trust's wish to facilitate the strike action whilst ensuring services were protected.

Ms Lemon reiterated that the strike action was legal and said that members would be aware of the potential for the UK government to review this in terms of the responsibilities under legislation to ensure the preservation of life. She explained that, in NI, negotiations had taken place as to what that meant in practice in terms of what calls would be responded to and what services would be protected. Ms Lemon said that this differed to practice on the mainland. She referred in particular to the RCN strike and the decision to derogate to Christmas day cover levels.

Ms Lemon said that, while the Trust had not yet been advised if action would escalate, further action was expected in January and Trust officers would meet with Trade Union colleagues to negotiate and agree the derogation list.

Ms Byrne advised that she had joined the National Directors of Operations teleconference the previous day and noted that colleagues in England were still working through derogations. She commended the positive relationship between the NIAS and Trade Union colleagues.

In relation to ambulance handovers, Mr Bloomfield said the DoH's approach had not been to mandate particular actions but to pass the issue to Trusts to secure an agreement. He said that, on 14 December, there had been 50 delayed handovers of over three hours with the longest being between 9-10 hours, meaning that crews and, most importantly, patients had been detained in ambulances outside EDs in cold weather. Mr Bloomfield said that he hoped the three hour handover would be implemented with a view to reducing this even further to 1-2 hours handover while, at the same time, progressing discussions around corridor cohorting as a result of SPPG colleagues undertaking visits to EDs. He said that the SPPG would monitor the implementation of the three hour handover and added SPPG colleagues had already been in contact with the Trust's Planning & Performance Directorate to get access to the contemporaneous data around handovers. Mr Bloomfield advised that the SPPG will intervene if there was any significant drift towards the three hours.

Mr Bloomfield emphasised that this was only a first step and said that the Trust remained impacted by lost hours due to delayed handovers. He said that the NIAS needed the DoH and SPPG's support to ensure that what had been agreed was delivered and that continued progress was made.

Mr Ashford said that, while he appreciated the huge contribution by Directors, he was not clear what was happening differently as a result. He believed this was evidenced in the fact if a patient had to wait over three hours, nothing had changed.

Mr Bloomfield confirmed that correspondence had been issued to all Trusts advising that, from 19 December, no handover should take longer than three hours. He explained that this was one action in a

suite of measures being taken and added that it was likely that there would be public announcements that individuals would have to leave hospital if deemed medically fit to do so. Mr Bloomfield said that another measure related to transferring patients from ED even if there was no bed for them in order to decongest EDs.

Mr Abraham commended the huge efforts being made and commented that there did not appear to be any meaningful progress from other Trusts. He reiterated his previous comments in relation to the NIAS being used as the safety valve for the HSC system.

Mr Abraham highlighted the current inflation rate. He was of the view that there would be significant challenges in 2023 and said this was in the context of Trusts trying to ensure a breakeven position at year-end. Mr Abraham suggested that, as the risk was monitored, efforts should be made to consider alternatives 'outside of the box' as to how the issue could be addressed.

The Chair said she had discussed with the Chief Executive the potential for a workshop to consider views on what alternative solutions they might suggest. She added that she had also spent some time revisiting Board minutes and acknowledged the huge efforts made and continuing to be made by Directors to address this issue and to ensure other Trusts viewed delayed handovers as HSC-wide rather than solely a NIAS issue.

Continuing, the Chair said she welcomed action being taken if Trusts did not meet the three hour handover threshold and assured members that there were a number of steps which could be taken. She acknowledged that it might be premature to have evidence of the impact of the three hour handover at the Trust's Accountability Review meeting on 21 December but said that she intended to raise the issue with the Permanent Secretary. The Chair also reminded members that the Permanent Secretary would attend the Board meeting on 9 February but reassured NED colleagues that Directors would highlight the issue at every available opportunity in the interim. She welcomed Mr Bloomfield's comments around working to reduce the handover threshold even further and said it was not acceptable that patients continued to wait in the back of ambulances.

The Chair referred to the position in England where handover delays were considerably longer than in NI. However, she said that,

while this was of little comfort to those patients waiting, she acknowledged that the three hour timeframe was an interim measure. The Chair said she would give some thought to convening a workshop and revert to colleagues in due course.

Ms Byrne acknowledged the frustrations felt by NED colleagues and said that the Trust's Senior Management Team shared that frustration. She said that Mr Bloomfield had underplayed the influence he had brought to bear on discussions and referred to the regular discussions with other Trusts; the Regulation and Quality Improvement Authority (RQIA) and professional officers from both the DoH and Trusts to see what changes the hospital structure could make in terms of consideration of nursing/care homes; SPPG colleagues in terms of having discussions with Trusts around escalated beds in wards and the identification of corridor cohort areas. Ms Byrne reminded that the NIAS was one of six Trusts and, therefore as such, was accountable to the DoH.

The Chair suggested that it might be helpful to have a pre-meeting to consider the areas for discussions when the Permanent Secretary joined the February Trust Board. She acknowledged the continuing frustration around the table and said she wanted to assure members of the ongoing focus on this issue. However, she said it would be important to manage the expectations of the Trust Board in terms of what could be achieved.

The Chair thanked Mr Bloomfield for his update which was **NOTED** by members.

6 **Culture Programme (TB15/12/2022/03)**

At the Chair's invitation, Ms Lemon presented the Culture Programme to members. She assured the meeting that, since initial discussion at the People, Finance & Organisational Development Committee in 2021, work had been progressed in the interim. Ms Lemon said that she would be keen to have endorsement from the Board as to the direction of travel and the overall approach adopted. She added that she would also like to bring some assurance to the Board that the issues of concern which had been previously highlighted, for example through the staff survey results, were being addressed. Ms Lemon noted the documentation which had been shared with members in advance of the meeting and said she intended to highlight a number of issues.

Ms Lemon highlighted the work which had been progressed, for example reviewing the staff survey results; employment cases; best practice in other ambulance services; sickness levels and engagement with staff. She explained that this had allowed a sense check to be carried out and the findings had confirmed the culture within the Trust.

Ms Lemon said that members may recall that one finding from the staff survey related to bullying and that staff would not necessarily recommend the Trust for others to work in as well as a reluctance to have any pride in working for the organisation. She said that, as a result, the plan 'Proud to work for NIAS' was developed around actions to be taken to improve the culture. Ms Lemon explained that a number of the actions had been progressed, including leadership development for example. She advised that this involved a slightly different approach than before with less emphasis on training but elements of approach to certain employment issues and more focus on reflection and value-based engagement with leaders and setting out expectations on how leaders could be better supported to provide the leadership culture expected within the Trust, for example through coaching and mentoring. Ms Lemon said that managers would not have had any exposure to that manner of support and added that Directors had indicated a willingness to act as mentors and participate in the programme.

Ms Lemon said the focus was on ensuring managers were exposed to reflective practice and invited Non-Executive Director colleagues to contact her if they would be interested in assisting.

Continuing, Ms Lemon pointed out that another indicator around culture related to that of employment processes and she said work had started around looking at what a 'just culture' meant in practice. She alluded to the reporting to the People Committee through the use of a balanced scorecard and emphasised the importance of the detail behind each of the figures presented on the scorecard in terms of understanding where the issues originated from. Ms Lemon said that work was ongoing to consider how to best apply alternative approaches where appropriate, for example, a leadership approach which had not always been prevalent in terms of robust leadership discussions where the tendency had been to invoke formal processes.

Ms Lemon referred to the implementation of the Trust's Health and Wellbeing Strategy which had been approved by the Board in August 2022 and said there was an inextricable link between organisations where staff felt valued and where their health and wellbeing was valued and looked after.

Ms Lemon said the Trust intended to hold a leadership conference in early 2023 to explore how to recognise strong leadership and what form that might take.

She pointed out that changing the culture in the organisation would take time and referred to the indicators which would signify a change in culture. Ms Lemon suggested that these indicators would include, for example, a reduction in the number of grievances and disciplinary cases; maximising attendance through a long-term plan to reduce absence. However, she said it would be important to be realistic in terms of a number of issues and she cited the examples of staff finishing shifts late; working in pressurised environments and exposure to trauma. Ms Lemon said it was important that staff started to see the Trust's focus on culture and the Trust addressing the issues identified including identifying the values that were expected of staff and which staff expected to see within the organisation.

Continuing, Ms Lemon said it was intended to undertake further staff surveys and engagement with staff to test how the culture work was progressing. She assured members that the work that could be progressed in the interim had been progressed and she hoped that the Board could endorse the approach taken.

The Chair acknowledged the elements of work which had been progressed and which had not required Board approval and explained that Ms Lemon was seeking Board endorsement to the direction of travel.

Mr Abraham commended the work which had been undertaken and Ms Lemon's verbal update on the work to date. He referred to the low figure of staff who would recommend the NIAS as a place to work and said he looked forward to seeing this figure materially increase over time.

The Chair welcomed reference to the intention to undertake further 'pulse' surveys which would be short and snappy as opposed to

traditional surveys which tended to be long and perhaps not conducted as frequently as pulse surveys would. She queried whether it was intended to carry out pulse surveys.

Responding, Ms Lemon acknowledged that there was a mixed economy on surveys and engagement sessions and said consideration was being given to mainstreaming ongoing satisfaction levels. She acknowledged Mr Abraham's point around being proud to work for NIAS. She believed this was a key indicator and a strong thread which ran through the entire culture programme and one which the Trust was keen to embed. She agreed that the frequency of staff surveys was important and said that if a survey was only conducted every three years, for example, the opportunity for staff to express their views would be limited. Therefore, she said ongoing pulse surveys and engagement became more important.

Mr Abraham referred to the statistic within the survey that 14% of staff felt they were working in an environment of bullying/harassment. He was of the view that this figure appeared high given that the Trust would not tolerate such behaviour and he invited Ms Lemon to comment on this.

Ms Lemon said it was clear from feedback following the staff survey that staff did not feel confident raising issues of concern and making complaints. She said that this had now formed the baseline and added that the Trust was progressing key work in this area. Ms Lemon said it would be important to look beyond the formal complaints and better understand the statistics and the culture of leadership.

She alluded to the leadership development programme referred to earlier and explained that this would focus on what good leadership looked like. She added that, while there was no doubt that the leadership approach of 'command and control' had its place at incident scenes for example, it was important that this was not mainstreamed as the Trust's leadership approach.

Ms Lemon pointed out that the maximising attendance project also looked at management of absence and how that was being conducted. She indicated that the Trust had introduced a KPI relating to bullying and harassment. Ms Lemon stressed the critical nature of the leadership development work and said it was easy, at times of extreme pressure, for managers' focus to be on responding

at times of pressure. She said that she had liaised with managers to ensure managers were released and able to dedicate time to their development.

Responding to a query from the Chair, Ms Lemon confirmed that it remained her intention to have the awards ceremony in March.

Following this discussion, the Culture Programme was **APPROVED** on a proposal from Mr Ashford. This proposal was seconded by Mr Dennison.

The Chair said that her preference would have been to discuss this important work in person and said she looked forward to seeing the Trust transform over the coming months and years.

7 **Clinical Plan/Strategy Development & Implementation - presentation (TB15/12/2022/04)**

The Chair welcomed Mr Neil Sinclair to the meeting and invited him to update members on the Medical Directorate's Clinical Plan/Strategy Development implementation.

Members noted that there had been tangible progress in the delivery of the Clinical Strategy with a key deliverable being having the team in place to ensure the clinical developments were made. Mr Sinclair highlighted the twelve areas emanating from the Clinical Strategy for progression and said that the clinical governance structure would act as the driver to allow the team to push forward with improvements and developments.

Referring to the work around the cardiac arrest project, Mr Sinclair confirmed that the staff were in place to lead the improvements and he advised that suspected cardiac arrest accounted for the majority of calls reviewed in the last month. He explained that the Education Team were developing a syllabus to roll-out a regional cardiac arrest programme to all staff and said this would be supported by developments around the use of the GoodSam app.

Mr Sinclair alluded to the work around research and development and commended Ms Julia Wolfe and team on the article published in the Journal of Paramedic Practice. He said that he and other members of the Education Team continued to liaise with colleagues from Ulster University around various courses.

The Chair acknowledged the progress made and welcomed the development of the profession, particularly with regard to populating the team. She thanked Mr Sinclair and his team for their work and said she looked forward to further updates.

Mr Sinclair withdrew from the meeting at this point.

8 **NIAS Gifts and Hospitality Policy (TB15/12/2022/05)**

At the Chair's invitation, Mr Nicholson drew the NIAS Gifts and Hospitality Policy to the attention of the Board. He explained that the policy was intended to provide advice to Trust staff who, in the course of their day to day work or as a result of their employment, either received offers of gifts and hospitality or provided gifts and hospitality to others on behalf of the Trust.

Mr Nicholson advised that the ARAC had considered the draft policy at its meeting on 8 December and had asked for the wording in relation to gifts to be amended to read '…apparent value of over £50…'. He said that the updated policy brought the Trust into line with other Trusts.

Mr Nicholson indicated that, in line with the Trust's Scheme of Delegation, the policy required Board approval.

The NIAS Gifts and Hospitality Policy was **APPROVED** on a proposal from Mr Ashford. This proposal was seconded by Dr Ruddell.

9 **NIAS Corporate Plan – Mid-Year Review (TB15/12/2022/06)**

Ms Paterson referred the meeting to the summary on page 3 of the paper and explained that, while a high percentage of actions remained on track, one should not underestimate the impact of system wide and winter pressures, coupled with industrial action, on the ability to deliver these actions in-year. She also referred to the objectives within the update report which had been rolled forward from previous years.

Continuing, Ms Paterson said that there was significant potential for financial constraints in the coming months which may impact the Trust's ability to obtain funding for specific programmes and

improvement work, thereby reducing its ability to release staff for training and participation in focused transformation.

Ms Paterson stressed the importance of continued monitoring and said it was a useful tool, coupled with the Trust's governance processes, to enable SMT to illustrate and escalate risks and issues to Committees and Trust Board as appropriate.

The Chair welcomed the fact that the mid-year review included the percentage of objectives not yet completed or on track to be completed. She referred to the update and asked whether a further review would be presented to Trust Board before year end.

Responding, Ms Paterson said it would be her intention to provide a further update before the year end if the timing allowed. She advised that the planning stage for next year's Corporate Plan had commenced. She alluded to the challenges facing the Trust in the coming months and estimated that the final achievement of objectives could be around 70% even though targets were showing higher.

The Chair agreed that it would be important to manage expectations and be mindful of the difficult months ahead. She believed that the mid-year review had been positive. The Chair said it was important not to lose sight of those objectives which had been rolled forward from previous years.

The Board **NOTED** the Mid-Year Review of the Corporate Plan.

10 **NIAS Corporate Risk Register (TB15/12/2022/07)**

Ms Paterson drew the Board's attention to the Corporate Risk Register and explained that, in line with the Trust's Risk Management Strategy, the Register was to be presented to the Board on an annual basis. She highlighted the addition of a new risk relating to 'Independent Ambulance Sector – Medicines Administration' and said this had been discussed in detail at the recent ARAC meeting.

Mr Ashford referred to recent media reports around pharmacy shortages of certain drugs and asked if this might impact on NIAS.

Responding, Dr Ruddell advised that, unlike hospital settings where more unusual drugs were used, for example, for advanced cancer treatments, EU Exit and the protocol had not impacted on the NIAS. However, he referred to a drug being used on a pilot basis by the Trust which had previously been available in injection form but was now being trialled in the form of a nasal spray. He advised that, due to the packaging and labelling of this drug, it was no longer possible to transfer the drugs from GB to Northern Ireland and said that the Trust was now exploring the possibility of sourcing it from the Republic of Ireland. He mentioned the recent increase in the incidence of Strep A and scarlet fever and advised that the penicillin requirement for treatment of this condition was only used by NIAS staff in the form of an injection and supplies were not being adversely affected.

Mr Bloomfield alluded to a meeting he and Dr Ruddell had had with the Chief Pharmaceutical Officer and colleagues from the DoH Pharmacy Branch and said they had been very supportive of the work being taken forward by Ms Catherine Hanna, NIAS Pharmacist. He highlighted to members that this was one example of an area of work which, until recently there had been no dedicated expertise. Mr Bloomfield said it was to be expected that, when an individual with the necessary expertise took up post, he/she would identify a programme of work to be taken forward. He said the Trust would need to seek support from the DoH to address the very significant governance risks associated with areas such as pharmacy and safeguarding.

Mr Bloomfield referred to correspondence received from the Medicines Regulator and said the Trust had put in place measures to address the Regulator's concerns.

Members **NOTED** the Corporate Risk Register.

11 Performance Report (November 2022) & Winter Plan (TB15/12/2022/08)

Ms Paterson advised that most of the actions being taken to address current pressures and support staff were being progressed by the Operational Improvement Group.

She referred to the particular focus on HSC productivity and efficiency. She reminded members that the development of the performance report was an iterative process and said her intention was to fully develop Directorate scorecards so as to demonstrate the Trust's focus on performance.

Continuing, Ms Paterson said that, in the interests of time, it had not been possible today to present to members some of the work ongoing around performance, efficiency and quality improvement. However, she suggested it would be important for members to receive a presentation to allow them to see the detail.

The Chair said she would welcome such a presentation and suggested that this might coincide with the Permanent Secretary's meeting with Trust Board on 9 February. She noted the improvements in performance in terms of call answering and said the Trust could clearly demonstrate its continued focus on productivity and efficiency.

Mr Bloomfield was of the view that the Trust could demonstrate a number of areas where there had been quality improvement, productivity and efficiency and said his preference would be to share details with members in advance of February.

The Performance Report (November 2022) was **NOTED** by the Board.

12 **Finance Report (Month 7) (TB15/12/2022/09)**

Mr Nicholson advised that the Trust was reporting a breakeven position for the seven month period ending 31 October 2022 as well as forecasting a breakeven position at the year end. He explained that this was subject to a number of assumptions, particularly in respect of assumed income, Covid-19 costs and efficiency savings. Mr Nicholson advised that the Trust was planning for the 2023-24 financial year in the knowledge that much of the funding had been made available on a non-recurrent basis with some resources not being guaranteed beyond 31 March 2023.

He further advised that the Trust was currently experiencing some pressures in relation to the capital programme and said this would

be the subject of further discussions at SMT over the coming weeks.

Mr Nicholson referred to the issue of holiday pay which had progressed and said he would provide an update to the ARAC and Trust Board in due course.

Continuing, Mr Nicholson reported that the use of the enhanced rates offered under the Covid-19 Rapid Response Shift Payment Scheme (CRRPS) had reduced since it had peaked in August. He pointed out that the CRRPS had not been offered recently in any area of the service and said he hoped that this would continue.

Mr Ashford welcomed the reduction in the use of the CRRPS.

The Chair thanked Mr Nicholson for his report which was **NOTED** by members.

13 **NIAS Charitable Trust Fund – Trustees' Annual Report & Accounts for the year ended 31 March 2022 (TB15/12/2022/10)**

The Board **NOTED** the final, audited, certified, approved Charitable Trust Fund Trustees' Annual Report and Accounts for the year ended 31 March 2022 which had been published on the Trust website.

14 **Committee Business:**

- **Safety, Quality, Experience & Performance Committee – report and minutes from meeting on 8 September 2022;**
- **People, Finance & Organisational Development Committee – minutes of meeting on 15 September 2022 and report of meeting on 24 November 2022;**
- **Audit & Risk Assurance Committee – minutes of meeting on 6 October 2022 and report of meeting on 8 December 2022 (TB15/12/2022/11)**

Members **NOTED** the various Committee minutes and reports of meetings.

Mr Abraham thanked those involved in the additional ARAC meeting on 8 December to consider the progress in addressing outstanding IA recommendations. He welcomed in particular the positive movement against a number of historic recommendations.

Mr Abraham referred to the progress made but acknowledged that this was subject to review by Internal Audit colleagues.

15 **Date of Next Meeting**

The next NIAS Trust Board will be held on Thursday 9 February 2023 at 10am. Venue to be confirmed.

16 **Any Other Business**

(i) Trust Seal

Mr Nicholson advised the Board that the Trust Seal had been applied on three occasions, namely:

- Emergency Services Design Team Framework for the provision of professional building/facility design; management, construction and supervision services;
- Downpatrick Cricket Club temporary decant location while Downpatrick Ambulance Station modular building was being replaced;
- Renewal of lease for Newcastle Ambulance Station, 18 Castlewellan Road.

(ii) Mr Brian McNeill

Concluding the meeting, the Chair said she wished to pay tribute to Mr McNeill who would retire from the NIAS at the end of January after many years' service.

She referred to the various posts Mr McNeill had held during his time in the NIAS and in which he had made significant contributions, most recently the development of the CRM business case. The Chair said that Mr McNeill's experience and expertise would be sorely missed and she wished him a long, healthy and happy retirement.

Mr McNeill noted that he had worked in the Trust for 39 years in various roles in PCS, paramedic, middle and senior management, training and Director posts.

Both Directors and Non-Executive Directors congratulated Mr McNeill on his impending retirement and wished him well.

THIS BEING ALL THE BUSINESS, THE CHAIR CLOSED THE PUBLIC MEETING AT 2.00 PM.

SIGNED: _____

DATE: _____

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD – 15 DECEMBER 2022

		INDIVIDUAL ACTIONING	UPDATE
	PUBLIC		
1	Update the ARAC and Trust Board on the holiday pay issue	PN	Update provided to ARAC on 19/1/23
2	Share presentation around performance, efficiency and quality improvement with members in advance of February	MP/CM	Included as item on February agenda ACTIONED
3	Share draft e-mail to Ms P Miller, DoH, re CRM business case with Mr McNeill for comment	NL	E-mail shared, comments received and sent to P Miller, DoH, on 15/12/22 ACTIONED
4	Update members at February meeting on discussions with HSC Chairs re funding etc	NL	Update to be provided at Feb meeting. ACTIONED
5	Manchester Arena Inquiry report: • provide update at future Board meeting; • keep members informed of gap analysis being undertaken by Blue Light Forum	NR	On agenda for February meeting ACTIONED Ongoing
6	Consideration to be given to a workshop where NEDs could explore potential 'outside of the box' solutions to delayed handovers	NL	Workshop confirmed for 1/2/23 ACTIONED

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

PRESENTATION OF PAPER

Date of Trust Board:	9 February 2023
Title of paper:	Approach to productivity and efficiency
Brief summary:	This paper is to demonstrate the focus and approach the organisation has taken to bring performance and quality improvements, as well as efficiency gains.
Recommendation:	**For Approval** ☐ **For Noting** ☒
Previous forum:	n/a
Prepared and presented by:	Neil Walker, Head of Performance Andoni Arandia, AD of Planning, Performance & Strategic Transformation Maxine Paterson, Director PP&CS
Date:	3 February 2023

PERFORMANCE IMPROVEMENT INITIATIVES

NIAS has delivered several performance improvement, operational efficiency and productivity projects across different teams.

February 2023

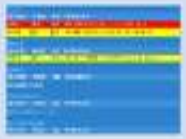
Improvement Area	Improvement Project	Benefits	Current Status

PCS – Non Emergency Patient Transport	Aims to the project:
	- Delivering an improved service delivery model by better understanding and forecasting demand and maximizing utilization and productivity.
	- Delivering an improved planning and scheduling methodology by use of data.
	- Delivering an improved patient experience
	- Delivering a governance and performance framework
		• Significant efficiency increases:
		  • Utilization increased by 5%
		  • Cancelled journeys reduced by 8%
		  • Arrival KPI: 31% more patients arriving on time
		  • Allocation time improved by 1h1m for transfers and 1h14m for discharges
		• Improved staff & patient experience:
		  • Staff feedback: positive and concerns addressed
		  • Patient feedback: favorable comments
			4/8 Sprints delivered
			
			4/8 Sprints ongoing

Timesheet Automation	Aims of the Project:
	- Delivering an automated tool that will save Station Officers and Managers conducting manual timesheet approvals
	- Develop an algorithm built upon agreed organisational parameters that will identify any timesheets outside parameters
	- Achieve 100% audit of all timesheet claims across the organisation
		• Creating Capacity:
		  • Releasing Operational Management time back circa 24hrs per month to the operational service by removing admin tasks from Operational Managers.
		• Quality & Control:
		  • 100% audit on all timesheet claims against predefined parameters consistently across the organisation
			Development and User acceptance testing in progress
			 

Self Service Business Insights	Aims of the Project:
	- Develop tools that allow our staff to make data driven decisions across the organisation
	- Improve our ability to plan across the organisation to maximise the resources available to us
	- Provide the insights into clinical practices within the organisation to drive education and better decision making.
		• Using data intelligence for operational planning:
		  • Improving our operational cover with clearer view of cover into future weeks
		  • More intelligent use of overtime to target capacity issues within our operational cover
		• Using data intelligence for clinical improvement:
		  • Create intelligence to improve our Hear & Treat and See & Treat rates
			Intelligence tools developed and rolled out within organisation.
			 

Improvement Area	Improvement Project	Benefits	Current Status

Handover	Aims of the Project
	- Produce a single source of the truth on Hospital Handover times across the region
	- Improve patient safety within the community with transparency of available Crews at EDs for Category 1 release
	- Collaborative approach to Handover between NIAS and Trusts to improve patient experience
		• Using data intelligence to improve outcomes:
		  • Operational level: Improved ability to make decisions with a single source of truth on handover times
		  • Clinical level: Improved patient safety as it is clearer who has clinical responsibility for the patient at all times
			On going. Live within the main EDs across the region
			 

Alternative Care Pathways	Development of Alternative Care Pathways
	- The project seeks to re-active and explore new pathways for patients
	- ACPs can involve conveyances to other locations (e.g. minor injury units) or non-conveyances (referrals) so the care needs of the patients can be attended to by the right team
	- Involves collaborative working with other trusts and community
		• Efficiency gains:
		  • Increased levels of productivity as ED conveyances get reduced, freeing up crews faster for delivery of capacity
		  • Alleviate the current ED turnaround pressures
		• Improved clinical outcomes:
		  • Improved care as the patients are sent to the right place
			Ongoing
			 

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

PRESENTATION OF PAPER

Date of Trust Board:	9 February 2023
Title of paper:	Overview of the Manchester Arena Inquiry Report and Recommendations
Brief summary:	The Manchester Arena Inquiry was an independent public inquiry established in October 2019 to investigate the deaths of the victims of the 2017 Manchester Arena attack. Volume Two of the Report examines the emergency response following the attack. Dr Ruddell will provide an overview of the Report and its recommendations and set out how the Trust intends to take forward learning from the Report.
Recommendation:	**For Approval** ☐ **For Noting** ☒
Previous forum:	n/a
Prepared and presented by:	Dr Nigel Ruddell, Medical Director
Date:	2 February 2023

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

PRESENTATION OF PAPER

Date of Trust Board:	9 February 2023
Title of paper:	Overview of Serious Adverse Incidents
Brief summary:	Ms Charlton will provide members with an overview of Serious Adverse Incidents.
Recommendation:	**For Approval** ☐ **For Noting** ☒
Previous forum:	n/a
Prepared and presented by:	Lynne Charlton, Director Quality, Safety & Improvement
Date:	2 February 2023

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

PRESENTATION OF PAPER

Date of Trust Board:	9 February 2023
Title of paper:	Draft Equality Action Plan and Disability Action Plan 2023-28
Brief summary:	Approval is sought to the attached draft Equality Action Plan and Disability Action Plan 2023-28. Section 75 of the Northern Ireland Act 1998 placed duties on all public authorities, including NIAS, to promote equality and good relations between people in different groups. The Action Plans follow on from previous Action Plans and set out the steps Trusts will take during the five-year period from April 2023 to meet the duties. Staff from NIAS' Equality Team have worked collaboratively with colleagues from the other HSC Trusts to develop the Action Plans, including listening events with the public. Once respective Trust Boards in each Trust have approved the Action Plans, they will go out for a period of public consultation and, subject to the outcome of this, will be agreed and published.
Recommendation:	**For Approval** ☒ **For Noting** ☐
Previous forums:	SMT – 24 January 2023
Prepared and presented by: **Date:**	John Gow, Equality Officer Michelle Lemon, Director of HR & OD 2 February 2023

Equality Action Plan 2023-2028

HSC Health and Social Care

This document is available in alternative formats and language on request.

Contents

Welcome

Welcome to our new draft Equality Action Plan. This Plan sets out the actions the Health and Social Care Trusts will take forward collaboratively over the next five years.

There are six Health and Social Care (HSC) Trusts in Northern Ireland. Five of whom provide integrated health and social care services. These are as follows:

- Belfast HSC Trust,
- Northern HSC Trust
- South Eastern HSC Trust
- Southern HSC Trust
- Western HSC Trust

And the sixth Trust is the Northern Ireland Ambulance Service, who is responsible for providing emergency, urgent and primary care services across all of Northern Ireland and safely transporting patients.

The six Trusts would like to take this opportunity to welcome you and invite you to engage in our consultation on our draft five year Equality Action Plan (2023-2028). This draft Equality Action Plan has been developed to seek to tackle ongoing and emergent inequalities experienced by people protected by the nine Section 75 groups- that is people of different ages, religious beliefs, racial groups, political opinions, marital status, sexual orientations, men and women generally, people with and without disabilities, people with and without caring responsibilities.

How we developed this action plan

Actions and priorities in this Plan have been informed by an audit of inequalities – add link. The purpose of the audit was to identify key areas of potential inequality. To ensure consistency of approach and equity across the region, the six Trusts have worked collaboratively to gather emerging themes in relation to key inequalities experienced by the nine equality categories. We have collated available research and data to identify emerging themes, which we shared at regional listening events in June and July 2022 with a range of stakeholders including service users, carers, staff and trade unions representatives. We have drafted our Equality Action Plan based on our consideration of the research and the feedback from the listening events. Our intention is to have actions that will make a real and meaningful difference to the lives of people in Northern Ireland by addressing the inequalities they experience or to better promote equality of opportunity. The audit of inequalities will also be a valuable resource for future equality screening and equality impact assessments.

Purpose of the plan

We recognise that inequalities have regrettably worsened during the unprecedented global Covid-19 pandemic and that the health and social care family, as a whole, is working continuously and collectively to try to address the long waiting lists, waiting times and workforce challenges. Many health inequalities will be addressed through the day-to-day provision of health and social care services – for example, higher prevalence of mental ill health will be directly addressed regionally through the implementation of the Mental Health Strategy and delivery of mental health services across the Trusts.

From the outset, it is important to acknowledge that this plan will not be able to tackle all of these systemic inequalities but will focus on those inequalities in health and social care experienced by those protected in law by the equality and good relations duties of Section 75 of the Northern Ireland Act 1998. We also know that some of the inequalities identified in our previous audit of inequalities are persistent, having not yet been fully addressed and will remain as ongoing themes, on which we will continue to focus. This action plan goes beyond our compliance with our respective Equality Schemes but is complementary to the Schemes and seeks to address inequalities relative to our functions. We have deliberately focussed our actions to achieve better accessibility in service provision and to promote inclusion and diversity for those who work in health and social care. This five year plan is designed to be flexible, adaptable and responsive to changing needs, emerging inequalities and circumstances. We will also review alongside our corporate plans and any legislative changes.

Our achievements so far

The Trusts have worked collaboratively to address inequalities and to promote equality of opportunity and good relations. This collective approach has helped us achieve regional best practice and consistency and allowed us to combine our resources to maximise our efforts.

We provide updates in our annual progress reports to the Equality Commission and to our Executive Teams and Trust Boards to demonstrate the progress we have made (all of which are available on our respective websites).

For illustrative purposes, here are some details on just a few of our successful actions in our last Equality Action Plan.

Regional Health and Social Care Good Relations statement

During 2020, we engaged with service users, staff, trade unions and representatives from the community and voluntary sector, the Equality Commission for Northern Ireland, the Northern Ireland Human Rights Commission, and the Community Relations Council to develop a regional HSC good relations statement.

We have displayed this poster across Trust facilities in Northern Ireland with an unequivocal and consistent message in terms of our commitment to good relations and the behaviours we expect from our staff, service users and those with whom we engage.

Establishment of Ethnically Diverse Staff Networks

Staff networks have been established by and for staff of different ethnicities across Trusts to help promote equality, diversity and inclusion in all that we do and to focus on the needs of our ethnically diverse workforce to address and eradicate race discrimination and intolerance and to remove barriers our staff may experience.

Joint Equality, Good Relations and Human Rights Forum

The Trusts have established a joint forum in partnership with colleagues in the Equality Commission, Human Rights Commission and Community Relations Council to help facilitate joint working and the sharing of information and expertise to help address inequalities and uphold human rights and promote equality and good relations in health and social care.

Making Communication Accessible

The issue of communication has and continues to feature as a barrier – with a clear need for Health and Social Care to make improvements. The Trusts worked with disabled people and representative organisations to co-develop a guide for HSC staff on how to provide accessible communication for people with a disability.

It has been recognised as a useful and valuable resource in improving communication for people with a disability and their experience in health and social care.

Guidance for our Trust Board and Executive Team

The Trusts also worked to develop a guidance for our Trust Board and Executive Team members as an aide memoire on the legislative requirements and matters to consider in their strategic decision-making.

Making a Difference Regional HSC Online Training

Equality, Good Relations, Disability and Human Rights training is mandatory for all staff and all professions and a regional HSC online resource entitled "Making a Difference" has been developed to enable staff and managers to complete this via e-learning. To complement this, the Trusts have also developed a guidance for staff to help them refresh their knowledge or reference as needed.

Supporting Carers

In recognition of the invaluable role that informal carers play, we held a workshop for health and social care staff who have caring responsibilities to identify how they can be supported to balance their caring responsibilities while continuing to work. The range of supports available to informal family carers includes a number of flexible working opportunities and a carer support programme.

Disability Equality Training Resource

Working in partnership with disabled people, we have co-produced a Disability Equality Training video. This video is delivered by people with a disability and is available for health and social care organisations and their partners to make sure disability people are treated with respect and dignity.

Disability Toolkit

The Disability Policy and Toolkit was co-developed by health and social care organisations and their respective trade union representatives and disability organisations. The one-stop Toolkit is available in easy-read format and a virtual, Page Tiger resource and provides a comprehensive overview of all issues related to disability for managers and staff.

Gender Identity and Expression Employment Policy

We have developed a policy that supports people who identify as transgender or non-binary in the workplace. We worked with individuals and with voluntary sector groups who represent people who identify as transgender or non-binary to inform our policy.

Value of co-design and collaborative working

None of this proactive work would have been possible without us engaging and working collectively with the people who face the inequality – those "experts by experience" ensure that these actions will make a real and meaningful difference. That is why we are keen and would encourage that as many people as possible take the time to review and influence the actions within our new draft plan.

What is in our draft Equality Action Plan

The following tables outline our actions for the next five years. The Plan includes actions aimed at:

- Improving the data we use to support decision making
- Addressing barriers to accessing health and social care
- Supporting our staff
    - Supporting informal/family carers
    - Partnership working

The principles of ***fairness, respect, dignity, equality and autonomy*** will inform our work.

How we will measure success of the actions in our plan

This five year Plan is designed to be flexible and responsive to changing circumstances and needs and will evolve over its lifespan. The plan illustrates how we will adopt an outcomes-based accountability approach to the promotion of equality of opportunity and good relations.

We will report annually on our progress against the plan via our S75 Annual Progress Report to the Equality Commission for Northern Ireland (ECNI), which is submitted at the end of August each year and available on all of our websites or by contacting the Trusts' Equality Units.

Section 1 – improving the data, we use to support decision-making

We know that high quality data plays a role in improving services and decision-making. When Trusts have good population data, they can identify areas that have worse health outcomes and target health and care resources to reduce health inequalities. Feedback from consultees has indicated that we need to improve that data we collect in relation to health and social care inequalities. The following actions are aimed at improving the data we collect to ensure the effective discharge of our S75 equality duties.

Actions	Timescale	How will we measure success
The Trusts monitor staff across the 9 equality categories to ensure equality of opportunity. Staff input their own equality information on an on-line system but there are currently gaps in the data available. 1. We will take active measures to encourage staff to update their equality monitoring information as part of Corporate Welcome/staff induction and by developing a regional and local campaign to encourage staff to update their equality profile information.	**September 2023 and onwards**	• Regular awareness raising campaigns to encourage staff to update their equality data. • Improve the percentage of staff completing their equality monitoring data.[1] • Promotional resources/Toolkits produced and disseminated to promote inclusion of all staff. • Input into the EQUIP project to ensure the next HR IT system is fully appropriate and fit for operational

[1] n.b. Provision of equality monitoring data on our Information System is voluntary for HSC staff but staff are encouraged to complete and update.

Actions	Timescale	How will we measure success
2. We will promote amongst staff the need to update their staff profile as part of corporate welcome/ staff induction. 3. Develop and organise regional and local campaigns with timescales for staff to update their equality profile information.		purpose. Regional subgroups to support its development and implementation • Benchmark where appropriate with examples of good practice within the wider NHS
Encompass is a new Health and Social Care Northern Ireland (HSCNI) wide programme that will introduce a digital integrated care record to Northern Ireland. 4. We will work collaboratively to influence the ENCOMPASS programme to ensure that it monitors ethnicity, first language and communication support needs of patients and service users. This will aid policy formulation, service delivery and help gather population health data	**2023/24**	• Ethnicity and communication support needs recorded on Encompass system. • Increased access to communication support in timely fashion.

Actions	Timescale	How will we measure success
Under a new way of planning and commissioning services, the Integrated Care System (ICS) will bring together health and social care organisations, partners in voluntary and community sectors and local government, to develop population health plans to improve outcomes and wellbeing and reduce health inequalities. 5. We will work with partners to ensure the inclusion and analysis of Section 75 data in the development of Population Health Plans.	**April 2024 onwards**	• Robust population health plans including Section 75 data. • Identification of health inequalities. • Targeted services that address identified health inequalities and improve health outcomes.

Section 2 – Addressing barriers to accessing health and social care

While much work has been done to date to promote equality of opportunity, it remains the case that there are a number of equality groups that continue to face particular and unique barriers. During the listening events, we heard many suggestions on how to improve equality of access to health and social care services. The following actions have been developed in response to what we have heard and are aimed at providing welcoming, person-centred and accessible services for everyone.

Actions	Timescale	How will we measure success
Trusts have a duty to promote good relations between persons of different religious belief, political opinion or racial group. The regional HSC good relations statement provides a consistent message in terms of our commitment to good relations. Belfast Health and Social Care Trust (BHSCT) has consulted on a co-produced Good Relations Strategy, which includes actions that will promote respect, equity and trust, and embrace diversity in all its forms. 6. All Trusts will adopt the Good Relations Strategy and work collaboratively, with our partners, to take forward the actions and ensure consistency across Northern Ireland.	**By April 2024**	Co-produced Good Relations Strategy. Strategy adopted by all Trusts. Consistent approach to promotion of good relations in HSC Trusts.

Actions	Timescale	How will we measure success
We know that there is a lot of information available on improving health and wellbeing but we need to make sure that the content is understood and accessible. 7. We will co-develop a series of health and social care seminars with representative organisations, communities and individuals to support health and wellbeing and address inequalities. 8. We will develop an online communication hub of best practice in accessibility for people with a disability. This will be supported with an accessible communication training programme for front line staff.	**2023 and biannually thereafter**	• Improved inclusive health and well-being information, targeted at the effected communities. • Two regional seminars held each year. • Feedback and evaluation of seminars. • Online resource hub available for staff to improve communication • Feedback and evaluation of communication hub.
During Covid 19, the increased use of facemasks caused communication difficulties for some service users with a disability, including Deaf and hard of hearing people and people who lip-read. 9. We will promote the two new models of facemasks, which have approved by Infection Prevention Control and are more accessible for people who have hearing loss, are Deaf/deaf and lip-read.	**2023 and ongoing**	• Greater awareness of the importance and availability of accessible facemasks. • Improved communication and patient experience. • Reduction in complaints. • Increase in compliments/positive feedback. • Proactive and targeted use of care opinion

Actions	Timescale	How will we measure success
A regional procurement process has commenced for the provision a Health and Social Care Communication Support Service for People who are d/Deaf, d/Deafblind and Hard of Hearing. The design and development of the service reflects the RQIA Review of Sensory Support Services and subsequent extensive research, public consultation and engagement with sign language users and interpreters. 10. We will work with our partners to secure a specialist provider to deliver a range of high quality, accessible, regionally consistent, and sustainable communication supports for people who are d/Deaf, d/Deafblind, or Hard of Hearing across all HSC services. 11. We will ensure the effective roll out of the new communication support service.	**1 April 2023 and ongoing**	• Regional consistency and equity of access to communication support for people who are Deaf/deaf or have hearing loss. • Improved access to communication support for people who are Deaf/deaf or have hearing loss. • Increased awareness of HSC staff of need to provide communication support. • Reduction in complaints about lack of communication support available/provided. • Improved satisfaction of service provided.
The Northern Ireland Health and Social Care Interpreting Service (NIHSCIS) provides professionally trained interpreters on a face to face basis and we also have a regional contract for telephone interpreting for people, whose first language is not English, when accessing health	**2024**	• Interpreting card for service users and patients to bring to their appointments to help support their communication needs • Reduction in complaints about lack of interpreting support.

Actions	Timescale	How will we measure success
and social care services across Northern Ireland. Feedback indicates that access to interpreting support remains a barrier for some when accessing services. 12 We will develop an interpreting card for patients and service users to present when they are in health and social facilities. The card will indicate that the service user needs an interpreter and include contact details for NIHSCIS. 13 We will promote this card and raise awareness with our staff in training sessions and other means.		• Staff feedback
Neurodiversity is a broad term, used to describe the many and varying ways in which human brains are wired. It encompasses the wide variety of ways humans think, learn, feel and process information. Neurodiversity can include Autism, ADHD, ADD, Dyslexia, Dyscalculia and Dyspraxia. We know there is a need to raise neurodiversity awareness in the workplace and in the provision of our services. 14 We will draft and co-produce a neurodiversity guidance and podcast for	**2024**	• Increased awareness and information provision for staff in terms of people who are neuro-diverse. • Improved user experience. • Improved awareness of information and services for people who are neuro-diverse. • Dissemination and launch of guidance

Actions	Timescale	How will we measure success
our staff along with key stakeholders including experts by experience. 15 We will produce an online signposting resource/service directory on how to access the appropriate neurodiversity services.		
We know that many homeless people face barriers when trying to access health and social care services resulting in health inequalities. Homeless people, including those made homeless because of marital breakdown, often use hospital emergency departments for treatment instead of going to see a GP. When discharged following a hospital admission, with no support, they may return to rough sleeping or sofa surfing which will not aid their recovery. 16 We will work in partnership with Health Protection and Health Improvement, Public Health Agency, other public authorities and community and voluntary sector organisations to establish a regional working group. This multi- agency approach will aim to improve homeless patients' experiences of health and social care services, including improving hospital discharge procedures and to share best practices.	**2025**	• Better partnership working to enhance user experience for people who are homeless • Shared best practice amongst practitioners when providing care to people who are homeless • Increased use of follow up services by patients who are homeless.

Actions	Timescale	How will we measure success
We know that rurality has an impact on equality of access to services, especially for older people, due to lack of accessible transport, times of appointments and the availability of rural and/or community transport. Covid-19 has resulted in a widening of the digital divide affecting older people who may not be familiar with technology. 17 We will work with our partners to ensure that the needs of older people, who reside in rural communities, are actively considered when planning service developments or redevelopments by promoting and monitoring the use of the Rural Needs Toolkit for Health and Social Care and completing Rural Needs Impact Assessments to identify mitigations put in place.	**April 2023**	• Increased awareness of the needs of older people who live rurally • Raised awareness of best practice in overcoming rural inequality and providing adequate and appropriate mitigations. • Increased number of rural needs impact assessments, where appropriate, which evidence consideration of rurality in service design and service change with reduction in any potential inequality for those living in rural areas.
We know that people may be reluctant to share their sexual orientation with health professionals and are unhappy having to disclose their sexual orientation repeatedly. We have also found that some people have had a negative experience when accessing health and social care services.	**April 2023 – March 2028**	• Adoption of Rainbow Badge initiative in each Trust to ensure regional consistency. • Monitor the number of staff taking part in the initiative in each Trust • Gather feedback from staff and service users.

Actions	Timescale	How will we measure success
18 We will implement the Rainbow badge initiative whereby staff will complete online training to gain a HSC Rainbow badge. The badge will be used to symbolise an open, non-judgemental and inclusive place for people that identify as LGBT+ 19 We will promote the Rainbow badge initiative at corporate induction. 20 We will develop a resource for staff comprising guidance produced by professional bodies in terms of best practice for inclusion for people who are LGBT+		• Increased staff awareness of best practice for inclusion for people who are LGBT+. • Reduction in complaints and increase in compliments.

Section 3 – Supporting our staff

We know that staff are our most valuable resource and the Health and Social Care system in Northern Ireland is indebted to the work that they do every day and in particular, throughout the pandemic. We are committed to celebrating and embracing diversity amongst our staff and to ensuring that they feel able to bring their authentic selves to work so that they feel valued and can continue to provide safe, effective and compassionate health and social care services.

Actions	By When	How will we measure success:
We have one of the most ethnically diverse workforces in the public sector and it is vital that we continue to promote the inclusion and visibility of staff who come from ethnically diverse backgrounds. 21 We will support the ongoing work of the Trusts' ethnically diverse staff networks. 22 We will forge stronger links across the region between our Ethnically Diverse Staff Networks.	**April 2024**	• Ethnically diverse staff networks established in each Trust area • Strengthened relationships and consolidation of good practice across the region.

Actions	By When	How will we measure success:
We know that there are still incidents of homophobia in the workplace to staff who are LGBT+ and we know that there is an under-declaration amongst staff who record their sexual orientation as LGBT+. 23 We will continue to work in partnership with LGBT+ representative organisations to ensure that training and awareness raising resources are consistent and up to date. 24 We will promote the regional HSC LGBT+ network for staff across Trusts.	**April 2023 and ongoing**	• Evaluation of training and resources. • Increased awareness of regional HSC LGBT+ network for staff.
Working carers represent a significant proportion of the working population. A growing number of people working in health and social care are trying to balance their jobs and their caring responsibilities. The entitlement to carers' leave and flexible working arrangements are two of the main support measures that can help informal carers to keep a balance between their work lives and caring. 25 We will improve awareness of options for flexible working, work-life balance	**Obtain baseline figures – April 23** **Improvements ongoing throughout the five years**	• Establish baseline on uptake of flexible working and monitor year on year increase in staff accessing these opportunities. • Increased awareness of flexible working, work-life balance and special leave policies • Monitoring reports produced twice a year on flexible working. • Accessible, easy to follow information available to all staff on

Actions	By When	How will we measure success:
and special leave policies to ensure they are accessible to all our staff. 26 We will provide more accessible employer childcare provisions and support staff who are carers		flexible working, work-life balance and special leave policies
It is important that staff who have or acquire a disability are supported in the workplace by overcoming any potential barriers to achieving their full potential. Trusts are committed to creating a safe and welcoming environment for all staff. 27 We will scope development of Staff Disability Forums and Networks to support regional consistency 28 We will implement the Disability Passport within HSC Trusts.	**March 2024**	Effective implementation and widespread use of Disability Passport
Health and social care staff must have the foundation of effective policies and relevant training to support them to provide the most inclusive and compassionate health and social care services. 29 We will develop a regional policy framework to ensure Equality, Diversity		• Equality, Diversity and Inclusion (EDI) policies reviewed. • Policies reflective of up to date advice and best practice from the Equality Commission and other legislative developments

Actions	By When	How will we measure success:
and Inclusion policies are reviewed in line with governance requirements. 30 We will ensure compliance with statutory mandatory equality training 31 We will update the Regional HSC 'Making a Difference' e-learning programme further to review of best practice in E-learning and EDI training. 32 We will identify an EDI Champion at a senior level in each Trust. 33 We will continue to adopt a zero tolerance approach to racial harassment/ discrimination/ bullying and abuse at work – as reflected in the regional Conflict, Bullying and Harassment Policy and Regional HSC Good Relations statement. 34 We will work in partnership with Trade Unions to ensure that staff who experience domestic and sexual violence are supported in the workplace.	**Through out the lifespan of the plan**	• Uptake of statutory mandatory equality training monitored • Regional HSC Making a Difference e-learning programme updated • Increased compliance levels with mandatory equality training • EDI Champion at senior level identified in each Trust. • Increased awareness of zero tolerance approach to racial harassment/ discrimination/ bullying and abuse at work • Regional consistency in EDI policies and equity for all staff across the Trusts • Updated training incorporating best practice identified. • Identified lead on EDI at senior level. • Trust domestic and sexual violence workplace policy in place and support networks established.

Actions	By When	How will we measure success:
Personal stories can really resonate and be most impactful in terms of effectively communicating key messages. We recognise that collaborating with people with lived experience can help to make a difference to improve equality and to educate staff. 35 We will engage with external experts and representative organisations to provide specialist training for employees. 36 We will develop a human rights based training programme for staff providing care for vulnerable people living in residential settings. 37 We will produce guidance on how to develop a Human Rights Based Approach in Health and Social Care service provision. 38 We will provide staff with racial and cultural competence training and associated resources co-designed by people with lived experience.	**April 2023-March 2028** **Ongoing** **2023** **2024** **2024**	• Training sessions developed delivered and evaluated • Marketing and promotional strategy to increase uptake of training across all Trusts. • Increased awareness and competence in providing person centred, person led care and what a human rights based approach. • Evaluation of training and associated resources.
We want to harness the talents of a diverse workforce and recognise that we need to take		• Baseline of workforce profile developed.

Actions	By When	How will we measure success:
a proactive approach in improving access to HSC employment for marginalised Section 75 groups. 39 We will work in partnership with relevant stakeholders to review our Employability Schemes to enhance employment opportunities for marginalised S75 groups. 40 We will develop actions in line with legislative provision to improve access to those Section 75 groups, where there is a low representation in our workforce. 41 We will address specific health inequalities for staff, for example provide menopause information sessions and celebrate men's wealth week to promote inclusion and visibility of gender specific issues in the workforce. 42 We will work collaboratively on the forthcoming gender pay gap legislation and determine appropriate methods of monitoring and reporting.	**By March 2024** **April 2024-March 2028 development** **March 2024** **Dependant on enactment of legislation.**	• Increase in workforce profile for under-represented staff. (Monitored by identifying the % of staff in each of the Agenda for Change Bands 1-9 in comparison with the overall workforce). • Scope in year 1 opportunities and availability of our employability schemes. • Improved access to employment for marginalised S75 groups • Equality data indicating better representation • Pay structure that ensures fairness and equity in pay and reward arrangements

Section 4 – Supporting informal/family carers

We know that many of us are likely to become a carer at some point in life and that informal carers cover a great part of care needs, often called the 'invisible workforce'. Strengthening the voice and representation of informal carers is the first step to address the challenges facing informal carers. Informal care can be physically and mentally demanding, leading carers to often feel exhausted, lonely, and strained.

Actions	By When	How will we measure success:
Recognition of the key role a carer plays is essential and we must provide support when the caring role is having a negative impact on the health and well-being of the informal carer. It is also important to make useful information and training easily accessible and available to informal carers. 43 We will work collectively to ensure that carers across the region are aware that they can have access to a conversation with their named worker in relation to their caring role and needs The conversation is carer led and encourages both staff and carers to take time to discuss the caring role.	**Quarterly monitoring** **2023 Annually**	• Increased uptake of carers assessments • Improved carer experience of the carer assessment process • Consistent, regional approach to Carers Rights Day • Carers across Northern Ireland receive the same information and know where to get help and support. • Increase in people who identify as carers, which will enable them to link into supports available.

Actions	By When	How will we measure success:
44 We will hold an annual event on Carers Rights Day to highlight care and caring and help informal, unpaid, family carers understand their rights and find out about support that may be available.		

Section 5 – Partnership Working

A new Integrated Care System (ICS) is currently being developed for Northern Ireland. This system signals a new way of planning and managing our health and social care services based on the specific needs of the population. The ICS approach harnesses the strengths in our existing partnerships and focuses on addressing the wider determinants of health and wellbeing through a population health approach.

Actions	By When	How will we measure success:
We will work in partnership with stakeholders and external organisations to raise awareness of key equality, diversity and inclusion (EDI) topics. 45 We will continue to work in partnership with the Department of Health, Equality Commission for Northern Ireland, the Northern Ireland Human Rights Commission and the Community Relations Council to allow strategic issues to be discussed and addressed at the Regional Equality and Human Rights Steering Group and the Joint	**March 2025** **Quarterly**	• Regional consistency and development of initiatives to promote equality of opportunity and protect and to promote human rights • Improved relationships and mutual understanding between HSC and ECNI, NIHRC and CRC • Better partnership working to address inequalities and improve physical and mental health and wellbeing

Actions	By When	How will we measure success:
Equality, Good Relations and Human Rights Forum. 46 We will work with representative organisations to co-develop Equality, Diversity and Inclusion initiatives.	**Biannual**	

Contact Details

For more details of what we have done so far, please refer to our respective Annual Progress Reports which are available online or by contacting the relevant Equality Team.

www.belfasttrust.hscni.net

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Disability Action Plan 2023-2028

HSC Health and Social Care

This document is available in alternative formats and language on request.

Contents

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Alternative Formats

This document is available in alternative formats including:

- Large font
- Braille
- Main minority ethnic languages
- DAISY
- Easy-read
- Electronic version.

Please see contact details of the relevant Equality Team in each Trust on Page 16.

Introduction

Welcome to our new draft Disability Action Plan. This plan sets out the actions the Health and Social Care Trusts will take forward collaboratively over the next five years.

There are six Health and Social Care (HSC) Trusts in Northern Ireland. Five of whom provide integrated health and social care services. These are as follows:

- Belfast HSC Trust,
- Northern HSC Trust
- South Eastern HSC Trust
- Southern HSC Trust
- Western HSC Trust

And the sixth Trust is the Northern Ireland Ambulance Service, who is responsible for providing emergency, urgent and primary care services across all of Northern Ireland and safely transporting patients.

The six Trusts would like to take this opportunity to welcome you and invite you to engage in our consultation on our draft five year Disability Action Plan (2023-2028).

Our plan lays out the actions that we are proposing in response to our dual disability duties under **Section 49A of the Disability Discrimination Act 1995 (as amended)** which are to:

- promote positive attitudes towards people with a disability and
- encourage their full participation in public life.

How we developed this action plan

The actions in the draft plan have been developed following feedback, which people with a disability gave us during an engagement event on 25th October 2022. This event was facilitated by Disability Action and through our ongoing collective and local engagement.

We remain committed to working in partnership with disabled people and their representative organisations and look forward to working collaboratively on our actions during the five-year plan.

This Plan is a live document. It is designed to be flexible and responsive to changing circumstances over the five year period. We will review it on an on-going basis and provide annual reports against progress. Thanks to everyone who helped to inform this plan – we value your expertise and your time in making this plan robust and meaningful.

What we propose to do in our Disability Action Plan

The draft action plan has been developed to progress our dual disability duties in promoting positive attitudes and encouraging full participation of disabled people in public life. Actions to specifically address inequalities experienced by people with disabilities are addressed specifically within our regional five year Equality Action Plan and have been informed by our engagement with disabled people and representative organisations. (Both the draft Disability Action Plan and the draft Equality Action Plan will be issued for formal consultation at the same time)

The following table outlines our proposed actions over the next five years to meet our dual disability duties.

Section 1 - Actions to promote positive attitudes towards people with a disability

What we were told	What we will do (*Actions*)	By When	How will we measure success
That there is a need for them to be listened to and inform the decision making process. People with disabilities want more clarity on how they can get	1. We will share opportunities for involvement to ensure the voice of disabled people is heard 2. We will work in partnership with relevant stakeholders to identify advocacy services	**March 2025** **March 2024**	• A Directory of Advocacy and Support Services produced and placed on each Trusts website (and in alternative formats • Involvement section on websites/ set up links with the Public Health Agency (PHA) "Engage" website • Improved links with PPI team's/involvement teams/and disabled people within the Trust and

What we were told	What we will do (*Actions*)	By When	How will we measure success
involved and be heard – lots going on but not well known	3. We will support staff with a disability to ensure they have a voice and are heard		community and voluntary organisations to better publicise opportunities on what is going on and how to get involved
That there is a need for visibility of people with disabilities	4. We will continue to develop our organisational culture to become more disability aware. 5. We will have an inclusive approach to the use of images which re-enforces a positive image of people with disabilities accessing our services 6. We will mark and celebrate allocated days to raise awareness at a local and regional level thereby working to promote disability inclusion 7. We will take every opportunity to promote and	**March 2028**	• Increased visibility of disabled people in Trust publications, use of social media and online presence • Use of alt text in our social media • Promotion, evaluation, and feedback on the Disability Toolkit completed • Ensure our disability equality training includes reference to myths, etiquette and language • Calendar of events organised annually in relation to Disability such as International Day of Persons with a Disability • Increased promotion of disability related events on our local intranets, social media, Trust websites and news items. • UNCRPD guide for HSC staff updated

What we were told	What we will do (*Actions*)	By When	How will we measure success
	advocate for the social model of disability 8. We will continue to promote the regional sign language service		• Sign language service (remote and in person) promoted • Our disability equality training will be based on the social model of disability • Our staff Mandatory Equality Training 'Making a Difference' is reviewed to ensure the Section 49A duties are explicitly referenced • Resources developed to promote good practice under the duties e.g. communication with d/Deaf person
There is a need for greater partnership working	9. We will promote early involvement and co-production of disabled people in developments to services and changes	**Year 2-5**	• Greater partnership and involvement opportunities for service user groups/advocacy groups, Community and Voluntary sector and HSC • Development of a specific database of disabled people and organisations that wish to be involved in co-production • Consultee database is reviewed and updated annually

What we were told	What we will do (*Actions*)	By When	How will we measure success
We need to raise awareness of our work on addressing the disability duties	10. We will work to enhance the profile and accessibility of the regional Disability Action Plan 11. We will increase awareness by ensuring the documents are accessible, in Plain English and easy read	**Ongoing**	• Increased awareness of the Disability Action Plan and the associated actions in the Trust and amongst our stakeholders • Easy read version available • Disability Action Plan available on Trust websites and internal intranets • Signed version available • Proactively disseminate the DAP to key stakeholders including community and voluntary sector
Our policies needs to be kept up to date and relevant, to help support our staff who have a disability to remain in the workplace	12. We will review our Disability Equality Policy for staff in line with best practice to ensure it remains fit for purpose and relevant 13. We will collaborate with Occupational Health colleagues 14. We will update our Disability Toolkit 15. We will work with relevant colleagues to ensure	**March 2025**	• Revised regional policy in place • Updated Disability Toolkit in place • Disability Equality Training delivered to OH colleagues if required

What we were told	What we will do (*Actions*)	By When	How will we measure success
	policy development and review promote the need for reasonable adjustments and S49A duties		
That there is a need for all HSC staff to be trained	16. We will review our training programmes for staff on disability, the two disability duties, and reasonable adjustments 17. We will ensure that Training is co-produced and includes those who have first-hand experience (experts by experience) and include reference to the social model, myths, language and how this links to patient centred care	**Annually** **March 2026**	• Evaluation of training provided • Feedback on training –notably from staff with a disability • Increased awareness of disability, legislative provision and reasonable adjustments • Co- Production of resources detailing the correct terminology to use
That there is a need for more opportunities for those with disabilities to gain	18. We will work in collaboration with relevant stakeholders to review our Employability Schemes to	**March 2024 scope**	• Opportunities and availability of our employability schemes scoped in year 1 • Development of actions, in line with the legislative provisions and

What we were told	What we will do (*Actions*)	By When	How will we measure success
employment within HSCNI	enhance employment opportunities 19. We will work to reduce barriers to recruitment to HSC for disabled people	**April 2024-March 2028 development**	supported by equality data, to improve access to employment for marginalised S75 groups • We will make any reasonable adjustments required for anyone with a disability during any recruitment

Section 2 - Actions to encourage participation by disabled people in public life

What we were told	What we will do (*Actions*)	By When	How will we measure success
There is a need to work with stakeholders to raise awareness of disability equality issues	20. We will invite representatives from the Regional Disabled People's Forum to partake and work alongside the Joint Regional Equality, Human Rights and Good Relations Forum and Joint Steering Group.	**Ongoing**	• Greater participation • Promotion of the voice of disabled peopled • Change in Terms of Reference and membership
That the disability legislation in NI is very complex and not accessible	21. We will work with key stakeholders (Equality Commission NI) to co-develop versions of the Disability Discrimination Act, and its relevance to Health and Social Care, in plain English and easy read to ensure that the legislation and disabled people's rights within it are more easy to understand	**March 2028**	• Resources produced and publicised • Evaluation and Feedback from stakeholders

What we were told	What we will do (*Actions*)	By When	How will we measure success
There is a need to improve visibility and awareness of jobs for anyone who is disabled	22. We will work towards Disability Positive Accreditation for all HSC organisations	**March 2028**	• Disability Positive accreditation achieved
We need to improve accessibility to services for people with a disability	23. We will work with colleagues in Capital Development and Estates and service areas to collaboratively promote accessible facilities 24. Involvement of service users on capital development task groups so they are sharing their expertise from conceptual stage.	**Ongoing**	• Improved accessibility for our service users, patients, staff and visitors • Feedback from service users via Care Opinion/Complaints • AccessAble guides in place for selected facilities
We need to make sure that carers can access support for their caring role.	25. We will work collaboratively to increase the visibility and awareness of the various supports available for carers	**Ongoing**	• Increase numbers on Carers Register • Improved uptake of carers assessments • Improved access to carer support programme • Increased awareness of carers role

What we were told	What we will do (*Actions*)	By When	How will we measure success
	26. We will promote the role of the Carers Co-ordinator in each Trust		• Better involvement of carers in decision making • Increase in type of supports offered Talking Therapies • Alternative Therapies • Respite • Young Carers
That better data on who our service users and patients and their communication support needs will help to improve mutual communication	27. We will ensure that the new HSCNI digital integrated care record (ENCOMPASS) facilitates mandatory fields relating to the communication support of service users who are disabled 28. Ensure involvement in ENCOMPASS project. *(Encompass is a new Health and Social Care Northern Ireland (HSCNI) wide initiative that will introduce a digital integrated care record to Northern Ireland.)*	**Ongoing** **March 2028**	• Communication support needs are recorded on the Encompass system • Engagement with disabled people • Improved communication and access to services • Development of robust population health plans, which seek to improve both physical and mental health outcomes and wellbeing of people within and across a defined local, regional or national population, while reduce health inequalities

What we were told	What we will do (*Actions*)	By When	How will we measure success
	29. We will work with ENCOMPASS to ensure that the communication support needs of service users are captured		
That it is difficult to gain employment or work experience in health and social care	30. We will partner with the community sector to support disability placement schemes for people with disabilities who experience barriers to employment. 31. We will work with staff, schools and disability organisations to promote health and social care as a disability friendly employer	**Ongoing** **Ongoing**	• Number of people in placements • Placement evaluations • Improved awareness of the Trust as a disability friendly employer

Contact Details

For more details of our achievements in meeting our dual disability duties, please refer to our respective Annual Progress Reports which are available online or by contacting the relevant Equality team.

www.belfasttrust.hscni.net

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Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

PRESENTATION OF PAPER

Date of Trust Board:	9 February 2023
Title of paper:	Review of NIAS Standing Orders
Brief summary:	A detailed review of the Trust's Standing Orders took place in 2021 with Trust Board approving the revisions at its meeting on 21 October 2021. The proposed revisions for the 2022 review were presented to the ARAC meeting on 19 January 2023. The Committee is recommending the revised Standing Orders to the Board for approval. If approved, the revised Standing Orders will be posted on the NIAS website.
Recommendation:	**For Approval** ☒ **For Noting** ☐
Previous forum:	SMT – 10 January 2023 ARAC – 19 January 2023
Prepared and presented by: **Date:**	Carol Mooney, Board Secretary Maxine Paterson, Director of PP&CS 2 February 2023

PROPOSED REVISIONS TO NIAS STANDING ORDERS

Page	Revision	Purpose
1	Definition of 'Chair of the Board (or Trust)' – insert 'appointed in accordance with the relevant legislation…' (NB Footnote inserted with reference to relevant legislation.)	Clarification
4	Definitions of SPPG and PHA added	Clarification
8	Para 2.1, 2.1.1 – insert 'The Chair of the Trust (appointed in accordance with the relevant legislation)… Para 2.2, 2.1.1 – insert 'The Chair and Non-Executive Directors of the Trust are appointed in accordance with the relevant legislation.'	Clarification
11	Replace 'HSCB' with 'SPPG'	Update
28	Amend Minister's title – remove '… Social Services & Public Safety'	Update
30	Para 4.8.1 – update reference to 'Code of Conduct for Board members of Public Bodies (June 2019)'	Update
31	Para 4.8.2 – insert date of publication of Higgs Report, ie 2003	Clarification
37	Insert 'The HSC Code of Conduct for HSC Employees (2016)'	Clarification
53	Scheme of Reservation & Delegation 'Policy Determination' – insert 'All policies, including any updates, will be approved at Committee level …'	Clarification
63	Decisions/Duties delegated by the Board to Committees: Safety and PFOD Committees - insertion of sentence 'The Committee will also consider and approve relevant policies.'	Update
	Amend pagination for Terms of Reference	Update
	Insert 'October 2022' at references to the Codes of Conduct and Accountability throughout the document	Update

Northern Ireland Ambulance Service
Health and Social Care Trust

STANDING ORDERS

And

SCHEME OF RESERVATION AND DELEGATION

February 2023

Title:	Standing Orders and Scheme of Reservation and Delegation		
Author:	Mrs Carol Mooney, Board Secretary		
Ownership:	Ms Maxine Paterson, Director of Planning, Performance and Corporate Services		
Date of Audit Committee Approval:		**Date of Trust Board Approval:**	
Operational Date:	21 October 2021	**Review Date:**	March 2024
Version No:	V3.0	**Supercedes:**	TW/4/Fin (03) 2014
Key words:	Standing Orders, Scheme of Reservation and Delegation, Standing Financial Instructions		
Other Relevant Policies:	Standing Financial Instructions		

Date	Version	Author	Comments
17 June 2019	V0.1	Andrew Phillips	Standing Orders benchmarked with HSC Trusts
18 June 2019	V1.0	Andrew Phillips	Approved at Audit Committee and Trust Board
21 October 2021	V2.0	Carol Mooney	Approved at Audit Committee and Trust Board

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SECTION A

1. INTERPRETATION AND DEFINITIONS FOR STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS

1.1 Save as otherwise permitted by law, at any meeting, the Chair of the Trust shall be the final authority on the interpretation of Standing Orders (on which they should be advised by the Chief Executive).

1.2 Any expression to which a meaning is given in the HPSS (NI) Order 1991, the Health and Social Care (Reform) Act (Northern Ireland) 2009 and other Acts/Orders relating to the HSC shall have the same meaning in these Standing Orders and Standing Financial Instructions and in addition:

1.2.1 **"Accounting Officer"** means the HSC Officer responsible and accountable for funds entrusted to the Trust. The officer shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive.

1.2.2 **"Trust"** means the Northern Ireland Ambulance Service (NIAS) Health & Social Care Trust.

1.2.3 **"Board"** means the Chair, Executive and Non-Executive members of the Trust collectively as a body.

1.2.4 **"Budget"** means a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.

1.2.5 **"Budget holder"** means the Director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation.

1.2.6 **"Chair of the Board (or Trust)"** is the person appointed in accordance with the relevant legislation[1] to lead the

[1] Regulation 3 of the Health and Social Services Trusts (Membership and Procedure) Regulations (Northern Ireland) 1994

Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression "the Chair of the Trust" shall be deemed to include the member acting as Chair of the Trust if the Chair is absent from the meeting or is otherwise unavailable.

1.2.7 **"Chief Executive"** means the Chief Officer of the Trust. The Chief Executive is the Trust's Accounting Officer.

1.2.8 **"Commissioning"** means the process for determining the need for and for obtaining the supply of healthcare, social care and related services by the Trust within available resources.

1.2.9 **"Committee"** means a Committee or Sub-Committee created and appointed by the Trust.

1.2.10 **"Committee members"** means persons formally appointed by the Board to sit on or to chair specific Committees.

1.2.11 **"Contracting and procuring"** means the systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.

1.2.12 **"Director of Finance"** means the Chief Financial Officer of the Trust.

1.2.13 **"Funds held on trust"** shall mean those funds which the Trust holds on date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under Article 16 of the HPSS (NI) Order 1991. Such funds may or may not be charitable.

1.2.14 **"Member"** means Executive or Non-Executive member of the Board as the context permits. Member, in relation to the Board, includes its Chair.

1.2.15 **"Associate Member"** means a person appointed to perform specific statutory and non-statutory duties which have been delegated by the Trust Board for them to perform and these duties have been recorded in an appropriate Trust Board minute or other suitable record.

1.2.16 **"Membership, Procedure and Administration Arrangements Regulations"** means HSS Trusts (Membership and Procedure) Regulations (Northern Ireland) 1994.

1.2.17 **"Nominated officer"** means an officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.

1.2.18 **"Officer"** means employee of the Trust or any other person holding a paid appointment or office with the Trust.

1.2.19 "**Audit and Risk Assurance Committee**" means a Committee whose primary role is to independently contribute to the Board's overall process for ensuring that an effective internal financial control system is maintained.

1.2.20 **"People, Finance and Organisational Development Committee"** (People Committee) means a Committee whose functions are concerned with providing assurance in relation to strategic HR issues and the Trust Board's statutory responsibility to break even.

1.2.21 "**Remuneration Committee & Terms of Service Committee**" means a Committee whose primary role is to advise the Board about appropriate remuneration and terms of service for the Chief Executive and all other direct reports to the Chief Executive.

1.2.22 **"Safety, Quality, Patient Experience and Performance Committee"** (Safety Committee) means a Committee whose functions are concerned with the arrangements for the purpose of monitoring and improving the quality and safety of health and social care

for which the Northern Ireland Ambulance Service Health and Social Care Trust has responsibility.

1.2.23 **"Secretary"** means a person appointed to act independently of the Board to provide advice on corporate governance issues to the Board and the Chair and monitor the Trust's compliance with the law, Standing Orders, and DoH guidance.

1.2.24 **"SFIs"** means Standing Financial Instructions.

1.2.25 **"SOs"** means Standing Orders.

1.2.26 **"Member acting as Chair"** means the Non-Executive member appointed by the Board to take on the Chair's duties if the Chair is absent for any reason.

1.2.27 **"DoH"** means the Department of Health.

1.2.28 "**SPPG**" means Strategic Planning and Performance Group.

1.2.29 "**PHA**" means Public Health Agency.

SECTION B – STANDING ORDERS

1. INTRODUCTION

1.1 Statutory Framework

The Northern Ireland Ambulance Service (NIAS) HSC Trust (the Trust) is a statutory body which came into existence on 1 April 1995 under the Northern Ireland Ambulance Service Health and Social Services Trust (Establishment) Order (Northern Ireland) 1995.

1.1.1 The principal place of business of the Trust is Northern Ireland Ambulance Service, Headquarters, Site 30, Knockbracken Healthcare Park, Saintfield Road, Belfast, BT8 8SG.

1.1.2 HSC Trusts are provided for under Article 10(1) of the Health and Personal Social Services (NI) Order 1991 and subsequently amended under Health and Social Care (Reform) Act (Northern Ireland) 2009.

1.1.3 The functions of the Trust are conferred by this legislation.

1.1.4 As a statutory body, the Trust has specified powers to contract in its own name and to act as a corporate trustee.

1.1.5 Schedule 3 of the HPSS (NI) Order 1991 specifies the duties, powers and status of HSC Trusts.

1.1.6 The Codes of Conduct and Accountability (October 2022) require the Trust to adopt Standing Orders for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions (SFIs) as part of Standing Orders setting out the responsibilities of individuals.

1.1.7 The Trust will also be bound by such other statutes and legal provisions which govern the conduct of its affairs.

1.2 Health and Social Care Framework

1.2.1 In addition to the statutory requirements, the Minister for Health, through the DoH, issues further directions and guidance. These are normally issued under cover of a circular or letter.

1.2.2 The Codes of Conduct and Accountability (October 2022) require that, among other things, Boards draw up a schedule of decisions reserved to the Board, and ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives (a scheme of delegation). The Code also requires the establishment of Audit and Remuneration Committees with formally agreed terms of reference. The Standards of Business Conduct make various requirements concerning possible conflicts of interest of Board members.

1.2.3 The Trust will produce and publish an annual report for each financial year within the timescales set by the DoH. The Annual Report will identify the Chair, Chief Executive and Non-Executive Directors, as well as the Chair and members of the Audit and Risk Assurance Committee, Safety, People and Remuneration Committees. It will also set out the numbers of meetings of the Board and those Committees and individual attendance by members.

1.2.4 The Trust will comply with all statutory requirements and Departmental directions, including the DoH Framework Document, Management Statement and Financial Memorandum, the Codes of Conduct and Accountability for Board Members of Health and Social Care bodies (October 2022) and other Codes of Conduct and directions as these apply to the functions, activities and conduct of Boards of Health and Social Care Trusts. Where these are updated or replaced, the new provisions and requirements will apply.

1.3 Delegation of Powers

1.3.1 The Trust has powers to delegate and make arrangements for delegation. The Standing Orders set out the detail of these arrangements. Under the Standing Order relating to the Arrangements for the Exercise of Trust Functions by Delegation (SO 5) the Trust is given powers to "make arrangements for the exercise, on behalf of the Trust of any of their functions by a committee, sub-committee or joint committee appointed by virtue of Standing Order 4 or by an officer of the Trust, in each case subject to such restrictions and conditions as the Trust thinks fit or as the Minister for Health may direct". Delegated Powers are covered in Section C of this document – Scheme of Reservation and Delegation.

1.4 Governance

1.4.1 Trust Boards are required to have in place integrated governance structures and arrangements that will lead to good governance and to ensure that decision-making is informed by intelligent information covering the full range of corporate, financial, clinical, social care, information and research governance aspects. This will better enable the Board to take a holistic view of the organisation and its capacity to meet its legal and statutory requirements and clinical, social care, quality, safety and financial objectives.

2. THE TRUST BOARD: COMPOSITION OF MEMBERSHIP, TENURE AND ROLE OF MEMBERS

2.1 Composition of the Membership of the Trust Board

In accordance with The Northern Ireland Ambulance Service Health and Social Services Trust (Establishment) Order (NI) 1995, the composition of the Board shall be:

2.1.1 The Chair of the Trust (appointed in accordance with the relevant legislation (following a recruitment process overseen by the DoH Public Appointments Unit)).

2.1.2 Up to five Non-Executive members (appointed by the DoH Public Appointments Unit).

2.1.3 Up to five Executive members (but not exceeding the number of Non-Executive members) including:

(a) the Chief Executive; and

(b) the Director of Finance;

The Trust Board shall have not less than eight members (unless otherwise determined by the Minister for Health and set out in the Trust's Establishment Order or such other communication from DoH).

2.2 Appointment of Chair and Members of the Trust

2.1.1 The Chair and Non-Executive Directors of the Trust are appointed in accordance with the relevant legislation.

2.3 Terms of Office of the Chair and Members

2.3.1 The regulations setting out the period of tenure of office of the Chair and members and for the termination or suspension of office of the Chair and members are contained in Part 2, Articles 7 - 9 of the HSS Trusts (Membership and Procedure) Regulations (NI) 1994.

2.4 Appointment and Powers of Vice-Chair

2.4.1 Subject to Standing Order 2.4.2 below, the Chair and members of the Trust may appoint one of their numbers, who is not also an Executive member, to be Vice-Chair, for such period, not exceeding the remainder of his term as a member of the Trust, as they may specify on appointing him/her.

2.4.2 Any member so appointed may at any time resign from the office of Vice-Chair by giving notice in writing to the Chair. The Chair and members may thereupon appoint another member as Vice-Chair in accordance with the provisions of Standing Order 2.4.1.

2.4.3 Where the Chair of the Trust has died or has ceased to hold office, or where they have been unable to perform their duties as Chair owing to illness or any other cause, the Vice-Chair shall act as Chair until a new Chair is appointed or the existing Chair resumes their duties, as the case may be; and references to the Chair in these Standing Orders shall, so long as there is no Chair able to perform those duties, be taken to include references to the Vice-Chair.

2.5 Joint Members

2.5.1 Where more than one person is appointed jointly to a post mentioned in Part 2, regulation 6 of the HSS Trusts (Membership and Procedure) Regulations (NI) 1994, those persons shall count for the purpose of Standing Order 2.1 as one person.

2.5.2 Where the office of a member of the Board is shared jointly by more than one person:

(a) Either or both of those persons may attend or take part in meetings of the Board;

(b) If both are present at a meeting they should cast one vote if they agree;

(c) In the case of disagreements, no vote should be cast;

(d) The presence of either or both of those persons should count as the presence of one person for the purposes of Standing Order 3.11 Quorum.

2.6 Role of Members

The Board will function as a corporate decision-making body, Executive and Non-Executive members will be full and equal members. Their role as members of the Trust Board will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions.

2.6.1 Chair

The Chair shall be responsible for the operation of the Board and chair all Board meetings when present. The Chair has certain delegated executive powers. The Chair must comply with the terms of appointment and with these Standing Orders.

The Chair shall liaise with the DoH Public Appointments Unit over the appointment of Non-Executive Directors and, once appointed, shall take responsibility for their induction, their portfolios of interests and assignments, and their performance.

The Chair shall work closely with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.

The Chair is responsible for leading the Board and for ensuring that it successfully discharges its overall responsibility for the organisation as a whole. The Chair is accountable to the Minister through the Departmental Accounting Officer. The Chair shall ensure that the Trust's policies and actions support the wider strategic

policies of the Minister and that the Trust's affairs are conducted with probity.

The Chair has a particular leadership responsibility on:-

- Formulating the Board's strategy for discharging its duties;
- Ensuring that the Board, in reaching decisions, takes proper account of guidance provided by the Minister, the sponsor department, the SPPG or the PHA;
- Ensuring that risk management is regularly and formally considered at Board meetings;
- Promoting the efficient, economic and effective use of staff and other resources;
- Encouraging and delivering high standards of regularity and propriety;
- Representing the views of the Board to the general public;
- Ensuring that the Board meets at regular intervals throughout the year and that the minutes of meetings accurately record the decisions taken and, where appropriate, the views of individual Board members.

The Chair shall also:

- Ensure that all members of the Board, when taking up office, are fully briefed on the terms of their appointment and on their duties, rights and responsibilities, and receive appropriate induction training, including on the financial management and reporting requirements of public sector bodies and on any differences which may exist between private and public sector practice;
- Advise the DoH of the needs of the Trust when Board vacancies arise, with a view to ensuring a proper balance of professional, financial or other expertise;
- Assess the performance of individual Board members. Board Members will be subject to ongoing performance appraisal, with a formal assessment being completed in consultation with Committee Chairs as appropriate by the Chair of the Board at the end of each year and prior to any proposed re-appointment or extension of the term of appointment

of individual members taking place. Members will be made aware that they are being appraised, the standards against which they will be appraised, and will have an opportunity to contribute to and view their report. The Chair of the Board will also be appraised on an annual basis by the DoH.

- Ensure the completion of the Board Governance Self-Assessment Tool on an annual basis. Assurance will be provided through the mid-year assurance statement that the tool is being completed, actions are being addressed and that any exception issues will be raised with the DoH.
- The Chair shall also ensure that Trust Board members are made aware of the Code of Conduct for Board Members of HSC Bodies (October 2022) including the Nolan "seven principles of public life", and the requirement for a comprehensive and publicly available register of Board Members' Interests. Communications between the Board, the Minister and the DoH shall normally be through the Chair. The Chair shall ensure that the other Board members are kept informed of such communications on a timely basis.

2.6.2 Non-Executive Members

The Non-Executive Members shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may however, exercise collective authority when acting as members of or when chairing a Committee of the Trust which has delegated powers.

2.6.3 Executive Members

Executive Members shall exercise their authority within the terms of these Standing Orders, the Scheme of Delegation and the Standing Financial Instructions.

2.6.4 Chief Executive

The Chief Executive shall be responsible for the overall performance of the executive functions of the Trust. He/she is the **Accounting Officer** for the Trust and shall be responsible for ensuring the discharge of obligations under Financial Directions and in line with the requirements of the Accounting Officer Memorandum for Trust Chief Executives issued by DoH.

The Chief Executive shall be directly accountable to the Chair and Non-Executive Members of the Board for ensuring Board decisions are implemented, that the organisation works effectively in accordance with government policy and public service values, and for the maintenance of proper financial stewardship. The Chief Executive should be allowed full scope, within clearly defined delegated powers, for action fulfilling the decisions of the Board.

2.6.5 Director of Finance

The Director of Finance shall be responsible for the provision of financial advice to the Trust and to its members and for the supervision of financial control and accounting systems. He/she shall be responsible along with the Chief Executive for ensuring the discharge of obligations under relevant Financial Directions.

2.7 Corporate Role of the Board

2.7.1 All business shall be conducted in the name of the Trust.

2.7.2 All funds received in trust shall be held in the name of the Trust as corporate trustee.

2.7.3 The powers of the Trust established under statute shall be exercised by the Board meeting in public session except as otherwise provided for in Standing Order 3.

2.7.4 The Board shall define and regularly review the functions it exercises on behalf of the Minister for Health.

2.8 Schedule of Matters Reserved to the Board and Scheme of Delegation

2.8.1 The Board may resolve that certain powers and decisions may only be exercised by the Board in formal session. These powers and decisions should be set out in Section C - 'Schedule of Matters Reserved to the Board' and shall have effect as if incorporated into the Standing Orders. Those powers which it has delegated to officers and other bodies are contained in the Scheme of Delegation.

2.9 Lead Roles for Board Members

2.9.1 The Chair will ensure that the designation of lead roles or appointments of Board members as required by DoH or as set out in any statutory or other guidance will be made in accordance with that guidance or statutory requirements (e.g. appointing a Lead Board Member with responsibilities for Infection Control or Child Protection Services etc.).

3. MEETINGS OF THE TRUST BOARD

3.1 Calling Meetings

3.1.1 Ordinary meetings of the Board shall be held at regular intervals at such times and places as the Board may determine. The Board shall determine the minimum number of meetings to be held each year.

In order to meet the social distancing requirements of Covid-19, the Board is unlikely to meet in person for the foreseeable future and so will meet by virtual means. As a result of this, the Trust will make alternative arrangements for public and staff involvement by virtual means.

3.1.2 The Chair of the Trust may call a meeting of the Board at any time.

3.1.3 One third or more members of the Board may requisition a meeting in writing. If the Chair refuses, or fails, to call

a meeting within seven days of a requisition being presented, the members signing the requisition may forthwith call a meeting.

3.2 Notice of Meetings and the Business to be Transacted

3.2.1 Before each meeting of the Board, a written notice specifying the business proposed to be transacted shall be delivered to every member and to everyone on the Board distribution list and posted on the Trust website at least five working days before the meeting. Lack of service of such a notice on any member shall not affect the validity of a meeting

3.2.2 In the case of a meeting called by members in default of the Chair calling the meeting, the notice shall be signed by those members.

3.2.3 No business shall be transacted at the meeting other than that specified on the agenda, or emergency motions allowed under Standing Order 3.6.

3.2.4 A member desiring a matter to be included on an agenda shall make his/her request in writing to the Chair at least 10 working days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 10 working days before a meeting may be included on the agenda at the discretion of the Chair.

3.2.5 Before each meeting of the Board, a public notice in accordance with Circular HSS (PPM) 4/2001 shall be issued detailing the time and place of the meeting. The public part of the agenda shall be posted on the Trust website www.nias.hscni.net at least one week before the meeting (required by section 54 of the Health and Personal Social Services Act (Northern Ireland) 2001).

3.3 Agenda and Supporting Papers

3.3.1 The Agenda will be sent to members at least five working days before the meeting and supporting papers,

whenever possible, shall accompany the agenda, but will be despatched no later than three working days before the meeting, save in emergency.

3.4 Petitions

3.4.1 Where a petition has been received by the Trust, the Chair may include the petition as an item for the agenda of the next meeting, providing it is appropriate for consideration by the Board. The Chair shall advise the meeting of any petitions that are not granted and the grounds for refusal

3.5 Notice of Motion

3.5.1 Subject to the provision of Standing Orders 3.7 'Motions: Procedure at and during a meeting' and 3.8 'Motions to rescind a resolution', a member of the Board wishing to move a motion shall send a written notice to the Chief Executive who will ensure that it is brought to the immediate attention of the Chair.

3.5.2 The notice shall be delivered at least five clear days before the meeting. The Chief Executive shall include in the agenda for the meeting all notices so received that are in order and permissible under governing regulations. This Standing Order shall not prevent any motion being withdrawn or moved without notice on any business mentioned on the agenda for the meeting.

3.6 Emergency Motions

3.6.1 Subject to the agreement of the Chair, and subject also to the provision of Standing Order 3.7 'Motions: Procedure at and during a meeting', a member of the Board may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Trust Board at the commencement of the business of the meeting as an additional item included in the agenda. The Chair's decision on the inclusion of an item shall be final.

3.7 Motions: Procedure at and during a Meeting

3.7.1 Who may propose

A motion may be proposed by the Chair of the meeting or any member present. It must also be seconded by another member.

3.7.2 Contents of motions

The Chair may exclude from the debate at his/her discretion any such motion of which notice was not given on the notice summoning the meeting other than a motion relating to:

(a) The reception of a report;

(b) Consideration of any item of business before the Trust Board;

(c) The accuracy of minutes;

(d) That the Board proceeds to next business;

(e) That the Board adjourns; and

(f) That the question be now put.

3.7.3 Amendments to motions

A motion for amendment shall not be discussed unless it has been proposed and seconded.

Amendments to motions shall be moved relevant to the motion, and shall not have the effect of negating the motion before the Board.

If there are a number of amendments, they shall be considered one at a time. When a motion has been amended, the amended motion shall become the substantive motion before the meeting, upon which any further amendment may be moved.

3.7.4 Rights of reply to motions

a) Amendments

The mover of an amendment may reply to the debate on their amendment immediately prior to the mover of the original motion, who shall have the right of reply at the close of debate on the amendment, but may not otherwise speak on it.

b) Substantive/Original motion

The member who proposed the substantive motion shall have a right of reply at the close of any debate on the motion.

3.7.5 Withdrawing a motion

A motion, or an amendment to a motion, may be withdrawn.

3.7.6 Motions once under debate

When a motion is under debate, no motion may be moved other than:

(a) An amendment to the motion;

(b) The adjournment of the discussion, or the meeting;

(c) That the meeting proceeds to the next business;

(d) That the question should be now put;

(e) The appointment of an 'ad hoc' committee to deal with a specific item of business;

(f) That a member be not further heard; and

(g) A motion under Section 23(2) of the Local Government Act (NI) 1972 resolving to exclude the

public, including the press (see Standing Order 3.17).

In those cases where the motion is either that the meeting proceeds to the 'next business' or 'that the question be now put', in the interests of objectivity, these should only be put forward by a member of the Board who has not taken part in the debate and who is eligible to vote.

If a motion to proceed to the next business or that the question be now put, is carried, the Chair should give the mover of the substantive motion under debate a right of reply, if not already exercised. The matter should then be put to the vote.

3.8 Motions to Rescind a Resolution

3.8.1 Notice of motion to rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the member who gives it and also the signature of three other members, and before considering any such motion of which notice shall have been given, the Trust Board may refer the matter to any appropriate Committee or the Chief Executive for recommendation.

3.8.2 When any such motion has been dealt with by the Trust Board, it shall not be competent for any Executive Member, other than the Chair, to propose a motion to the same effect within six months. This Standing Order shall not apply to motions moved in pursuance of a report or recommendations of a Committee or the Chief Executive.

3.9 Chair of Meeting

3.9.1 At any meeting of the Trust Board, the Chair shall preside. In the Chair's absence, the Chair of Audit and Risk Assurance Committee shall assume the position of Chair.

3.9.2 In the absence of the Chair and Chair of the Audit and Risk Assurance Committee, any such member (who is not also an Executive Member of the Trust) as the members present shall choose, shall preside.

3.10 Chair's Ruling

3.10.1 The decision of the Chair of the meeting on questions of order, relevancy and regularity (including procedure on handling motions) and their interpretation of the Standing Orders and Standing Financial Instructions, at the meeting, shall be final.

3.11 Quorum

3.11.1 No decisions may be taken at a meeting unless at least one-third of the whole number of the Chair and voting members appointed, (including at least one Non-Executive Director Member and one Executive Director Member) are present.

3.11.2 An officer in attendance for an Executive Director Member but without formal acting up status, may not count towards the quorum.

3.11.3 If the Chair or member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (Standing Order 7), that person shall no longer count towards the quorum. If a quorum is then not available for the passing of a resolution on any matter, that matter may be discussed further but not voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting.

3.12 Voting

3.12.1 Save as provided in Standing Orders 3.13 – 'Suspension of Standing Orders' and 3.14 – 'Variation and Amendment of Standing Orders', every question put to a vote at a meeting shall be determined by a majority of the votes of members present and voting on the question. In the case of an equal vote, the person

presiding (ie: the Chair of the meeting shall have a second, and casting vote).

3.12.2 At the discretion of the Chair, all questions put to the vote shall be determined by oral expression or by a show of hands, unless the Chair directs otherwise, or it is proposed, seconded and carried that a vote be taken by paper ballot.

3.12.3 If at least one third of the members present so request, the voting on any question may be recorded so as to show how each member present voted or did not vote (except when conducted by paper ballot).

3.12.4 If a member so requests, their vote shall be recorded by name.

3.12.5 In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote.

3.12.6 A manager who has been formally appointed to act up for an Officer Member during a period of incapacity or temporarily to fill an Executive Director vacancy shall be entitled to exercise the voting rights of the Officer Member.

3.12.7 A manager attending the Trust Board meeting to represent an Officer Member during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Officer Member. An Officer's status when attending a meeting shall be recorded in the minutes.

3.12.8 For the voting rules relating to joint members, see Standing Order 2.5.

3.13 Suspension of Standing Orders

3.13.1 Except where this would contravene any statutory provision or any direction made by the Minister for Health or the rules relating to the Quorum (Standing Order

3.11), any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the whole number of the members of the Board are present (including at least one member who is an Officer Member of the Trust and one Member who is not) and that at least two-thirds of those members present signify their agreement to such suspension. The reason for the suspension shall be recorded in the Trust Board's minutes.

3.13.2 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chair and Members of the Trust.

3.13.3 No formal business may be transacted while Standing Orders are suspended.

3.13.4 The Audit and Risk Assurance Committee shall review every decision to suspend Standing Orders.

3.14 Variation and Amendment of Standing Orders

3.14.1 These Standing Orders shall not be varied except in the following circumstances:

(a) Upon a notice of motion under Standing Order 3.5;

(b) Upon a recommendation of the Chair or Chief Executive included on the agenda for the meeting;

(c) That two thirds of the Board members are present at the meeting where the variation or amendment is being discussed, and that at least half of the Trust's Non-Executive members vote in favour of the amendment;

(d) Providing that any variation or amendment does not contravene a statutory provision or direction made by the Minister for Health.

3.15 Record of Attendance

3.15.1 The names of the Chair and Directors/members present at the meeting shall be recorded and, if necessary, the point at which they join, leave or resume their place at the meeting shall also be noted.

3.16 Minutes

3.16.1 The minutes of the proceedings of a meeting shall be drafted, signed and presented to the next Board meeting.

No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate.

A copy of the approved minutes will be posted on the Trust website www.nias.hscni.net following their approval at the next ensuing meeting.

3.16.2 The minutes of all Board Committees shall be formally recorded and brought to the public Board meeting for information except where confidentiality needs to be expressly protected. After each meeting, the Chair of the Committee shall present a written report to the next Trust Board meeting. At any point, the Committee Chair shall also draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action.

3.17 Admission of Public and the Press

See Standing Order 3.1.1. In order to meet the social distancing requirements of Covid-19, the Board is unlikely to meet in person for the foreseeable future and so will meet by virtual means. As a result of this, members of the public, the media and staff will be unable to attend or observe in person. The Trust will make alternative arrangements for public and staff involvement by virtual means.

3.17.1 Reserved sections

Trust Board meetings are held in public to openly demonstrate how decisions within the Trust are made and recorded. On occasion, there may be issues which the Board requires to discuss in private and in this case a "reserved" meeting may be convened with a separate agenda which is not made public.

These may include subjects that are:

a) Demonstrably protected in terms of the Data Protection Act (ie staff or service user personal information); or

b) Commercially sensitive; or

c) Constituted information intended for publication at a later date.

Where a meeting or part of a meeting is dealing with a potentially sensitive or confidential issue, the Chair of the meeting should inform those present that the item under consideration is confidential and a reserved section is required The public shall be required to withdraw upon a resolution of the Trust Board as follows:

'that representatives of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest', Section 23(2) of the Local Government Act (NI) 1972.

3.17.2 General disturbances

The Chair or the person presiding over the meeting shall give such directions as they think fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Trust's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential

nature of the business to be transacted, the public will be required to withdraw upon the Trust Board resolving as follows:

`That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Trust Board to complete its business without the presence of the public', Section 23(2) of the Local Government Act (NI) 1972.

3.17.3 Business proposed to be transacted when the press and public have been excluded from a meeting

Matters to be dealt with by the Trust Board following the exclusion of representatives of the press, and other members of the public, as provided in 3.17.1 and 3.17.2 above, shall be confidential to the members of the Board.

Notwithstanding the provisions of 3.17 (1&2) above, the Trust Board shall make arrangements to ensure that any discussion of confidential matters relating to staff, patients or commercially sensitive issues are conducted by the Board meeting "In Committee". A separate confidential minute of such meetings will be maintained and approved by the Board at its next meeting. In addressing such matters, they shall operate with full executive powers.

Members and Officers or any employee of the Trust in attendance shall not reveal or disclose the contents of any "In Committee" meeting or papers marked 'In Confidence' or minutes headed 'Items Taken in Reserved section' outside of the Trust, without the express permission of the Trust. This prohibition shall apply equally to the content of any discussion during the Board meeting which may take place on such reports or papers.

3.17.4 Use of mechanical or electrical equipment for recording or transmission of meetings

In order to avoid undue disruption to Board meetings, television crews/press photographers or other media

representatives can have access for a maximum of ten minutes prior to the meeting commencing. This will be subject to agreement of the Chair.

Nothing in these Standing Orders shall be construed as permitting the introduction by the public, or press representatives, of recording, transmitting, video or similar apparatus into meetings of the Trust or Committee thereof. Such permission shall be granted only upon resolution of the Trust Board.

3.18 Observers at Trust Meetings

3.18.1 The Trust will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any of the Trust Board's meetings and may change, alter or vary these terms and conditions as it deems fit.

3.19 Procedures for Addressing the Board

3.19.1 Deputations from any meeting, association, public body or an individual may be permitted to address a meeting of the Board, subject to the following conditions:

- The subject is on the agenda;
- The Board Secretary has received three working days' notice, in writing, of the intended deputation, its purpose and a brief synopsis of content. The presentation/speaking notes must be submitted to the Board Secretary in advance of the meeting. The Chair will decide on the appropriateness of the presentation.

3.19.2 The specified notice may be waived at the discretion of the Chair. Any deputation will be confined to a presentation by not more than two persons, per agenda item, and not to exceed 10 minutes duration. The Chair may at his/her discretion vary the number of individuals permitted to address the meeting. The Chair will decide if a Trust response is appropriate and there will be no right of reply by the speaker. The decision of the Chair will be final on this matter.

The Chair will also consider requests for questions from the public based on the following conditions:

- all questions must be relevant to an item included on the agenda;
- individuals will be restricted to a maximum of two questions each;
- once a question is answered by a member of Trust Board, as directed by the Chair, there will be no further discussions on this question; and
- the decision of the Chair will be final in relation to public questions.

3.19.3 The Trust recognises the important statutory role the Patient and Client Council has in relation to representing the interests of the public in all matters of health and social care within the Trust's area. The Trust will therefore, grant the right for the Council to request attendance at any Trust Board meeting to raise specific agenda items. The Chair may at his/her discretion allow the Council to be heard during Board discussion of the item in questions.

4. APPOINTMENT OF COMMITTEES AND SUB-COMMITTEES

4.1 Appointment of Committees

4.1.1 Subject to such directions as may be given by the Minister for Health, the Trust Board may appoint Committees of the Trust.

The Trust shall determine the membership and Terms of Reference of Committees and Sub-Committees and shall receive and consider reports of such Committees. Only in exceptional circumstances will the Trust Board delegate executive powers to a Committee. A Committee may only exercise such executive powers as are delegated to it by the Trust Board.

The Chair of the Trust Board will appoint Non-Executive Directors to Committees of the Board and will nominate one of them as Chair of the Committee.

4.2 Joint Committees

4.2.1 Joint Committees may be appointed by the Trust by joining together with one or more other Trusts consisting, wholly or partly, of the Chair and members of the Trust or other health service bodies, or wholly of persons who are not members of the Trust or other health bodies in question.

4.2.2 Any Committee or joint Committee appointed under this Standing Order may, subject to such directions as may be given by the Minister for Health~~, Social Services and Public Safety~~ or the Trust or other health bodies in question, appoint Sub-Committees consisting wholly or partly of members of the Committees or Joint Committee (whether or not they are members of the Trust or health bodies in question) or wholly of persons who are not members of the Trust or health bodies in question or the Committee of the Trust or health bodies in question.

4.3 Applicability of Standing Orders and Standing Financial Instructions to Committees

4.3.1 The Standing Orders and Standing Financial Instructions of the Trust, as far as they are applicable, shall as appropriate apply to meetings and any Committees established by the Trust. In which case the term "Chair" is to be read as a reference to the Chair of other Committee as the context permits, and the term "member" is to be read as a reference to a member of other Committee also as the context permits. (There is no requirement to hold meetings of Committees established by the Trust in public.)

4.4 Terms of Reference

4.4.1 Each such Committee shall have such Terms of Reference and powers and be subject to such conditions (as to reporting back to the Board), as the Board shall decide and shall be in accordance with any legislation and regulation or direction issued by the Minister for Health. Such Terms of Reference shall have effect as if incorporated into the Standing Orders.

4.5 Delegation of Powers by Committees to Sub-Committees

4.5.1 Where Committees are authorised to establish Sub-Committees, they may not delegate executive powers to the Sub-Committee unless expressly authorised by the Trust Board.

4.6 Approval of Appointments to Committees

4.6.1 The Board shall approve the appointments to each of the Committees which it has formally constituted. Where the Board determines, and regulations permit, that persons, who are neither members nor officers, shall be appointed to a Committee the terms of such appointment shall be within the powers of the Board as defined by the Minister for Health. The Board shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

4.7 Appointments for Statutory functions

4.7.1 Where the Board is required to appoint persons to a Committee and/or to undertake statutory functions as required by the Minister for Health, and where such appointments are to operate independently of the Board, such appointments shall be made in accordance with the regulations and directions made by the Minister for Health.

4.8 Committees Established by the Trust Board

Trust Board Committees will be held by virtual means for the foreseeable future.

The Committees, Sub-Committees, and Joint-Committees established by the Board are:

4.8.1 Audit and Risk Assurance Committee

In line with the requirements of the Cabinet Office's Code of Conduct for Board Members of Public Bodies (June 2019)~~Cabinet Office's guidance on Codes of Practice for Public Bodies (DF/DFP 03/06)~~, the Audit and Risk Assurance Handbook (NI) 2018, and the Codes of Conduct and Accountability (October 2022), an Audit and Risk Assurance Committee will be established and constituted to provide the Trust Board with an independent and objective review of its financial systems, governance and internal control arrangements.

The Terms of Reference will be approved by the Trust Board, will be reviewed on a periodic basis and will be posted on the Trust website www.nias.hscni.net.

The Committee will be comprised exclusively of Non-Executive Directors and shall consist of not less than three members, of which one must have significant, recent and relevant financial experience. A quorum shall be two members. None of these members should be the Chair or members of the Remuneration and Terms of Service Committee. One member of the Committee

shall be the Chair of the Safety Committee. The Committee will meet on at least three occasions per year.

4.8.2 **Remuneration and Terms of Service Committee**

In line with the requirements of the Codes of Conduct and Accountability (October 2022), and the Higgs report (2003), a Remuneration and Terms of Service Committee will be established and constituted. As a minimum, the role of the Committee will be to advise the Trust Board about appropriate remuneration and terms of service for the Chief Executive and other Senior Executives including:

(a) All aspects of salary (including any performance related elements/bonuses);

(b) Provisions for other benefits, including pensions and cars; and

(c) Arrangements for termination of employment and other contractual terms.

The Terms of Reference will be approved by the Trust Board, will be reviewed on a periodic basis and will be posted on the Trust website www.nias.hscni.net.

The Committee will be comprised exclusively of the Chair of the Trust and at least two Non-Executive Directors. None of these members should be members of the Audit and Risk Assurance Committee. A quorum shall be two members. The Committee will meet on at least two occasions per year.

4.8.3 **Safety, Quality, Patient Experience and Performance Committee**

In line with the statutory duty of quality which is carried by the Chief Executive, a Safety, Quality, Patient Experience and Performance Committee will be established and constituted to provide the Trust Board with an independent and objective review that effective

and regularly reviewed arrangements are in place to support the implementation, maintenance and development of governance (both clinical and non-clinical) and risk management and that such matters are properly considered and communicated to the Trust Board.

The Terms of Reference will be approved by the Trust Board, will be reviewed on a periodic basis and will be posted on the Trust website www.nias.hscni.net.

The Committee will be comprised exclusively of Non-Executive Directors and shall consist of not less than three members. One member of the Committee shall be the Chair of Audit and Risk Assurance Committee. A quorum shall be two members. The Committee will meet on at least three occasions per year.

4.8.4 **People, Finance and Organisational Development Committee**

A People, Finance and Organisational Development Committee will be established and constituted to provide the Trust Board with an independent and objective review of Human Resources, Finance and Organisational Development functions.

The Terms of Reference will be approved by the Trust Board, will be reviewed on a periodic basis and will be posted on the Trust website www.nias.hscni.net

The Committee will be comprised exclusively of Non-Executive Directors and shall consist of not less than three members. A quorum shall be two members. The Committee will meet on at least three occasions per year.

4.8.5 **Other Committees**

The Board may also establish such other Committees as required to discharge the Trust's responsibilities.

5. ARRANGEMENTS FOR THE EXERCISE OF TRUST FUNCTIONS BY DELEGATION

5.1 Delegation of Functions to Committees, Officers or Other Bodies

5.1.1 Subject to such directions as may be given by the Minister for Health, the Board may make arrangements for the exercise, on behalf of the Board, of any of its functions by a Committee, Sub-Committee appointed by virtue of Standing Order 4, or by an officer of the Trust, or by another body as defined in Standing Order 5.1.2 below, in each case subject to such restrictions and conditions as the Trust thinks fit.

5.1.2 Section 13, Schedule 3 of the HPSS (NI) Order 1991 allows for regulations to provide for the functions of Trust's to be carried out by third parties. In accordance with The HSS Trusts (Membership and Procedure) Regulations (NI) 1994, the functions of the Trust may also be carried out in the following ways:

(a) By another Trust or service providing body;

(b) Jointly with any one or more of the following: HSC Trusts, Boards, agencies or a Centre of Procurement Expertise (in respect of procurement and logistics) or service providing body.

5.1.3 Where a function is delegated by these Regulations to another Trust, then that Trust or health service body exercises the function in its own right; the receiving Trust has responsibility to ensure that the proper delegation of the function is in place.

5.1.4 In situations involving the delegation to Committees, Sub-Committees or officers, the Trust delegating the function retains full responsibility.

5.1.5 Where a function is to be carried out on behalf of the Trust by a third party, appropriate arrangements will be put in place by contract or Service Level Agreement to

ensure performance standards, monitoring arrangements and accountability.

5.2 Emergency Powers and Urgent Decisions

5.2.1 The powers which the Board has reserved to itself within these Standing Orders (see Standing Order 2.9) may in emergency or for an urgent decision be exercised by the Chair and the Chief Executive after having consulted at least two Non-Executive Members. The exercise of such powers by the Chair and the Chief Executive shall be reported to the next formal meeting of the Trust Board in public session for formal ratification.

5.3 Delegation to Committees

5.3.1 The Board shall agree from time to time to the delegation of executive powers to be exercised by other Committees, or Sub-Committees, or Joint-Committees, which it has formally constituted in accordance with directions issued by the Minister for Health. The constitution and terms of reference of these Committees, or Sub-Committees, or Joint Committees, and their specific executive powers shall be approved by the Board.

5.3.2 When the Board is not meeting as the Trust in public session, it shall operate as a Committee and may only exercise such powers as may have been delegated to it by the Trust in public session.

5.4 Delegation to Officers

5.4.1 Those functions of the Trust which have not been retained as reserved by the Board or delegated to other Committee or Sub-Committee or Joint-Committee shall be exercised on behalf of the Trust by the Chief Executive. The Chief Executive shall determine which functions he/she will perform personally and shall nominate officers to undertake the remaining functions for which he/she will still retain accountability to the Trust. However, he/she shall not assign absolutely to

any other person any of the responsibilities set out in the Management Statement/Financial Memorandum.

5.4.2 The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals which shall be considered and approved by the Board. The Chief Executive, or in his/her absence the Director of Finance, may approve interim amendments to the Scheme of Delegation, which shall be considered and given retrospective approval by the Board at its next annual review.

5.4.3 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of the Director of Finance to provide information and advise the Board in accordance with statutory or DoH requirements. Outside these statutory requirements, the roles of the Director of Finance shall be accountable to the Chief Executive for operational matters.

5.5 Schedule of Matters Reserved to the Board and Scheme of Delegation of Powers

5.5.1 The arrangements made by the Board as set out in the "Schedule of Matters Reserved to the Board" and "Scheme of Delegation" of powers shall have effect as if incorporated in these Standing Orders.

5.6. Duty to Report Non-Compliance with Standing Orders and Standing Financial Instructions

5.6.1 If, for any reason, these Standing Orders or the Standing Financial Instructions are not complied with in any significant or material respect, full details shall be reported to the Audit and Risk Assurance Committee. All members of the Trust Board and staff have a duty to disclose any significant or material non-compliance to the Chief Executive as soon as possible.

5.7 Charitable Trust Funds

5.7.1 In line with its role as a corporate trustee for any funds held in trust (Standing Order 2.7.2), either as charitable

or non-charitable funds, the Trust Board will establish 'Financial Procedures – Charitable Trust Funds' to administer those funds in accordance with any statutory or other legal requirements.

6. OVERLAP WITH OTHER TRUST POLICY STATEMENTS/ PROCEDURES, REGULATIONS AND THE STANDING FINANCIAL INSTRUCTIONS

6.1 Policy Statements: General Principles

6.1.1 The Trust Board will determine an appropriate mechanism for the formal approval of policies and procedures. The formal approval will be recorded in an appropriate minute and will be deemed, where appropriate, to be an integral part of the Trust's Standing Orders and Standing Financial Instructions.

6.2 Standing Financial Instructions

6.2.1 Standing Financial Instructions adopted by the Trust Board in accordance with the Financial Regulations shall have effect as if incorporated in these Standing Orders.

6.3 Specific Guidance

6.3.1 Notwithstanding the application of Standing Order 6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with all relevant guidance and legislation.

7. DUTIES AND OBLIGATIONS OF BOARD MEMBERS/DIRECTORS AND SENIOR MANAGERS UNDER THESE STANDING ORDERS

7.1 Codes of Conduct and Accountability (October 2022)

7.1.1 The Code of Conduct and Code of Accountability for Board Members of Health and Social Care bodies (October 2022), provides the basis on which Board members of HSC bodies should seek to fulfil the duties and responsibilities conferred upon them by DoH. The Codes of Conduct and Accountability (October 2022)

shall be made available to all Board members. Board members shall subscribe to it and shall be judged upon the manner in which it is observed.

The HSC Code of Conduct for HSC Employees (2016) incorporates the principles contained within the Code of Conduct for HPSS Managers 2013 and supercedes it. It is applicable to all HSC employees, including managers, and sets out the core standards of conduct expected by all HSC staff.

7.2 Declaration of Interests

7.2.1 Requirements for Declaring Interests and Applicability to Board Members

The Trust's policy on Standards of Business Conduct requires Trust Board Members to declare interests which are relevant and material to the HSC Trust of which they are a member. All existing Board members should declare such interests and any Board members appointed subsequently should do so on appointment. Any future relevant and material interests should also be declared immediately by the member upon acquisition.

7.2.2 Interests which are Relevant and Material

Interests which should be regarded as "relevant and material" are:

(a) Directorships, including Non-Executive Directorships held in private companies or PLCs (with the exception of those of dormant companies);

(b) Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the HSC;

(c) Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the Trust;

(d) A position of authority in a charity or voluntary organisation in the field of health and social care;

(e) Any connection with a voluntary or other organisation contracting for Trust services;

(f) Research funding/grants that may be received by an individual or their department;

(g) Interests in pooled funds that are under separate management.

Where any member of the Trust Board comes to know that the Trust has entered into or proposes to enter into a contract in which he/she or any person connected with him/her (as defined in Standing Order 7.3 below and elsewhere) has any pecuniary interest, direct or indirect, the Board member shall declare his/her interest by giving notice in writing of such fact to the Trust as soon as practicable.

7.2.3 Advice on Interests

If Board members have any doubt about the relevance of an interest, this should be discussed with the Chair of the Trust or with the Trust's Chief Executive.

Influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

7.2.4 Recording of Interests in Trust Board Minutes

At the time Board members' interests are declared, they should be recorded in the Trust Board minutes.

Any changes in interests should be declared at the next Trust Board meeting following the change occurring and recorded in the minutes of that meeting. The Chief Executive will be responsible for ensuring that the Trust Register of Interests is duly updated. Where a conflict of

interest is established or perceived, the Board member shall withdraw and play no part in the relevant discussion unless the Chair deems that it is unnecessary for them to do so.

7.2.5 Publication of Declared Interests in Annual Report

Where a Board member has an interest in any body which has transacted with the Trust, then the financial quantification of that transaction(s) shall be published in the Trust's Annual Report and Accounts for the year in question, together with an appropriate description of the member's interest. The Chief Executive is responsible for ensuring that this information is reflected in the Register of Interests.

7.2.6 Conflicts of interest which arise during the course of a meeting

During the course of a Trust Board meeting, if a conflict of interest is established, the Board member concerned should withdraw from the meeting and play no part in the relevant discussion or decision (see overlap with Standing Order 7.4).

7.2.7 Declaration of Objectivity and Interests for those Officers Engaged in Award of Contract

Trust Officers participating in the preparation, evaluation and award of contracts must complete a declaration of objectivity and interests during the course of the tendering process to ensure the transparency of the process and that decisions made are not compromised. The administration of the declaration process will be handled by the Trust's procurement provider in accordance with appropriate guidance. Where a potential conflict of interest is apparent, the procurement provider will contact the Chief Executive or Director of Finance to agree the appropriate course of action.

7.3 Register of Interests

7.3.1 The Chief Executive will ensure that a Register of Interests is established to record formally any declarations of interests of Board or Committee members. In particular the Register will include details of all directorships and other relevant and material interests (as defined in Standing Order 7.2.2) which have been declared by both Executive and Non-Executive Trust Board members.

7.3.2 These details will be kept up to date by means of an annual review of the Register in which any changes to interests declared during the preceding twelve months will be incorporated.

7.3.3 The Register will be posted on the Trust website www.nias.hscni.net on an annual basis.

7.4 Exclusion of Chair and Members in Proceedings on Account of Pecuniary Interest

7.4.1 Definition of Terms used in Interpreting 'Pecuniary' Interest

For the sake of clarity, the following definition of terms is to be used in interpreting this Standing Order:

(a) **"Spouse"** shall include any person who lives with another person in the same household (and any pecuniary interest of one spouse shall, if known to the other spouse, be deemed to be an interest of that other spouse);

(b) **"Contract"** shall include any proposed contract or other course of dealing.

(c) "**Pecuniary interest"**

Subject to the exceptions set out in this Standing Order, a person shall be treated as having an indirect pecuniary interest in a contract if:

(1) He/she, or a nominee of his/her, is a member of a company or other body (not being a public body), with which the contract is made, or to be made or which has a direct pecuniary interest in the same, or

(2) He/she is a partner, associate or employee of any person with whom the contract is made or to be made or who has a direct pecuniary interest in the same.

(d) **Exception to Pecuniary interests**

A person shall not be regarded as having a pecuniary interest in any contract if:

(1) Neither he/she or any person connected with him/her has any beneficial interest in the securities of a company of which he/she or such person appears as a member, or

(2) Any interest that he/she or any person connected with him/her may have in the contract is so remote or insignificant that it cannot reasonably be regarded as likely to influence him/her in relation to considering or voting on that contract, or

(3) Those securities of any company in which he/she (or any person connected with him/her) has a beneficial interest, do not exceed £5,000 in nominal value or one per cent of the total issued share capital of the company or of the relevant class of such capital, whichever is the less.

Provided however, that where paragraph (3) above applies, the person shall nevertheless be obliged to disclose/declare their interest in accordance with Standing Order 7.2.2(b).

7.4.2 Exclusion in Proceedings of the Trust Board

(a) Subject to the following provisions of this Standing Order, if the Chair or a member of the Trust Board has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust Board at which the contract or other matter is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

(b) The Minister for Health may, subject to such conditions as he/she may think fit to impose, remove any disability imposed by this Standing Order in any case in which it appears to him/her in the interests of the HSC that the disability should be removed. (see Standing Order 7.4.3 on the 'Waiver' which has been approved by the Minister for Health).

(c) The Trust Board may exclude the Chair or a member of the Board from a meeting of the Board while any contract, proposed contract or other matter in which he/she has a pecuniary interest is under consideration.

(d) Any remuneration, compensation or allowance payable to the Chair or a Member by virtue of paragraph 9, Schedule 3 of the Health and Personal Social Services (Northern Ireland) Order 1991 shall not be treated as a pecuniary interest for the purpose of this Standing Order.

(e) This Standing Order applies to a Committee or Sub-Committee and to a Joint Committee or Sub-Committee as it applies to the Trust and applies to a member of any such Committee or Sub-Committee (whether or not he/she is also a member of the Trust) as it applies to a member of the Trust.

7.4.3 Waiver of Standing Orders made by the Minister for Health

(a) Power of the Minister for Health to make Waivers

Under regulation 20(2) of the HSS Trusts (Membership and Procedure) Regulations (NI) 1994, DoH may issue waivers if it appears in the interests of the HSC that the disability in regulation 11 (which prevents a Chair or a member from taking part in the consideration or discussion of, or voting on any question with respect to, a matter in which he has a pecuniary interest) should be removed. Any waiver that has been agreed will be in line with sub-sections (b) to (d) below.

(b) Definition of 'Chair' for the Purpose of Interpreting this Waiver

For the purposes of paragraph 7.4.3(c) below, the "relevant Chair" is:

(1) At a meeting of the Trust, the Chair of that Trust;

(2) At a meeting of a Committee:

(i) In a case where the member in question is the Chair of that Committee, the Chair of the Trust:

(ii) In the case of any other member, the Chair of that Committee.

(c) Application of Waiver

A waiver will apply in relation to the disability to participate in the proceedings of the Trust on account of a pecuniary interest.

It will apply to:

(1) A member of the Trust, who is a healthcare professional, within the meaning of regulation 5(5) of the Regulations, and who is providing or performing, or assisting in the provision or performance, of –

(i) Services under the Health and Personal Social Services (Northern Ireland) Order 1991; or

(ii) Services in connection with a pilot scheme under the Health and Personal Social Services (Northern Ireland) Order 1991;

For the benefit of persons for whom the Trust is responsible:

(2) Where the 'pecuniary interest' of the member in the matter which is the subject of consideration at a meeting at which he is present:

(i) Arises by reason only of the member's role as such a professional providing or performing, or assisting in the provision or performance of, those services to those persons;

(ii) Has been declared by the relevant Chair as an interest which cannot reasonably be regarded as an interest more substantial than that of the majority of other persons who:

(a) Are members of the same profession as the member in question,

(b) Are providing or performing, or assisting in the provision or performance of, such of those services as he provides or performs, or assists in the provision or performance of, for the benefit of persons for whom the Trust is responsible.

(d) Conditions which apply to the Waiver and the removal of having a pecuniary interest

The removal is subject to the following conditions:

(1) The member must disclose his/her interest as soon as practicable after the commencement of the meeting and this must be recorded in the minutes;

(2) The relevant Chair must consult the Chief Executive before making a declaration in relation to the member in question pursuant to paragraph 7.4.3(b)(2) above, except where that member is the Chief Executive;

(3) In the case of a meeting of the Trust:

(i) The member may take part in the consideration or discussion of the matter which must be subjected to a vote and the outcome recorded;

(ii) May not vote on any question with respect to it.

(4) In the case of a meeting of the Committee:

(i) The member may take part in the consideration or discussion of the matter which must be subjected to a vote and the outcome recorded;

(ii) May vote on any question with respect to it; but

(iii) The resolution which is subject to the vote must comprise a recommendation to, and be referred for approval by, the Trust Board.

7.5 Standards of Business Conduct

7.5.1 Trust Policy and National Guidance

All Trust staff and members of must comply with the Code of Conduct for HSC Employees (September 2016).

7.5.2 Interest of Officers in Contracts

(a) Any officer or employee of the Trust who comes to know that the Trust has entered into or proposes to enter into a contract in which he/she or any person connected with him/her (as defined in Standing Order 7.4) has any pecuniary interest, direct or indirect, the Officer shall declare their interest by giving notice in writing of such fact to the Chief Executive as soon as practicable.

(b) An Officer should also declare to the Chief Executive any other employment or business or other relationship of his/her, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

(c) The Trust will require interests, employment or relationships so declared to be entered in a Register of Interests of staff.

7.5.3 Canvassing of and Recommendations by Members in Relation to Appointments

(a) Canvassing of members of the Trust or of any Committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

(b) Members of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment; but this paragraph of

this Standing Order shall not preclude a member from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

7.5.4 Relatives of Members or Officers

(a) Candidates for any staff appointment under the Trust shall, when making an application, disclose in writing to the Trust whether they are related to any member or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him liable to instant dismissal.

(b) The Chair and every member and officer of the Trust shall disclose to the Trust Board any relationship between himself and a candidate of whose candidature that member or officer is aware. It shall be the duty of the Chief Executive to report to the Trust Board any such disclosure made.

(c) On appointment, members (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Trust whether they are related to any other member or holder of any office under the Trust.

(d) Where the relationship to a member of the Trust is disclosed, the Standing Order headed 'Disability of Chair and members in proceedings on account of pecuniary interest' (Standing Order 7.4) shall apply.

8. CUSTODY OF SEAL, SEALING OF DOCUMENTS AND SIGNATURE OF DOCUMENTS

8.1 Custody of Seal

8.1.1 The common seal of the Trust shall be kept in a secure place by the Chief Executive or a Manager nominated by him/her.

8.2 Sealing of Documents

8.2.1 Documents should only be sealed following a resolution by the Trust Board. In exceptional circumstances, a document shall be sealed in advance of a resolution by the Trust Board and retrospective resolution sought at the following Trust Board meeting. Where it is necessary that a document shall be sealed, the seal shall be affixed in the presence of the Chief Executive/or other Executive Director nominated by the Chief Executive, who is not from the originating department, along with one Non-Executive Director and shall be attested by them.

8.3 Register of Sealing

8.3.1 The Chief Executive shall keep a register in which he/she, or another manager of the Trust authorised by him/her, shall enter a record of the sealing of every document.

8.4 Signature of Documents

8.4.1 Where any document will be a necessary step in legal proceedings on behalf of the Trust, it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Executive or any Executive Director.

8.4.2 In land transactions, the signing of certain supporting documents will be delegated to Managers and set out clearly in the Scheme of Delegation but will not include the main or principal documents effecting the transfer (e.g. sale/purchase agreement, lease, contracts for construction works and main warranty agreements or any document which is required to be executed as a deed).

SECTION C - SCHEDULE OF POWERS RESERVED TO THE BOARD

The 'Schedule of Powers reserved to the Board' is sub-divided to correspond with the seven key functions of the Board for which it is held accountable by the Department of Health on behalf of the Minister.

These are:-

1. To establish the overall strategic direction of the organisation within the policy and resources framework determined by the Department/Minister;

2. To oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary;

3. To ensure effective financial stewardship through value for money, financial control and financial planning and strategy;

4. To ensure that high standards of corporate governance and personal behaviour are maintained in the conduct of the business of the whole organisation;

5. To appoint, appraise and remunerate senior executives;

6. To ensure effective dialogue between the organisation and the local community on its plans and performance and that these are responsive to the community's needs;

7. To ensure that the Trust has robust and effective arrangements in place for clinical and social care governance and risk management.

These matters are to be regarded as a guideline to the minimum requirement and shall not be interpreted as to exclude any other issues which it might be appropriate, because of their exceptional nature, to bring to the Board. The Chair, in consultation with the Chief Executive shall determine whether other issues outwith the following schedules of reserved powers shall be brought to the Board for consideration.

SECTION C - SCHEME OF RESERVATION AND DELEGATION

1.1 DECISIONS RESERVED TO THE BOARD

DELEGATED TO	AUTHORITIES / DUTIES DELEGATED
Trust Board	**General Enabling Provision** The Board may determine any matter, for which it has delegated or statutory authority, in full session within its statutory powers.
Trust Board	**Regulations and Control** 1. Approve Standing Orders (SOs), a Schedule of Matters Reserved to the Board and Standing Financial Instructions for the regulation of its proceedings and business. 2. Suspend Standing Orders. 3. Vary or amend the Standing Orders. 4. Ratify any urgent decisions taken by the Chair and Chief Executive in public session in accordance with Standing Order 5.2 5. Approve a Scheme of Delegation of powers from the Board to Committees and Officers. 6. Require and receive the Declaration of Board members' interests that may conflict with those of the Trust and determine the extent to which that member may remain involved with the matter under consideration.

DELEGATED TO	AUTHORITIES / DUTIES DELEGATED
	7. Require and receive the Declaration of Officers' interests that may conflict with those of the Trust. 8. Approve arrangements for dealing with complaints. 9. Adopt the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto. 10. Receive reports from Committees including those that the Trust is required by the Minister for Health, or other regulation to establish and to take appropriate action on. 11. Consider the recommendations of the Trust's Committees where the Committees do not have executive powers. 12. Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate Trustee for funds held on trust. 13. Establish Terms of Reference and reporting arrangements of all Committees and Sub-Committees that are established by the Board. 14. Approve arrangements relating to the discharge of the Trust's responsibilities as an appointee for patients' and clients' property. 15. Authorise use of the seal. 16. Ratify or otherwise instances of failure to comply with Standing Orders brought to the Chief Executive's attention in accordance with Standing Order 5.6. 17. Initiate disciplinary procedures for members of the Board or employees who are in breach of statutory requirements or Standing Orders.

DELEGATED TO	AUTHORITIES / DUTIES DELEGATED
Trust Board	**Appointments / Dismissal** 1. Appoint the Vice Chair of the Board. 2. Appoint and dismiss Committees (and individual members) that are directly accountable to the Board. 3. Appoint, appraise, discipline and dismiss Executive Directors (subject to Standing Order 2.2). 4. Confirm appointment of members of any Committee of the Trust as representatives on outside bodies. 5. Appoint, appraise, discipline and dismiss the Secretary (if the appointment of a Secretary is required under Standing Orders). 6. Approve proposals of the Remuneration Committee regarding Executive Directors and the Chief Executive.
Trust Board	**Strategy, Plans and Budgets** 1. Define the strategic aims and objectives of the Trust, and approve strategic plans. 2. Approve proposals for ensuring quality and developing clinical and social care governance in services provided by the Trust, having regard to any guidance issued by the Minister for Health. 3. Approve the Trust's policies and procedures for the management of risk 4. Approve Outline and Final Business Cases for Capital Investment.

DELEGATED TO	AUTHORITIES / DUTIES DELEGATED
	5. Approve budgets on an annual basis. 6. Approve the Trust's proposed organisational development proposals. 7. Ratify proposals for acquisition, disposal or change of use of land and/or buildings. 8. Approve PFI proposals. 9. Approve the opening of bank accounts and Trust banking arrangements. 10. Approve proposals on individual contracts (other than HSC contracts) of a capital or revenue nature in accordance with the Scheme of Delegation. 11. Approve proposals in individual cases for the write off of losses or making of special payments in accordance with the Scheme of Delegation. 12. Approve individual compensation payments in accordance with the Scheme of Delegation. 13. Approve proposals for action on litigation against or on behalf of the Trust in accordance with the Scheme of Delegation.
Trust Board/ Committee	**Policy Determination** All policies, including any updates, will be approved at Committee level and brought to the attention of Trust Board through the regular updates brought forward by the Committee Chairs. Procedures related to policies deemed relevant by a Director will also, where necessary, be presented with its associated policy. These procedures will have previously been considered by the Senior Management Team.

DELEGATED TO	AUTHORITIES / DUTIES DELEGATED
	In addition, Trust Board will, once per year, be presented with a register detailing the policies, and including such information as review dates and monitoring information, including scrutiny at Committee level. In exceptional circumstances, the Committee Chair or the Trust's Senior Management Team may take a view that the significance of the policy and its impact on the organisation is such that it merits direct consideration by the Trust Board. The Chief Executive will agree this in consultation with the Chair. There may also be regional policies which the Trust Board is required to adopt and these will be considered at Trust Board.
Trust Board	**Audit** 1. Receipt of the annual Report to Those Charged With Governance from the external auditor and agreement of proposed action, taking account of the advice, where appropriate, of the Audit and Risk Assurance Committee. 2. Receipt of an annual report from the Internal Auditor and agree action on recommendations where appropriate of the Audit and Risk Assurance Committee.
Trust Board	**Annual Reports and Accounts** 1. Receive and approve the Trust's Annual Report and Accounts. 2. Receive and approve the Accounts for Charitable Trust Funds.

DELEGATED TO	AUTHORITIES / DUTIES DELEGATED
Trust Board	**Monitoring** 1. Receipt of such reports as are required by statute or DoH regulation and other such reports as the Board sees fit from Committees in respect of their exercise of powers delegated. 2. Continuous appraisal of the affairs of the Trust by means of the provision to the Board as the Board may require from Directors, Committees, and Officers of the Trust as set out in management policy statements. All monitoring returns required by the DoH shall be reported, at least in summary, to the Board. 3. Receive reports on financial performance against budget and Trust Delivery Plan, including progress in meeting specific strategic, HSCB and DoH objectives and targets.
Trust Board	Approve procedure for declaration of hospitality and sponsorship.
Trust Board	Ensure proper and widely publicised procedures for voicing complaints, concerns about misadministration, breaches of Code of Conduct, and other ethical concerns.
Trust Board	Board members share corporate responsibility for all decisions of the Board.

Trust Board	The Board has seven key functions for which it is held accountable by the DoH on behalf of the Minister for Health: 1. To establish the overall strategic direction of the organisation within the policy and resources framework determined by the Department/Minister; 2. To oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary; 3. To ensure effective financial stewardship through value for money, financial control and financial planning and strategy; 4. To ensure that high standards of corporate governance and personal behaviour are maintained in the conduct of the business of the whole organisation; 5. To appoint, appraise and remunerate senior executives; 6. To ensure effective dialogue between the organisation and the local community on its plans and performance and that these are responsive to the community's needs; 7. To ensure that the Trust has robust and effective arrangements in place for clinical and social care governance and risk management.

Trust Board	It is the Board's duty to: 1. act within statutory financial and other constraints; 2. be clear what decisions and information are appropriate to the Board and draw up Standing Orders, a Schedule of Decisions Reserved to the Board and Standing Financial Instructions to reflect these, ensure that management arrangements are in place to enable responsibility to be clearly delegated to Senior Executives for the main programmes of action and for performance against programmes to be monitored and Senior Executives held to account; 3. establish performance and quality measures that maintain the effective use of resources and provide value for money; 4. specify its requirements in organising and presenting financial and other information succinctly and efficiently to ensure the Board can fully undertake its responsibilities; 5. establish Audit and Risk Assurance, People, Safety and Remuneration Committees on the basis of formally agreed Terms of Reference that set out the membership of the Sub-Committee, the limit to their powers, and the arrangements for reporting back to the main Board.

1.2 SCHEME OF DELEGATION DERIVED FROM THE CODES OF CONDUCT AND ACCOUNTABILITY (OCTOBER 2022)

DELEGATED TO:	AUTHORITIES / DUTIES DELEGATED:
Trust Board	HSC Trust Boards must comply with legislation and guidance issued by the DoH on behalf of the Minister for Health, respect agreements entered into by themselves or on their behalf and establish terms and conditions of service that are fair to the staff and represent good value for taxpayers' money.
All Board Members	Subscribe to Codes of Conduct and Accountability (October 2022).
Chair and Non-Executive Members	Chair and Non-Executive members are responsible for monitoring the executive management of the organisation and are responsible to the Minister for Health for the discharge of those responsibilities.
Chair	It is the Chair's role to: 1. provide leadership to the Board; 2. enable all Board members to make a full contribution to the Board's affairs and ensure that the Board acts as a team; 3. ensure that key and appropriate issues are discussed by the Board in a timely manner, 4. ensure the Board has adequate support and is provided efficiently with all the necessary data on which to base informed decisions;

	5. lead Non-Executive Board members through a formally-appointed Remuneration & Terms of Service Committee of the main Board on the appointment, appraisal and remuneration of the Chief Executive and (with the latter) other Senior Executives; 6. appoint Non-Executive Board members to all Sub-Committees of the main Board; 7. advise the Minister for Health on the performance of Non-Executive Board members.
Chief Executive	The Chief Executive is accountable to the Chair and Non-Executive members of the Board for ensuring that its decisions are implemented, that the organisation works effectively, in accordance with Government policy and public service values and for the maintenance of proper financial stewardship. The Chief Executive should be allowed full scope, within clearly defined delegated powers, for action in fulfilling the decisions of the Board. The other duties of the Chief Executive as Accounting Officer are laid out in the Accounting Officer Memorandum.

1.3 DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES

DELEGATED TO:	AUTHORITIES / DUTIES DELEGATED:
Non-Executive Directors	Non-Executive Directors are appointed by the Minister for Health following a recruitment process overseen by the DoH Public Appointments Unit to bring independent judgement to bear on issues of strategy, performance, key appointments and accountability through the DoH to the Minister and to the local community.
Chair and Directors	Declaration of potential conflict of interests.
Audit and Risk Assurance Committee	The Committee shall contribute to the establishment, review and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisation's objectives. The Committee will: 1. Review the adequacy of all risk and control related disclosure statements (in particular the Governance Statement), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board. 2. Review the adequacy of the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.

DELEGATED TO:	AUTHORITIES / DUTIES DELEGATED:
	3. Review the adequacy of the policies for ensuring compliance with relevant regularity, legal and code of conduct requirements, including the Trust's Standing Orders and Standing Financial Instructions. 4. Review the adequacy of the policies and procedures for all work related to fraud and corruption. 5. Review the Schedule of Losses and Special Payments and will make recommendations to the Board. 6. Review the effectiveness and findings of the internal and external audit services, considering the implications of, and managements responses to their work. 7. Review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation. 8. Review the Trust's Annual Report and the Financial Statements before submission to the Board, focusing particularly on: • The wording in the Governance Statement and other disclosures relevant to the Terms of Reference of the Committee • Changes in, and compliance with, accounting policies and practices • Unadjusted mis-statements in the financial statements • Major judgemental areas • Significant adjustments resulting from the audit 9. Ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board. 10. Consider and approve relevant policies.

DELEGATED TO:	AUTHORITIES / DUTIES DELEGATED:
Remuneration and Terms of Service Committee	The Committee will: 1. Advise the Board about appropriate remuneration and terms of service for the Chief Executive and Senior Executives. 2. All aspects of salary (including any performance-related elements/bonuses); 3. Provisions for other benefits, including pensions and cars; 4. Arrangements for termination of employment and other contractual terms; 5. Make recommendations to the Board on the remuneration and terms of service of the Chief Executive and Senior Executives to ensure they are fairly rewarded for their individual contribution to the Trust - having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such staff; 6. Proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate advise on and oversee appropriate contractual arrangements for such staff; 7. Determine the necessary arrangements for remuneration of Senior Executives, taking account of DoH guidance. 8. Consider and approve relevant policies.

DELEGATED TO:	AUTHORITIES/DUTIES DELEGATED:
Safety, Quality, Patient Experience and Performance Committee	The Committee will be responsible for assuring the NIAS Board that effective and regularly reviewed arrangements are in place to support the implementation, maintenance and development of Governance (clinical and non-clinical) and risk management and that such matters are properly considered and communicated to the Board. The Committee will also consider and approve relevant policies.
People, Finance and Organisational Development Committee	The Committee will be responsible for assuring the NIAS Board that effective and regularly reviewed arrangements are in place to support Human Resources, Finance and Organisational Development functions within the Trust. The Committee will also consider and approve relevant policies.
Trust Board	HSC Trust Boards must comply with legislation and guidance issued by the DoH on behalf of the Minister for Health, respect agreements entered into by themselves or on their behalf and establish terms and conditions of service that are fair to the staff and represent good value for taxpayers' money.

1.4 SCHEME OF DELEGATION DERIVED FROM THE ACCOUNTING OFFICER MEMORANDUM

DELEGATED TO:	AUTHORITIES / DUTIES DELEGATED:
Chief Executive	Accountable through HSC Accounting Officer to Parliament/NI Assembly for stewardship of Trust resources.
Chief Executive	Ensure the accounts of the Trust are prepared under principles and in a format directed by the DoH. Accounts must disclose a true and fair view of the Trust's income and expenditure and its state of affairs. Sign the accounts on behalf of the Trust Board.
Chief Executive	Sign a statement in the accounts outlining responsibilities as the Accounting Officer. Sign a statement in the accounts outlining responsibilities in respect of Internal Control.
Chief Executive	Ensure effective management systems that safeguard public funds and assist the Trust Chair to implement requirements of corporate governance including ensuring managers: • "have a clear view of their objectives and the means to assess achievements in relation to those objectives • be assigned well defined responsibilities for making best use of resources having the information, training and access to the expert advice they need to exercise their responsibilities effectively."

Chief Executive	Implement requirements of corporate governance.
Director of Finance	Achieve value for money from the resources available to the Trust and avoid waste and extravagance in the organisation's activities. Follow through the implementation of any recommendations affecting good practice as set out on reports from the Northern Ireland Audit Office (NIAO).
Director of Finance	Operational responsibility for effective and sound financial management and information.

DELEGATED TO:	AUTHORITIES / DUTIES DELEGATED:
Chief Executive	Primary duty to ensure that Director of Finance discharges the function of providing effective and sound financial management and information.
Chief Executive	Ensuring that expenditure by the Trust complies with Parliamentary/NI Assembly requirements.
Chief Executive	Chief Executive, supported by Director of Finance, to ensure appropriate advice is given to the Board on all matters of probity, regularity, prudent and economical administration, efficiency and effectiveness.
Chief Executive	If the Chief Executive considers that the Board or Chair is doing something that might infringe probity or regularity, he/she should set this out in writing to the Chair and the Board. If the matter is unresolved, he/she should ask the Audit and Risk Assurance Committee to enquire and if necessary the DoH.
Chief Executive	If the Board is contemplating a course of action that raises an issue not of formal propriety or regularity but affects the Chief Executive's responsibility for value for money, the Chief Executive should draw the relevant factors to the attention of the Board. If the outcome is that he/she are overruled, it is normally sufficient to ensure that his/her advice and the overruling of it are clearly apparent from the papers. Exceptionally, the Chief Executive should inform the DoH. In such cases, the Chief Executive should, as a member of the Board, vote against the course of action rather than merely abstain from voting.

1.5 SCHEME OF DELEGATION FROM STANDING ORDERS

DELEGATED TO	AUTHORITIES / DUTIES DELEGATED:
Chair	Final authority in interpretation of Standing Orders.
Trust Board	Appointment of Member acting as Chair
Chair	Call meetings.
Chair	Chair all Board meetings and associated responsibilities.
Chair	Give final ruling in questions of order, relevancy and regularity of meetings.
Chair	Having a second or casting vote
Chair	Suspension of Standing Orders
Audit and Risk Assurance Committee	Audit and Risk Assurance Committee to review every decision to suspend Standing Orders (power to suspend Standing Orders is reserved to the Board)
Trust Board	Variation or amendment of Standing Orders
Trust Board	Formal delegation of powers to Sub-Committees or Joint Committees and approval of their constitution and terms of reference. (Constitution and terms of reference of Sub Committees may be approved by the Chief Executive.)

DELEGATED TO	AUTHORITIES / DUTIES DELEGATED:
Chair & Chief Executive	The powers which the Board has retained to itself within these Standing Orders may in emergency be exercised by the Chair and Chief Executive after having consulted at least two Non-Executive members.
Chief Executive	The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals that shall be considered and approved by the Board, subject to any amendment agreed during the discussion.
Trust Board	Disclosure of non-compliance with Standing Orders to the Chief Executive as soon as possible.
Trust Board & Officers	Declare relevant and material interests.
Director of Finance	Maintain Register(s) of Interests.
All	Comply with the guidance contained in the Trust's Policy on Standards of Business Conduct for HSC Staff.
All	Disclose relationships between self and candidates for staff appointment. (Chief Executive to report the disclosure to the Board.)
Director of Finance	Keep seal in safe place and maintain a register of sealing.

DELEGATED TO	AUTHORITIES / DUTIES DELEGATED:
Chief Executive	Approve and sign all documents which will be necessary in legal proceedings.

Audit and Risk Assurance Committee

Title:	**Audit and Risk Assurance Committee Terms of Reference**		
Author(s):	Paul Nicholson, Andrew Phillips		
Ownership:	Committee Chair		
Date of Committee Approval:	7 October 2021	**Date of Trust Board Approval:**	21 October 2021
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Date:	**Version:**	**Author:**	**Comments:**
21/10/21	V1.0	C Mooney	

Audit and Risk Assurance Committee

TERMS OF REFERENCE

CONTENTS

1. CONSTITUTION

1.1 The Trust Board (The Board) hereby resolves to establish a Committee of the Board to be known as the Audit and Risk Assurance Committee (The Committee).

1.2 The Committee is a non-executive Committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference or as may be delegated by the Board on an ad hoc basis.

1.3 All procedural matters in respect of the conduct of the meetings of the Committee shall be in accordance with the Trust's Standing Orders.

1.4 The Committee will regularly review and reflect on best practice and adopt new learning as part of a commitment to continuous improvement.

2. MEMBERSHIP OF THE COMMITTEE

2.1 Trust Non-Executive Directors that are to be included as members of this Committee will be nominated by the Trust Board Chair and the Committee shall consist of not less than three members.

2.2 One of the members of the Committee will be appointed Chair of the Committee by the Chair of the Trust Board.

2.3 The Chair of the Trust Board shall not be a member of the Committee.

2.4 None of these members should be members of the Remuneration Committee.

2.5 One member of the Committee shall be the Chair of the Safety, Quality, Patient Experience and Performance Committee.

2.6 In the absence of the Committee Chair, another Non-Executive Member may be temporarily appointed to that role by agreement of the Non-Executive Directors.

2.7 One member of the Committee must have significant, recent and relevant financial experience.

2.8 A quorum shall be two non-Executive members including the Committee Chair.

3. ATTENDANCE

3.1 The Director of Finance, Director of Planning, Performance and Corporate Services and appropriate Internal and External Audit representatives shall normally attend meetings. However, at least once a year, the Committee should meet privately with the External and Internal Auditors.

3.2 The Chief Executive, Executive Directors and other Officers of the Trust may be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that Director or Officer. The Trust Board Chair may attend by invitation as an observer.

3.3 The Chief Executive should be invited to attend at least twice annually, to discuss with the Committee the process for assurance that supports the Mid-Year Assurance Statement and the Governance Statement.

3.4 A representative from the Sponsor Department (Department of Health) will be invited and may attend meetings of the Committee as an observer.

3.5 The Board Secretary shall attend to take minutes of the meeting and provide appropriate support to the Chair and Committee members.

4. FREQUENCY OF MEETINGS

4.1 Meetings shall be held not less than three times a year and, where necessary, can be conducted remotely using such as teleconference/video conferencing.

4.2 The Chair of the Committee may convene additional meetings as is deemed necessary.

4.3 The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

5. AUTHORITY

5.1 The Audit and Risk Assurance Committee's primary role is to independently contribute to the Board's overall process for ensuring that an effective internal financial control system is maintained.

5.2 The Board will always retain responsibility for such control and will act after taking account of the recommendations and assurances of the Committee. The Committee, therefore, does not have the executive authority of the Board, but does have sufficient membership, authority and resources to perform its role independently and effectively.

5.3 The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee.

5.4 The Committee is authorised by the Board to obtain external legal, clinical or other independent professional advice and to secure the attendance of individuals with relevant experience and expertise if it considers this necessary.

6. DUTIES

The duties of the Committee can be categorised as follows:

Governance, Risk Management and Internal Control

6.1 The Committee shall contribute to the establishment, review and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisation's objectives.

6.2 In particular the Committee will review:

- The adequacy of all risk and control related disclosure statements (in particular the Mid-Year Assurance Statement and the Governance Statement), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board;
- The adequacy of the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;
- The adequacy of the policies for ensuring compliance with relevant regularity, legal and code of conduct requirements, including the Trust's Standing Orders and Standing Financial Instructions;
- The adequacy of the policies and procedures for all work related to fraud and corruption as required by the Department of Health (DoH) and the Business Services Organisation's (BSO) Counter Fraud and Probity Service (CFPS);
- The annual schedule of losses and compensation payments;
- The register of Direct Award Contracts;
- Health and Safety;
- Information Governance, Performance and Compliance – UK GDPR;
- NIAS ICT Performance and Cyber Security;
- Procurement and Logistics including NIAS Stores operation.

6.3 In carrying out its work, the Committee will primarily utilise the work of Internal Audit, External Audit, and other assurance functions where appropriate, but will not be limited to these functions.

6.4 The Committee will also seek reports and assurances from other Trust Committees through their respective Chairs, Directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

6.5 This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

Internal Audit

6.6 The Committee shall seek to ensure that there is an effective internal audit function established by management that meets the Public Sector Internal Audit Standards and provides appropriate independent assurance to the Audit and Risk Assurance Committee, Chief Executive and Board. This will be achieved by:

- Consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal;
- Review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework;
- Consideration of the Head of Internal Audit's annual report, major findings of internal audit work (and management's response), and ensure co-ordination between the Internal and External Auditors to optimise audit resources;
- Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation;
- Annual review of the effectiveness of internal audit.

External Audit

6.7 The Committee shall review the work and findings of the External Auditor appointed by the Northern Ireland Audit Office and consider the implications of, and management's responses to, their work. This will be achieved by:

- Consideration of the performance of the External Auditor;
- Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Audit Strategy;
- Discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust;
- Review of all External Audit reports, including consideration of the annual Report to Those Charged with Governance before submission to the Board and any work carried out

outside the Annual Audit Strategy, together with the appropriateness of management responses.

Other Assurance Functions

6.8 The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation.

6.9 These may include, but will not be limited to, any reports issued by the Comptroller and Auditor General or Public Accounts Committee, reviews by DoH commissioned bodies, the Regulation and Quality Improvement Authority (RQIA) or professional and regulatory bodies with responsibility for the performance of staff or functions (e.g. Joint Royal Colleges Ambulance Liaison Committee (JRCALC), Health Care Professions Council (HCPC), Royal Colleges, accreditation bodies, etc.).

Financial Reporting

6.10 The Committee shall review the Trust's Annual Report and Accounts as well as the Charitable Trust Funds Annual Report and Accounts before submission to the Board, focusing particularly on:

- The wording in the Governance Statement and other disclosures relevant to the Terms of Reference of the Committee;
- Changes in, and compliance with, accounting policies and practices
- Unadjusted mis-statements in the financial statements;
- Major judgemental areas;
- Significant adjustments resulting from the audit;
- The Committee should also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided to the Board.
- Banking and Treasury Management including Charitable Trust Funds

Value for Money

6.11 The Committee shall oversee the adequacy of the Trust's arrangements for ensuring that Value for Money (VFM) is obtained in the expenditure of all public funds entrusted to its care. This will include a review of the findings from, and management's response to, all value for money audit reports issued to the Trust as part of the regional VFM programme sponsored by DoH.

6.12 Consider and approve relevant policies.

7. REPORTING

7.1 The minutes of Committee meetings shall be formally recorded and submitted to the Board following approval by the Committee. After each meeting, the Chair of the Committee shall make a written report to the next Trust Board meeting. At any point, the Chair shall draw to the attention of the Board any issues that require disclosure to the full Board or require executive action.

7.2 The Committee will report to the Board annually on its work in support of the Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the organisation, the integration of governance arrangements and the appropriateness of the self-assessment against quality and assurance standards.

7.3 The Chair shall liaise with the Chairs of other Committees on any issues or matter which may be relevant to their areas of responsibility.

8. REVIEW

8.1 The Terms of Reference should be reviewed annually.

9. OTHER MATTERS

9.1 The Agenda will be sent to members at least five working days before the meeting and supporting papers, wherever

possible, shall accompany the agenda, but will be dispatched no later than three working days before the meeting, save in an emergency.

9.2 An explanatory cover note will be provided for each agenda item.

People, Finance and Organisational Development Committee

Title:	People, Finance and Organisational Development Committee Terms of Reference		
Author(s):	Paul Nicholson, Michelle Lemon		
Ownership:	PFOD Chairs		
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Date:	**Version:**	**Author:**	**Comments:**
21/10/21	V2.0	C Mooney	

People, Finance and Organisational Development Committee

TERMS OF REFERENCE

CONTENTS

1 CONSTITUTION

1.1 The Trust Board (The Board) hereby resolves to establish a Committee of the Board to be known as the People, Finance & Organisational Development Committee (The Committee).

1.2 The Committee is a Non-Executive Committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference or as may be delegated by the Board on an ad hoc basis.

1.3 All procedural matters in respect of conduct of meetings of the Committee shall be in accordance with the Trust's Standing Orders.

1.4 The Committee will regularly review and reflect on best practice and adopt new learning as part of a commitment to continuous improvement.

2 MEMBERSHIP OF THE COMMITTEE

2.1 Trust Non-Executive Directors that are to be included as members of this Committee will be nominated by the Trust Board Chair.

2.2 Two Non-Executive Members of the Committee will be appointed as Co-Chairs of the Committee by the Trust Board Chair. One Co-Chair shall have responsibility for all matters relating to People and Organisational Development and one Co-Chair shall have responsibility for all matters relating to Finance.

2.3 In the absence of the Committee Co-Chairs, another Non-Executive Member may be temporarily appointed to that role by agreement of the Non-Executive Directors.

2.5 A quorum shall be two Non-Executive members.

3 ATTENDANCE AT MEETINGS

3.1 The Director of Human Resources and the Director of Finance shall normally attend meetings.

3.2 The Chief Executive, all Directors, Assistant Directors and senior managers with responsibility for workforce and finance related functions will be invited to attend as appropriate.

3.3 The Board Secretary shall attend to the minutes of the meeting and provide appropriate support to the Committee Co-Chairs and Committee members.

4 FREQUENCY OF MEETINGS

4.1 Meetings shall be held not less than three times a year, and where necessary can be conducted remotely using such as teleconference/video conferencing.

5 AUTHORITY

5.1 The Committee will be responsible for assuring the NIAS Board that effective and regularly reviewed arrangements are in place to support Human Resources, Finance and Organisational Development functions within the Trust.

5.2 The Board will always retain responsibility for such control and will act after taking account of the recommendations and assurances of the Committee. The Committee, therefore, does not have the executive authority of the Board, but does have sufficient membership, authority and resources to perform its role independently and effectively.

5.3 The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

5.4 The Committee is authorised by the Board to obtain external legal, clinical or other independent professional advice and to secure the attendance of individuals with relevant experience and expertise if it considers this necessary.

6 DUTIES

The duties of the Committee can be categorised as follows:

6.1 Provide assurance to Trust Board in relation to all strategic issues relating to Human Resources, workforce and organisational development to deliver the Trust's Strategy, Plans and standards as determined by Trust Board.

These include those related to:

- Health and Wellbeing
- Learning and Development
- Employment Law
- Workforce Planning
- Recruitment and Retention
- Equality and Diversity
- Whistleblowing
- Pay and Conditions
- Culture

This list is not exhaustive and focus will evolve as the work of the Committee develops.

6.2 Provide assurance on the quality and effectiveness of targeted plans to support the organisation in delivering a positive patient centred culture, embedding the values and behaviours that the Trust aspires to demonstrate, including collective and compassionate leadership.

6.3 Provide assurance on the development and implementation of the Workforce Planning, Estates and Fleet strategies.

6.4 Ensure consideration of an evidence-based approach to workforce and organisational development work streams to include quantitative and qualitative information.

6.5 To independently contribute to the Board's overall process for ensuring that the Trust Board delivers its statutory responsibility to break even. This includes:

- To review in detail the financial strategy, so as to be able to confirm to the Trust Board the basis of acceptance.

- To review the financial monitoring information in sufficient detail to advise the Trust Board, with confidence, concerning the financial performance of the Trust.

- To keep Directors up-to-date regarding the financial outlook for the Trust, and to review the key financial assumptions used in estimating the projected position.

- To review achievement of cost improvements and income generation activities in line with the Trust Delivery Plan.

- To receive regular updates on actions taken by the Director of Finance to ensure the provision of effective and sound financial management and information.

- To ensure the Director of Finance provides assurance that adequate training is delivered on an on-going basis to budget holders to enable them to manage their responsibilities.

- To assist and recommend training for SMT and Board, as appropriate.

6.6 Consider and approve relevant policies.

7 REPORTING

7.1 The Minutes of Committee meetings shall be formally recorded and submitted to the Board following approval by the Committee. After each meeting, the relevant Co-Chair of the Committee shall make a written report to the next Trust Board meeting. At any point, the Co-Chair shall draw to the attention of the Board any issues that require disclosure to the full Board or require executive action.

7.2 The Committee will report to the Board annually on its work in support of the Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the organisation, the integration of governance arrangements and the appropriateness of the self-assessment against quality and assurance standards.

7.3 The Co-Chairs shall liaise with the Chairs of other Committees on any issues or matter which may be relevant to their areas of responsibility.

8 REVIEW

8.1 The Terms of Reference should be reviewed annually.

9 OTHER MATTERS

9.1 The agenda will be sent to members at least five working days before the meeting and supporting papers, wherever possible, shall accompany the agenda, but will be dispatched no later than three working days before the meeting, save in an emergency.

9.2 An explanatory cover note will be provided for each agenda item.

Remuneration and Terms of Service Committee

Title:	**Remuneration and Terms of Service Committee Terms of Reference**		
Author(s):	C Mooney		
Ownership:	Trust Chair		
Date of Committee Approval:		**Date of Trust Board Approval:**	21 October 2021
Operational Date:	June 2018	**Review Date:**	October 2022
Version No:	V2.0	**Supersedes:**	
Key Words:			
Links to Other Policies / Procedures:			

Version Control:			
Date:	**Version:**	**Author:**	**Comments:**
21/10/21	V2.0	C Mooney	

Remuneration and Terms of Service Committee

TERMS OF REFERENCE

CONTENTS

1 CONSTITUTION

1.1 The Trust Board (The Board) hereby resolves to establish a Committee of the Board to be known as the Remuneration and Terms of Service Committee (The Committee)

1.2 The Committee is a Non-Executive Committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference or as may be delegated by the Board on an ad hoc basis.

1.3 All procedural matters in respect of the conduct of the meetings of the Committee shall be in accordance with the Trust's Standing Orders.

1.4 The Committee will regularly review and reflect on best practice and adopt new learning as part of a commitment to continuous improvement.

2 MEMBERSHIP OF THE COMMITTEE

2.1 Trust Non-Executive Directors that are to be included as members of this Committee will be nominated by the Trust Board Chair and the Committee shall consist of not less than three members.

2.2 The Chair of the organisation shall be Chair of the Committee.

2.3 None of these members should be members of the Audit and Risk Assurance Committee.

2.4 In the absence of the Committee Chair, another Non-Executive Member may be temporarily appointed to that role by agreement of the Non-Executive Directors.

2.5 A quorum shall be two members including the Committee Chair.

3 ATTENDANCE

3.1 The Trust Board Chair, Chief Executive and Director of Human Resources shall normally attend meetings.

3.2 The Board Secretary shall attend to take minutes of the meeting and provide appropriate support to the Chair and Committee members.

4 FREQUENCY OF MEETINGS

4.1 Meetings shall be held not less than two times a year and where necessary can be conducted remotely using such as teleconference/video conferencing.

5 AUTHORITY

5.1 The Committee's primary role is to advise the Board about appropriate remuneration and terms of service for the Chief Executive and all other direct reports to the Chief Executive. Advice to the Board on remuneration should include all aspects of salary (including any performance-related elements/bonuses and any allowances), provisions for other benefits including pensions and cars, as well as arrangements for termination of employment and other contractual terms.

5.2 The Board will always retain responsibility for such control and will act after taking account of the recommendations and assurances of the Committee. The Committee, therefore, does not have the executive authority of the Board, but does have sufficient membership, authority and resources to perform its role independently and effectively.

5.3 The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

5.4 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

6 DUTIES

The duties of the Committee can be categorised as follows:

6.1 Recommend to the Board about appropriate remuneration and terms of service for the Chief Executive and Executive Directors employed by the Trust, having proper regard to the Trust's circumstances and performance. Recommendations will also take into account Directions and/or guidance issued by the Department of Health and to the provisions of any national/regional arrangements where appropriate. Matters considered shall include:-

- All aspects of salary (including any performance-related elements/bonuses)
- Provisions for other benefits e.g. Lease cars
- Arrangements for termination of employment and other contractual terms.

6.2 Monitor and evaluate the performance management process in respect of the Chief Executive and Executive Directors (and other senior employees where appropriate). This will include:-

- Encouraging effective appraisal of staff
- Scrutinising objectives for:
  - Consistency
  - Robustness
  - Alignment with Government and Departmental priorities and local priorities
- Ensuring robust process has taken place
- Monitoring for consistency of assessment

- Recommending overall banding and award for Senior Executives

6.3 Advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

6.4 Ensure that all provisions regarding disclosure of remuneration, including pensions, are fulfilled.

6.5 Consider and approve relevant policies.

7 REPORTING

7.1 The Minutes of Committee meetings shall be formally recorded and submitted to the Board following approval by the Committee. After each meeting, the Chair of the Committee shall make a written report to the next Trust Board meeting. At any point, the Chair shall draw to the attention of the Board any issues that require disclosure to the full Board or require executive action.

8 REVIEW

8.1 The Terms of Reference should be reviewed annually.

9 OTHER MATTERS

9.1 The Agenda shall be sent to members at least five working days before the meeting and supporting papers, wherever possible, shall accompany the agenda, but shall be dispatched no later than three working days before the meeting, save in an emergency.

9.2 An explanatory cover note will be provided for each agenda item.

Safety, Quality, Patient Experience and Performance Committee

Title:	**Safety, Quality, Patient Experience and Performance Committee Terms of Reference**		
Author(s):	C Mooney		
Ownership:	Committee Chair		
Date of Committee Approval:	11 June 2020	**Date of Trust Board Approval:**	21 October 2021
Operational Date:	21 October 2021	**Review Date:**	October 2022
Version No:	V2.0	**Supercedes:**	
Key Words:			
Links to Other Policies / Procedures:			

Version Control:			
Date:	**Version:**	**Author:**	**Comments:**
21/10/21	V2.0	C Mooney	

Safety, Quality, Patient Experience and Performance Committee

TERMS OF REFERENCE

CONTENTS

1 CONSTITUTION

1.1 The Trust Board (The Board) hereby resolves to establish a Committee of the Board to be known as the Safety, Quality, Patient Experience and Performance Committee (The Committee).

1.2 The Committee is a Non-Executive Committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference or as may be delegated by the Board on an ad hoc basis.

1.3 All procedural matters in respect of conduct of meetings of the Committee shall be in accordance with the Trust's Standing Orders.

1.4 The Committee will regularly review and reflect on best practice and adopt new learning as part of a commitment to continuous improvement.

2 MEMBERSHIP OF THE COMMITTEE

2.1 Trust Non-Executive Directors that are to be included as members of this Committee will be nominated by the Trust Board Chair.

2.2 A Non-Executive Member of the Committee will be appointed Chair of the Committee by the Trust Board Chair.

2.3 The Trust Board Chair shall not be a member of the Committee but may attend meetings in an ex-officio capacity.

2.4 In the absence of the Committee Chair, another Non-Executive Member may be temporarily appointed to that role by agreement of the Non-Executive Directors.

2.5 One member of the Committee shall be the Chair of the Audit and Risk Assurance Committee.

2.6 Where practicable, one member of the Committee should have a clinical background.

2.7 A quorum shall be two Non-Executive members including the Committee Chair.

3 ATTENDANCE AT MEETINGS

3.1 All Directors shall normally attend meetings (subject to the issues to be considered on the agenda).

3.2 The Trust Board Chair, Chief Executive and other Officers of the Trust may attend and will be particularly expected to do so when the Committee is discussing areas of risk or operation that are the responsibility of that Officer.

3.3 The Board Secretary shall attend to the minutes of the meeting and provide appropriate support to the Committee Chair and Committee members.

4 FREQUENCY OF MEETINGS

4.1 Meetings shall be held not less than three times a year, and where necessary can be conducted remotely using such as teleconference/video conferencing.

5 AUTHORITY

5.1 The Committee will be responsible for assuring the NIAS Board that effective and regularly reviewed arrangements are in place to support the implementation, maintenance and development of Governance (clinical and non-clinical) and risk management and that such matters are properly considered and communicated to the Board.

5.2 The Board will always retain responsibility for such control and will act after taking account of the recommendations and assurances of the Committee. However, the Committee does have the delegated authority of the Board, through sufficient membership, authority and resources to perform its role independently and effectively.

5.3 The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee.

5.4 The Committee is authorised by the Board to obtain external legal, clinical or other independent professional advice and to secure the attendance of individuals with relevant experience and expertise if it considers this necessary. In particular, the Committee must be satisfied that it is able to provide appropriate clinical assurance.

6 DUTIES

The duties of the Committee can be categorised as follows:

6.1 Governance, Risk Management, Internal Control, Safety, Quality, Patient Experience and Performance - The Committee shall contribute to the establishment, review and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisation's objectives with a particular focus on safety, quality, patient experience and performance.

6.2 In particular the Committee will:

6.2.1 Provide assurance that adequate systems and processes are in place to support the achievement of the organisation's objectives and strategically manage clinical and non-clinical risks.

6.2.2 Provide assurance that adequate systems and processes are in place for the delivery of high-quality patient care that is safe, effective and patient focused through the review and monitoring of:

- Clinical and operational activities;
- Operational performance;
- Safeguarding;
- Professional self-regulation;
- Development and implementation of national standards of care and practice;
- Clinical audit activity;
- Professional and clinical performance standards;
- Continuing professional development for all staff;
- Adverse incidents and complaints with a clinical component;
- Infection prevention and control arrangements;
- Clinical research and development activity;
- Personal and public involvement (PPI) arrangements and activities;
- Corporate social responsibility;

- Emergency planning and business continuity;
- Information governance;
- Compliance with the relevant DoH controls assurance standards and associated action plans.
- Clinical Effectiveness Audit
- Compliments and Complaints
- Quality Assurance and Annual Quality Report
- Complex Case Team
- Medicines Management
- Clinical Practice and Guidance
- Community First Responders
- Control Room Performance
- Clinical Support Desk
- Voluntary Car Service and Independent Sector Management

6.2.3 Review the Trust's Assurance Framework and the Trust's Risk Register and to make recommendations to Trust Board for action as required to ensure high quality patient care. In reporting to the Trust Board the committee will seek to reach consensus in any decisions made. Where consensus cannot be reached, the issue will be referred to the Trust Board for further discussion and if necessary a decision.

6.2.4 Report and review the outcome of Serious Adverse Incidents (SAI) including Serious Clinical Adverse Incidents in line with DoH guidance and to ensure that appropriate remedial action has been taken including measures to prevent recurrence.

6.2.5 Receive reports from other Committees and Working Groups in relation to areas of risk and governance.

6.2.6 Provide Trust Board with regular reports on the management of risk and quality of patient care, an annual report on clinical governance and an annual quality report.

6.3 [2]In carrying out its work, the Committee will utilise the work of Internal Audit, External Audit, and other assurance

[1] Safety First – A framework for sustainable Improvement in the HPSS (March 2006)
[2] Procedure for reporting and follow up of SAI (April 2010)

functions where appropriate, but will not be limited to these functions. It will also seek reports and assurances from other Trust Committees through their respective Chairs, Directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

6.4 This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

6.5 Other Assurance Functions - The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation.

6.6 These may include, but will not be limited to, any reports issued by the Comptroller and Auditor General or Public Accounts Committee, reviews by DoH commissioned bodies, the Regulation and Quality Improvement Authority (RQIA) or professional and regulatory bodies with responsibility for the performance of staff or functions (e.g. Joint Royal Colleges Ambulance Liaison Committee (JRCALC), Health and Care Professions Council (HCPC), Royal Colleges, accreditation bodies, etc.).

6.7 Governance Statement - The Committee shall review the Governance Statement and other disclosures relevant to the Terms of Reference of the Committee.

6.8 Consider and approve relevant policies.

7 REPORTING

7.1 The minutes of Committee meetings shall be formally recorded and submitted to the Board following approval by the Committee. After each meeting, the Chair of the Committee shall make a written report to the next Trust Board meeting. At any point, the Chair shall draw to the attention of the Board any issues that require disclosure to the full Board or require executive action.

7.2 The Committee will report to the Board annually on its work in support of the Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the organisation, the integration of

governance arrangements and the appropriateness of the self-assessment against the Quality Standards and Controls Assurance Standards.

7.3 The Chair shall liaise with the Chairs of other Committees on any issues or matter which may be relevant to their areas of responsibility.

8 REVIEW

8.1 The Terms of Reference should be reviewed annually.

9 OTHER MATTERS

9.1 The agenda will be sent to members at least five working days before the meeting and supporting papers, wherever possible, shall accompany the agenda, but will be dispatched no later than three working days before the meeting, save in an emergency.

9.2 An explanatory cover note will be provided for each agenda item.

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

PRESENTATION OF PAPER

Date of Trust Board:	9 February 2023
Title of paper:	NIAS Board Governance Self-Assessment Tool (BGSAT) 2021-22
Brief summary:	The Trust is required to complete the BGSAT on an annual basis. Board approval is sought to the BGSAT for the year ended 31 March 2022.
Recommendation:	**For Approval** ☒ **For Noting** ☐
Previous forum:	SMT – 10 January 2023 ARAC – 19 January 2023
Prepared and presented by: **Date:**	Carol Mooney, Board Secretary Maxine Paterson, Director of PP&CS 2 February 2023

NIAS
Board Governance Self-Assessment
for
2021-22

DATE: TBC

DRAFT

1. Board composition and commitment

1.1 Board positions and size

Ref	Prompt	NIAS Assessment	Evidence of compliance with good practice (Please reference supporting documentation below)	Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or areas where additional assurance is required.
GP1	The size of the Board (including voting and non-voting members of the Board) and Board Committees is appropriate for the requirements of the business. All voting positions are substantively filled.	A	Board and Committee papers and minutes	Trust has recently appointed substantive Directors of Finance and HR.	Trust currently has one NED vacancy.	Terms of office for a further two NEDs are due to finish in May 2023. This means that there will be three vacancies on the Trust Board. The recruitment exercise for these has not yet commenced (as at Dec 2022)
GP2	The Board ensures that it is provided with appropriate advice, guidance and support to enable it to effectively discharge it responsibilities.	G	Board and Committee papers and minutes	Members' views have continually been sought around the information they would wish to have presented.		
GP3	It is clear who on the Board is entitled to vote.	G	Standing Orders Board and Committee papers and minutes			

GP4	The composition of the Board and Board Committees accord with the requirements of the relevant Establishment Order or other legislation, and/or the ALB's Standing Orders.	G	Standing Orders Establishment Order Board and Committee papers and minutes			
GP5	Where necessary, the appointment term of NEDs is staggered so they are not all due for re-appointment or to leave the Board within a short space of time.	A G	NED Letters of Appointment	Recruitment exercise for three NED positions (to be undertaken by DoH Appointments Unit).	DoH Appointment Unit should note the need to stagger terms of office as two NED positions are due to end on the same date.	Terms of office for a further two NEDs are due to finish in May 2023. The recruitment exercise for these has not yet commenced (as at Dec 2022)

1.1

Ref	Prompt	NIAS Assessment	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	The Chair and/or CE are currently interim or the position(s) vacant.	G		
RF2	There has been a high turnover in Board membership in the previous two years (i.e. 50% or more of the Board are new compared to two years ago).	G		
RF3	The number of people who routinely attend Board meetings hampers effective discussion and decision-making.	G		

1. Board composition and commitment

1.2 Balance and calibre of Board members

Ref	Prompt	NIAS Assessment	Evidence of compliance with good practice (Please reference supporting documentation below)	Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or areas where additional assurance is required.
GP1	The Board can clearly explain why the current balance of skills experience & knowledge amongst Board members is appropriate to effectively govern ALB over the next 3-5 years. In particular this includes consideration of the value each NED will provide in helping the Board to effectively oversee implementation of the ALB's business plan.	G	Board and Committee papers and minutes	Arrangements have been put in place for independent expert financial advice to be provided to the Trust's ARAC Arrangements have been put in place for independent clinical assurance to be provided to the Trust's Safety Committee		NB impact of current NED vacancy and imminent vacancies

GP2	The Board has an appropriate blend of NEDs e.g. from the public, private and voluntary sectors.	G	Board member biographies on website			NB impact of current NED vacancy and imminent vacancies
GP3	The Board has had due regard under *Section 75 of the Northern Ireland Act 1998 to the need to promote equality of opportunity: between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation; between men and women generally; between persons with a disability and persons without; and between persons with dependants and persons without.*	G	NIAS Section 75 return			
GP4	There is at least one NED with a background specific to the business of the ALB.	A	Board member biographies on website	The Trust has appointed a Senior Clinical Adviser to the Safety Cttee and an Independent Adviser to the ARAC to support NEDs in carrying out their challenge and		NB Impact of NED vacancy and imminent vacancies. Competitions are run by the PAU which has to operate within the Code of Public Appointments

				scrutiny function. Discussions are ongoing with the DoH Sponsor Branch and PAU re the appointment of a NED with a knowledge and understanding of clinical matters to ensure there is informed independent scrutiny of NIAS clinical matters.		
GP5	Where appropriate, the Board includes people with relevant technical and professional expertise.	A	Board member biographies on website	Arrangements have been put in place for independent expert financial advice and independent clinical assurance to be provided to the Trust's ARAC and Safety Committee respectively. See GP4 above.		-
GP6	There is an appropriate balance between Board members (both Executive and NEDs) that are new to the Board (i.e. within their first 18 months) and those that have served	G	Staggered nature of members' terms of office refer			'Appropriate balance' is not defined. Measures to achieve balance are constrained and outside Trust control as NED appointments are made by DoH PAU.

	on the Board for longer.					
GP7	The majority of the Board are experienced Board members.	G	Board member biographies on website			
GP8	The Chair of the Board has a demonstrable and recent track record of successfully leading a large and complex organisation, preferably in a regulated environment.	G	Chair's biography on website		.	. Definition of terms used is required
GP9	The Chair of the Board has previous non-executive experience.	G	Chair's biography on website			
GP10	At least one member of the Audit Committee has recent and relevant financial experience.	G	Board member biographies on website	The ARAC Chair has recent and relevant financial experience. However additional arrangements have also been put in place for independent expert financial advice to be provided to the ARAC		

1.2

Ref	Prompt	NIAS Assessment	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	There are no NEDs with a recent and relevant financial background.	G		While the current Chair of the ARAC has recent and relevant financial experience, arrangements have also been put in place for independent expert financial advice to be provided to the Trust's ARAC
RF2	There is no NED with current or recent (i.e. within the previous 2 years) experience in the private/ commercial sector.	G		
RF3	The majority of Board members are in their first Board position.	G		
RF4	The majority of Board members are new to the organisation (i.e. within their first 18 months).	G		

RF5	The balance in numbers of Executives and Non Executives is incorrect.	R	Issue of the NED vacancies has been raised with DoH PAU.	NB imminent vacancies. Responsibility for appointment of NEDs lie with the DoH PAU.
RF6	There are insufficient numbers of Non Executives to be able to operate committees.	G		Members have acknowledged that an increase in the NED complement would allow the establishment of a further Committee

1. Board composition and commitment

1.3 Role of the Board

Ref	Prompt	NIAS Assessment	Evidence of compliance with good practice (Please reference supporting documentation below)	Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or areas where additional assurance is required.
GP1	The role and responsibilities of the Board have been clearly defined and communicated to all members.	G	Standing Orders Code of Conduct Induction programme Management Statement	Induction and related documentation for NEDs being revised		
GP2	Board members are clear about the Minister's policies and expectations for their ALBs and have a clearly defined set of objectives, strategy and remit.	G	NIAS Strategy to Transform 2020-2026 NIAS Corporate Plan 2020-21 Appointment Letters			
GP3	There is a clear understanding of the roles of Executive and Non-Executive Board members.	G	Code of Conduct Appointment Letters Standing Orders Job descriptions Management Statement.			
GP4	The Board takes collective responsibility	G	Standing Orders			

	for the performance of the ALB.		Board & Committee minutes and papers			
GP5	NEDs are independent of management.	G	Standing Orders Board and Committee minutes and papers			
GP6	The Chair has a positive relationship with the Minister and sponsor Department	G		Minister for Health appointed January 2020. A programme of regular meetings have been established between Minister and Trust Chairs		
GP7	The Board holds management to account for its performance through purposeful challenge and scrutiny.	G	Board and Committee papers and minutes	.		
GP8	The Board operates as an effective team.	G	Board and Committee papers and minutes			
GP9	The Board shares corporate responsibility for all	G	Board and Committee papers and minutes Standing Orders			

	decisions taken and makes decisions based on clear evidence.					
GP10	Board members respect confidentiality and sensitive information.	G	Board and Committee papers and minutes			
GP11	The Board governs, Executives manage.	G	Board and Committee papers and minutes Scheme of Delegation	Trust has revised its Committee structure and the Standing Orders, including the SoD, to reflect the new Committee structure.	NIAS Trust Board is a unitary Board, established by statute which includes Executives as Board members	
GP12	Individual Board members contribute fully to Board deliberations and exercise a healthy challenge function.	G	Board and Committee papers and minutes			
GP13	The Chair is a useful source of advice and guidance for Board members on any aspect of the Board.	G	Board and Committee papers and minutes			
GP14	The Chair leads meetings well, with a clear focus on the issues facing the ALB,	G	Board and Committee papers and minutes			

	and allows full and open discussions before major decisions are taken.					
GP15	The Board considers the concerns and needs of all stakeholders and actively manages it's relationships with them.	G	PPI strategies Board and Committee papers and minutes Section 75 Return A Whistleblowing procedure is in place.	PPI, Whistleblowing & Speaking Out Champions identified	The Trust actively considers the concerns of stakeholders. However Covid-19 has impacted significantly on conducting face-to-face meetings. The Trust would acknowledge there is an opportunity to improve further, dependent upon resource constraints being addressed. Patient liaison is a challenge as patients are often unwell whilst in our care.	
GP16	The Board is aware of and annually approves a scheme of delegation to its Committees.	G	Scheme of Delegation Committee Terms of Reference Standing Orders	Trust has revised its Committee structure and the Standing Orders, including the SoD, to reflect the new Committee structure.		
GP17	The Board is provided with timely and robust	G			The Board receives assurance through the	

	post-evaluation reviews on all major projects and programmes.				Strategic Implementation Group (SIG) on the delivery of major projects.	

1.3

Ref	Prompt	NIAS Assessment	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	The Chair looks constantly to the Chief Executive to speak or give a lead on issues.	G		The Chair also looks to Board members to contribute as appropriate.
RF2	The Board tends to focus on details and not on strategy and performance.	G		.
RF3	Board becomes involved in operational areas.	G		There are occasions when Board members need to focus on operational issues, for example when there is reputational risk or significant performance failure.
RF4	The Board is unable to take a decision without the Chief Executive's recommendation.	G		
RF5	The Board allows the Chief Executive to dictate the Agenda.	G		

RF6	Regularly, one individual Board member dominates the debates or has an excessive influence on Board decision making.	G		

1. Board composition and commitment

1.4 Committees of the Board

Ref	Prompt	NIAS Assessment	Evidence of compliance with good practice (Please reference supporting documentation below)	Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or areas where additional assurance is required.
GP1	Clear terms of reference are drawn up for each Committee including whether it has powers to make decisions or only make recommendations to the Board.	G	Committee Terms of Reference Board and Committee papers and minutes Standing Orders	Trust has revised its Committee structure and the Standing Orders, including the SoD, to reflect the new Committee structure.		
GP2	Certain tasks or functions are delegated to the Committee but the Board as a whole is aware that it carries the ultimate responsibility for the actions of its Committees.	G	Committee Terms of Reference Board and Committee papers and minutes Standing Orders	1.4 GP1 refers		
GP3	Schemes of delegation from the Board to the	G	Standing Orders Standing Financial Instructions	1.4 GP1 refers		

	Committees are in place.					
GP4	There are clear lines of reporting and accountability in respect of each Committee back to the Board.	G	Committee Terms of Reference Board and Committee papers and minutes Standing Orders	1.4 GP1 refers		
GP5	The Board agrees with the Committees what assurances it requires and when, to feed its annual business cycle.	G	Committee Terms of Reference Governance Framework and Statement Board and Committee papers and minutes Standing Orders	1.4 GP1 refers		
GP6	The Board receives regular reports from the Committees which summarises the key issues as well as decisions or recommendations made.	G	Board and Committee papers and minutes	Trust has put in place process for a Committee highlight report to be presented at Trust Board meetings. Trust Board also receives copies of Committee minutes		
GP7	The Board undertakes a formal and rigorous annual evaluation of the performance of its Committees.	G	Role of ARAC extended to include risk. Safety Cttee Chair working alongside senior Clinical Adviser to ensure Cttee members were well briefed on how to approach clinical scrutiny. PFOD Cttee underwent an extensive review both in relation to the	Committees continually evaluate their roles and performance and make adjustments as necessary.		Not clear on terminology used, ie …'formal and rigorous'

			presentation of financial & HR elements.			
GP8	It is clearly documented who is responsible for reporting back to the Board.	G	Committee Terms of Reference Board and Committee papers and minutes			

1.4

Ref	Prompt	NIAS Assessment	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	The Board notes the minutes of Committee meetings and reports, instead of discussing same.	G	Board agenda records Committee minutes as being 'For Information' but opportunity is given for the discussion of business conducted at Committee level. The Committee Chairs provide a Committee highlight report to draw Board members' attention to specific issues.	The Board Chair operates an 'open door' policy to NEDs and provides Committee Chairs with opportunity to identify issues which require Board attention.
RF2	Committee members do not receive performance management appraisals in relation to their Committee role.	G	.	Chair appraises NEDs on their Committee roles within their annual appraisal
RF3	There are no terms of reference for the Committees.	G		
RF4	Non Executives are unaware of their differing roles between the Board and Committees.	G		

RF5	The Agenda for Committee meetings is changed without proper discussion and/or at the behest of the Executive team	G		Committee agendas are shared with the respective Committee Chair in advance of meetings and relevant Directors meet with Committee Chairs to discuss agenda content.

1. Board composition and commitment

1.5 Board member commitment

Ref	Prompt	NIAS Assessment	Evidence of compliance with good practice (Please reference supporting documentation below)	Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or areas where additional assurance is required.
GP1	Board members have a good attendance record at all formal Board and Committee meetings and at Board events.	G	Board and Committee papers and minutes Annual Report	Board Secretary maintains Board/Committee attendance register		
GP2	The Board has discussed the time commitment required for Board (including Committee) business and Board development, and Board members have committed to set aside this time.	G	NED Appraisal Board member Job Descriptions			
GP3	Board members have received a copy of the Department's Code of Conduct and Code of Accountability for Board Members of	G	Board and Committee papers and minutes Standing Orders NED Appraisals			

	Health and Social Care Bodies or the Northern Ireland Fire and Rescue Service. Compliance with the code is routinely monitored by the Chair.		Executive Director Appraisal (by Chief Executive)			
GP4	Board meetings and Committee meetings are scheduled at least 6 months in advance.	G	Schedule of Board/ Committee meetings			

1.5

Ref	Prompt	NIAS Assessment	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	There is a record of Board and Committee meetings not being quorate.	G		
RF2	There is regular non-attendance by one or more Board members at Board or Committee meetings.	G		
RF3	Attendance at the Board or Committee meetings is inconsistent (i.e. the same Board members do not consistently attend meetings).	G		
RF4	There is evidence of Board members not behaving consistently with the behaviours expected of them and this remaining unresolved.	G		
RF5	The Board or Committee has not achieved full attendance at at least one meeting within the last 12 months.	G		

2. Board evaluation, development and learning

2.1 Effective Board level evaluation

Ref	Prompt	NIAS Assessment	Evidence of compliance with good practice (Please reference supporting documentation below)	Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or areas where additional assurance is required.
GP1	A formal Board Governance Self-Assessment has been conducted within the previous 12 months.	G		2020-21 BGSAT was approved by Trust Board in June 2021.		
GP2	The Board can clearly identify a number of changes/ improvements in Board and Committee effectiveness as a result of the formal evaluations that have been undertaken.	G		The Trust has revised its Committee structure and an additional Committee has been established. BSO Internal Audit carried out a Board Effectiveness audit in 2021-22.		
GP3	The Board has had an independent evaluation of its effectiveness and the effectiveness of its	G		BSO Internal Audit carried out a Board Effectiveness audit in 2021-22. That audit		

	Committees within the last 2 years by a 3rd party that has a good track record in undertaking Board effectiveness evaluations.			constitutes the independent review.		
GP4	In undertaking its formal evaluation, the Board has used an approach that includes various evaluation methods. In particular, the Board has considered the perspective of a representative sample of staff and key external stakeholders (e.g. commissioners, service users and clients) on whether or not they perceive the Board to be effective.	R			The Board has not yet had the opportunity to consider how input from external stakeholders will be secured but this is under active consideration by the Chair in conjunction with the Board Secretary.	
GP5	The focus of the evaluation included traditional 'hard' (e.g. Board information, governance structure) and 'soft' dimensions of effectiveness. In the case of the latter, the evaluation considered as a minimum:	R	Board papers, agendas and minutes.		As above	

	• The knowledge, experience and skills required to effectively govern the organisation and whether or not the Board's membership currently has this; • How effectively meetings of the Board are chaired; • The effectiveness of challenge provided by Board members; • Role clarity between the Chair and CE, Executive Directors and NEDs, between the Board and management and between the Board and its various sub-committees; • Whether the Board's agenda is appropriately balanced between: strategy and current performance; finance and quality; making decisions and noting/receiving					

	information; matters internal to the organisation and external considerations; and business conducted at public board meetings and that done in confidential session.					

2.1

Ref	Prompt	NIAS Assessment	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	No formal Board Governance Self-Assessment has been undertaken within the last 12 months.	G		A BGSAT was undertaken in the 2020-21 year.
RF2	The Board Governance Self-Assessment has not been independently evaluated within the last 3 years.	G		BSO Internal Audit carried out a Board Effectiveness audit in 2021-22. That audit constitutes the independent review.
RF3	Where the Board has undertaken an evaluation, only the perspectives of Board members were considered and not those outside the Board (e.g. staff, etc).	G	The Trust has conducted a review of its governance structures at Committee level to assess the effectiveness of the governance and assurance processes within that. This was carried out in full consultation with SMT and the findings have been reflected in the Trust Standing Orders.	The Trust does not consider it necessary to confirm Board effectiveness in this way
RF4	Where the Board has undertaken an evaluation, only one evaluation method was used (e.g. only a survey	G	As above	

	of Board members was undertaken).			

2. Board evaluation, development and learning

2.2 Whole Board development programme

Ref	Prompt	NIAS Assessment	Evidence of compliance with good practice (Please reference supporting documentation below)	Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or areas where additional assurance is required.
GP1	The Board has a programme of development in place. The programme seeks to directly address the findings of the Board's annual evaluation (see previous section) and contains the following elements: understanding the relationship between the Minister, the Department and their organisation, e.g. as documented in the Management Statement; development specific to the business of their organisation; and reflecting on the effectiveness of the Board and its	G	Workshops NED appraisal HSC seminars/any other relevant training which NEDs may consider helpful are also available			

	supporting governance arrangements.					
GP2	Understanding the relationship between the Minister, Department and the ALB - Board members have an appreciation of the role of the Board and NEDs, and of the Department's expectations in relation to those roles and responsibilities.	G	Management Statement NED Appraisal Executive Director Appraisal Job Descriptions			
GP3	Development specific to the ALB's governance arrangements – the Board is or has been engaged in the development of action plans to address governance issues arising from previous self-assessments, independent evaluations, Internal Audit reports, serious adverse incident reports and other significant control issues.	G	Board and Committee papers and minutes Annual Report Governance Framework and Statement Internal Audit Reports	Work is ongoing within the Trust to address IA recommendations		
GP4	Reflecting on the effectiveness of the Board and its	G	Board and Committee Papers and Minutes			

	supporting governance arrangements -The development programme includes time for the Board as a whole to reflect upon, and where necessary improve: The focus and balance of Board time; The quality and value of the Board's contribution and added value to the delivery of the business of the ALB; How the Board responded to any service, financial or governance failures; Whether the Board's subcommittees are operating effectively and providing sufficient assurances to the Board; The robustness of the ALB's risk management processes; The reliability, validity and comprehensiveness of information received by the Board.		Annual Report Governance Framework and Statement Internal Audit Reports Workshop			

GP5	Time is 'protected' for undertaking this programme and it is well attended.	G	Board workshops	Need to forward plan for workshops		
GP6	The Board has considered, at a high-level, the potential development needs of the Board to meet future challenges.	G	NED Appraisals	Need to forward plan for workshops		

2.2

Ref	Prompt	NIAS Assessment	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	The Board does not currently have a Board development programme in place for EDs or NEDs.	G		Ongoing Board workshops. Members have opportunity to identify any training/development they require and to discuss with Chair
RF2	The Board Development Programme is not aligned to helping the Board comply with the requirements of the Management Statement and/or fulfil its statutory responsibilities.	G		

2. Board evaluation, development and learning

2.3 Board induction, succession and contingency planning

Ref	Prompt	NIAS Assessment	Evidence of compliance with good practice (Please reference supporting documentation below)	Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or areas where additional assurance is required.-0
GP1	All members of the Board, both Executive and Non-Executive, are appropriately inducted into their role as a Board member. Induction is tailored to the individual Director and includes access to external training courses where appropriate. As a minimum, it includes an introduction to the role of the Board, the role expectations of NEDs and Executive Directors, the statutory duties of Board members and the business of the ALB.	G	Induction Programmes Job Descriptions	The induction related documentation for NEDs is being revised with a view to having it available online. 2021-22 Boardroom Apprentice progressed some work in relation to this but this is to be progressed further in the 2022-23 year.		

GP2	Induction for Board members is conducted on a timely basis.	G	Induction Programme .			
GP3	Where Board members are new to the organisation, they have received a comprehensive corporate induction which includes an overview of the services provided by the ALB, the organisation's structure, ALB values and meetings with key leaders.	G	Induction Programme			
GP4	Deputising arrangements for the Chair and CE have been formally documented.	G	Standing Orders Chief Executive Notification of deputising arrangements		Arrangements do not cover any need for extended period of deputising.	
GP5	The Board has considered the skills it requires to govern the organisation effectively in the future and the implications of key Board-level leaders leaving the organisation. Accordingly, there are demonstrable succession plans in	R		Discussions will continue with the DoH PAU to ensure the requirements of Board positions are kept current. The Trust's SMT has also acknowledged the need to have effective		

	place for all key Board positions.			succession planning in place within the Trust		

2.3

Ref	Prompt	NIAS Assessment	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	Board members have not attended the CIPFA "On Board" training course within 3 months of appointment.	G		
RF2	There are no documented arrangements for chairing Board and committee meetings if the Chair is unavailable.	G		Arrangements do not provide for any extended unavailability of the Chair or Committee Chairs
RF3	There are no documented arrangements for the organisation to	G		Arrangements do not provide for any extended unavailability of the Chief Executive

	be represented at a senior level at Board meetings if the CE is unavailable.			
RF4	NED appointment terms are not sufficiently staggered.	R		A number of NED terms of office are due to cease at the same time. However this is not within the gift of the Trust as responsibility for NED recruitment/appointment/terms of office lies with the DoH/PAU.

2. Board evaluation, development and learning

2.4 Board member appraisal and personal development

Ref	Prompt	NIAS Assessment	Evidence of compliance with good practice (Please reference supporting documentation below)	Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or areas where additional assurance is required.
GP1	The effectiveness of each Non-Executive Board member's contribution to the Board and corporate governance is formally evaluated on an annual basis by the Chair	G	NED Appraisal			
GP2	The effectiveness of each Executive Board member's contribution to the Board and corporate governance is formally evaluated on an annual basis in accordance with the appraisal process prescribed by their organisation.	G				

GP3	There is a comprehensive appraisal process in place to evaluate the effectiveness of the Chair of the Board that is led by the relevant Deputy Secretary (and countersigned by the Permanent Secretary).	G	Annual Chair Appraisal			
GP4	Each Board member (including each Executive Director) has objectives specific to their Board role that are reviewed on an annual basis.	G	Remuneration Committee minutes (for Executive Directors)			No requirement for NED objectives outside Committee Chairs or for ED Board roles. DoH guidance required.
GP5	Each Board member has a Personal Development Plan that is directly relevant to the successful delivery of their Board role.	R				No PDP element addressing role as Board member within appraisal template. The Chair has raised this with PAU.
GP6	As a result of the Board member appraisal and personal development process, Board members can evidence improvements that they have made in the quality of their	G	Board and Committee papers and minutes NED Appraisal		Not part of Executive Director Appraisal process but addressed for NEDs at annual assessment with Chair. No PDP element addressing role as Board member.	As for GP4.

	contributions at Board-level.					
GP7	Where appropriate, Board members comply with the requirements of their respective professional bodies in relation to continuing professional development and/or certification.	G	Addressed as part of annual appraisal			

2.4

Ref	Prompt	NIAS Assessment	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	There is not a robust performance appraisal process in place at Board level that includes consideration of the perspectives of other Board members on the quality of an individual's contribution (i.e. contributions of every member of the Board (including Executive Directors) on an annual basis and documents the process of formal feedback being given and received.	G		
RF2	Individual Board members have not received any formal training or professional development relating to their roles.	G	'On Board' training upon appointment as well as any ad hoc training	
RF3	Appraisals are perceived to be a 'tick box' exercise.	G		Appraisals are not considered to be a tick box exercise by either NEDs or EDs.

RF4	The Chair does not consider the differing roles of Board members and Committee members.	G		EDs are not members of any Committee – they are attendees only.

3. Board insight and foresight

3.1 Board performance reporting

Ref	Prompt	NIAS Assessment	Evidence of compliance with good practice (Please reference supporting documentation below)	Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or areas where additional assurance is required.
GP1	The Board has debated and agreed a set of quality and financial performance indicators that are relevant to the Board given the context within which it is operating and what it is trying to achieve. Indicators should relate to priorities, objectives, targets and requirements set by the Dept.	G	NIAS TDP Board and Committee papers and minutes Annual Report			
GP2	The Board receives a performance report which is readily understandable for all members and includes: • performance of the ALB against a	G	Board and Committee papers and minutes Annual Report		Performance reporting to the Trust Board has been enhanced over the last year, working towards the introduction of a new format of integrated	

	range of performance measures including quality, performance, activity and finance and enables links to be made; • Variances from plan are clearly highlighted and explained ; • Key trends and findings are outlined and commented on ; • Future performance is projected and associated risks and mitigating measures; • Key quality information is triangulated (e.g. complaints, standards, Dept targets, serious adverse incidents, limited audit assurance) so that Board members can accurately describe where problematic services lines are ;Benchmarking of				quality and performance report	

	performance to comparable organisations is included where possible.					
GP3	The Board receives a brief verbal update on key issues arising from each Committee meeting from the relevant Chair. This is supported by a written summary of key items discussed by the Committee and decisions made	G	Board and Committee papers and minutes	The Trust receives written Committee minutes (when approved), allowing each Committee Chair to update where necessary. However, a written highlight report, providing a summary of the key items discussed and decisions made, is provided after each Committee to the next Trust Board.		
GP4	The Board regularly discusses the key risks facing the ALB and the plans in place to manage or mitigate them.	G	Board and Committee papers and minutes Governance Framework and Statement			
GP5	An action log is taken at Board meetings. Accountable individuals and challenging/demanding timelines are assigned. Progress against	G	Board and Committee papers and minutes Action Log reviewed at each Board meeting.			

	actions is actively monitored. Slips in timelines are clearly identifiable through the action log and individuals are held to account.					

3.1

Ref	Prompt	NIAS Assessment	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	Significant unplanned variances in performance have occurred.	G	.	
RF2	Performance failures were brought to the Board's attention by an external party and/or not in a timely manner.	G		
RF3	Finance and Quality reports are considered in isolation from one another.	G		
RF4	The Board does not have an action log.	G		
RF5	Key risks are not reported/escalated up to the Board.	G		

3. Board insight and foresight

3.2 Efficiency and Productivity

Ref	Prompt	NIAS Assessment	Evidence of compliance with good practice (Please reference supporting documentation below)	Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or areas where additional assurance is required.
GP1	The Board is assured that there is a robust process for prospectively assessing the risk(s) to quality of services and the potential knock-on impact on the wider health and social care community of implementing efficiency and productivity plans.	G	Board and Committee papers and minutes Annual Report Governance Framework and Statement NIAS TDP			
GP2	The Board can provide examples of efficiency and productivity plans that have been rejected or significantly modified due to their potential impact on quality of service.	G				

GP3	The Board receives information on all efficiency and productivity plans on a regular basis. Schemes are allocated to Directors and are RAG rated to highlight where performance is not in line with plan. The risk(s) to non-achievement is clearly stated and contingency measures are articulated.	G G A				Trust Board is considering how best the risks to non-achievement can be articulated and monitored.
GP4	There is a process in place to monitor the ongoing risks to service delivery for each plan, including post implementation reviews.	G	Board and Committee papers and minutes			

3.2

Ref	Prompt	NIAS Assessment	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	The Board does not receive performance information relating to progress against efficiency and productivity plans.	G		
RF2	There is no process currently in place to prospectively assess the risk(s) to quality of services presented by efficiency and	G		

	productivity plans.			
RF3	Efficiency plans are based on a percentage reduction across all services rather than a properly targeted assessment of need.	G		
RF4	The Board does not have a Board Assurance Framework (BAF).	G		

3. Board insight and foresight

3.3 Environmental and strategic focus

Ref	Prompt	NIAS Assessment	Evidence of compliance with good practice (Please reference supporting documentation below)	Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or areas where additional assurance is required.
GP1	The Chief Executive presents a report to every Board meeting detailing important changes or issues in the external environment (e.g. policy changes, quality and financial risks). The impact on strategic direction is debated and, where relevant, updates are made to the ALB's risk registers and Board Assurance Framework (BAF).	G	Board and Committee papers and minutes			
GP2	The Board has reviewed lessons learned from SAIs, reports on discharge of	G	Board and Committee papers and minutes.			

	statutory responsibilities, negative reports from independent regulators etc and has considered the impact upon them. Actions arising from this exercise are captured and progress is followed up.					
GP3	The Board has conducted or updated an analysis within the last year to inform the development of the Business Plan.	G	Corporate Plan 2022-23			
GP4	The Board has agreed a set of corporate objectives and associated milestones that enable the Board to monitor progress against implementing its vision and strategy for the ALB. Performance against these corporate objectives and milestones are reported to the board on a quarterly basis.	G	Board and Committee papers and minutes Strategy to Transform 2020-2026 Corporate Plan 2022-23			

GP5	The Board's annual programme of work sets aside time for the Board to consider environmental and strategic risks to the ALB. Strategic risks to the ALB are actively monitored through the Board Assurance Framework (BAF).	G	Board and Committee papers and minutes Workshops	Need to forward plan workshops		

3.3

Ref	Prompt	NIAS Assessment	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	The Board does not have a clear understanding of Executive/Departmental priorities and its statutory responsibilities, business plan etc.	G		
RF2	The Board's annual programme of work does not set aside time for the Board to consider environmental and strategic risks to the ALB.	G		
RF3	The Board does not formally review progress towards delivering its strategies.	G		Trust has established the NIAS' Strategy Implementation Group to oversee and support implementation of all significant transformation work across NIAS, rather than multiple structures to support many projects.

3. Board insight and foresight

3.4 Quality of Board papers and timeliness of information

Ref	Prompt	NIAS Assessment	Evidence of compliance with good practice (Please reference supporting documentation below)	Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or areas where additional assurance is required.
GP1	The Board can demonstrate that it has actively considered the timing of the Board and Committee meetings and presentation of Board and Committee papers in relation to month and year end procedures and key dates to ensure that information presented is as up-to-date as possible and that the Board is reviewing information and making decisions at the right time.	G	Board and Committee papers and minutes			
GP2	A timetable for sending out papers to members is in place and adhered to.	G	Standing Orders			

			Board and Committee papers and minutes			
GP3	Each paper clearly states what the Board is being asked to do (e.g. noting, approving, decision, and discussion).	G	Board and Committee papers and minutes Cover papers (marked For Approval, For Noting, For Information) are drafted to accompany agenda items for consideration by Board and Committees			
GP4	Board members have access to reports to demonstrate performance against key objectives and there is a defined procedure for bringing significant issues to the Board's attention outside of formal monthly meetings.	G	Board and Committee papers and minutes Standing Orders		Board meets on a bi-monthly schedule	
GP5	Board papers outline the decisions or proposals that Executive Directors have made or propose. This is supported; where appropriate, by: an appraisal of the relevant alternative options; the rationale for choosing the	G	Board and Committee papers and minutes			

	preferred option; and a clear outline of the process undertaken to arrive at the preferred option, including the degree of scrutiny that the paper has been through.					
GP6	The Board is routinely provided with data quality updates. These updates include external assurance reports that data quality is being upheld in practice and are underpinned by a programme of clinical and/or internal audit to test the controls that are in place.	G	Board and Committee papers and minutes Internal Audit Reports			
GP7	The Board can provide examples of where it has explored the underlying data quality of performance measures that have been RAG rated green.	G	Board and Committee papers and minutes Internal and External Audit Reports			
GP8	The Board has defined the information it requires to enable effective oversight and control of the	G	Board and Committee papers and minutes Assurance Framework	Continued liaison with NEDs to determine the level of information they require		

	organisation, and the standards to which that information should be collected and quality assured.					
GP9	Board members can demonstrate that they understand the information presented to them, including how that information was collected and quality assured, and any limitations that this may impose.	G	Board and Committee papers and minutes			
GP10	Any documentation being presented complies with Departmental guidance, where appropriate e.g. business cases, implementation plans.	G	Board and Committee papers and minutes			

3.4

Ref	Prompt	NIAS Assessment	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	Board members do not have the opportunity to read papers e.g. reports are regularly tabled on the day of the Board meeting and members do not have the opportunity to review or read prior to the meeting. The volume of papers is impractical for proper reviewing.	G		
RF2	Board discussions are focused on understanding the Board papers as opposed to making decisions.	G		
RF3	The Board does not routinely receive assurances in relation to data	G		

	quality or where reports are received, they have highlighted material concerns in the quality of data reporting.			
RF4	Information presented to the Board lacks clarity, or relevance; is inaccurate or untimely; or is presented without a clear purpose, e.g. is it for noting, discussion or decision?	G		
RF5	The Board does not discuss or challenge the quality of the information presented or, scrutiny and challenge is only applied to certain types of information of which the Board have knowledge and/or experience, e.g. financial information	G		

3. Board insight and foresight

3.5 Assurance and risk management

Ref	Prompt	NIAS Assessment	Evidence of compliance with good practice (Please reference supporting documentation below)	Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or areas where additional assurance is required.
GP1	The Board has developed and implemented a process for identification, assessment and management of the risks facing the ALB. This should include a description of the level of risk that the Board expects to be managed at each level of the ALB and also procedures for escalating risks to the Board.	G	Board and Committee papers and minutes Risk Strategy Corporate Risk Register Internal and External Audit Reports			
GP2	The Board has identified the assurance information they require, including assurance on the	G	Board and Committee papers and minutes Internal and External Audit Reports			

	management of key risks, and how this information will be quality assured.					
GP3	The Board has identified and makes use of the full range of available sources of assurance, e.g. Internal/External Audit, RQIA, etc	G	Board and Committee papers and minutes Internal and External Audit Reports			
GP4	The Board has a process for regularly reviewing the governance arrangements and practices against established Departmental or other standards e.g. the Good Governance Standard for Public Services.	G	Self-assessment process for Trust Board and Committees .			
GP5	The Board has developed and implemented a Clinical and Social Care Risk assessment and management policy across the ALB, where appropriate.	G	Risk Strategy Internal and External Audit Reports			
GP6	An executive member of the Board has been	G	Job Description			

	delegated responsibility for all actions relating to professional regulation and revalidation of all applicable staff.					

3.5

Ref	Prompt	NIAS Assessment	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	The Board does not receive assurance on the management of risks facing the ALB.	G		
RF2	The Board has not identified its assurance requirements, or receives assurance from a limited number of sources.	G		
RF3	Assurance provided to the Board is not balanced across the portfolio of risk, with a predominant focus on financial risk or areas that have historically been problematic.	G		
RF4	The Board has not reviewed the ALB's	G		

	governance arrangements within the last two years.			

4. Board engagement and involvement

4.1 External stakeholders

Ref	Prompt	NIAS Assessment	Evidence of compliance with good practice (Please reference supporting documentation below)	Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or areas where additional assurance is required.
GP1	The Board has an approved PPI consultation scheme which formally outlines and embeds their commitment to the involvement of service users and their carers in the planning and delivery of services.	G	Board and Committee papers and minutes			
GP2	A variety of methods are used by the ALB to enable the Board and senior management to listen to the views of service users, commissioners and the wider public, including 'hard to reach' groups like non-English	G	Board and Committee papers and minutes PPI Strategy Care Opinion feedback			

	speakers and service users with a learning disability. The Board has ensured that various processes are in place to effectively and efficiently respond to these views and can provide evidence of these processes operating in practice.					
GP3	The Board can evidence how key external stakeholders (e.g. service users, commissioners and MLAs) have been engaged in the development of their business plans for the ALB and provide examples of where their views have been included and not included in the Business Plan.	G	PPI Strategy		While this has proved difficult in the context of Covid-19, the Trust has undertaken a number of online engagement sessions with stakeholders.	
GP4	The Board has ensured that various communication methods have been deployed to ensure that key external stakeholders understand the key	G	PPI Strategy Board and Committee papers and minutes			

	messages within the Business Plan.					
GP5	The Board promotes the reporting and management of, and implementing the learning from, adverse incidents/near misses occurring within the context of the services that they provide	G	Board and Committee papers and minutes Public-facing accountability			
GP6	The ALB has constructive and effective relationships with its key stakeholders	G	Board and Committee papers and minutes Annual Report Public-facing accountability			

4.1

Ref	Prompt	NIAS Assessment	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	The development of the Business Plan has only involved the Board and a limited number of ALB staff.	G		
RF2	The ALB has poor relationships with external stakeholders, with examples including clients, client organisations etc.	G		Unclear exactly what this is asking but we have rated it as green as we consider ourselves to have good relationships with external stakeholders.
RF3	Feedback from clients is negative e.g. complaints, surveys and findings from	G		The Trust continues to receive more compliments than complaints. SMT review these, as well as summaries from Care Opinion, at the weekly SMT meetings. Complaints/Care Opinion summaries are also regularly considered and discussed at the Trust's Safety Committee.

	regulatory and review reports.			
RF4	The ALB has received adverse negative publicity in relation to the services it provides in the last 12 months.	G		
RF5	The Board has not overseen a system for receiving, acting on and reporting outcomes of complaints.	G		The Trust has continued to respond to and investigate complaints during the Covid-19 pandemic as well as identifying any learning. Concerted efforts have been made to address the complaints backlog and a number of pilots are currently underway with a view to accelerating complaint investigations.

4. Board engagement and involvement

4.2 Internal stakeholders

Ref	Prompt	NIAS Assessment	Evidence of compliance with good practice (Please reference supporting documentation below)	Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or areas where additional assurance is required.
GP1	A variety of methods are used by the ALB to enable the Board and senior management to listen to the views of staff, including 'hard to reach' groups like night staff and weekend workers. The Board has ensured that various processes are in place to effectively and efficiently respond to these views and can provide evidence of these processes operating in practice.	G	Staff meetings via Zoom Use of staff WhatsApp group/social media Staff attendance at Board/ Committee meetings Leadership walkabouts Station visits Board and Committee papers and minutes		Leadership walkabouts/station visits have proved difficult in the context of Covid-19. However these have recommenced and will increase over the coming months.	
GP2	The Board can evidence how staff have been engaged in the development of their Corporate &	G	Staff engagement meetings in development of Strategy To Transform 2020-26 NIAS TDP			

	Business Plans and provide examples of where their views have been included and not included.					
GP3	The Board ensures that staff understand the ALB's key priorities and how they contribute as individual staff members to delivering these priorities.	G	Strategy to Transform 2020-2026 NIAS Corporate Plan 2020-21 Annual Report Board and Committee papers and minutes	Work ongoing around staff appraisal		
GP4	The ALB uses various ways to celebrate services that have an excellent reputation and acknowledge staff who have made an outstanding contribution to service delivery and the running of the ALB.	G	Long Service Medal Ceremony Queens Ambulance Medal Compliments Staff recognition awards/ ceremony	Trust held virtual staff recognition award ceremony on 1 April 2022.		
GP5	The Board has communicated a clear set of values/behaviours and set out how staff that do not behave consistent with these values will be managed. Examples can be provided of how management have	G	Annual Report Disciplinary Procedures Grievance Procedures Board and Committee papers and minutes Review of arrangements governing crew work schedules (Working Time Directive etc).			

	responded to staff that have not behaved consistent with the ALB's stated values/behaviours.					
GP6	There are processes in place to ensure that staff are informed about major risks that might impact on customers, staff and the ALB's reputation and understand their personal responsibilities in relation to minimising and managing these key risks.	G	Board and Committee papers and minutes Clinical/Non-Clinical Memos & Updates Emergency Planning Engagement Untoward Incident Reports Serious Adverse Incident Reports			

4.2

Ref	Prompt	NIAS Assessment	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	The ALBs latest staff survey results are poor.	A	'Healthy People, Healthy Place' NIAS Health and Wellbeing Strategy, with associated implementation plan will be presented to Trust Board in August 2022. Trust Board due to consider Culture Programme at its meeting in December 2022. Work ongoing to embed new approach to culture within organisation.	
RF2	There are unresolved staff issues that are significant (e.g. the Board or individual Board members have received 'votes of no confidence', the ALB does not have productive relationships with trade unions etc.).	G		

RF3	There are significant unresolved quality issues.	G		
RF4	There is a high turnover of staff.	G		
RF5	Best practice is not shared within the ALB.	G		

4. Board engagement and involvement

4.3 Board profile and visibility

Ref	Prompt	NIAS Assessment	Evidence of compliance with good practice (Please reference supporting documentation below)	Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or areas where additional assurance is required.
GP1	There is a structured programme of events/meetings that enable NEDs to engage with staff (e.g. quality/leadership walks; staff awards, drop in sessions) that is well attended by Board members and has led to improvements being made.	G	Long Service Medal Ceremony Station Visits	The opportunity for NEDs to undertake station visits and ride-alongs with staff, for example, have been curtailed in the context of Covid-19. However these have recommenced and will increase in future months. Leadership walkabouts by the Executive Team were paused in the context of Covid-19. However there will be a focus on recommencing these in the coming months.		
GP2	There is a structured programme of	G	Chair diary			

	meetings and events that increase the profile of key Board members, in particular, the Chair and the CE, amongst external stakeholders.		CX diary	While such events have been impacted by Covid-19, participation in a number of meetings/events has been facilitated via Zoom		
GP3	Board members attend and/or present at high profile events.	G	Chair diary CX diary Corporate Diary	While such events have been impacted by Covid-19, participation in some meetings/events has been facilitated via Zoom		
GP4	NEDs routinely meet stakeholders and service users.	R			The opportunity to do so has been severely impacted by Covid-19. The Chair has endeavoured to do so where possible. However as all our Board meetings were virtual in 2021-22, this proved more difficult for NEDs.	
GP5	The Board ensures that its decision-making is transparent. There are processes in place that enable stakeholders to easily find out how and why key decisions have	G	Board and Committee papers and minutes are made available to the public online			

	been made by the Board without reverting to freedom of information requests.					
GP6	As a result of the Board member appraisal and personal development process, Board members can evidence improvements that they have made in the quality of their contributions at Board-level.	G	Board and Committee papers and minutes NED Appraisal Workshops, particularly in relation to the structures of the Board and its Committees and the development of Committee Chair meetings with the Trust Board Chair		On-going development	See 2.4 GP6

4.3

Ref	Prompt	NIAS Assessment	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	With the exception of Board meetings held in public, there are no formal processes in place to raise the profile and visibility of the Board.	G	Frequent press releases Increased social media activity	Under constant review
RF2	Attendance by Board members is poor at events/meetings that enable the Board to engage with staff (e.g. quality/leadership walks; staff	G		

	awards, drop in sessions).			

5. Board Governance Self- Assessment Submission

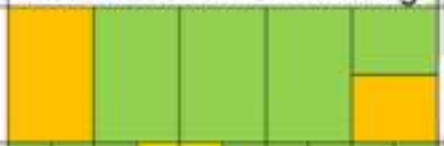
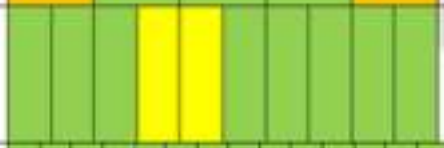
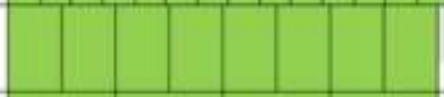
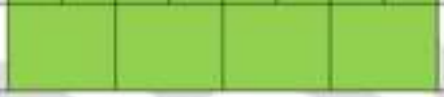
Name of ALB NI Ambulance Service Trust

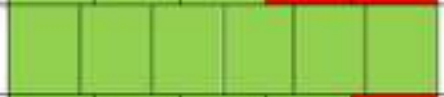
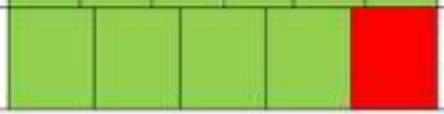
Date of Board Meeting at which Submission was discussed

Approved by

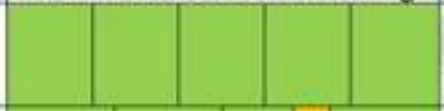
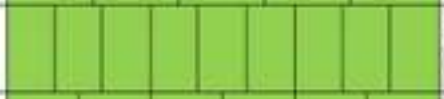
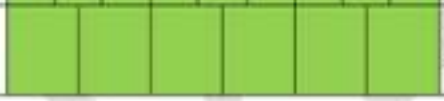
(ALB Chair)
(electronically signed due to Covid-19)

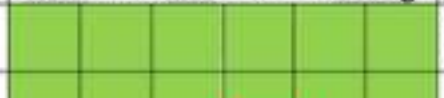
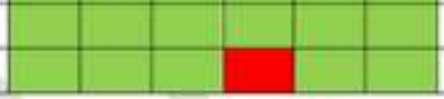
5. Summary Results

1.Board composition and commitment		
Area	Self Assessment Rating	Additional Notes
1.1 Board positions and size		Trust currently has one NED vacancy and two imminent vacancies in May 2023. NED recruitment exercise has not yet commenced (as at Dec 2022).
1.2 Balance and calibre of Board members		Discussions are ongoing with the DoH Sponsor Branch and PAU re the appointment of a NED with a knowledge and understanding of clinical matters to ensure there is informed independent scrutiny of NIAS clinical matters.
1.3 Role of the Board		
1.4 Committees of the Board		
1.5 Board member commitment		

2.Board evaluation, development and learning		
Area	Self Assessment Rating	Additional Notes
2.1 Effective Board level evaluation		Board needs to consider how best to secure input from external stakeholders will be secured.
2.2 Whole Board development programme		
2.3 Board induction, succession and contingency planning		Further work required around succession planning. Discussions will continue with the DoH PAU to ensure the requirements of Board positions are kept current.

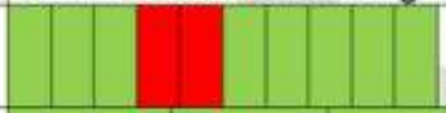
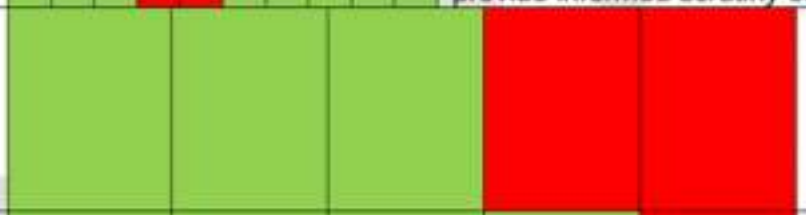
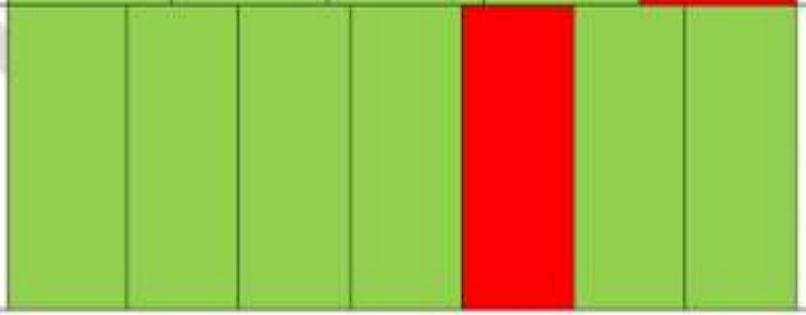
2.4 Board member appraisal and personal development		Consideration to be given to NED Personal Development Plans which are directly relevant to the successful delivery of their Board role.

3.Board insight and foresight		
Area	Self Assessment Rating	Additional Notes
3.1 Board performance reporting		Work being finalised around the provision of an Integrated Quality & Performance Report for the Board. Balanced scorecards are presented regularly at PFOD Cttee
3.2 Efficiency and Productivity		Trust Board is considering how best the risks to non-achievement can be articulated and monitored.
3.3 Environmental and strategic focus		Trust has implemented the digitisation of Board papers over the last year
3.4 Quality of Board papers and timeliness of information		Efforts are continuing to ensure Board papers are concise and issued on a timely basis.
3.5 Assurance and risk management		BGSAT completed on an annual basis and any remedial actions identified.

4. Board engagement and involvement		
Area	Self Assessment Rating	Additional Notes
4.1 External stakeholders		Has proved difficult in context of Covid-19. Use of Care Opinion feedback
4.2 Internal stakeholders		
4.3 Board profile and visibility		NEDs unable to meet stakeholders/SUs due to Covid-19.

TRAINING AND/OR ASSURANCE REQUIRED

Areas where additional training/guidance assurance is required		
Area	Self Assessment Rating	Additional Notes

Areas where additional assurance is required		
Area	Self Assessment Rating	Additional Notes
1.2 Balance and calibre of Board members		The Chair is currently in discussion with the Sponsorship Branch re appointing a NED with a clinical background to provide informed scrutiny of clinical matters.
2.1 Effective Board level evaluation		The Board needs to consider how input from external stakeholders will be secured but this is under active consideration by the Chair in conjunction with the Board Secretary.
2.3 Board induction, succession and contingency planning		The Chair will be continuing discussions with the DoH PAU to ensure the requirements of Board positions are kept alive
2.4 Board member appraisal and personal development		No PDP element addressing role as Board member within appraisal template. The Chair will raise this with PAU. However information on potential training courses has been shared with NEDs. The Chair has raised this with individuals NEDs at their appraisal.

6. Board impact case studies

6. Board impact case studies

Overview

This section focuses on the impact that the Board is having on the ALB and considers a recent case study in one of the following areas:

1. Performance failure in the area of quality, resources (Finance, HR, Estates) or Service Delivery;
2. Organisational culture change; and
3. Organisational strategy.

6. Board impact case studies

6.1 Measuring the impact of the Board using a case study approach

This section focuses on the impact that the Board is having on the ALB, it's clients, including other organisations, patients, carers and the public. The Board is required to submit one of three brief case studies:

1. A recent case study briefly outlining how the Board has responded to a performance failure in the area of quality, resources (Finance, HR, Estates) or service delivery. In putting together the case study, the Board should describe:
    - Whether or not the issue was brought to the Board's attention in a timely manner;
    - The Board's understanding of the issue and how it came to that understanding;
    - The challenge/ scrutiny process around plans to resolve the issue;
    - The learning and improvements made to the Board's governance arrangements as a direct result of the issue, in particular how the Board is assured that the failure will not re-occur.

2. A recent case study on the Board's role in bringing about a change of culture within the ALB. This case study should clearly identify:
    - The area of focus (e.g. increasing the culture of incident reporting; encouraging innovation; raising quality standards);
    - The reasons why the Board wanted to focus on this area;
    - How the Board was assured that the plan(s) to bring about a change of culture in this area were robust and realistic;
    - Assurances received by the Board that the plan(s) were implemented and delivered the desired change in culture.

3. A recent case study that describes how the Board has positively shaped the vision and strategy of the ALB. This should include how the NEDs were involved in particular in shaping the strategy.

Note: Recent refers to any appropriate case study that has occurred within the past 18 months.

6. Board impact case studies ALB

Name....NIAS..... Date .....Jan 2023.....

Brief description of area of focus	**Patient Care Services (PCS)**
Outline reasons / rationale for why the Board wanted to focus on this area	Trust's Chief Executive asked Internal Audit to look at Patient Care Services as it had been recognised that PCS were not operating effectively or efficiently.
Outline how the Board was assured that the plan/ (s) in place were robust and realistic	➢ PCS Project Board reporting line to the Trust's Strategic Implementation Group (SIG), and ultimately SMT, Safety Committee & Board in place; ➢ Balanced scorecard & PCS specific KPIs approved. All work being taken forward is broken down into "sprints". Current sprint is finalising distribution and access list for performance monitoring purposes; ➢ Intention is for highlight report to be included in Trust Board Performance Report (presented at each Board meeting) under Operational Performance section from 31/12/22; ➢ Compliance against valid timestamps is a PCS KPI and will be monitored across PCS & Independent Ambulance Service (IAS) on a monthly basis, and included as agenda item at quarterly meetings with IAS; ➢ Stocktake of available and required MDTs to be completed November 2022. Roll out expected to be completed in line with expected completion of PCS Improvement Project ➢ "Perfect Day – Planning & scheduling live testing" to take place in the autumn. New planning procedures for NEAC to maximise efficiency and improve productivity. Results very encouraging. Will be considered by SIG & SMT for roll out – action plan under development and will be shared with SMT in December for approval with a view of commencing implementation by late Jan/early Feb 2023; ➢ Web based booking system functionality purchased with plan to install this in December 2022 and testing to commence Jan 2023. This will support the adoption of web based booking as the preferred option for outpatients & scheduled appointments in PCS;

	VCS ➢ VCS & Taxi Task & Finish Group established – this is a subgroup of the PCS Improvement Group exploring proposals to maintain and consider increasing use of VCS under appropriate arrangements; ➢ Plans in place for the group to meet with VCS colleagues in dedicated short forum workshops to discuss issues under three main themes that will shape the service moving forward : - Reasonable volunteering expenses - PPE & Equipment - Training, Governance & Support
Outline the assurances received by the Board that the plan/(s) were implemented and delivered the desired changes in culture	Various challenges faced during pandemic. However, momentum has now been restored. Safety Cttee and Trust Board receive regular updates in relation to the progress of this work.
Specifically explain how the NEDs were involved	While there has been no direct NED involvement in this work, NEDs have received updates at Committee and Board meetings and have fed into progress.

END OF DOCUMENT

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

PRESENTATION OF PAPER

Date of Trust Board:	9 February 2023
Title of paper:	Trust Performance Report - January 2023
Brief summary:	This paper is presented to Trust Board for noting This paper outlines the Trust performance across key metrics up to and including 31st December 2023
Recommendation:	**For Approval** ☐ **For Noting** ☒
Previous forum:	SMT – 24 January 2023
Prepared and presented by: **Date:**	Neil Walker, Head of Performance Maxine Paterson, Director PPCS 2 February 2023

TRUST PERFORMANCE REPORT

NORTHERN IRELAND AMBULANCE SERVICE

January 2023

for December 2022 Data and Performance

NIAS Changes To Operational Actions To Support Pressures

Resource Escalation Action Plan (REAP)

- At the time of writing of this report, the Trust is in REAP 3 Major Pressure. We have received notification of industrial action received by the Trust on xx January 2023. In response, the Trust stood up its command and control structures to plan, manage and recover from the industrial action short of strike between 16 January and 29 January 2023.

Clinical Safety Plan (CSP)

- In keeping with National Ambulance Trusts, NIAS has developed a Clinical Safety Plan (CSP) to operationally support the REAP taken forward by a dedicated Task & Finish Group on behalf of the organisation
- The simple and dynamic plan will be used in situations of excessive call volume or reduction in staff numbers enabling NIAS to respond in a timely and appropriate manner to increased service pressure, enabling a NIAS-wide response as soon as identified triggers are met.
- Implementation of the plan has required the re-profiling of existing resources with input from senior management and clinical support at times of escalating pressure.
- The effectiveness of the procedure is monitored by the EAC Senior Leadership Team specifically reviewing any serious incident reports and complaints related to the implementation of the plan.

Current Pressures – Volume of 999 Calls Answered

- **December 22** has seen a sharp increase in demand compared to December 21. YTD demand in down 4% from fin year 2021-22 to fin year 2022-23. However, in the same time period YTD, **incidents** have **decreased** by 6% from fin year 2021-22 to fin year 2022-23
- **Demand** experienced by **NIAS in December 2022** was the highest experienced during the past three years. On average **730 calls per day** were made to NIAS
- **Call answer performance** dipped below the **90%** target for the month. **December 2022** saw call answer performance achieve **84.5%**
- **December 2022** has seen an unprecedented number of duplicate calls 9,173. This is again the largest volume of duplicate calls the Trust has ever received in a month.

Northern Ireland Ambulance Service
Health and Social Care Trust

Current Pressures – Impact on Response Time Performance Category 1

- Category 1 Mean and 90th percentile outturn positions demonstrate similar performance to Trusts within England with the shape of the lines within the charts closely correlated
- Meeting the targets for Mean and 90th percentile remains a challenge for NIAS as it does for Trusts within England

Demand: C1 Response Times (Measures A25 & A26)

Mean Category 1	National	NIAS
Dec 21 (mins)	09:14	11:59
Dec 22 (mins)	10:57	12:23
21/22 Change (+/-)	+01:43 mm:ss	+00:24 mm:ss
Deviation from Target (Dec 22)		+04:23 mm:ss

- Category 1 Mean Response time has increased by 24secs from Dec 21
- Our deviation from target however persists at >4mins for Dec 22

90th Centile Category 1	National	NIAS
Dec 21 (mins)	16:14	23:43
Dec 22 (mins)	19:25	24:31
21/22 Change (+/-)	+03:11 mm:ss	+00:48 mm:ss
Deviation from Target (Nov 22)		+09:31 mm:ss

- Category 1 90th Centile Response time has increased by 48 seconds from Dec 21
- Our deviation from target however persists at >9mins for Dec 22

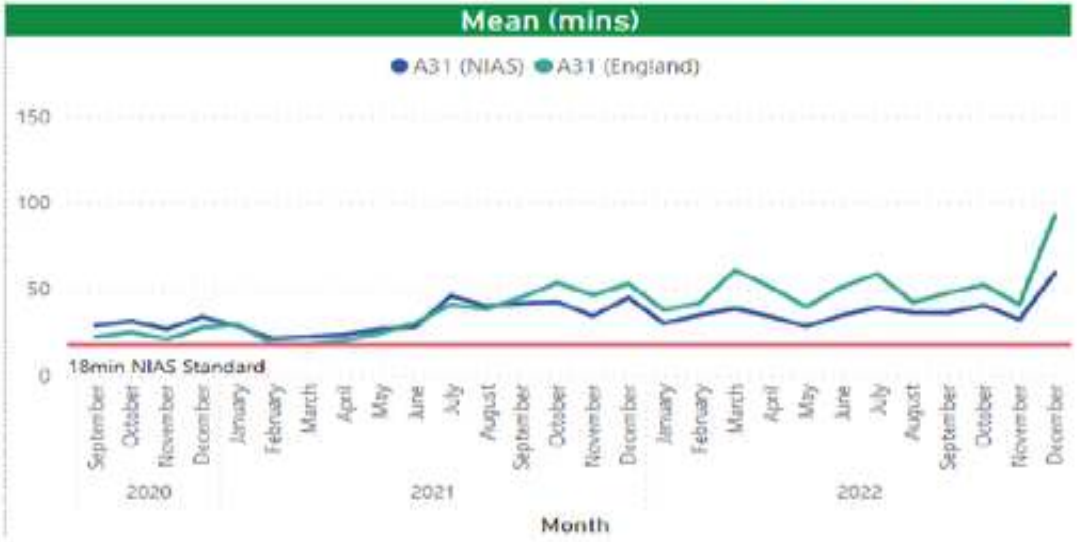
*** Note clock starts for NIAS Cat 1 and England Cat 1 target calls are different**

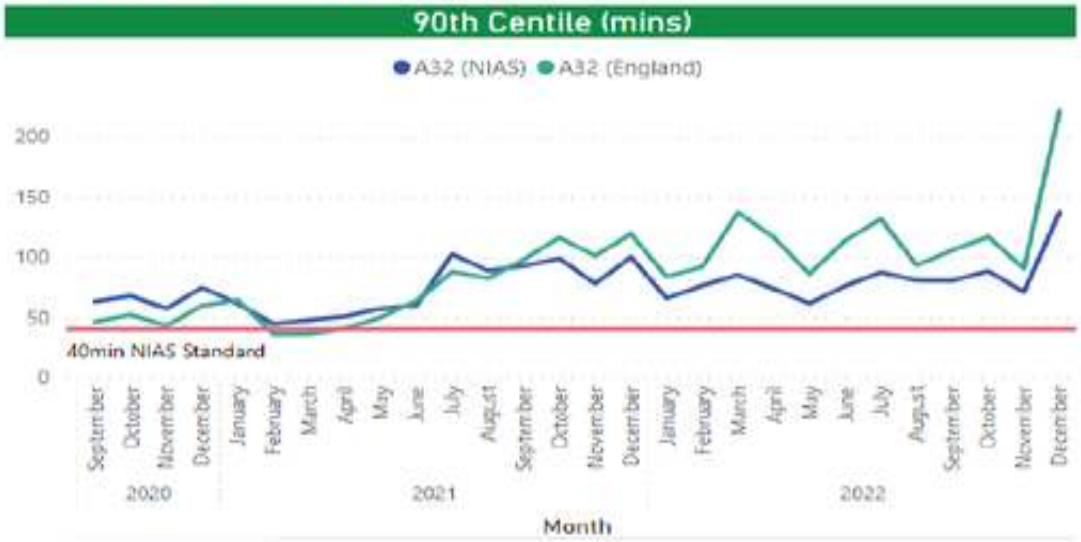
Northern Ireland Ambulance Service
Health and Social Care Trust

Current Pressures – Impact on Response Time Performance Category 2

- Category 2 Mean and 90th percentile have seen a similar increase across the English Trusts to what has been experienced within NIAS
- NIAS performance has continued to improve since July 21, however it continues to be a significant challenge to achieve either Mean or 90th Centile targets.

Demand: C2 Response Times (Measures A31 & A32)





Mean Category 2	National	NIAS
Dec 21 (mins)	53:22	45:14
Dec 22 (mins)	01:32:54	59:37
21/22 Change (+/-)	+39:32 mm:ss	+14:23 mm:ss
Deviation from Target (Dec 22)		+41:37 mm:ss

- Category 2 Mean Response time has increased by over 14mins from Dec 21.
- Our deviation from target was >41 mins for Dec 22

90th Centile Category 2	National	NIAS
Dec 21 (mins)	01:59:14	01:40:08
Dec 22 (mins)	03:41:48	02:17:17
21/22 Change (+/-)	+:01:42:34 mm:ss	+37:09 mm:ss
Deviation from Target (Dec 22)		+01:37:17 mm:ss

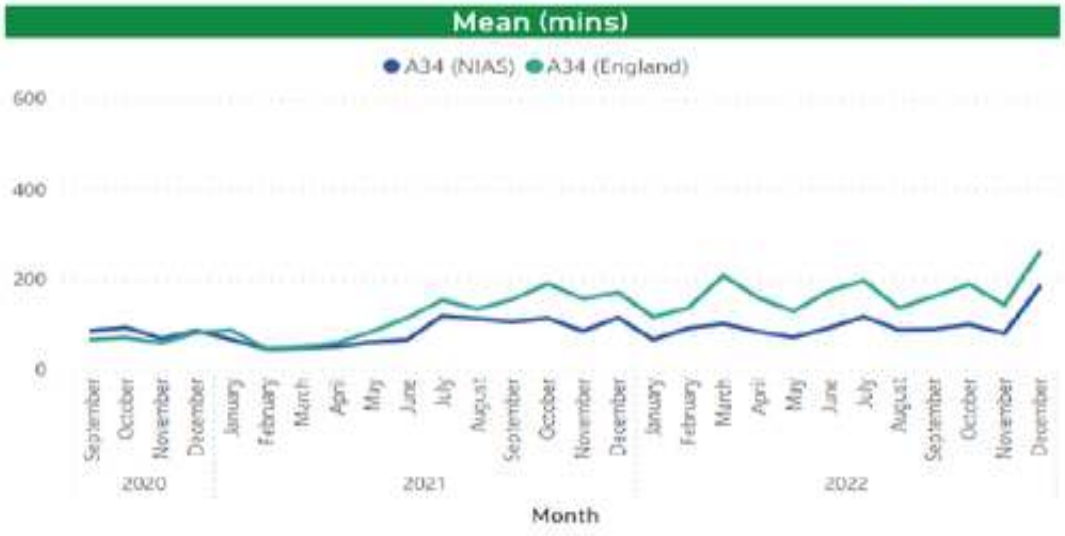
- Category 2 90th Centile Response time has increased by over 37mins from Dec 21.
- Our deviation from target was significant at over 1hr 37mins for Dec 22

Northern Ireland Ambulance Service
Health and Social Care Trust

Current Pressures – Impact on Response Time Performance Category 3

- Category 3 Mean and 90th percentiles within NIAS have very similar profiles to the English Trusts.
- The 90th percentile target continues to be a challenge for NIAS and the English Trusts

Demand: C3 Response Times (Measures A34 & A35)



Mean Category 3	National	NIAS
Dec 21 (mins)	02:51:03	01:55:04
Dec 22 (mins)	04:19:10	03:02:57
21/22 Change (+/-)	+01:28:07 mm:ss	+:01:07:53mm:ss
Deviation from Target (Dec 22)		

- Category 3 Mean Response time has increased by over 1hr from Dec 21
- This is a significantly better position than the English Trusts that are experiencing mean performance for Dec 22 of 4 hours 19 mins.

90th Centile Category 3	National	NIAS
Dec 21 (mins)	07:11:36	04:59:32
Dec 22 (mins)	11:05:56	08:35:41
21/22 Change (+/-)	+03:54:20 mm:ss	+:03:36:09 mm:ss
Deviation from Target (Dec 22)		+06:35:41 hh:mm:ss

- Category 3 90th Centile response time has increased by over 3hrs 36mins from Dec 21
- Our deviation from target remains a significant challenge at over 6hr 35 mins for Dec 22

Northern Ireland Ambulance Service
Health and Social Care Trust

Current Pressures – Handover Times Acute Hospitals

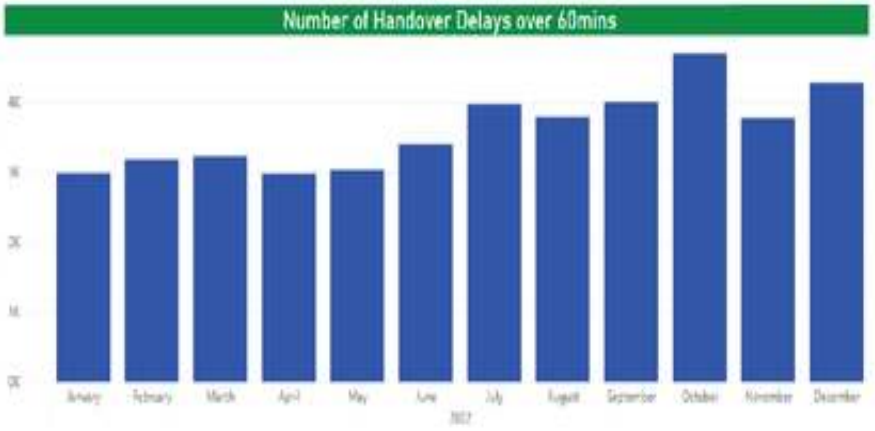
HANDOVER TIMES

The handover time standard of 15 minutes from arrival at an ED.

In December 2022, NIAS experienced a total of 13,675 lost hours. This is the equivalent of 37 shifts per day, with crews waiting with patients outside EDs, 32% of our planned capacity. These lost hours were experienced from 10,281 instances where our crews waited longer than 15mins to handover their patient at ED. 4,286 of these instances were over 60mins in length.

In October 2022, 73% of the 13,675 lost hours occurred at the four ED sites listed below in order of volume of hours lost:

Ulster Hospital
Antrim Area Hospital
Craigavon Hospital
Royal Victoria



Number of Handover Delays over 15mins

Hospital Attended	Total Attendances	Total Handovers	Total Handovers Over 15mins	% Over 15mins	Total Time Lost (Hours)
ULSTER HOSPITAL	19430	19429	18084	93.07%	26,691.80
ROYAL VICTORIA	27834	27833	25144	90.34%	24,709.20
ANTRIM AREA HOSPITAL	21505	21503	19663	92.36%	21,359.80
CRAIGAVON AREA HOSPITAL	18201	18201	16797	92.29%	19,504.89
CAUSEWAY HOSPITAL	7829	7829	7014	89.59%	9,762.51
ALTNAGELVIN HOSPITAL	15266	15265	13115	85.91%	9,058.72
DAISYHILL NEWRY	7406	7406	6857	92.59%	6,095.31
MATER INFIRMORUM	8062	8062	7245	89.87%	5,755.59
SOUTH WEST ACUTE HOSPITAL	8542	8542	6749	79.01%	3,903.85
R/BELF FOR SICK CHILDREN	1983	1983	1289	65.00%	793.51
Total	**136058**	**136054**	**122157**	**89.78%**	**127,575.19**

Number of Handover Delays over 60mins

Hospital Attended	Total Attendances	Total Handovers	Total Handovers Over 60mins	% Over 60mins	Total Time Lost (Hours)
ULSTER HOSPITAL	19430	19429	8252	42.47%	17,140.77
ROYAL VICTORIA	27834	27833	9996	35.91%	11,800.83
ANTRIM AREA HOSPITAL	21505	21503	7426	34.53%	11,667.50
CRAIGAVON AREA HOSPITAL	18201	18201	6470	35.55%	11,100.68
CAUSEWAY HOSPITAL	7829	7829	3483	44.57%	5,923.66
ALTNAGELVIN HOSPITAL	15266	15266	2390	15.66%	4,027.38
DAISYHILL NEWRY	7406	7406	2021	27.29%	2,933.10
MATER INFIRMORUM	8062	8062	2012	24.96%	2,557.23
SOUTH WEST ACUTE HOSPITAL	8542	8542	947	11.09%	1,384.11
R/BELF FOR SICK CHILDREN	1983	1983	106	5.35%	453.88
Total	**136058**	**136054**	**43103**	**31.68%**	**69,189.13**

In the last 12 months (January 2022– December 22), 90% of the handovers exceeded the 15min target at our acute EDs, resulting in circa 127k hours lost. The lost hours experienced in December 2022 is a 23% increase from November 22, whilst the number of instances of delay handovers decreased by 3% in the same period. Therefore, December seen a significant increase in the length of delay experienced as evidenced by the increase in >60min delays

The 13,675 operational hours being lost (eq. to 1,139 12-hours shifts per month or 37 12h shifts per day). The number of handover delays in excess of 60mins has increased in December 22 to 4,286 occurrences during the 31 days of December resulting in 138, 60-minute delays per day during the month.

Actions Taken To Address Current Pressures & Support Staff

A range of activities are ongoing across Directorates involving a number of leads to assist in addressing performance pressures and identifying service improvement initiatives including:

- Stabilisation of the Operational management structure is a key priority for delivery in the coming weeks;
- Work is ongoing to safely deploy the derogation list for Category 2 calls across both day and night shifts. The derogation list are group of Category 2 calls that have been identified, from a clinical perspective, as being able to be held for a length of time to prioritise crews being released at the end of shift;
- Improving CSD cover and resilience is a key priority to deliver the most appropriate care to patients in the most appropriate setting;
- Alternative shift patterns continue to be worked on to bolster cover further into the evening. These alternative shifts are being targeted across the greater Belfast area;
- Additional HALOs supported across three of the larger EDs with improved hours of operation & covering of rota gaps provided by Station Officers/Supervisors;
- Additional staff welfare support at EDs with ongoing provision of staff refreshments at welfare points at EDs;
- Improved utilisation of our data to provide enhanced planning tools across operations and to remove admin processes that take away operational hours for our station officers;
- Continued discussion between HSCB/NIAS colleagues to progress with dedicated ambulance handover areas and discussions regarding alternatives to ED conveyance (including direct access to Urgent Care Centres/Phone First etc);
- A renewed focus on Patient Care Pathways to maximise opportunities, signpost patients appropriately, and contribute to reducing conveyance rates;
- PCS crews continue to support our A&E crews on a daily basis and we are working to increase the capacity the PCS crews can provide;
- Priority areas identified to direct all available resources to when the organisation is in periods of sustained pressure. Resourcing these areas as a priority will maximise the organisations ability to respond during times of sustained pressure;
- The Operations Improvement Steering Group continue to drive forward key initiatives outlined above across Operations and other Directorates.

Northern Ireland Ambulance Service
Health and Social Care Trust

Current Pressures - Staffing

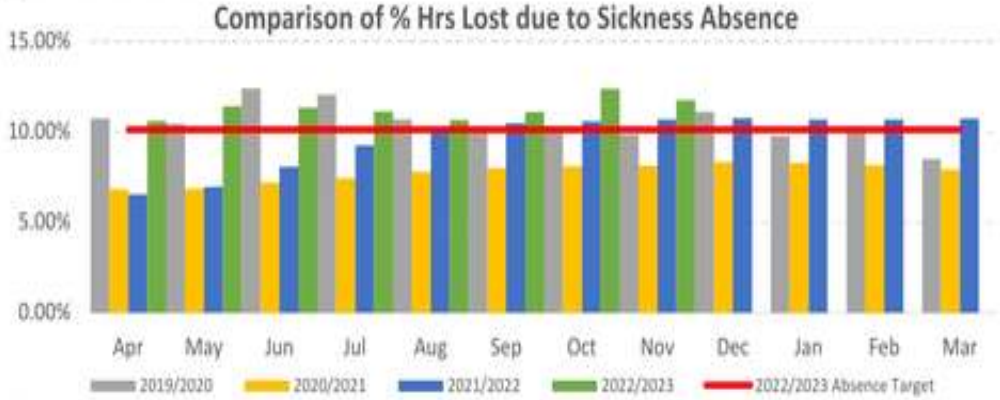
STAFF ABSTRACTIONS

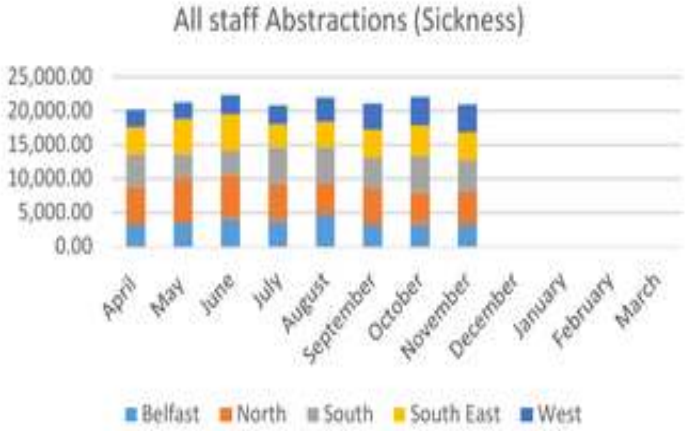
Figures demonstrate that cumulative sickness absence levels between 2022/2023 are higher than figures in the same period in 2021/2022. This can be partially attributed to the re-categorisation of Covid-19 absence to sickness absence wef 1 October 2022.

Despite improved absence management and wellbeing initiatives, attendance remain as a high level concern. This is not expected to reduce imminently as we are aware that December presented with an increase in illnesses in the community, increasing Covid and public health advice to stay at home if experiencing a respiratory condition. While there is no scientific evidence to prove a correlation, it is our view that these matters are interdependent, coupled with the clear message in HSC that the system is under extreme pressure. Despite focus on attendance management, it is only part of the context, and more employees are feeling the impact of significant services pressure and the inevitable impact on the health of a proportion of them. This may mask the current increased focus and any impact that it has on attendance as the context is worsening.

Figures reported are for all staff (excluded Bank Staff and Non-Executive Directors) and demonstrate hours lost, with average days lost based on a standard 7.5 hour day, consistent with Regional HSC Reporting of Sickness Absence. HRPTS figures are correct at time of reporting but may be subject to change.

2022/23 Monthly Sickness Absence including Comparators to Previous Reporting Year (2022/23)												
MONTH	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
ABSENCE TARGET (2022/23)	10.12% (Pending DOH confirmation- this is a 5% improvement on 2022 position)											
Cumulative % hrs lost (21/22)	6.56%	6.97%	8.09%	9.28%	10.08%	10.48%	10.59%	10.70%	10.78%	10.69%	10.69%	10.77%
Monthly % hrs lost (21/22)	6.56%	7.41%	10.34%	12.76%	13.19%	12.48%	11.28%	11.39%	11.45%	9.86%	10.69%	11.71%
Cumulative % hrs lost (22/23)	10.62%	11.00%	11.12%	11.13%	11.03%	11.04%	11.21%	11.27%				
Monthly % hrs lost (22/23)	10.62%	11.43%	11.34%	11.14%	10.68%	11.11%	12.40%	11.77%				
Monthly % hrs lost (S/T)	2.78%	2.03%	2.00%	1.95%	2.30%	2.71%	3.55%	2.40%				
Monthly % hrs lost (L/T)	9.74%	9.40%	9.34%	9.20%	10.29%	10.37%	8.85%	9.37%				
Monthly % hrs lost COVID 19 (Sickness and self-isolation)	4.31%	2.37%	3.48%	3.65%	1.47%	1%	1.76%	1.73%				
Av. days lost (7.5 hrs) per Employee per Mth	2.18	2.08	2.45	2.29	2.31	2.38	2.17	2.06				
Av.Estimated costs (£'000)	636	644	673	649	614	643	734	671				
Cumulative % Hrs Lost 2022/2023:	11.27%											





Northern Ireland Ambulance Service
Health and Social Care Trust

Service User Feedback & Serious Adverse Incidents

Serious Adverse Incidents

During December 2022, the Trust reviewed 10 potential SAIs resulting in notification of 4 SAIs. Currently we have 20 open SAIs - of which two are Level 2 and the remainder are Level 1.

Themes

The 3 key National Ambulance Risk and Safety Forum themes remain consistent as:

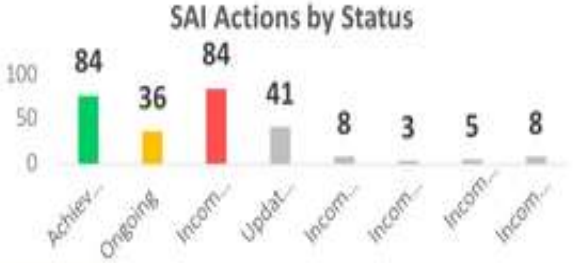
- Delays in call answering and dispatch
- Clinical Assessment and or treatment on scene
- Call handling and dispatch incidents

Training

Further bespoke training specific to NIAS procedures has been planned for 16 March 2023 & 22 March 2023.
An expression of interest has gone out to all staff who have completed the previous CLS training to participate in this bespoke training with positive feedback received.

Actions & Recommendations

The SAI team are still actively reviewing all outstanding actions and recommendations from SAIs dating back to 2018. This renewed focus has significantly improved the status of all outstanding recommendations. To date, 84 of the 204 outstanding actions have been evidenced and completed with work ongoing on a further 84.



Complaints, Compliments & Care Opinion

During Dec 22, **16 complaints** & **34 compliments** were received.

Themes

The 3 key themes remain consistent as: Delay in Accident & Emergency Response; Staff Attitude; and concern regarding treatment.

Timeliness of Process

16 complaints were closed in December 2022.

Timeliness of Closed Cases	Percentage
% of complaints closed within 20 day target	50%
% of complaints that took between 20 and 40 days to close	13%
% of complaints that took over 40+ days to close	37%
Timeliness of Open Cases	**No. of Days**
Average no. days cases(x35) open at 31 Dec 2022	80

Learning

Of the 16 complaints closed, 4 complaints resulted in learning including: staff call reflection exercise; private taxi firm performance (x2); and CSD patient capacity considerations.

Care Opinion

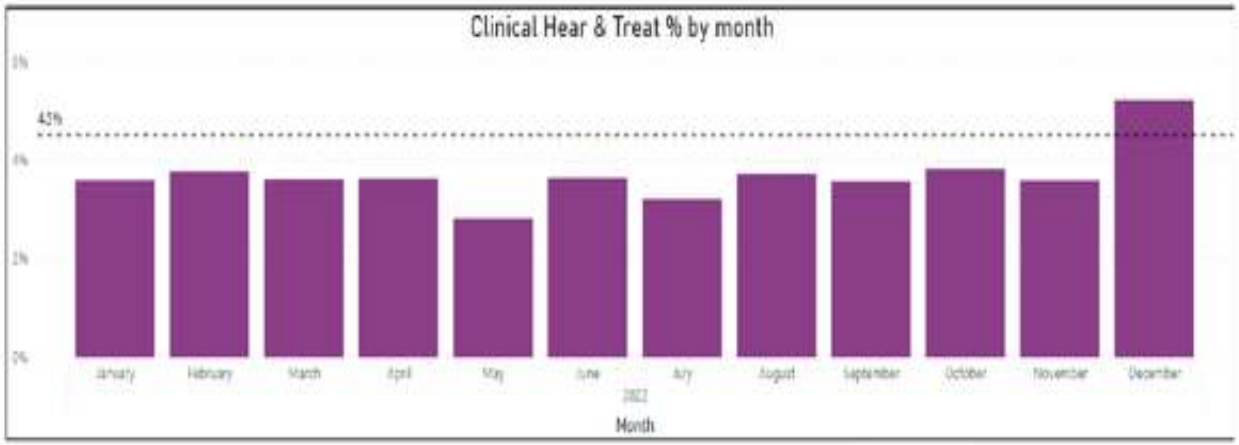
During December 2022, 11 **stories** were submitted via Care Opinion. By 3 January, these stories were viewed 421 times.
The main areas of feedback were:
What's good – Care, Paramedics, Comfortable
Improvements – Ambulance wait times
Feelings – Cared for, Comfortable, Reassured

10K More Voices

Launched 9 June 2022, seeking experiences of those who have engaged with NIAS as part of an urgent or emergency presentation.
As of 30 December, **125** completed surveys have been returned of which 100 (83%) were either strongly positive/ positive and **10 (8%)** were strongly negative (re response times).

Northern Ireland Ambulance Service
Health and Social Care Trust

Clinical Performance



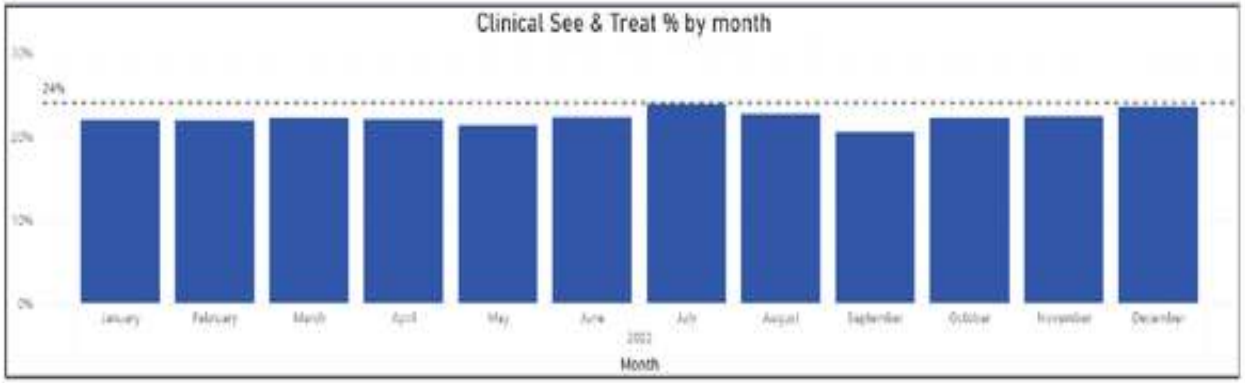
PROGRESS

We have developed a revised dashboard which will support an quality and improvement approach to Hear and Treat outcomes.

Clinical Support Desk recruitment has been challenging and recruitment is ongoing. The team at present has 15 of 21 posts filled.

Improvement trajectory is to increase Hear and Treat by 1% by 31 March 2022.

December's increase in volume is linked to increased call volume and ongoing analysis beyond this time period is required.



We have developed a revised See and Treat dashboard, which will allow for analysis of practice down to station level.

NIAS has developed a suite of care pathway and alternative destinations to provide a range of alternatives to the Emergency Department referral pathway.

Increasing see and treat use will require education and support of clinicians to support safe and effective changes in practice. A supportive education package is being developed.

Improvement trajectory to increase See and Treat by 1% by 31 March 2022.

SPPG 2022-23 NIAS Submissions

Strategic context and Background

- As the HSC strives to rebuild services in the wake of the pandemic, there is a need for a renewed focus on performance in order to be assured that HSC resources are being appropriately utilised/maximised and that activity levels return to at least pre-COVID-19 levels.
- The SPPG expects that this service area will return to pre-COVID-19 levels of service provision as a minimum as soon as possible, but before 31 March 2023
- NIAS are constrained in part by pressures at the hospital front door, but there is a need to reduce conveyance rates, moving towards rates in other parts of the UK. By increasing see and treat rates especially for Category 4 patients, this will ease pressure on NIAS and Emergency Departments
- There is also a need for NIAS to improve response times and to work with Trusts to improve ambulance handover processes and times, which will help release ambulances to attend to calls.
- The targets for improving response times and reducing handover delays have been set for March 2023 as they are in part outside the control of NIAS and will be dependent on the Trusts making the required improvements to Length of Stay and discharge.
- PPCS are coordinating input across the organisation into Unscheduled Care planning at a regional level. NIAS has a central role to play in delivering the necessary changes required in the delivery of an integrated unscheduled care system, and a range of NIAS staff are currently contributing to different sub-groups of USC planning across the region including patient safety, pathways and performance optimisation.
- The following two slides show the submission made by NIAS to SPPG for the month of September 22 and FY 2022/23 Quarter 2 across the five key performance areas for NIAS - Demand, response times, See and Treat rate, Hear and Treat rate and Handover delays.
- Trust Board will be kept informed of the performance submitted to SPPG through this Performance report in 2022-23, where possible, indicators are broken down to Divisional level.

Appendix A – SPPG November 22 Submission

Demand and Response Times

The Trust's second SPPG submission was made on 7 November 2022 for October 2022. Work is still ongoing with SPPG on monitoring of these indicators and inputs from other Trust colleagues.

The following slides outline the performance that was reported by the Trust across the following indicators

Demand – Call Answer Performance
Response Times – Category 1 & 2 (mean and 90th Percentile)
Pre-Hospital Care – See & Treat Rate
Handover Performance – within 15mins, 30mins and 60mins. Long waiters >3hrs

SPPG RAG Key:

RAG KEY	
Percentage Measures:	
Red	>5% from Target
Amber	0 and <=5% from Traget
Green	On or better than Target
Response Times:	
Red	> 5mins from Target
Amber	<= 5mins from Target
Green	On or better than Target

Performance Measure	Metric	Target	Trust	July 2022	August 2022	September 2022	QUARTER 2	October 2022	November 2022	December 2022	QUARTER 3
Demand	% of Calls Answered within 5 secs	90%	Region	83.8%	87.7%	93.8%	88.0%	91.5%	91.9%	84.5%	89.0%
Response times	Category 1 Mean	11 mins	Region	00:11:07	00:10:58	00:11:20	00:11:08	00:11:34	00:10:54	00:12:23	00:11:23
	Category 1 90th Percentile	21 mins	Region	00:21:40	00:22:10	00:22:10	00:22:00	00:22:58	00:19:53	00:24:31	00:22:38
	Category 2 Mean	22 mins	Region	00:39:11	00:36:46	00:38:28	00:37:56	00:46:43	00:32:39	00:49:17	00:44:59
	Category 2 90th Percentile	46 mins	Region	01:27:14	01:20:11	01:26:17	01:22:55	01:28:18	01:16:58	02:17:17	01:39:05
	Category 1 Mean	11 mins	Belfast	00:07:32	00:07:14	00:07:47	00:07:31	00:08:15	00:06:46	00:08:15	00:07:47
	Category 1 90th Percentile	21 mins	Belfast	00:12:54	00:12:12	00:13:16	00:12:54	00:13:28	00:11:46	00:14:00	00:13:25
	Category 2 Mean	22 mins	Belfast	00:31:41	00:25:02	00:28:58	00:28:14	00:29:12	00:21:16	00:30:48	00:43:05
	Category 2 90th Percentile	46 mins	Belfast	01:28:01	01:22:58	01:29:46	01:24:23	01:28:30	01:11:55	02:28:11	01:40:00
	Category 1 Mean	11 mins	South East	00:13:16	00:12:38	00:12:44	00:12:53	00:12:21	00:11:39	00:13:52	00:12:40
	Category 1 90th Percentile	21 mins	South East	00:24:03	00:24:49	00:23:43	00:24:36	00:24:23	00:22:54	00:25:34	00:24:31
	Category 2 Mean	22 mins	South East	00:47:53	00:45:56	00:46:37	00:46:52	00:50:27	00:41:22	01:13:44	00:58:38
	Category 2 90th Percentile	46 mins	South East	01:45:09	01:40:44	01:43:31	01:43:07	01:48:21	01:28:11	02:48:02	02:06:17
	Category 1 Mean	11 mins	Northern	00:13:36	00:12:52	00:14:10	00:13:32	00:12:49	00:12:08	00:14:20	00:13:11
	Category 1 90th Percentile	21 mins	Northern	00:23:47	00:25:15	00:26:27	00:24:56	00:25:59	00:22:15	00:28:41	00:26:09
	Category 2 Mean	22 mins	Northern	00:43:21	00:37:09	00:37:51	00:39:08	00:46:26	00:32:38	01:02:01	00:45:47
	Category 2 90th Percentile	46 mins	Northern	01:28:15	01:19:05	01:23:34	01:25:25	01:25:01	01:11:29	02:11:57	01:37:06
	Category 1 Mean	11 mins	Southern	00:13:03	00:13:04	00:13:41	00:13:16	00:14:04	00:11:51	00:14:52	00:13:40
	Category 1 90th Percentile	21 mins	Southern	00:25:20	00:25:08	00:26:55	00:25:35	00:26:37	00:23:20	00:28:34	00:26:37
	Category 2 Mean	22 mins	Southern	00:49:46	00:39:27	00:37:48	00:39:06	00:45:57	00:33:01	01:04:59	00:46:07
	Category 2 90th Percentile	46 mins	Southern	01:28:28	01:19:21	01:17:22	01:22:25	01:33:36	01:08:19	02:22:17	01:44:59
	Category 1 Mean	11 mins	Western	00:09:41	00:09:53	00:09:40	00:09:45	00:11:28	00:09:17	00:11:47	00:10:52
	Category 1 90th Percentile	21 mins	Western	00:18:34	00:20:26	00:18:04	00:19:11	00:23:18	00:18:38	00:22:31	00:21:46
	Category 2 Mean	22 mins	Western	00:26:27	00:26:11	00:25:09	00:25:57	00:28:07	00:25:14	00:38:45	00:31:07
	Category 2 90th Percentile	46 mins	Western	00:57:25	00:54:05	00:53:01	00:55:03	01:08:42	00:52:08	01:21:14	01:07:03

Appendix A – SPPG November 22 Submission

Pre Hospital Care and Handover Times

Performance Measure	Metric	Target	Trust	July 2022	August 2022	September 2022	QUARTER 2	October 2022	November 2022	December 2022	QUARTER 3
Pre-Hospital Care (Clinical Hear & Treat)	% of Calls Resolved With Telephone Advice	22%	Region	18%	16%	15%	16%	17%	19%	12%	12%
Pre-Hospital Care (Clinical Hear & Treat)	% of Patients Seen and treated by NAS	25%	Region	25%	22%	23%	23%	24%	22%	24%	23%

SPPG RAG Key:

RAG KEY	
Percentage Measures:	
Red	>5% from Target
Amber	0 and <=5% from Traget
Green	On or better than Target
Response Times:	
Red	> 5mins from Target
Amber	<= 5mins from Target
Green	On or better than Target

Handover delays continue to be a significant challenge for the Trust and regional work is now ongoing with colleagues in other Trusts to address handovers.

It is recognised that to address issues with Handover delays, that Trusts need to work together with NIAS in address this issues.

Further to this, there is recognition at a regional level that indicators within NIAS' gift to deliver are trending in a positive way.

Performance Measure	Metric	Target	Trust	July 2022	August 2022	September 2022	QUARTER 2	October 2022	November 2022	December 2022	QUARTER 3
Hospital Handovers	<= 15mins	27%	Region								
	<=30mins	69%	Region								
	<=60mins	87%	Region								
	>3hrs	0.25%	Region								
	No. of patients >3hrs	270 (per Annum) 22 (per month)	Region	67	36	72	88	111	83	21	109
	<= 15mins	31%	Belfast								
	<=30mins	64%	Belfast								
	<=60mins	91%	Belfast								
	>3hrs	0.16%	Belfast								
	No. of patients >3hrs	45 (per Annum) 4 (per month)	Belfast	18	6	16	39	11	9	14	34
	<= 15mins	19%	South East								
	<=30mins	54%	South East								
	<=60mins	85%	South East								
	>3hrs	1.23%	South East								
	No. of patients >3hrs	213 (per Annum) 18 (per month)	South East	56	28	26	110	33	28	16	107
	<= 15mins	34%	Northern								
	<=30mins	78%	Northern								
	<=60mins	95%	Northern								
	>3hrs	0.04%	Northern								
	No. of patients >3hrs	11 (per Annum) 1 (per month)	Northern	2	1	0	3	1	0	0	1
	<= 15mins	23%	Southern								
	<=30mins	68%	Southern								
	<=60mins	90%	Southern								
	>3hrs	0.34%	Southern								
	No. of patients >3hrs	81 (per Annum) 7 (per month)	Southern	0	0	7	7	2	0	0	2
	<= 15mins	29%	Western								
	<=30mins	59%	Western								
	<=60mins	91%	Western			68.7%					
	>3hrs	0.13%	Western			0.05%			0.15%		
	No. of patients >3hrs	28 (per Annum) 2 (per month)	Western	0	0	1	1	0	2	0	2

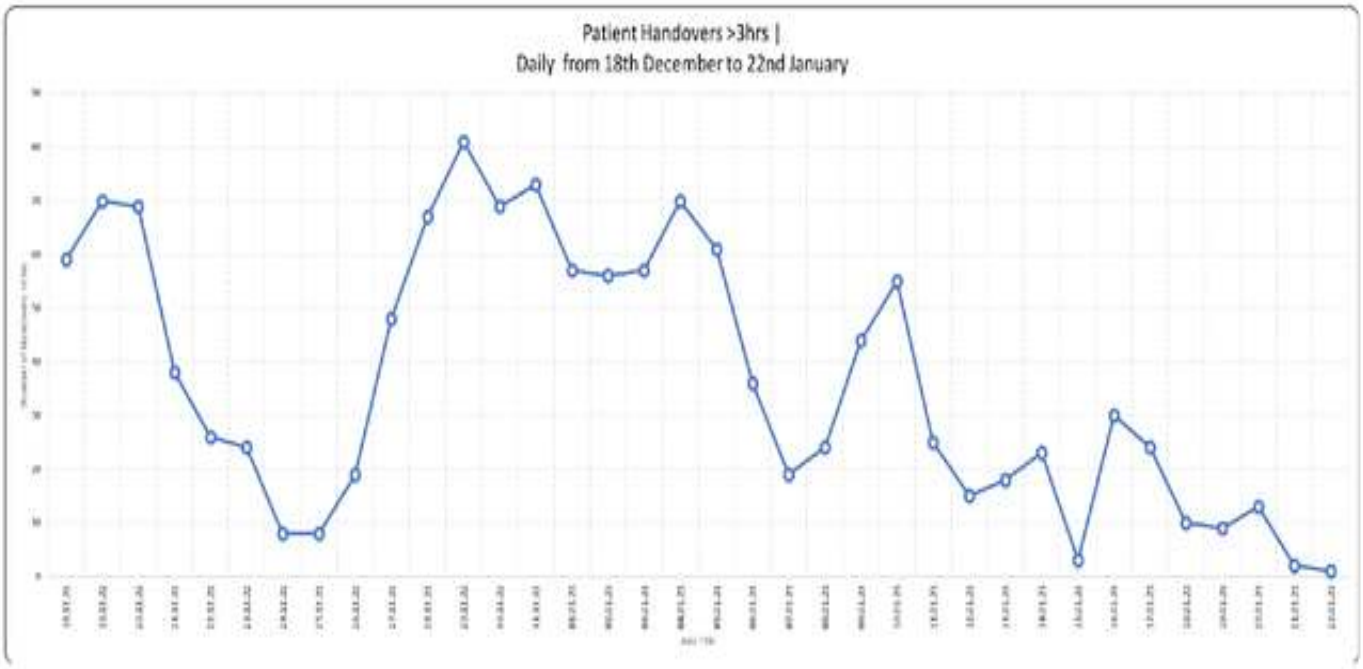
Appendix B – Regional 3 Hour Handover Performance

3 Hour Handover Performance

On 19 December 2022, all Trusts committed to delivering a maximum handover delay of 3hrs.
Below is the weekly performance by receiving hospital for the 3hr maximum handover delay.

It must be recognised that there was significant pressure within the HSC system the week between Christmas and the New Year and the first week of January. Therefore progress towards the measure has not been as prompt as we would have hoped.

There are signs of improvement over the past week and NIAS is committed to work with Trusts across the region to realise the commitment made by all Trusts



- End Of Report -

Trust Board Finance Report

December 2022 (Month 9)

Northern Ireland Ambulance Service
Health and Social Care Trust

Contents

Executive Summary

Statutory financial performance targets	RAG status
Manage within allocated Revenue Resource Limit (RRL) / Achieve financial break-even	
The Trust is reporting a breakeven position for the nine months ending 31 December 2022 and forecasting a breakeven position at year end, subject to a number of assumptions particularly in respect of assumed income, Covid-19 costs and efficiency savings. The Trust continues to work with SPPG and DoH to finalise the resource requirements in relation to these issues and other financial pressures and deficits for the current year and beyond.	
Manage within allocated Capital Resource Limit (CRL)	
The Trust has received a Capital Resource Limit (CRL) allocation of £6.315m. This includes allocations for Fleet & Estate, ICT, Backlog Maintenance and IFRS16 Leases. The Trust is currently forecasting full spend against the CRL allocation at year end, but there are a number of risks in relation to this. The Trust continually reviews capital schemes to understand and mitigate against these risks.	
Prompt payment target-95% of suppliers within 30 days	
Cumulative performance is 96.2% at 31 December 2022 (Month 9). As aged invoices are cleared and paid, performance between months can vary.	

Manage within allocated Revenue Resource Limit (RRL) / Achieve financial break-even

The Trust is currently reporting a breakeven position for the nine months ending 31 December 2022 (Month 9) and and also at year end subject to a number of key risks and assumptions particularly in respect of Covid-19 costs, efficiency savings, Agenda for Change and other investments. Specifically:

- The agreed RRL at Month 9 is £107.391m of which £95.227m is recurrent (previously £99.590m of which £95.941m was recurrent).
- Covid-19 Costs – The Trust has received allocations of £12.660m (previous forecast £12.752m) of Covid-19 costs across the areas of Workforce (£3.66m), Service Delivery (£7.2m), Equipment & Supply (£1.2m), Corporate Cleaning (£0.6m) . With the exception of equipment and supply costs, the Trust was initially advised not to assume Covid allocations beyond the first quarter of the financial year. Following discussion with SPPG/DoH, funding has been confirmed for the full year and allocations have been received. The Trust is exploring additional costs experienced over the winter period with a view to securing additional Covid allocations in the current year.
- Efficiency Savings – The Trust has been set a target of £2.602m. Initial estimates were that only £1m of this target would be met, and this will only be on a non recurrent basis. Additional non recurrent support has been provided by SPPG/DoH and further non recurrent measures have been identified to achieve the balance of savings required in 2022-23.

Manage within allocated Revenue Resource Limit (RRL) / Achieve financial break-even

- The Trust has received subsequent correspondence from DoH/SPPG requesting that Trusts should contain costs in areas that would not have an immediate impact on service delivery. The SPPG/DoH have also requested Trusts to deliver a reduction in expenditure on Agency staff costs (£0.379m) and other savings (£0.079m) during the rest of the financial year. These are not expected to be matched with a reduction in RRL in the current year and plans are in place to reduce Agency staff costs for the rest of the year and beyond.
- Agenda for Change – The costs of regrading and pay awards will be fully funded. Details of the Agenda for Change pay award for 2022-23 have been issued and arrangements for payment are being implemented. Progress on the regional treatment of holiday pay overtime has been made which is reflected in this report and will be reviewed in detail as part of the final accounts for 2022-23.
- Investment – Inescapable pressures (£1.336m), Demography (£0.706m) and additional Covid costs remain under discussion and are subject to the completion of Investment Proposal Templates. Increased energy costs, based on current best estimates, have largely been supported.
- The Trust continues to work through a process of review with SPPG/DoH to finalise the position in relation to these funds.
- Accounting Treatment – Assuming no unsupported major in year changes to accounting treatment.
- Regional financial planning for 2023-24 with Trusts and DoH/SPPG is against a backdrop of what is expected to be a seriously constrained financial position across the public sector in 2023-24.

Directorate Financial Position

- Underlying the overall financial forecast is a complex budgetary position within each Directorate. Budget and actual expenditure by Directorate at December 2022 (Month 9) is shown opposite.
- The level of underspends against the pay budget has reduced as vacancies across the Trust are filled. Any underspend is used to fund overtime costs to maintain services and provide operational cover. There are also significant levels of sickness absence that can create a financial pressure beyond budgeted levels.
- Expenditure on Voluntary and Private Ambulance Services and patients taxis is also being incurred to maintain cover and performance.
- The significant additional expenditure, particularly in respect of Covid-19, is included in the financial assumptions in the current year. This additional assumed funding is reflected in these statements.
- This position also reflects the progress in relation to the regional treatment of holiday pay overtime.

NIAS Trust Board Budget Report at December 2022

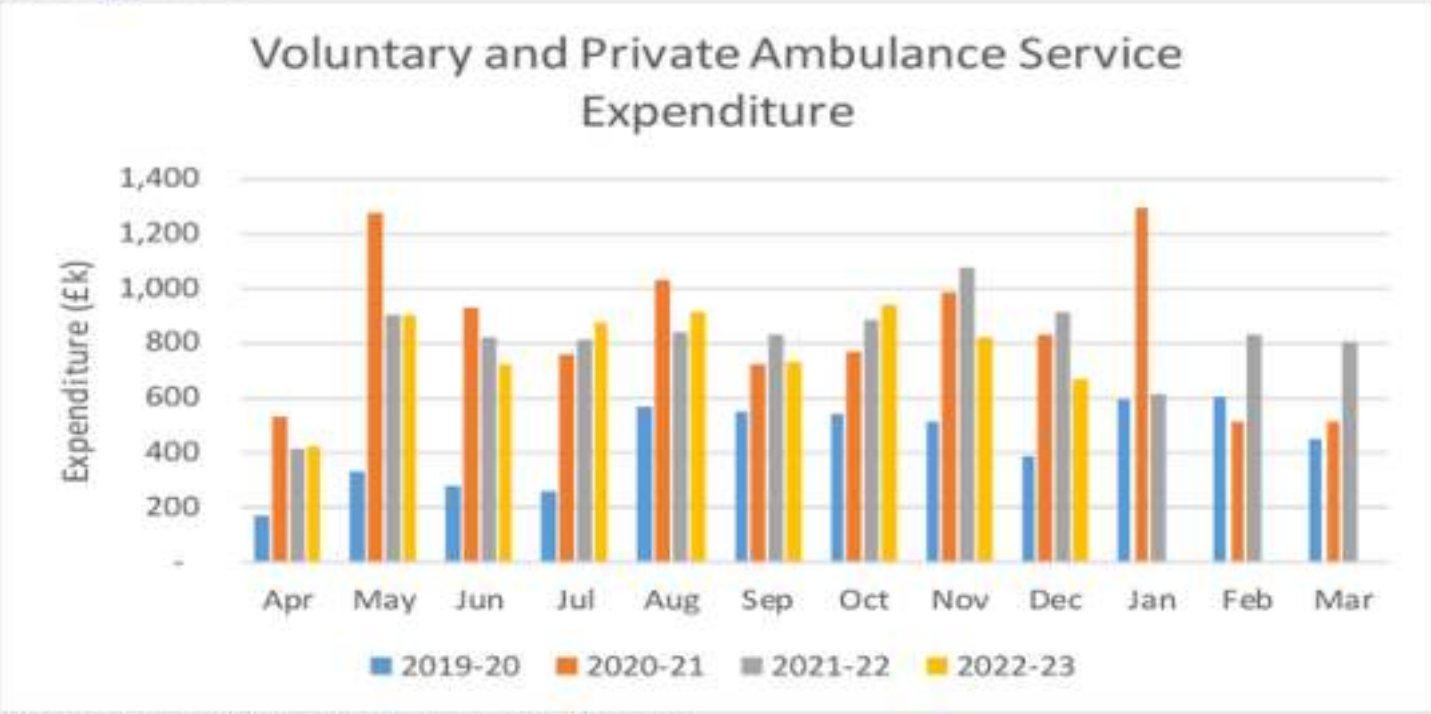
			YTD		
		FYB	Budget	Actual	Variance
Chief Executive's Office					
	Payroll	210	162	158	4
	Non-Payroll	136	126	123	4
Chief Executive's Office Total		346	288	281	7
Director of Finance					
	Payroll	(6,703)	(6,073)	(6,078)	5
	Non-Payroll	531	441	436	6
Director of Finance Total		(6,172)	(5,632)	(5,642)	10
Director of HR					
	Payroll	1,468	1,053	1,047	5
	Non-Payroll	676	511	509	3
Director of HR Total		2,144	1,564	1,556	8
Dir of Ops (incl Divisions & RCC)					
	Payroll	66,082	53,891	53,930	(39)
	Non-Payroll	19,995	17,105	17,126	(21)
Dir of Ops (incl Divisions & RCC) Total		86,077	70,995	71,056	(60)
Medical Director					
	Payroll	9,633	7,841	7,840	1
	Non-Payroll	1,070	958	958	0
Medical Director Total		10,703	8,797	8,798	1
Director of Safety, Qual & Imp					
	Payroll	2,985	1,458	1,451	7
	Non-Payroll	732	111	114	(3)
Director of Safety, Qual & Imp Total		3,717	2,569	2,565	5
Director of CRNI, Fleet & Estates					
	Payroll	867	646	651	(4)
	Non-Payroll	520	385	380	5
Director of CRNI, Fleet & Estates		1,387	1,032	1,031	1
Director of Plan, Perf & Corp					
	Payroll	2,855	2,135	2,132	3
	Non-Payroll	1,409	1,025	1,020	5
Director of Plan, Perf & Corp Total		4,263	3,161	3,153	8
	NIAS Total Payroll	83,324	62,222	62,222	0
	NIAS Total Non-Payroll	24,470	20,663	20,663	0
NIAS Total		106,845	82,885	82,884	0

Northern Ireland Ambulance Service
Health and Social Care Trust

Voluntary & Private Ambulance Services (VAS/PAS)

The Trust benefited from significant additional funds in 2020-21 and 2021-22 as part of the response to Covid-19. This funding was applied to additional support from VAS/PAS to maintain and enhance ambulance provision during this difficult period. The Trust welcomes the support that VAS/PAS has given NIAS and HSC during this time.

- Expenditure on VAS/PAS in 2019-20 was £5.2m. Expenditure in 2020-21 was £10.1m and in 2021-22 was £9.7m. This level of expenditure has been affordable given operational vacancies within the Trust and also with the additional resources provided in response to the pandemic. As the output of the training school fills vacancies and the impact of the pandemic recedes, levels of expenditure should reduce. Expenditure by month in 2022-23 is shown below
- The sustained impact of Covid-19 has resulted in the continued reliance on VAS/PAS to maintain services in the current year. The Trust has largely been operating at the highest levels of escalation and VAS/PAS spend remains significant, though has reduced in the last three months. Significant additional costs in relation to the provision of patient taxis are also being incurred.



Overtime Expenditure

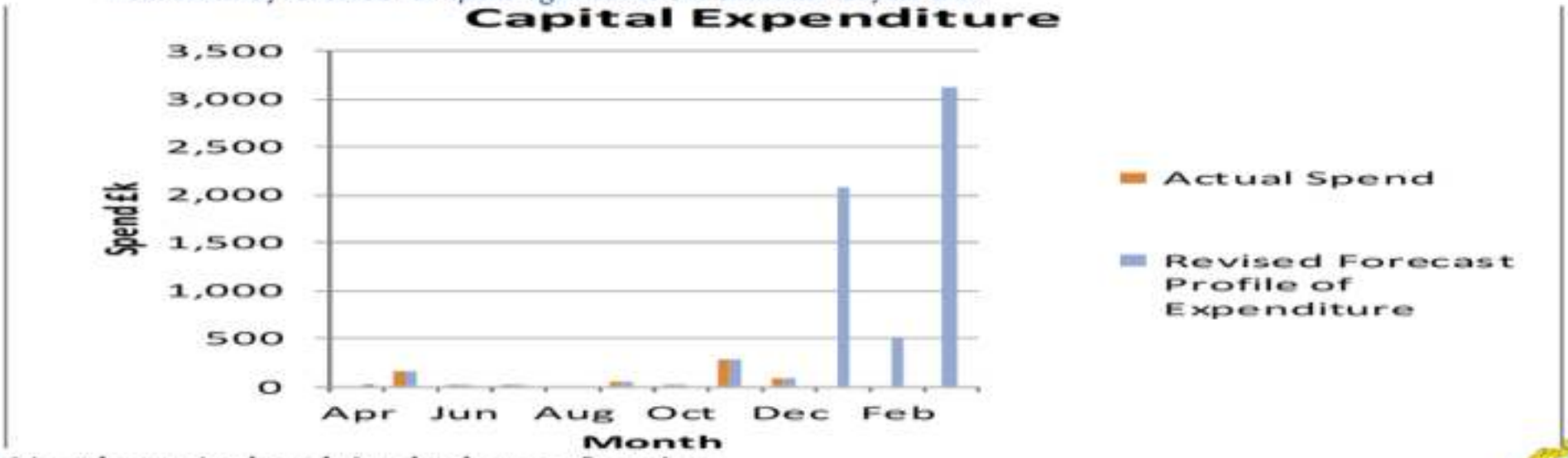
The Trust relies significantly on the use of overtime for the provision of services, predominantly for the provision of Ambulance cover. This reliance is for a number of reasons including vacancies, planned and unplanned absences and additional cover or programmes of work.

- Overtime is payable to staff in pay bands 1-7 under Agenda for Change (AfC) terms and conditions at a rate of time plus one half, with the exception of public holidays which are paid a double time.
- Overtime is paid monthly in arrears and claims should routinely be submitted within three months of the work being carried out. Staff also have the option of taking time off in lieu as an alternative to an overtime payment.
- Given the varying requirements for overtime, expenditure can vary significantly at different times in the year. However, even with this variability, overtime has been remarkably consistent in previous years averaging circa £6m per annum.
- The Trust has instigated a programme of work to recruit substantively to positions and rotas that have historically been filled with overtime. There is however a significant lead time for the recruitment and training of these staff. As the output of the training school fills vacancies and the impact of the pandemic recedes, levels of expenditure should reduce.
- Regionally, additional enhancements have been introduced to encourage staff to undertake additional shifts, including overtime payments for staff in pay bands 8a and above. Costs under the Covid Rapid Response Payment Scheme are now included in this graphical analysis. Reliance on these payments has reduced steadily since peaking in August.

Northern Ireland Ambulance Service
Health and Social Care Trust

Manage within allocated Capital Resource Limit (CRL)

- The Trust has received a Capital Resource Limit (CRL) allocation of £6.315m (previously £6.349m). This includes allocations for Fleet & Estate (£4.700m), ICT (£1.119m), Backlog Maintenance (£0.250m) and IFRS16 Leases (£0.246m)
- Expenditure has traditionally been profiled towards the end of the financial year due to a number of factors, including business case approval, the availability of funds, procurement timescales, supplier capacity, internal capacity, project risks and lead times. Significantly, expenditure on fleet is profiled to the end of the financial year to maintain a smooth fleet age profile.
- These risks have been compounded recently due to a number of factors including EU exit, the global movement of goods, the global availability of raw materials and also associated costs of materials, production and delivery. The Trust continually reviews capital schemes to understand and mitigate against these risks.
- In an effort to manage the traditional and exceptional risks, there is an element of over programming on the current capital programme. This will be managed through additional bids and funding or the deferral of schemes into 2023-24.
- Provisional figures for expenditure at December 2022 (Month 9) is £0.608m against this allocation of £6.315m. The Trust currently forecasts full spend against the CRL allocation at year end.



Prompt Payment of Invoices

- The Trust is required to pay non HSC trade creditors in accordance with the Better Payments Practice Code and Government Accounting Rules. The target is to pay 95% of invoices within 30 calendar days of receipt of a valid invoice, or the goods and services, whichever is the latter. A further regional target to pay 70% (increased from 60%) of invoices within 10 working days (14 calendar days) has also been set.

- Performance by number of invoices paid for each of these measures is shown below. A range of plans are in place to improve and maintain performance in this area. As aged invoices are cleared and paid, performance between months can vary.

- Both the 95% and 70% targets have been achieved in the last two years. The Trust will continue with efforts to maintain this level of performance in 2022-23.

Number	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD Cum	Target
Total bills paid	2,203	2,929	2,632	2,301	2,565	2,476	2,221	3,221	2,167				22,715	
Total bills paid within 30 calendar days of receipt of undisputed invoice	2,124	2,784	2,488	2,232	2,454	2,385	2,157	3,127	2,105				21,856	
% bills paid on time 30 days	96.4%	95.0%	94.5%	97.0%	95.7%	96.3%	97.1%	97.1%	97.1%				96.2%	>95%
Total bills paid within 10 working days (14 calendar days)	1,696	1,926	1,882	1,935	1,561	1,763	1,839	2,590	1,763				16,955	
% bills paid on time 10 days	77.0%	65.8%	71.5%	84.1%	60.9%	71.2%	82.8%	80.4%	81.4%				74.6%	>70%

End of Report

Northern Ireland Ambulance Service
Health and Social Care Trust

'SAFETY' COMMITTEE REPORT TO TRUST BOARD 12/12/22

The Safety, Quality, Patient Experience and Performance Committee met on Monday 12 December 2022.

	Strategic Review of Clinical Education The Committee received a detailed update in relation to this area of work. The Committee noted the importance of ensuring consideration was given to both informal and formal feedback from students as they progressed through the BSc course.
	Cardiac Arrest Improvement Plan Mr Sinclair advised the Committee that the Plan had been based on 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. An Out of Hospital Cardiac Arrest masterclass for NIAS staff had been held on 16 November and consideration was being given to holding further masterclasses on different topics.
	Clinical Support Desk The Committee noted that information around performance in relation to 'Hear and Treat' and 'See and Treat' would now be included in the Performance Report presented to Trust Board. An update was also provided on CSD recruitment and the Trust's efforts to encourage applications from other professional groups, for example, nursing.
	Position report on NIAS safeguarding The Committee noted the improvement in the Trust's baseline with regard to safeguarding and received an update on staff training. The Committee was advised that there was a need for increased infrastructure within the area of safeguarding. It noted that the Trust was participating in a peer review process as well as being involved in domestic homicide reviews and case management reviews for children.
	Emergency Preparedness & Response Annual Report 2021-22 The Committee noted this report which reflected the activity of the Trust's emergency preparedness and response for the year 2021-22. It further

	noted that there had been a decrease in the number of incidents responded to in the last reported year 2018-19. The Committee was advised of the review of the Trust's emergency planning arrangements being undertaken by the Association of Ambulance Chief Executives (AACE).
	Community First Responder Volunteers The Committee received a detailed overview of the Community First Responder (CFR) Scheme from Ms Stephanie Leckey, Community Resuscitation Lead, and noted that there were now 21 schemes in operation with over 300 volunteers. It expressed its appreciation to those volunteers participating in the various CFR Scheme.
	Infection Prevention and Control: Key Performance Indicators: Hygiene and Cleanliness: 1 August – 30 September 2022 The Committee noted the report which covered a number of areas, namely Hand Hygiene; Personal Protective Equipment; IPC e-learning IPC face-to-face training and Aseptic Non-Touch Technique.
	Patient Care Services (PCS) (including Voluntary Car Services) - update The Committee received an update in relation to the PCS Improvement Project as well as the Voluntary Car Services.
	Public & Personal Involvement (PPI) Action Plan – update The Committee noted the Action Plan and the intention to have clear timeframes identified in future papers.
	Serious Adverse Incidents (SAIs): current position and learning outcomes The Committee noted that 24 SAIs had been reported to the Strategic Planning and Performance Group (SPPG) from April 2022 to date. 15 of these had related to a delayed NIAS response outside of the standard and that, on eight of these occasions, the patient had sadly passed away. The Committee was advised that, over a three-month period, 1,600 patients had waited more than 80 minutes for a Cat 2 response and the Trust would not be necessarily aware of the harm caused to patients as a result.

Northern Ireland Ambulance Service
Health and Social Care Trust

Complaints and Compliments: current position and learning outcomes

The Committee was advised that, during the period 1 April to 31 October 2022, 139 complaints had been reported to the Trust and that 99% of these had been acknowledged within two working days.

During the same period, a total of 203 complaints had been closed. This represented a 55% increase for the same period during the 2020-21 year.

Northern Ireland Ambulance Service
Health and Social Care Trust

MINUTES OF THE AUDIT AND RISK ASSURANCE COMMITTEE (ARAC) HELD ON THURSDAY 8 DECEMBER 2022 AT 10AM VIA ZOOM

PRESENT:	Mr W Abraham	Non-Executive Director (Chair)
	Mr D Ashford	Non-Executive Director
IN ATTENDANCE:	Mr M Bloomfield	Chief Executive
	Ms R Byrne	Director of Operations (joined the meeting at 10.45am)
	Ms L Charlton	Director of Quality, Safety & Improvement (left the meeting at 11.30am)
	Ms M Lemon	Director of HR & OD (joined the meeting at 10.50am)
	Mr P Nicholson	Director of Finance, Procurement, Fleet & Estates
	Mr B McNeill	CRM Programme Director
	Dr N Ruddell	Medical Director
	Mr A Arandia	Asst Director Planning, Performance & Corporate Services (rep Ms Paterson)
	Ms K Keating	Risk Manager
	Ms N Lappin	Trust Chair
	Ms B McAuley	Asst Director of Finance
	Mr I McCutcheon	Financial Accounting Manager
	Mr S Knox	External Audit Northern Ireland Audit Office
	Ms C Hagan	External Audit ASM
	Ms J Shorthall	External Audit ASM
	Ms C McKeown	Head of Internal Audit, BSO
	Mrs L Mitchell	Independent Adviser to Committee
	Mrs C Mooney	NIAS Board Secretary

Welcome, introduction and format of meeting

The Chair welcomed everyone to the meeting and reminded those present that, while there were other agenda items to consider, the main

focus of today's meeting would be on progress in addressing the outstanding IA recommendations.

1 Apologies

No apologies were noted.

2 Declaration of Potential Conflict of Interest & Confirmation of Quorum

The Chair confirmed that the meeting was quorate and asked those present to declare any conflicts of interest now or as the meeting progressed.

The Chair noted the fact that, in accordance with the Trust Standing Orders, the Non-Executive Director (NED) membership of the Audit Committee 'shall consist of not less than three members'. He advised that he had drawn this requirement to the Trust Chair's attention in the context of appointing additional NEDs when this was possible.

The Chair also stressed the confidentiality of information presented.

3 Previous Minutes (AC08/12/22/01)

The minutes of the meeting on 6 October 2022 were **APPROVED** on a proposal from Mr Ashford and seconded by the Chair.

4 Matters Arising (AC08/12/22/02)

4.1 Action List

The Committee **NOTED** the Matters Arising.

5 Committee Chair's Business

The Chair reiterated his intention that the focus of the meeting would be on progress in addressing the outstanding IA recommendations.

6 External Audit

6.1 2021-22 Report to Those Charged With Governance (RtTCWG) (AC08/12/22/03)

Mr Knox advised that the Committee had already discussed the Report when it had been in draft format and confirmed that there had been no significant changes since that time. He indicated that the Trust accounts had now been certified with a qualified audit opinion and the Charitable Trust Funds had been given an unqualified opinion.

The Committee **NOTED** the Report.

6.2 Audit of the Northern Ireland Ambulance Service Heath and Social Care Trust: Letter of Understanding (AC08/12/22/04)

Mr Knox referred members to the Letter of Understanding which he explained was refreshed every 3-4 years. He advised that the Letter did not differ significantly from the previous version.

The Committee **NOTED** the Letter of Understanding.

7 NIAS Mid-Year Assurance Statement (MYAS) (AC08/12/22/05)

Mr Nicholson reminded the Committee that the draft Mid-Year Assurance Statement had not been available to share at the October meeting. However, the draft Statement had subsequently been shared with Committee members via e-mail on 25 October. Mr Nicholson explained that the draft Statement had been submitted to the DoH advising that approval would be sought to the draft at the Committee's December meeting.

Mr Nicholson explained that the Statement reflected the Trust's Governance Statement which was an integral element of the Trust's Annual Report and Accounts. He referred the Committee to pages 7-8 of the Statement and said that focus of this year's Statement was on delays at Emergency Departments and patient handovers.

The Chair suggested that figures around the lost operational capacity should be included to emphasise the significant impact on the Trust.

Mr Ashford referred to Appendix A and queried why the Integrated Command and Control System (ICCS) had not been included.

In response, Mr Bloomfield explained that there had been a light touch taken to this year's Mid-Year Assurance Statement and updates had only been given on those areas which had changed since the year end assurance statement as well as confirming that the Trust was continuing to address those actions which had been identified.

Responding to a question from the Chair, Mr Nicholson explained that, while the Mid-Year Assurance Statement had been signed off by the Chief Executive, it had been made clear when submitted to the DoH that it remained in draft format until the Committee had approved.

Mr Nicholson indicated that it would be possible to revisit the section of the Statement as had been suggested by the Chair and amend as necessary. He pointed out that there was reference later in the Statement to the harm caused to patients as a result of delayed handovers as well as reference to various meetings which had been held to discuss the matter. Mr Nicholson added that the issue of delayed handovers would also focus on the Accountability Review meeting which the Chair and Chief Executive would have with DoH colleagues on 21 December.

Mr Bloomfield alluded to correspondence shared with Non-Executive Directors from the Permanent Secretary following the Unscheduled Care Summit and said it was important that members were aware of the continued discussion around this issue. He added that a further meeting involving Trust Chief Executives would be held the following day to report back to the DoH on progress.

Subject to the change being made, the Mid-Year Assurance Statement was **APPROVED** on a proposal by Mr Ashford which was seconded by the Chair.

8 **Corporate Risk Register (AC08/12/22/06)**

Ms Keating advised that a new risk 739 'Independent Ambulance Sector - Medicines Administration' had been added to the Register, now taking the total number of risks on the Corporate Risk Register from 20 to 21. She indicated that two risks had been rated as extreme, namely Risk 357 'Ambulance Turn Around Times at Emergency Departments' and Risk 311 'Cyber Security' while updates had been made to risks relating to sickness absence (Risk 403); CRM (Risk 591); Use of IAS/PCS on A&E Support (Risk 719) and Attracting and Retaining Suitably Qualified Staff (Risk 575).

Dr Ruddell provided a detailed update to the background to the medicines administration issue and the rationale for its escalation to the Corporate Risk Register, in particular the historical use of NIAS drugs by NIAS paramedics who were covering St John Ambulance shifts. He clarified that the St John organisation, like all of the voluntary and independent ambulance providers, would be used within the regional framework to transport lower acuity patients and would not need to have access to medication.

The Chair believed that the risk had been identified and mitigated and he sought clarification on why it had been included in the Risk Register.

Responding, Dr Ruddell said that, when initially identified, the issue had posed a significant risk to the Trust in terms of the potential for the Trust's medicines licence to be withdrawn theoretically by the Medicines Regulator if they had deemed it sufficiently serious.

Dr Ruddell explained that the Trust participated in the Local Intelligence Network (LIN) where Controlled Drugs Accountable Officers from all Trusts were required to report any loss of drugs. He reminded members that recent reviews indicated that the Trust had robust systems in place. It remained the case that no system was foolproof when management of drugs fell to the responsibility of individual staff. Dr Ruddell welcomed the Trust's plans to move to an electronic tracking system and said that the risk to the Trust's reputation and from Regulator scrutiny was not to be underestimated.

Agreeing with the points made by Dr Ruddell, Mr Bloomfield advised that the correspondence from the Medicines Regulator had made

clear the actions required, including reviewing a range of policies and Standard Operating Procedures which would take time. He said he was confident that no NIAS drugs were being used by other providers and confirmed that the risk would remain on the Risk Register until such times the Trust was satisfied that all required actions had been taken. Mr Bloomfield said that it would be premature to confirm that the Trust had addressed the issues identified by the Medicines Regulator and added that there was a significant piece of work to be completed before reaching that stage.

Mr Ashford said that he was content with Risk 739 and, while welcoming the work which had already been undertaken, acknowledged the work to be done.

He noted the update around Risk 357 and asked if any further progress had been made.

Responding, Mr Bloomfield acknowledged that there had been significant media coverage around unscheduled care pressures and delayed handovers generally. He referred to correspondence which he had recently shared with Board members and said he would discuss this in more detail at the December Board meeting.

Mr Bloomfield said that members would be aware of the unscheduled care summit which had taken place on 9 November and to which NIAS officers had significant input. He explained that, while the summit discussed measures to prepare for winter, there was a heavy focus at the workshop on the issue of delayed ambulance handovers and what needed to be done to address this.

Continuing, Mr Bloomfield said that those attending from NIAS had presented figures in terms of the lost capacity, SAIs as well as highlighting the cases of patients who had come to harm as a result of the lack of resources available to NIAS. Mr Bloomfield said that the subsequent correspondence dated 11 November 2022 from the Permanent Secretary had made it clear that the situation was unacceptable and, at that stage, 25% of capacity was being lost. He advised that the DoH had asked all Trusts to agree how to address this and to start corridor cohorting of ambulance patients at the start of December. Mr Bloomfield indicated that, while two Trusts had agreed to this, the remaining Trusts had not. He said that members would have received a copy of the NIAS response to the Permanent Secretary's correspondence which stated that, as at

30 November, no Trusts had confirmed the commencement of corridor cohorting. Mr Bloomfield said that NIAS officers had met with each Trust individually, however, no Trust was willing to commence corridor cohorting on its own. He said that he could understand the rationale behind this in that if one Trust was turning around ambulances quickly, more ambulances would present. Others Trusts had explained that they had no physical space within their respective EDs to be able to corridor cohort patients.

Mr Bloomfield advised that there had been detailed discussion at the Performance Transformation Executive Board, following which the Permanent Secretary wrote to Trusts to clarify that it was not the DoH's role to mandate any action across the Trusts but asked the Trusts to have focused discussion on what could be done before Christmas.

Mr Bloomfield advised that he had chaired the Trust meeting on Monday past and said Ms Charlton, Dr Ruddell and Ms Byrne had also attended. He undertook to provide an update to Trust Board.

He assured members that, other than planning for industrial action, there was no other higher priority issue across the entire HSC system than delayed handovers.

Mr Ashford thanked Mr Bloomfield for his update and said that the update appeared to be very similar to what had been given to members previously. He alluded to the concept of ambulance handover zones as potential solutions and said that Trusts had not implemented these. Mr Ashford referred to the harm being caused to patients in the back of ambulances.

He said that he was not confident that action would be taken to address the situation. Mr Ashford stressed that, for the avoidance of any doubt, he was not criticising Directors in any way and was of the view that it was for Trust Board to escalate the issue.

The Chair pointed out that the ARAC was the primary forum where this risk could be examined in detail. He thanked the senior team for their considerable efforts to address this issue. The Chair repeated a view he had previously voiced around the ambulance service being used as a 'safety valve' for the entire HSC system at the expense of NIAS' capability and performance.

He said that, while he was encouraged by the progress, he had been encouraged before and efforts to address the issue of delayed handovers had not come to fruition.

The Chair asked how failure to address handover delays was being reflected in other Trusts' Risk Registers and asked if Internal Audit would assign limited assurance because of Trusts' failure to address such a critical issue. He said there was evidence to show that patients were coming to harm as a result.

Ms McKeown advised that Internal Audit had not provided assurance in this specific area to other organisations. She indicated that the other Trusts were similar to NIAS in terms of governance by the DoH and similar internal Committee and Board structure.

The Chair pointed out that Trusts continued to fail to address this issue and said he would be keen to know how they might mitigate the risk. He was of the view that, if the issue was not reflected in Trust Risk Registers, he would discuss further with the Trust Chair and Chief Executive.

Ms Lappin suggested that the Chair may wish to make contact with the Chair of the DoH ARAC around this issue. She believed that the key focus should remain the significant risk to patients caused by delayed handovers. Ms Lappin said she intended to raise the issue at the Accountability Review meeting on 21 December and said members would have the opportunity to discuss the issue further when the Permanent Secretary joined them at the February Board meeting.

Ms Lappin expressed her disappointment in noting that the latest improvement trajectories were not positive. She pointed out that, while of little comfort to members, NIAS was in a relatively better position than its counterparts in the UK where handover delays were continually in excess of 15-20 hours. Ms Lappin acknowledged members' continuing frustrations and referred to discussions at the October Trust Board around what further steps the Trust Board could take within its limited authority. However she reminded members that the Trust Board could not hold other Trusts to account. She added that handover delays represented a risk to the whole HSC system and therefore to the DoH. Ms Lappin said she was assured that discussions were continuing.

The Chair suggested that being aware of how, and whether, other Trusts had reflected the risk in their respective Risk Registers would inform any discussions with the Chair of the DoH ARAC. He commended those involved on the actions taken to date and stressed that one needed to adopt a curious and creative approach when looking at this issue.

Mr Ashford said he would be content to leave further discussion to the Board meeting. He agreed with Ms Lappin's point that the Trust did not have the authority to hold other Trusts to account and said, if it became clear that no progress was being made, the NIAS Board's role was to escalate the matter to those who could hold other Trusts to account and look to the Permanent Secretary to take the lead in addressing the issue.

Ms Charlton highlighted the important role of the regulator and confirmed that she and Mr Bloomfield had met with colleagues from the Regulation and Quality Improvement Authority (RQIA) which had a significant interest in this particular aspect of care. She said there had been significant learning from inspections undertaken by the Care Quality Commission (CQC) and added that the CQC had published their findings.

The Chair said it was helpful to look at the various layers in terms of how the risk was being treated and believed this would assist in being able to emphasise its importance. He was of the view that, by keeping the issue on the ARAC agenda, the Committee continued to exert maximum pressure to ensure the risk was addressed.

Following this discussion, the Corporate Risk Register was **APPROVED** by members. It was noted that the Register would be submitted to the Trust Board in line with the Risk Management Strategy.

9 **NIAS Gifts and Hospitality Policy (AC08/12/22/07)**

Mr Nicholson explained that the updated policy was intended to provide advice to Trust staff who, in the course of their day to day work or as a result of their employment, either received offers of gifts and hospitality or provided gifts and hospitality to others on behalf of the Trust.

He pointed out that all decisions by Trust staff on the provision or acceptance of gifts and hospitality must be able to withstand both internal and external scrutiny. They must be defensible as being in the direct interest of the organisation, as being proportionate to that interest and within limits that were acceptable to the Trust Board.

The Chair suggested that the wording be amended to read '…apparent value of over £50…'. He also alluded to the cost of living and suggested that reference be included to reflect the date of drafting so as to avoid having to continually amend the policy each year.

Subject to these changes being made, the Gifts and Hospitality Policy was **APPROVED** by the Committee on a proposal from the Chair which was seconded by Mr Ashford.

It was noted that the Policy would be submitted to the December Trust Board.

10 **Progress on outstanding Internal Audit Recommendations**

Mr Nicholson explained that the report shared with members in advance of the meeting provided specific updates on outstanding internal audit recommendations where the implementation date had passed.

Referring to the position as at the end of November 2022, Mr Nicholson drew members' attention to the detail on the 56 recommendations which were considered partially or not implemented at mid-year. In addition, he said, there was an assessment by NIAS management as to whether the recommendation would be fully implemented by 31 March 2023.

Mr Nicholson reminded members that the assessment had been graded as Red 'At Risk'; Amber 'On Track to be implemented by end of 2022/23' and Green 'Complete'.

He advised the Committee that 12 (22%) of the outstanding recommendations were considered to be implemented; 41 (73%) were on track to be implemented before the financial year end and three (5%) were at risk of being implemented by the year end.

Continuing he pointed out that 42 out of the 56 (75%) outstanding recommendations were considered significant in that they specifically related to findings which had given rise to a limited or unacceptable assurance. Mr Nicholson indicated that 40 (95%) of the significant findings had either been implemented or were on track to be implemented before the end of the financial year.

Mr Nicholson explained that this NIAS assessment would be formally reviewed by Internal Audit by 31 March 2023, along with associated evidence, to support the year end position as fully or partially implemented. He added that this process of meetings and monitoring of progress would continue for the rest of the year and was being embedded into the Trust's developing Performance Management framework.

Ms McKeown expressed her agreement with Mr Nicholson's comments and said, while the updates provided by Directors and other managers would be important, evidence to support the implementation of the recommendation would be key.

Ms McKeown explained that the Committee would consider the outstanding IA recommendations and clarified that this would not include those reports which had been issued in the interim period or those recommendations where the implementation date had not yet passed.

At this point in the meeting, Mr Ashford and Ms Mitchell declared an interest as Associates of the HSC Learning Centre.

At the Chair's invitation, Directors and managers provided detailed updates on the outstanding recommendations.

Mr Nicholson said that the updates will have provided members with a sense of the work which had been undertaken and he added that this had not been without its challenges. He indicated that many of the recommendations had financial implications. Mr Nicholson thanked Internal Audit colleagues for their assistance. He highlighted the need to maintain a focus on addressing the recommendations.

The Chair thanked all involved and acknowledged that the updates provided were subject to review by Internal Audit colleagues.

Committee members welcomed the progress made and conveyed their thanks to those involved for their continuing efforts. Members also encouraged the ongoing dialogue between officers and Internal Audit to determine the evidence required and believed this was key to ensuring the outstanding recommendations were addressed.

Ms McKeown said she had found the updates useful and recognised the huge amount of work ongoing across the Trust. She acknowledged the clear progress which had been made and agreed with earlier comments that evidence was key and should be provided to Internal Audit as soon as possible to allow recommendations to be closed ahead of the year end.

Mr Bloomfield said he hoped this morning's discussion had been helpful to members that, despite ongoing pressures and challenges, officers continued to be focused on the outstanding recommendations.

Ms Lappin thanked the Chair for inviting her to attend the meeting and commended the clear efforts which had gone into reaching this point.

The Chair conveyed his thanks to Mrs Mitchell for her contribution behind the scenes.

11 Closed Meeting

The Chair advised that he did not propose to have a Closed Meeting.

12 Any Other Business

The Chair said it had been remiss of him at the start of the meeting not to congratulate Mr Nicholson on his appointment as Director of Finance, Procurement, Fleet and Estates.

13 Date, time and venue of next meeting

The next meeting of the Audit Committee will take place on Thursday 19 January 2023. Arrangements to be confirmed.

The remaining ARAC date for 2022-23 is as follows:

- Thursday 30 March 2023

All meetings will commence at 10am unless otherwise stated.

THIS BEING ALL THE BUSINESS, THE CHAIR CLOSED THE MEETING AT 12.40PM

SIGNED: William Abraham

DATE: 19 January 2023

Northern Ireland Ambulance Service
Health and Social Care Trust

AUDIT AND RISK ASSURANCE COMMITTEE REPORT TO TRUST BOARD

The Audit and Risk Assurance Committee met on Thursday 19 January 2023 and I would like to bring the following issues to the attention of the Board in advance of the formal minutes.

1.	**Matters Arising From Previous Meeting** **Risk 357 Ambulance Turnaround Times at Emergency Departments** It was noted that a dedicated Trust Board workshop has been arranged to discuss this risk.
2.	**Chairman's Business** I will be attending the Departmental Audit and Risk Assurance Committee on 7 March as an observer and I will feedback observations to the ARAC Committee in due course.
3.	**Direct Award Contracts Register** The Committee was provided with an update on the Direct Award Contracts Register.
4.	**Fraud Update** The Committee received a verbal update from the Director of Finance on a number of fraud cases.
5.	**Progress on Achieving Business as Usual – Rebuilding and Recovery** The Committee received a verbal update on progression by the Trust to achieve business as usual status following the pandemic.
6.	**Internal Audit** **Progress Report** The Deputy Head of Internal Audit presented the audit report on absence management, which has received a Limited Assurance. The Director of HR briefed the Committee on the 'Maximising Attendance Project' and the Committee was reassured that management has taken appropriate action to address the deficiencies in this area. Management has been requested to provide a progress update at the May ARAC Committee meeting.

Northern Ireland Ambulance Service
Health and Social Care Trust

7.	**External Audit** **NIAO Audit Strategy 2022-23** The External Auditors presented the Audit Strategy for 2022-23 to the Committee. It should be noted that the auditors highlighted that the holiday pay accrual which resulted in a qualified opinion on the accounts in 2020-21 and 2021-22 will be reclassified as a provision on the basis of a Department of Health directive and this will result in an unqualified opinion on the accounts for 2022-23 (subject to no other issues arising). I would advise that this is a positive position for the Trust. The Committee approved the NIAO Audit Strategy for 2022-23. **NIAO Letter to the Chief Executive on Changes to Audit Approach** The Committee noted a letter to the Chief Executive dated 5 December 2022 from the NIAO, which advises on changes to the audit approach by the External Auditors.
8.	**Review of NIAS Standing Orders** The Committee reviewed the proposed changes to the Trust Standing Orders and recommends approval by the Trust Board.
9.	**Board Governance Self Assessment Tool** The Committee reviewed the Board Governance Self Assessment Questionnaire for 2021-22 and subject to one amendment the Committee approved for further consideration by the Trust Board.
10.	**BSO Annual Assurance** A letter from the BSO to the Chief Executive dated 19 December 2022 providing assurance for 2021-22 was noted by the Committee.

Submitted By:
William Abraham
Chair of Audit and Risk Assurance Committee

19 January 2023