NORTHERN IRELAND AMBULANCE SERVICE TRUST

TRUST BOARD - THURSDAY 23 MARCH 2023 AT 10AM

Conference Room, NIAS North Division HQ,

121-125 Antrim Road, Ballymena BT42 2HD

Agenda

1 Welcome, Apologies & Declarations of Conflict of Interest

For Information

2 Minutes of the previous meeting held on 9 February 2023

For Approval

3 Matters Arising

For Decision

4 Chair's Update

For Noting

5 Chief Executive's Update

For Noting

6 Patient Care Pathways - 1 Year Update - presentation

For Noting

7 Performance Report (February)

For Noting

8 NIAS Communications Strategy

For Approval

9 Update on Regional Electronic Ambulance Communications Hub (REACH)

For Noting

10 Finance Report (Month 10)

For Noting

11 Committee Business:

- Safety Cttee - minutes from meeting on 12 December 2022 & report from meeting on 28 February 2023

For Information

12 Date & venue of next meeting: Thursday 11 May 2023 at 10am. Arrangements to be confirmed.

13 Any Other Business

Invitees

Mr. William Abraham

Mr. Dale Ashford

Mr. Michael Bloomfield

Mrs. Rosie Byrne

Ms. Lynne Charlton

Ms. Verity Cochrane

Mr. Jim Dennison

Mr. Trevor Haslett

Ms. Nicole Lappin

Ms. Michelle Lemon

Carol Mooney

Mr. Paul Nicholson

Ms. Maxine Paterson

Dr. Nigel Ruddell

Mr. Jamie Wilson

Northern Ireland Ambulance Service
Health and Social Care Trust

Minutes of NIAS Trust Board held on Thursday 9 February 2023 at 11am in the Lagan Room, The Mount Conference Centre, 2 Woodstock Link, Belfast BT6 8DD

Present:	Mrs N Lappin	Chair
	Mr D Ashford	Non Executive Director
	Mr T Haslett	Non Executive Director
	Mr M Bloomfield	Chief Executive
	Ms R Byrne	Director of Operations
	Mr P Nicholson	Director of Finance, Procurement, Fleet & Estates
	Dr N Ruddell	Medical Director
Apologies:	Mr W Abraham	Non Executive Director
	Mr J Dennison	Non Executive Director
	Ms M Lemon	Director of HR & OD
In Attendance:	Ms L Charlton	Director of Quality, Safety & Improvement
	Ms M Paterson	Director of Performance, Planning & Corporate Services (left the meeting at 12.15pm)
	Mrs C Mooney	Board Secretary
	Mr A Arandia	Asst Director Performance, Planning & Corporate Services (rep Ms Paterson)
	Mr N Walker	Head of Performance (for agenda item 6 only)
	Mr J Wilson	Boardroom Apprentice

1 Welcome, Introduction & Apologies

The Chair welcomed members to the meeting and 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 (TB09/02/2023/01)

The minutes of the previous meeting held on 15 December 2022 were **APPROVED** on a proposal from Mr Ashford and seconded by Mr Haslett.

3 Matters Arising (TB09/02/2023/02)

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

Mr Nicholson advised that he had provided the ARAC with an update in relation to the holiday pay issue and confirmed that formal correspondence had now been received from the DoH. He said that he was now working through the process, including the accounting treatment and figures within the accounts. Mr Nicholson said that the issue would remain for some time before it was fully resolved.

4 Chair's Update

The Chair alluded to an action from the previous meeting in which she had undertaken to report back on discussions at the HSC Chairs' Forum in relation to the budget. She advised that, when HSC Chairs had met, it had been clear that the system would breakeven. The Chair indicated that discussions had focussed on workforce and the fact that that workforce had come through the Covid-19 pandemic and continued to try to deliver services in increasingly challenging circumstances. The Chair noted that a further meeting of HSC Chairs was scheduled to take place in March when she expected the discussions to focus on actions to be taken in the 2023-24 year.

Continuing, the Chair advised that, in discussions with the DoH Public Appointments Unit, she had raised the fact that two Non-Executive Directors were approaching the end of their second term of office in mid-May. She said that the DoH was minded to offer extensions to Mr Haslett and Mr Abraham and would likely be in touch in the coming days.

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

5 Chief Executive's Update

At the Chair's invitation, Mr Bloomfield commenced his Chief Executive's report by noting that the period since the December Board meeting had been one of the most challenging periods for the service and added that the pressures had been at levels that had not been seen previously.

Mr Bloomfield said that, regrettably during this period, there had been a number of deaths where there had been a delay in getting an ambulance response to patients. He indicated that there had been media coverage in relation to this at the start of January and said that Ms Charlton would go into further detail on this later in the meeting. He stressed that the deaths were not necessarily as a direct result of the delays, but it was appropriate to review these as Serious Adverse Incidents.

Continuing, Mr Bloomfield said that, since the December Board meeting, a considerable amount of his and colleagues' time had been taken up with very focussed discussions across the system to try to put in place measures to alleviate pressures including a particular focus on ambulance handovers.

Mr Bloomfield alluded to the range of measures which had been announced before Christmas including a three-hour maximum handover backstop. He said members had discussed this in detail at the workshop held on 1 February and in discussions earlier that morning with the Permanent Secretary. Mr Bloomfield welcomed the improvements made since early January and said these had made a difference to staff, and importantly patients, in terms of knowing they would not spend longer than three hours waiting outside an ED and that staff would have more capacity to respond to calls in the community.

Mr Bloomfield pointed out that, not only had the long waits outside EDs been reduced, but average handover times had also reduced. He added that the challenge now was to maintain and improve upon this position. Mr Bloomfield said that Trust Chief Executives had recently agreed to further reduce the three-hour maximum handover to two hours from the start of March.

Continuing, Mr Bloomfield said that, given the extent of pressures between Christmas and the New Year, a number of virtual staff engagement sessions had been held during January to explain in more detail the actions being taken across the HSC. He

acknowledged that there had been some confusion amongst staff around the three-hour maximum backstop and he had thought it important to meet with staff to explain the role NIAS had played in reaching these decisions. Mr Bloomfield said that the engagement sessions also provided staff with the opportunity to raise any concerns they may have had and for Directors to listen to the experiences and challenges faced by staff as well as any suggestions around service improvement.

Mr Bloomfield said that, as a result of the media attention on the Trust, he had received a number of requests from elected representatives to meet with him, Dr Ruddell and Ms Byrne. He confirmed that they had recently met with a Sinn Fein delegation and were scheduled to meet with DUP representatives in the coming weeks. He added that he would also speak at the forthcoming Alliance Party conference.

Mr Bloomfield said that such engagements provided the Trust with the opportunities to ensure there was an understanding of the pressures facing the service.

Mr Bloomfield reported that members would be aware of the further strike action which took place on 26 January. He said that this had proved more challenging than the initial strike on 12 December because all Trade Unions had participated on this occasion and there had been fewer agreed derogations. Mr Bloomfield said that there had been potential for considerable disruption. However the significant planning in the weeks leading up to 26 January and positive working relationships with Trade Union colleagues had ensured that everything had gone as smooth as possible.

Mr Bloomfield acknowledged that, whilst there had been some reduction in activity, the Trust's performance on 26 January had been effective. He indicated that a number of Directors had visited staff on picket lines as well as in the Emergency Ambulance Control (EAC) to show their support for the action staff felt necessary to take and added that there had been a positive atmosphere. He pointed out that the staff's dispute was against the Government's pay policy and not the Trust.

Mr Bloomfield paid tribute to Ms Byrne who had led the Trust's preparations as Gold Commander and to the Tactical Cell which had been in operation for the 24-hour period as well as other staff

across the Trust who had supported the arrangements. Mr Bloomfield said that the significant preparations put in place would assist in future as more strikes were inevitable until the pay dispute was resolved.

Mr Ashford sought further detail around the derogation list.

Responding, Mr Bloomfield cited the example that crews would not respond to calls from health care settings, including nursing homes.

Ms Byrne said that the derogations impacted on hospital flow and those waiting outside EDs. She reiterated that engagement with Trade Union colleagues had been positive and colleagues across the Trust had been assured that everything was being managed well through the Tactical Cell. Ms Byrne highlighted the collaborative approach across Directorates and the significant input from Emergency Planning colleagues.

Mr Bloomfield said it was possible that Trade Unions would reduce the derogation list further in the event of further industrial action. He pointed out that on the day of strike action, an arrangement was in place whereby calls could be upgraded which were not derogated. He added that there had been Trade Union presence in the EAC to monitor this which had worked well.

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

6 **Approach to productivity and efficiency (TB09/02/2023/03)**

At the Chair's invitation, Ms Paterson explained that performance improvement across the Trust was a key enabler to improve services and deliver on the Trust's strategic plan and said the Trust was currently exploring various areas to increase productivity and efficiency.

Mr Arandia advised that the Trust had delivered several performance improvement, operational efficiency and productivity projects across different team as well as focusing on delivering improvements in patient safety. He pointed out that, given the expected financial climate, it was important to continue to focus on driving improved productivity and efficiency within the Trust.

Through the presentation, Mr Walker and Mr Arandia took members through the detail of a number of examples to showcase the work currently underway within the Trust. These examples included PCS – Non-Emergency Patient Transport; Timesheet Automation; Self-Service Business Insights; Handover and Alternative Care Pathways.

Mr Arandia said that further details would be shared with members in the coming months, including deep dives into specific areas.

Ms Paterson explained that the automation of timesheets had allowed the removal of interfaces which did not add value and she added that Station Officers could now focus on other work.

Mr Bloomfield indicated that this was an issue which had been identified in his regular meetings with Station Officers. He said that, while important from the perspective of ensuring staff were paid, it was critical to consider how such duties could be removed from Station Officers and completed in another manner.

Continuing, Mr Arandia referred to the Self-Service Business Insights which had developed tools to allow staff make data driven decisions across the organisation.

Mr Walker said that this work had helped improve planning around the Trust's operational cover and currently the Trust could see operational cover into April. He explained that the system updated every 30 minutes and that any changes on the Global Rostering System were reflected. Mr Walker said that the project allowed oversight of those staff on core shift and overtime reliance on any day, thereby allowing managers to see gaps in cover, particularly at critical times, for example at times of industrial action. He added that the development of this tool allowed the Resource Management Centre (RMC) to focus on their core business.

Ms Byrne confirmed that the project had been welcomed by Operations staff and said that the tool was now used on a daily basis and was working well. She added that the tool was also used for the planning of annual leave.

Ms Charlton commented that the impact of BI solutions should not be underestimated and highlighted their importance when Director on-call. She alluded to recommendations from Serious Adverse

Incidents around the need for increased awareness of operational cover and said the BI solution had assisted in this regard. Ms Charlton said that the tool had proved very helpful in recent staff engagement sessions and its use had been highlighted in terms of the Trust becoming more sophisticated and targeting overtime where it was needed.

Mr Bloomfield referred to the slide shown by Mr Walker which gave an overview of planned cover and pointed out that, of a total of 20 shifts, only three were showing as amber. He said that this allowed the Trust to focus in on the need to provide cover for those particular shifts. Mr Bloomfield pointed out that cover was not currently the issue in terms of the challenges being experienced in relation to response times. He said the Trust was providing the level cover for which it was commissioned and hoped this provided assurance to Trust board.

Mr Arandia advised that, while the tool allowed a more data focused, decision-making approach, it also delivered the benefits of collaborative working at all levels throughout the Trust.

Mr Walker referred to the project around Alternative Care Pathways and explained that the BI solution allowed the Trust to target where resources were sent to, ensuring that the right resource was dispatched to the right patient. He said that this had been made possible through the collaborative efforts of the Clinical Service Desk (CSD) and the clinical team. Mr Walker advised that the system allowed the Trust to drill down into the granular level which in turn assisted with education and training. He indicated that the tool would be invaluable as CSD had been significant in terms of managing risk at times of industrial action, for example.

Dr Ruddell commented that the Trust continued to measure performance relating to response times etc and he would welcome the opportunity to use the same business intelligence tools to provide up-to-date analysis of clinical outcomes. He added that the REACH system was a key part in delivering this and the information it provided was a necessity for many of the clinical projects that the Trust was trying to deliver.

The Chair welcomed the work that had been carried out to date and said she looked forward to seeing how this developed in other

areas. She pointed out that the patients would benefit as the service became more effective.

Referring to the earlier meeting with the Permanent Secretary, Mr Bloomfield said it was clear that the DoH did not intend to allocate funding to inefficient systems. He alluded to the recent industrial action and advised that the Trust had had five individuals on the CSD who liaised directly with Trust medical/nursing colleagues to challenge a number of requests for inter-facility transfers, for example those requests for a Cat 2 response and for which it was appropriate and satisfactory to use an Intermediate Care Vehicle.

Mr Bloomfield said that this approach should be used consistently to ensure resources were utilised more effectively.

Mr Walker alluded to the handover improvement work which had been progressed in conjunction with colleagues across other Trusts. He said that the project had aimed to produce a single source position on hospital handover times across NI. He explained that the project had enabled the use of data intelligence to agree a timestamp in EDs in respect of handovers, thereby improving outcomes at operational and clinical levels.

Ms Paterson pointed out that this initiative had been agreed at the Unscheduled Care Summit held in October 2022 and said it was appropriate that all Trusts were using the same baseline for timestamping handovers. She commended the Operational team and said they had done great work in ensuring the tool was utilised within each ED.

Ms Byrne indicated that, from an operational perspective, the tool, which was used in real time, allowed for planning in terms of where efficiencies could made and allowed Station Officers and Hospital Liaison Ambulance Officers (HALOs) to see where crews were experiencing delays. She said that further work was ongoing to determine why handover times might be longer than expected and the potential reasons for this.

Mr Bloomfield agreed that this tool would help to drill down further into the data and believed that the introduction of an agreed baseline across Trusts in terms of when handovers took place negated any discrepancies that might arise.

Mr Walker said that the data allowed the Trust to see potential variations in practice and what referral pathways were in place. He confirmed that work was ongoing across Trusts to determine where efforts might be focused to maximise efforts. Mr Walker said the focus was on becoming more data rich and applying the data available to the challenges which had been identified.

Mr Ashford referred to the figure quoted which demonstrated that 31% more patients were arriving on time for appointments. He welcomed the work carried out and commended all involved. Mr Ashford sought further detail around the tools used and asked if they had been procured by the Trust from an external source.

Responding, Ms Paterson explained that NIAS staff had been provided with the necessary training to develop their capabilities and were now able to provide valuable and powerful information. She added that the team had been empowered and engaged and were a valuable resource within the Trust.

Mr Haslett echoed Mr Ashford's comments in relation to more patients arriving on time. He referred to the Hazardous Area Response Team (HART) and the low number of calls responded to by the team.

Dr Ruddell clarified that this did not accurately reflect the full volume of work undertaken by HART who were often dispatched as a secondary resource to complex calls. He explained that the team also undertook other duties which were their primary roles, eg fulfilling the need for regular specialist training. Dr Ruddell indicated that HART also supported crews responding to high category calls as well as deploying to calls in the Belfast area when there were not engaged on HART-specific incidents. As a result, the team had developed considerable experience in responding to cardiac arrests and the Medical Directorate was considering the potential for cross-links with the HEMS team.

Mr Walker pointed out that HART would respond to cardiac arrest calls as first responders but that the conveyance of such patients would be attributed to the crew so as to avoid multiple coding.

Dr Ruddell acknowledged the high volume of training undertaken by HART personnel and confirmed that the team would support operational frontline staff, particularly in cardiac arrest calls.

Mr Bloomfield said it would be important to strike a balance in terms of ensuring the team was able to respond to high category calls and those calls for which it would be appropriate to dispatch a HART response.

The Chair thanked Mr Arandia and Mr Walker for their presentation and said she looked forward to further updates when available.

Mr Walker withdrew from the meeting at this point.

7 **Overview of Manchester Arena Inquiry Report and Recommendations (TB09/02/2023/04)**

The Chair reminded members of the circumstances surrounding the terrorist attack on the Manchester Arena in May 2017 which resulted in the tragic death of 22 innocent victims who had attended a pop concert. She advised that the Manchester Arena Inquiry had been established in October 2019 and was an independent public inquiry to investigate the deaths of the victims of the attack. Volume Two of the Inquiry Report examined the emergency response following the attack.

The Chair asked that an element of the discussion at today's Board meeting would inevitably focus on how the recommendations might be taken forward and the monitoring/reporting arrangements to be put in place.

Dr Ruddell acknowledged that the report made for difficult reading and said the Coroner had identified that the delayed response of the emergency service had resulted in casualties dying from survivable injuries.

Dr Ruddell advised that the Inquiry Report made a total of 149 recommendations which had been divided into those which should be addressed at a local or national level. He indicated that a number of recommendations were specifically aimed at ambulance services across the UK with a number having indirect implications for individual ambulance Trusts.

Continuing, Dr Ruddell advised that he was engaged through the Association of Ambulance Chief Executives (AACE), the National Ambulance Resilience Unit (NARU) and the National Ambulance

Service Medical Directors forum (NASMED) to discuss the implications. He pointed out that some recommendations had already been implemented as a result of developing clinical practice while others were being progressed.

Dr Ruddell indicated that there would be changes to emergency planning within the Trust and said that these changes would be taken forward by the Emergency Preparedness, Resilience and Response Team which was itself going through a review. He commented on the implications for clinical practice, training, operational response and in particular the 24/7 management support.

Dr Ruddell drew members' attention to the spreadsheet which identified the recommendations and which agency would be responsible for the monitoring/reporting of the recommendation as well as those recommendations which would impact on NIAS.

Dr Ruddell indicated that, as yet, there had been no contact from the DoH and he emphasised that a number of the recommendations did not apply solely to English ambulance services but ambulance services throughout UK. He clarified that, while the representative bodies were based in England, they would produce guidelines and best practice for implementation.

The Chair referred to the fact that the Inquiry Report had been published in late 2022 and expressed concern that the DoH had not yet been in contact with the Trust. She was of the view that the DoH needed to be fully aware of the recommendations and how these translated to the NI context.

Mr Bloomfield pointed out that, as well as the NI DoH, it would be important for the Civil Contingencies Group NI to be aware of the detail of the recommendations and their implications for NI. He advised the meeting that he, Ms Byrne and Ms Paterson had met recently with the newly established Blue Light Forum representing the three blue light agencies, ie the PSNI, the NIFRS and the NIAS. Mr Bloomfield said that the Inquiry Report had been the single agenda item for discussion at the Forum's first meeting when members considered those recommendations which cut across the three organisations.

Dr Ruddell pointed out that one of the themes of the Inquiry Report had been that of 'mutual aid' where other ambulance Trusts would assist in such circumstances. He highlighted that the NIAS did not have that option in Northern Ireland and would call upon the National Ambulance Service in the Republic of Ireland for assistance if required. Dr Ruddell said he had made the point for the need to share risk assessment information with colleagues in the Republic of Ireland. He added that the Home Office was currently giving this consideration.

Mr Haslett said he had been struck by the number of recommendations which had been put forward post incident and queried how much of the report was aimed at preventing such an incident.

Dr Ruddell explained that the Inquiry Report had been divided into two Volumes – the first focused on the intelligence services, counter terrorism and security arrangements.

Mr Ashford expressed his concern that the DoH had not yet contacted the Trust to discuss the Report and he suggested that the Trust should engage with DoH colleagues.

Dr Ruddell advised that there were a number of recommendations within the report with which NASMED and AACE did not necessarily agree. He said it was likely that the organisations would respond clarifying why they disagreed with certain recommendations and pointed out that the recommendations were not requirements.

Continuing, Dr Ruddell said that another theme of the Report was the importance of communications which were often chaotic in the first few minutes of a major incident. He said it was fortunate in NI to have single Police, Fire and Rescue and Ambulance Services who already undertook joint JESIP training. He explained that JESIP models and standards set out a standard approach to multi-agency working, along with training and awareness for responding organisations to train staff. Dr Ruddell emphasised the importance of all individuals involved to understand their role.

Dr Ruddell acknowledged that a number of the recommendations required resourcing in terms of requiring additional equipment as well as the training and development of staff. However he accepted

that the most important issue would be the resourcing of 24/7 management cover.

Dr Ruddell reminded the meeting of the Trust's request in early 2022 for AACE to review its internal emergency planning arrangements and he acknowledged that a key issue would be to ensure staff received refresher training and clearly understood their individual roles and on-call arrangements. He added that further challenges would be presenting in ensuring staff were released to undertake the necessary training.

Ms Byrne pointed out that this included training for senior on-call and Director on-call so there was absolute clarity around roles and responsibilities.

Mr Ashford referred to the need for multi-agency training also.

Mr Bloomfield said he had omitted, in his earlier update to Trust Board, to report on his and the Chair's attendance at the Accountability Review meeting with the Permanent Secretary on 21 December 2022. He said that he had taken the opportunity at that meeting to brief the Permanent Secretary on the AACE review commissioned by the Trust into its internal emergency planning arrangements. Mr Bloomfield said he had advised the Permanent Secretary that it was likely the review would identify significant issues, particularly the challenges presented by not having 24/7 operational management support and the need to provide refresher training. He pointed out that there would be associated financial implications.

Continuing, Mr Bloomfield clarified that the 24/7 operational management cover was included within the CRM business case and he suggested that there might be a strong case for removing this from the CRM business case with a view to ensuring it was within a separate emergency planning business case. However, he said it would be important for the Trust to consider the AACE review when finalised as well as the financial implications. Mr Bloomfield referred to the Manchester Arena Inquiry Report and suggested it was not possible to fully implement learning from such tragic incidents without incurring costs.

Dr Ruddell advised that, from a NIAS perspective, consideration and responding to the Report's recommendations would require a

cross-Directorate approach. He suggested that, in the knowledge that there were gaps to be considered by the various representative organisations, the Trust should proceed with its consideration of the relevant recommendations, linking with the Blue Light Forum where necessary.

The Chair referred to those recommendations to be progressed by the NIAS and sought clarification on whether there was an immediacy to any. She suggested it would be appropriate for the Trust's Safety Committee to oversee the Trust's response to the recommendations and queried whether it was Dr Ruddell's intention to brief the Committee on the interim actions to be taken.

Responding, Dr Ruddell confirmed that a number of actions had already been implemented and advised that the NIAS was the first service to have begun training on new triage techniques. He pointed out that it would be important, as well as ensuring staff were clear on their roles and responsibilities in the event of a major incident, that staff knew how to manage a critical situation. Dr Ruddell suggested it would be key to provide relevant training for on-call officers and confirmed that NARU had facilitated such training to the Trust's Emergency Planning Officers who would in turn cascade the training to other staff.

The Chair acknowledged that Dr Ruddell's comments would provide assurance to the Committee but she believed it would be helpful for the Committee to consider an action plan with defined timescales for completion of actions.

Mr Bloomfield said that he and Dr Ruddell would consider how best to ensure DoH colleagues were involved in this work. He said it would be important to ensure the NI context was represented and taken into account at national level while being cognisant of potential financial implications.

Dr Ruddell clarified that the NASMED would consider those recommendations which were specifically clinical in nature and consider the need to update national clinical guidelines if necessary.

The Chair asked for consideration to be given as to the appropriate overview arrangements by the Safety Committee. She thanked Dr Ruddell for providing an overview to the Board.

Members **NOTED** the overview of the Manchester Arena Inquiry Report and Recommendations.

8 **Overview of Serious Adverse Incidents (TB09/02/2023/05)**

At the Chair's invitation, Ms Charlton presented an overview of Serious Adverse Incidents (SAIs) and advised that the Trust had notified the Strategic Planning and Performance Group (SPPG) of nine SAIs where there had been a delayed response and the patient outcome had been death. She said it was not immediately clear if the delayed response in each incident had directly attributed to the patient outcome and a review of causal factors in each case would be undertaken. She added that a further SAIs had been notified to the SPPG in mid-January. Ms Charlton highlighted the increased number of incidents noted in December 2022.

Ms Charlton reminded members that the purpose of a SAI was to learn from those incidences where things went wrong and reiterated that the focus was on learning and prevention of recurrence. She alluded to the number of incidents received by the Trust and pointed out that only a small number of these were notified as SAIs. Ms Charlton referred to the importance of family involvement in a SAI review and accepted that it was, on occasions, understandably difficult for the families involved to understand that the focus was on learning and she highlighted the importance of meaningful and sensitive engagement in this regard. Ms Charlton said that, as well as the impact on the families involved, it was important to acknowledge the impact on staff.

Ms Charlton referred to the category of calls and the duration of delayed response and acknowledged how difficult this would have been for families and friends who were with the patient during this wait.

Continuing, Ms Charlton referred to the Rapid Review Group (RRG) which met on a weekly basis to consider incidents and, on occasions, complaints which might be categorised as SAIs. She outlined the attendance at the RRG meetings and clarified that not all incidents discussed at the RRG met the criteria for SAI notification.

Ms Charlton reiterated the importance of learning from SAIs and ensuring that the sharing of learning was disseminated throughout

the organisation and regionally as appropriate. She highlighted the need for support for staff and the need to demonstrate the just culture approach.

The Chair thanked Ms Charlton for presenting her overview and believed that this had been done sensitively.

Mr Bloomfield acknowledged the emotional impact on families and staff. He highlighted that it was not possible to determine if the delayed response had contributed to the patient outcome. He expressed his appreciation to Dr Ruddell for undertaking a number of media interviews.

Dr Ruddell referred to the experience of patients and their families waiting for an ambulance and said this impact should not be underestimated.

Ms Charlton explained that the Trust would advise the Coroner of any SAIs and said that consideration would be given to whether a serious risk had been presented by the delayed response to the patient. She also explained that, in the context of a delayed response, it was understandable that those calling for help felt it necessary to make multiple calls to query the estimated time of arrival of the ambulance. Staff in the Control Room had experienced the moral impact of knowing that they did not have the capacity to respond to the call and this could result in additional pressure on the occasions when the callers' fear, anxiety and frustration had the potential to come across as aggression.

The Chair said that this was another sensitive and difficult aspect of an already challenging job. She added that the Trust Board had previously expressed its gratitude to those officers who met with families who had been traumatised by the loss of a loved one.

The Chair said she wished to put on record again the Board's appreciation to those officers who took the time to meet with families. She also acknowledged the impact on staff and said the Board very often did not see this nor the impact on the call takers in the Emergency Ambulance Control.

Members **NOTED** the overview of SAIs as presented by Ms Charlton.

9 **Draft Equality Action Plan and Disability Action Plan 2023-28 (TB09/02/2023/06)**

In Ms Lemon's absence, Mr Bloomfield explained that Board approval was sought to the draft Equality Action Plan and Disability Action Plan 2023-28.

He advised that 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. Mr Bloomfield indicated that the Action Plans followed on from previous Plans and set out the steps Trusts would take during the five-year period from April 2023 to meet the duties. He said that staff from the Trust's Equality Team had worked collaboratively with other HSC Trust colleagues to develop the Action Plans, including holding listening events with the public.

Mr Bloomfield advised that, once respective Trust Boards in each Trust had approved the Action Plans, they would be issued for a period of public consultation and, subject to the outcome of this, would be agreed and published.

The Board **APPROVED** the Action Plans on a proposal from Mr Ashford. This proposal was seconded by Mr Haslett.

10 **Review of NIAS Standing Orders (TB09/02/2023/07)**

The Chair advised that the Standing Orders had last been reviewed in October 2021. She explained that the proposed revisions were minor in nature and had been reviewed by the ARAC at its meeting on 19 January 2023 and recommended for approval by the Board.

The Board **APPROVED** the revisions to the Standing Orders on a proposal from Mr Ashford. This proposal was seconded by Mr Haslett.

11 **Board Governance Self-Assessment Tool (TB09/02/2023/08)**

The Chair drew the Board's attention to the Board Governance Self-Assessment Tool for 2021-22 which had been discussed by the

ARAC at its meeting on 19 January 2023 and recommended for approval by the Board.

She referred to Section 1.2, GP4 and explained her rationale in wishing to have a Non-Executive Director with an understanding and knowledge of clinical matters to ensure that was informed independent scrutiny of NIAS clinical matters. The Chair advised that she had been discussing this issue with DoH colleagues who were considering how they could address this in the current recruitment exercise for Non-Executive Directors.

Dr Ruddell said that he would very much welcome clinical challenge from a Non-Executive Director colleague and referred to the expertise provided to the Safety Committee through the engagement of the current Clinical Adviser. He encouraged the Chair to continue to pursue this with the DoH.

Ms Charlton agreed with Dr Ruddell's comments. She thanked the Chair for raising this point with the DoH and said it would be important for Directors to continue to be challenged at Board level.

The Chair alluded to the Management Statement Financial Memorandum (MSFM), in particular paragraph 2.1.1 which stated that 'The approved overall aims for the Trust are as follows: To improve health and social well-being outcomes, through a reduction in preventable disease and ill-health, by providing effective, high quality, equitable and efficient health and social care...' and believed that the Trust did not have a Non-Executive Director with a background specific to the work of the Trust.

Members agreed that a red RAG rating should be attributed to GP4.

Subject to this amendment, the Board **APPROVED** the Board Governance Self-Assessment Tool for 2021-22 on a proposal from Mr Ashford. This proposal was seconded by Dr Ruddell.

12 **Performance Report (TB09/02/2023/09)**

Members **NOTED** the Performance Report as at January 2023.

Mr Haslett welcomed the improvement in Cat 2 response times and acknowledged that further improvements were required.

The Chair pointed out that, for the past number of Board meetings, the practice had been to report on the Performance Report by exception. However she suggested that it would be helpful to discuss the report in detail at the March meeting.

Mr Ashford agreed and believed that the report provided a comprehensive overview. He commended all involved in its development.

Mr Bloomfield said that the response times for Cat 2 and 3 on pages 5 and 6 respectively clearly showed the challenges experienced by the Trust in December and said this had been supported by Ms Charlton's earlier presentation in relation to Serious Adverse Incidents.

13 **Finance Report (Month 9) (TB09/02/2023/10)**

Mr Nicholson commenced his report by advising that the Trust was reporting a breakeven position for the nine months ending December 2022 and was forecasting a breakeven position at year end. He said that the Trust was currently awaiting a number of allocations, including the pay award which, while not yet agreed, would be paid to staff in March.

Mr Nicholson said it was clear that there would be a constrained financial envelope across the public sector in 2023-24 and alluded to the earlier presentation on productivity and efficiency which, he added, would become even more important.

Continuing, Mr Nicholson reported that there had been some reduction in the Trust's use of voluntary and private ambulance services over the last three months. However, he said, there had been significant additional costs in relation to the provision of patient taxis during that period.

In terms of overtime expenditure, Mr Nicholson advised that, while there had been a reduction on the reliance of the Covid-19 Rapid Response Payment Scheme (CRRPS), overtime remained at a significant level and was higher than it had been in previous years. He reminded members that previously overtime had remained consistent averaging approx. £6 million per annum.

Mr Nicholson reported that the Trust was now in the last two months of its current Capital Resource Limit (CRL) and said the Trust had received assurances from suppliers that many elements of the capital programme would be completed by 31 March 2023. He acknowledged that, in an effort to manage the traditional and exceptional risks, there was an element of over-programming on the current capital programme which would be managed through additional bids and funding or the deferral of schemes into the 2023-24 year. Mr Nicholson indicated that the Trust had been successful in a recent bid to the DoH for £0.5 million towards the estates programme.

Mr Nicholson reported that the Trust's prompt payment of invoices remained strong and said he was hopeful that the Trust would again meet its target to pay 95% of invoices within 30 calendar days. He advised that a regional target to pay 70% of invoices within 10 working days had recently been increased from 60%.

Mr Haslett referred to the increase in overtime and to Mr Arandia's earlier presentation on productivity and efficiency and said he hoped that further monitoring would assist in reducing expenditure further in this area. He commented on the fact that the Trust was nearing the end of the financial year and there had been minimal expenditure on the capital programme. However, he acknowledged that the Trust had managed to remain within budget each year.

The Chair was of the view that it was unlikely that the 'J-curve', referred to by Mr Haslett on previous occasions, would be addressed. She acknowledged that some contracts lended themselves to expenditure being spread throughout the year and said that the majority of suppliers would be 'end year loaded'. She suggested that one would see less of a 'J-curve' moving into the 2023-24 year.

Mr Nicholson agreed with the Chair's assessment and commented that he had never before seen such a sharp increase. He added that his preference would be to have the majority of expenditure incurred by Christmas each year.

The Chair suggested it might be helpful for the PFOD Committee to understand the reason why the profile had been so sharp and the actions being taken by the Trust to mitigate this.

Mr Bloomfield drew the Board's attention to page 8 of the Finance Report, in particular the Trust's expenditure on CRRPS. He said it was encouraging to see the steady reduction on CRPPS payments since August and said the decision by the Senior Management Team to make these payments available only in extenuating circumstances had been correct.

The Chair thanked Mr Nicholson for presenting the Finance Report (Month 7) which was **NOTED** by the Board.

14 **Committee Business:**

- **Safety, Quality, Experience & Performance Committee – report from meeting on 12 December 2022;**
- **Audit & Risk Assurance Committee – minutes of meeting on 8 December 2022 and report of meeting on 19 January 2023 (TB09/02/2023/11)**

Mr Ashford referred to Ms Leckey's presentation on the work of the Community Resuscitation Team to the December Safety Committee and said members had been extremely impressed by those individuals who had trained to become Community First Responders.

Mr Bloomfield paid tribute to the small Team and pointed out that the provision of training and ongoing support to Community First Responders represented a small but very important element of the Team's work. He said that the Team also visited schools to teach CPR.

Dr Ruddell alluded to the fact that Ms Leckey's presentation had mentioned a number of new developments, including the GoodSam initiative. He explained that, from 7 February, a much larger number of individuals registered with GoodSam may be alerted to cardiac arrests in Northern Ireland.

Members **NOTED** the Committee minutes and reports.

15 **Date of Next Meeting**

The next NIAS Trust Board will be held on Thursday 23 March 2023 at 10am. Venue to be confirmed.

16 **Any Other Business**

(i) Launch of children's ambulance

Mr Nicholson advised the Board that he had recently attended the launch of the children's ambulance which had been developed from a partnership between the Children's Heartbeat Trust, Northern Ireland Specialist Transport and Retrieval (NISTAR) and NIAS.

(ii) Disaster Response Team

Ms Byrne advised that the Trust had supported a member of staff in being deployed to Turkey to work a member of the disaster response team.

THIS BEING ALL THE BUSINESS, THE CHAIR CLOSED THE PUBLIC MEETING AT 1.15PM.

SIGNED: _____

DATE: _____

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

PRESENTATION OF PAPER

Date of Trust Board:	23 March 2023
Title of paper:	Patient Care Pathways (PCP) - 1 Year Update
Brief summary:	Presentation brought to present on the year review of Patient Care Pathways within NIAS, following the appointment of the Clinical Pathways Lead. Presentation will include headline events over the last year in the portfolio, data from the same and plans moving forward.
Recommendation:	**For Approval** ☐ **For Noting** ☒
Previous forum:	SMT – 7/3/23
Prepared and presented by: **Date:**	Karl Bloomer, Clinical Pathways Lead Dr Nigel Ruddell, Medical Director 16 March 2023

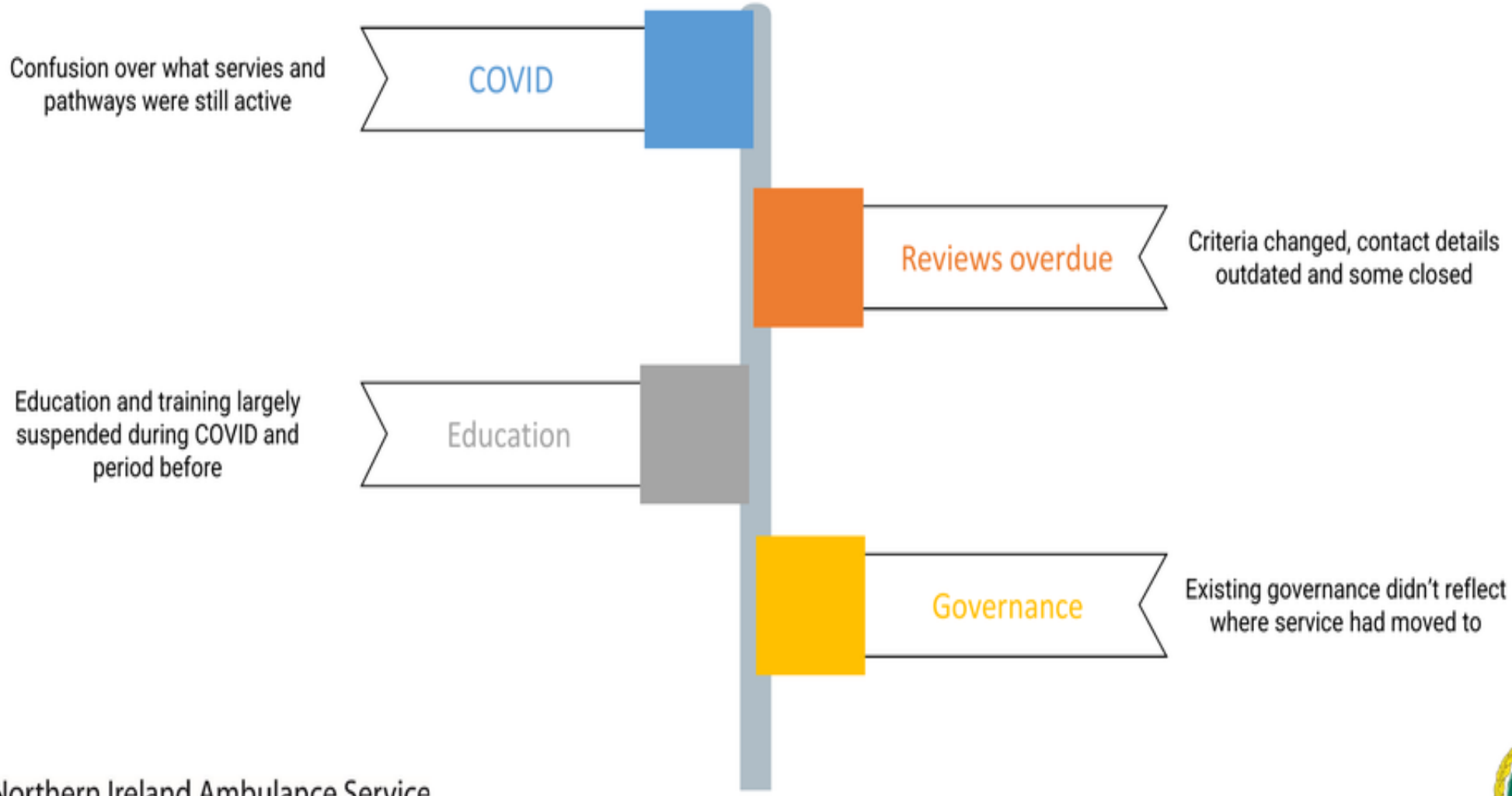
PATIENT CARE PATHWAYS

Patient Care Pathways (PCP)

1 Year Update

Karl Bloomer - *Clinical Pathways Lead*

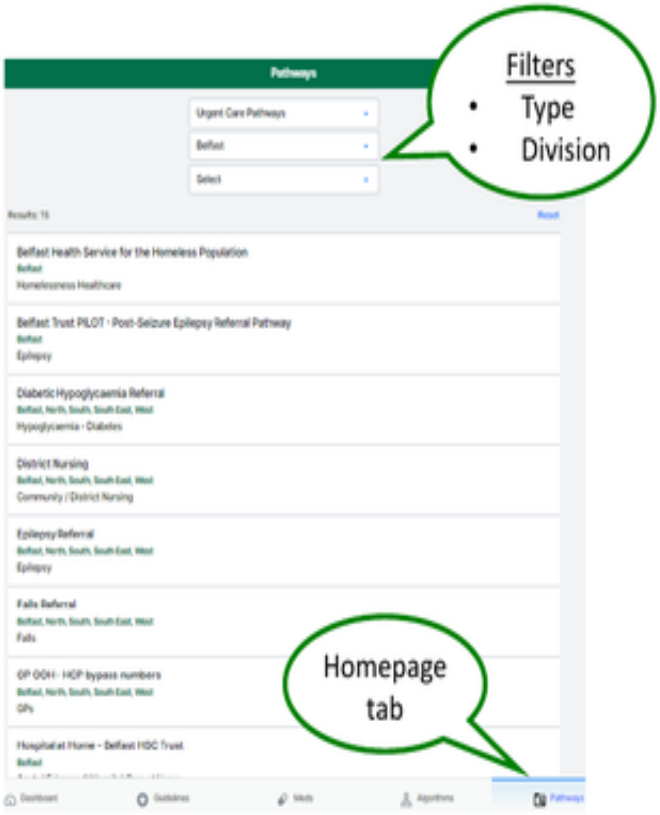
Where we were



Key developments

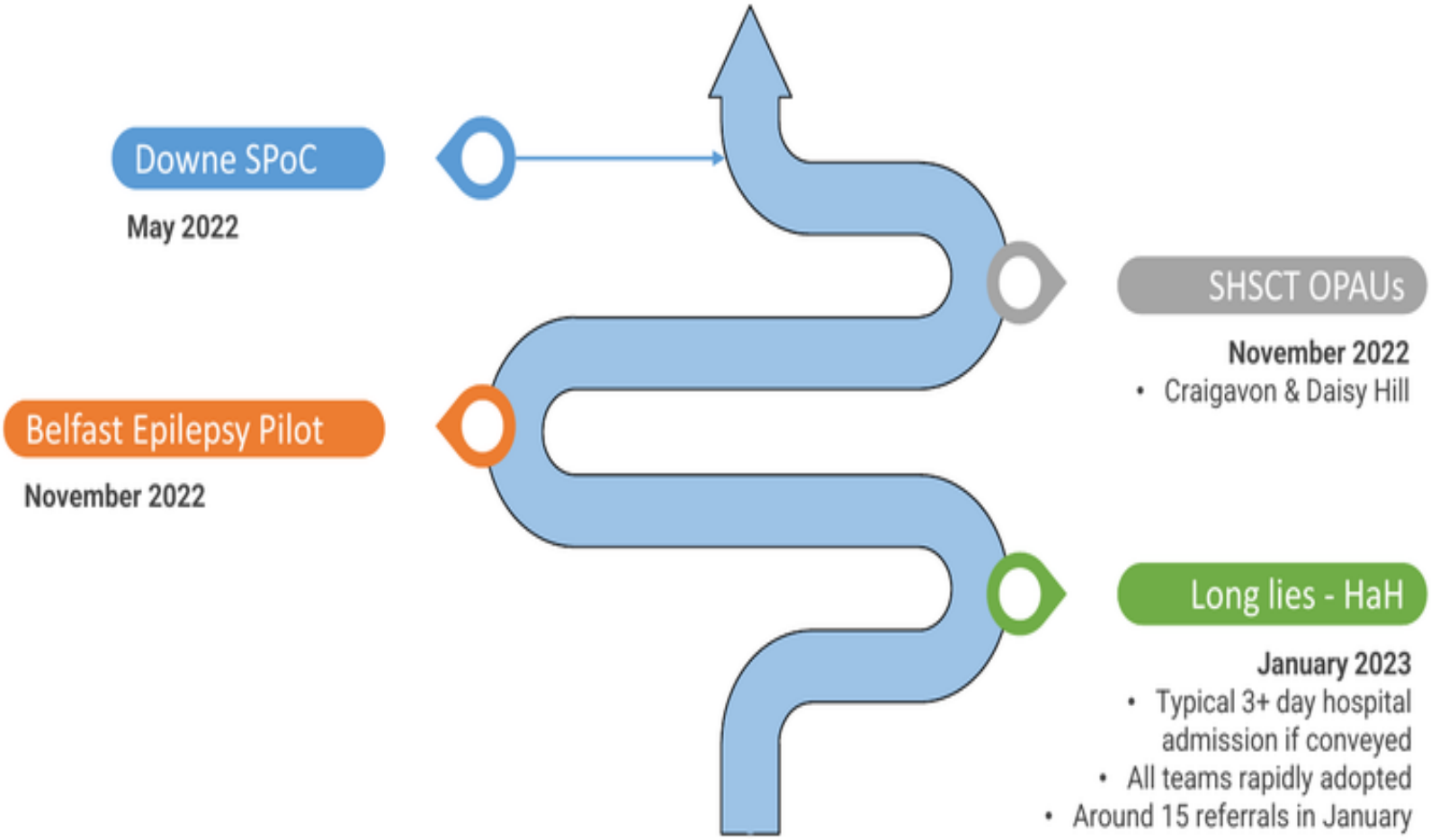
Foundations and Relaunch Strategy

Digital Pathways Directory



New Pathways
Launched in 2022/23

PATIENT CARE PATHWAYS URGENT CARE



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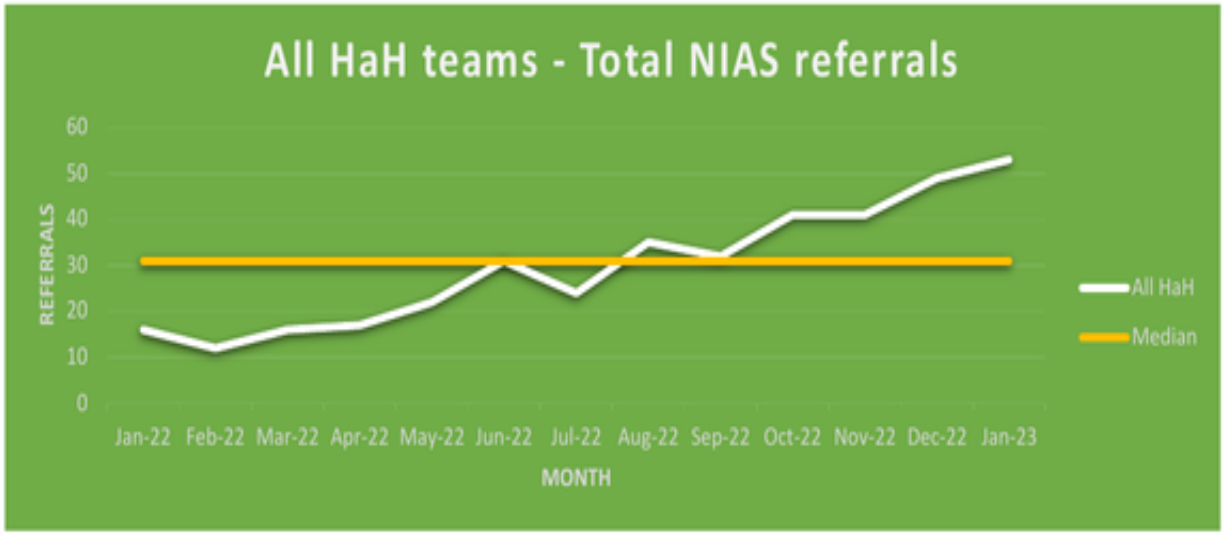
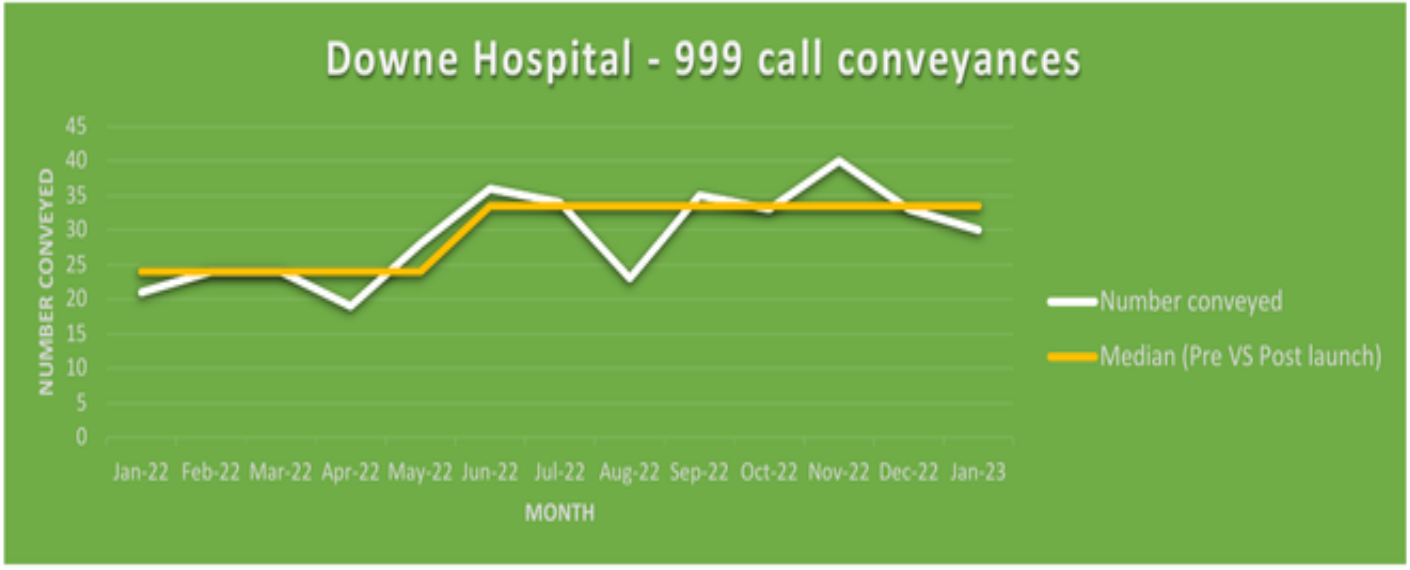
Data outcomes

Increasing Referrals Trend

PATIENT CARE PATHWAYS URGENT CARE

- Hospital at Home
  - ✓ Demonstrable return on staff education and awareness sessions
- Less time lost waiting at EDs
- Less bed days taken up
- Better patient outcomes/ satisfaction

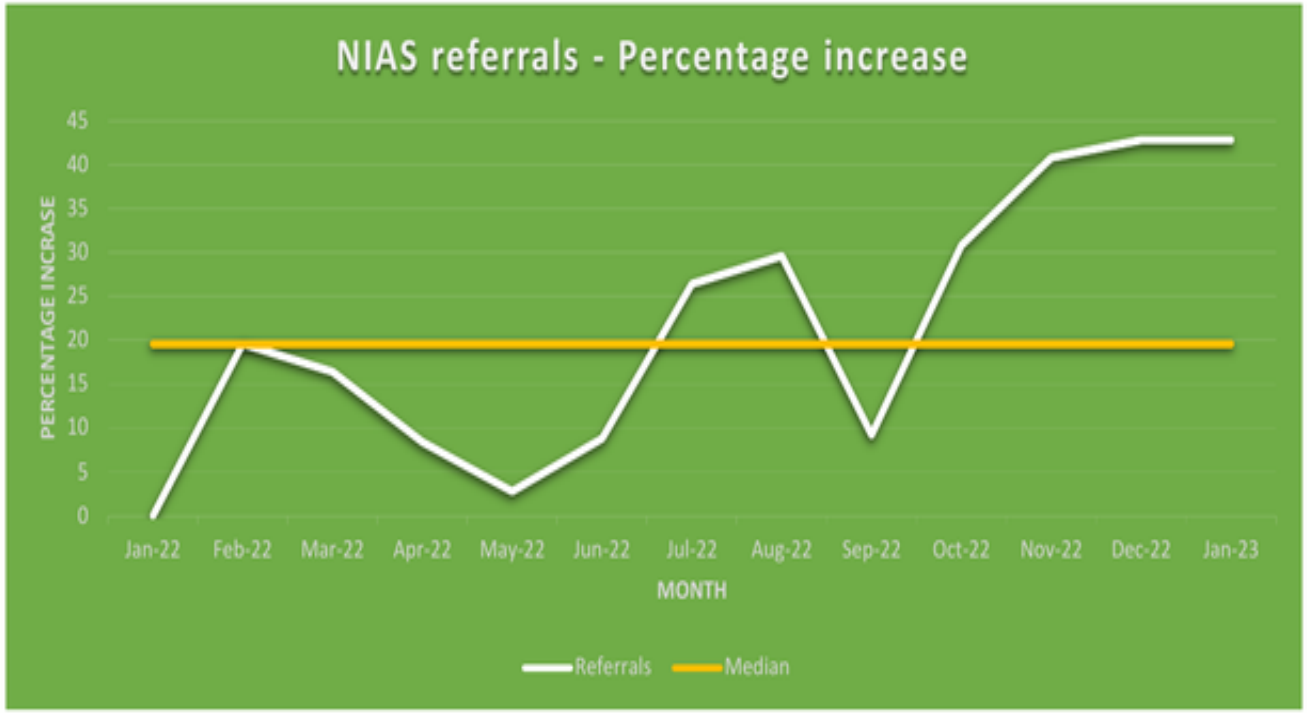




- Downe SPoC – May 2022
- Increase maintained post intervention
- Positive staff feedback

Data outcomes

Increasing Referrals Trend



Future Pathway Developments - 2023

PATIENT CARE PATHWAYS URGENT CARE

Direct Admission discussions

- Altnagelvin - ACU
- Causeway Hospital - OPAU
- Omagh - Bespoke pathway in discussion
- 3-6 months

Education

- Urgent Care / CDM day
- Continued CPD events
- 9-18 months

Mental Health

- Mental Health interagency discussions
- Control room
- 6-18 months

Palliative

- Palliative Care Locality Board
- Macmillan
- 6-12 months

Audit

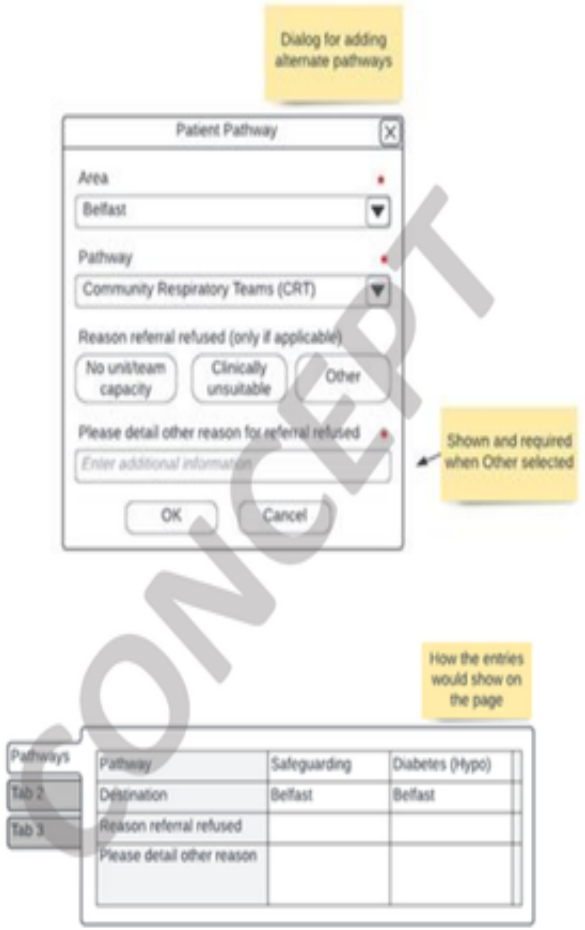
- Care bundles
- Support tailored
- 3-9 months

Digital referrals developments

ePCR update

- Automated digital referrals defined and with developer – awaiting test version.

  - ✓ Removes need for crews to ring EAC
  - ✓ Multiple referrals can be made
  - ✓ Real time NIECR link
  - ✓ Referral email sent once ePCR completed



Why do it?

'Care was invaluable at a most difficult time. I don't even think my mum would have received this level of care even as an in-patient.

It has stabilised her and the info given to us was valuable going forward. I would recommend this service to anyone'

'This was an exceptional service. Should be developed to other services/areas'

'The acute care at home were phenomenal. Absolutely professional care given to our mom. Kind, very caring, empathetic and very attentive to her needs.

Would definitely encourage and recommend people to use this amazing service. Our family is very grateful to the team.'

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

PRESENTATION OF PAPER

Date of Trust Board:	23 March 2023
Title of paper:	Trust Performance Report - February 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 31 January 2023
Recommendation:	**For Approval** ☐ **For Noting** ☒
Previous forum:	SMT – 27/2/23
Prepared and presented by: **Date:**	Neil Walker, Head of Performance Maxine Paterson, Director PPCS 16 March 2023

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST PERFORMANCE REPORT

NORTHERN IRELAND AMBULANCE SERVICE

February 2023

for January 2023 Data and Performance

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NIAS Changes To Operational Actions To Support Pressures

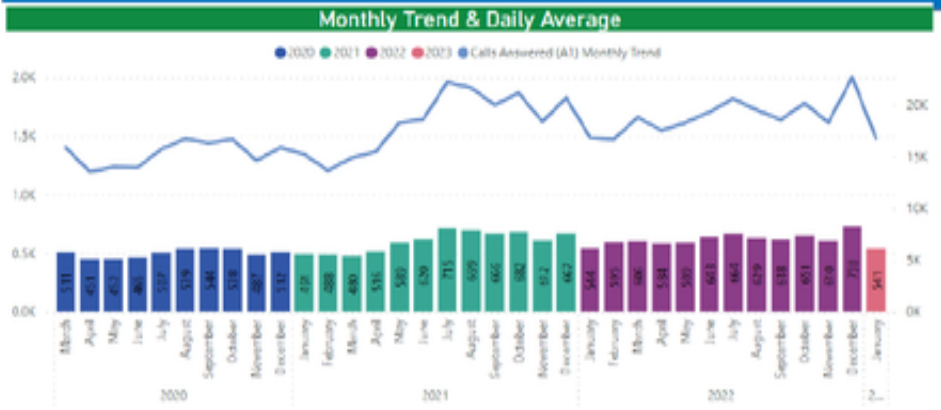
Resource Escalation Action Plan (REAP)

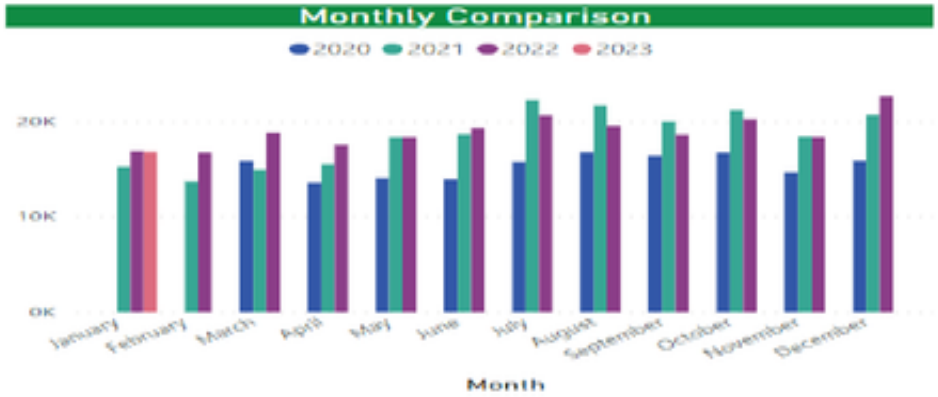
- At the time of writing of this report, the Trust is in REAP 4 Extreme Pressure, having just come through the second period of industrial action in 2023. In response, the Trust stood up its command and control structures to plan, manage and recover from the industrial action. It must be noted that the Trust was also informed on 21 February 2023 that the Unison union will continue throughout March with action short of strike.

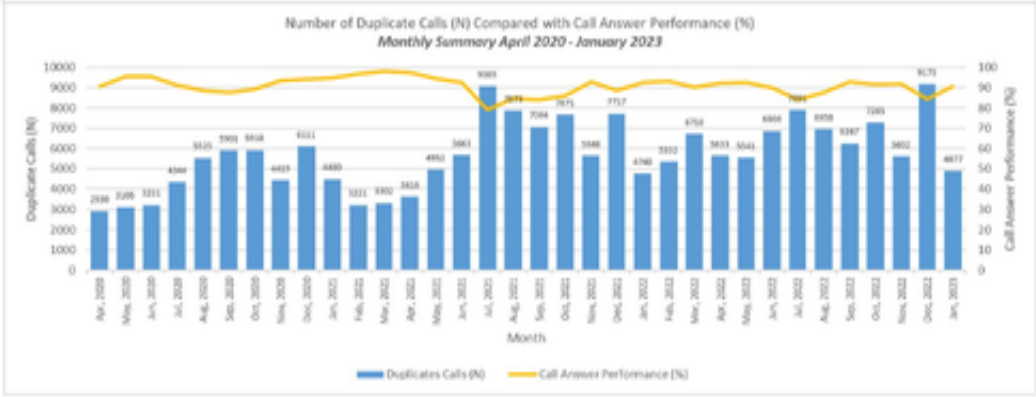
Clinical Safety Plan (CSP)

- 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





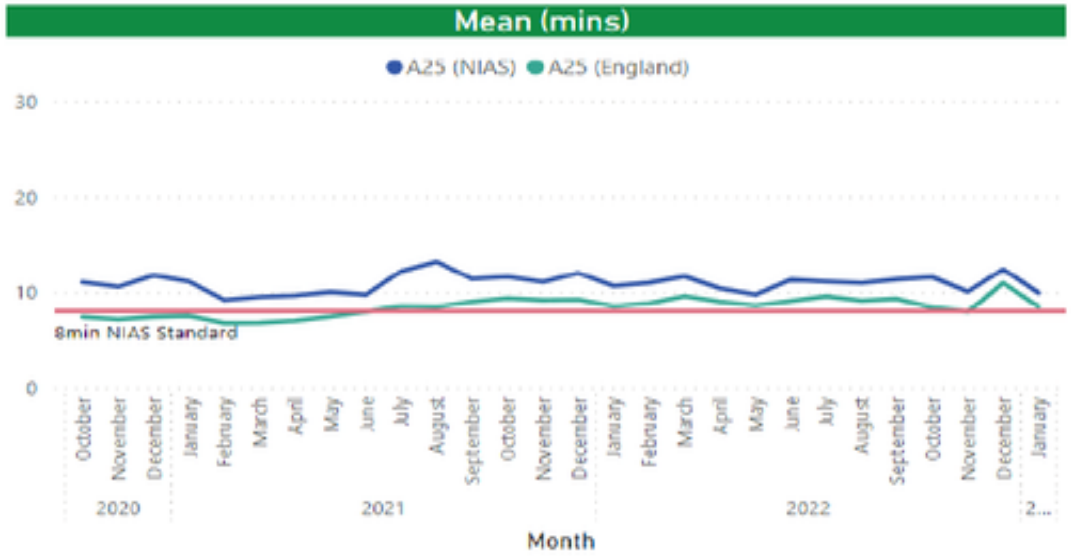


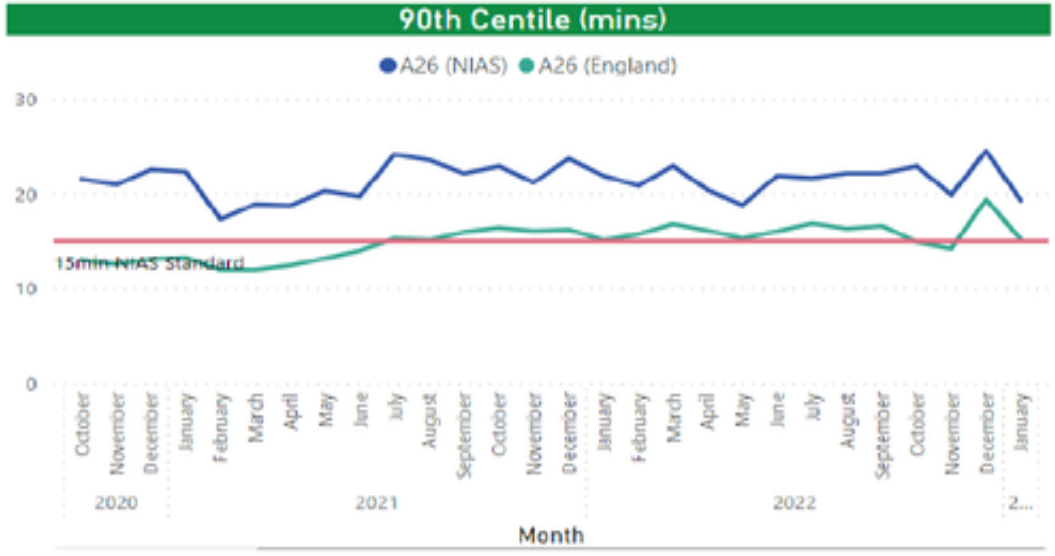
- **January 23** saw similar demand levels with compared with January 22 . **YTD demand** is **static** comparing fin year 2021-22 to fin year 2022-23. However, in the same time period YTD, **incidents** have **decreased** by **6%** from fin year 2021-22 to fin year 2022-23
- **Demand** experienced by **NIAS in January 2023** was significantly down compared to December 2022. On average 190 calls less per day was experienced.
- **Call answer performance** recovered in January 2023 to exceeding the **90%** target for the month. **January 2023** saw call answer performance achieve **92%**
- **January 2023** also saw a reduction in duplicate calls to 4,877. This is a reduction of over 4000 calls from December 2022

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
Jan 22 (mins)	08:31	10:39
Jan 23 (mins)	08:30	09:56
22/23 Change (+/-)	-00:01 mm:ss	-00:43 mm:ss
Deviation from Target (Jan 23)		+01:56 mm:ss

- Category 1 Mean Response time has decreased by 43secs from Jan 22
- Our deviation from target however persists at >1min for Jan 23

90th Centile Category 1	National	NIAS
Jan 22 (mins)	15:06	21:56
Jan 23 (mins)	15:11	19:19
22/23 Change (+/-)	+00:05 mm:ss	-02:37 mm:ss
Deviation from Target (Jan 23)		+04:19 mm:ss

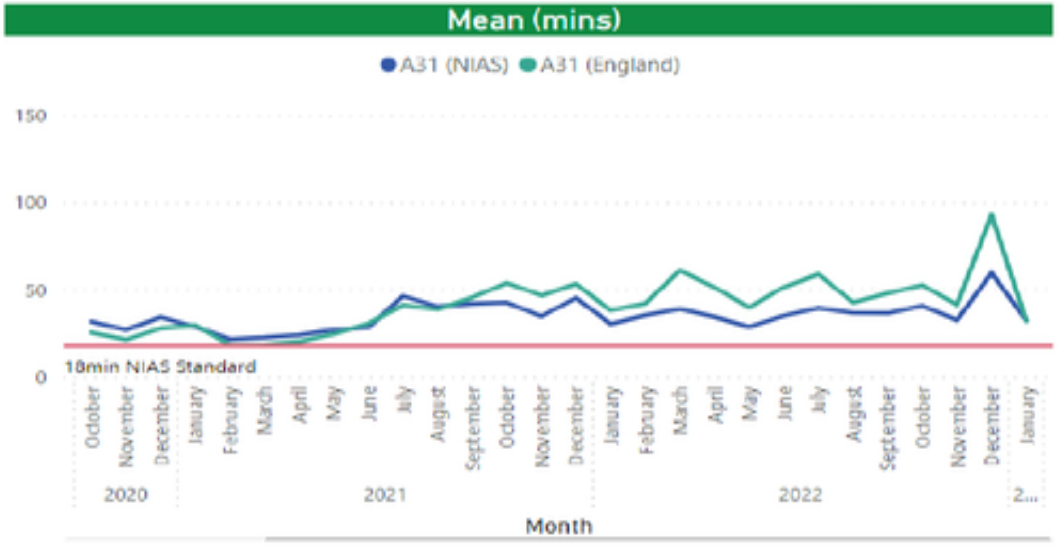
- Category 1 90th Centile Response time has decreased by >2mins from Jan 22
- Our deviation from target however persists at >4mins for Jan 23

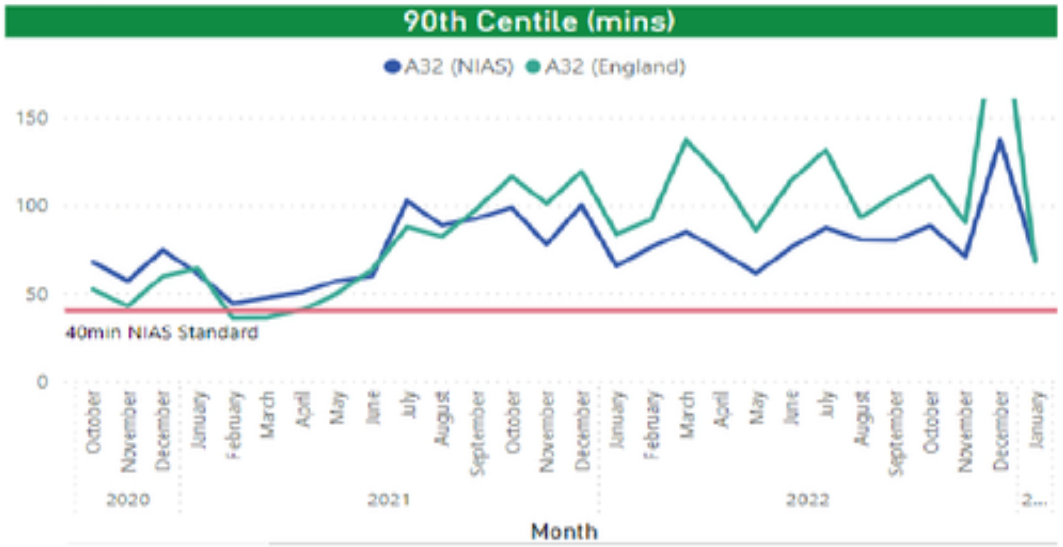
*** Note clock starts for NIAS Cat 1 and England Cat 1 target calls are different**

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
Jan 22 (mins)	38:04	30:21
Jan 23 (mins)	32:06	32:31
22/23 Change (+/-)	-05:58 mm:ss	+02:10 mm:ss
Deviation from Target (Jan 23)		+14:31 mm:ss

- Category 2 Mean Response time has increased by over 2mins from Jan 22.
- Our deviation from target was >14 mins for Jan 23

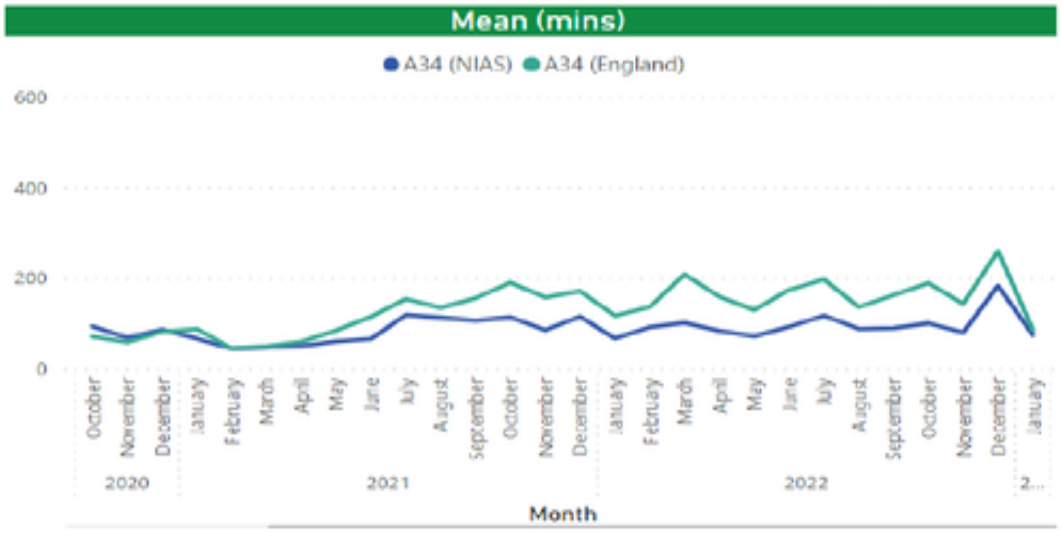
90th Centile Category 2	National	NIAS
Jan 22 (mins)	01:23:37	01:05:33
Jan 23 (mins)	01:08:01	01:09:45
22/23 Change (+/-)	-15:36 mm:ss	+04:12 mm:ss
Deviation from Target (Jan 23)		+29:45 mm:ss

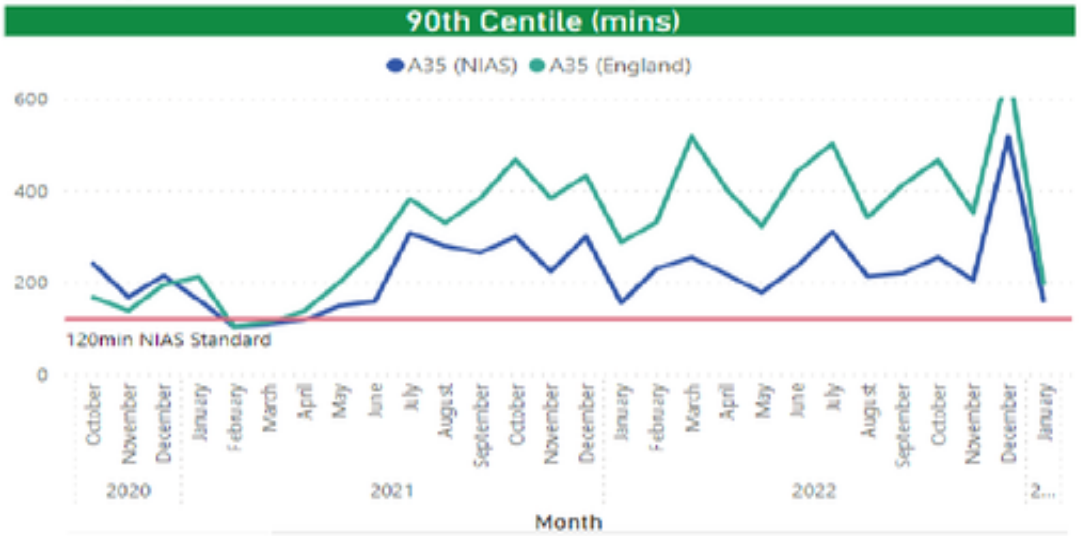
- Category 2 90th Centile Response time has increased by over 4mins from Jan 22.
- Our deviation from target was significant at over 29mins for Jan 23

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
Jan 22 (mins)	01:56:52	01:06:31
Jan 23 (mins)	01:26:09	01:14:41
22/23 Change (+/-)	-30:43 mm:ss	+08:10mm:ss
Deviation from Target (Jan 23)		

- Category 3 Mean Response time has increased by over 8mins from Jan 22
- This is a better position than the English Trusts that are experiencing mean performance for Jan 23 of >30mins longer.

90th Centile Category 3	National	NIAS
Jan 22 (mins)	04:47:19	02:35:41
Jan 23 (mins)	03:17:28	02:40:25
22/23 Change (+/-)	-01:29:51 mm:ss	+04:44 mm:ss
Deviation from Target (Jan 23)		+40:25 mm:ss

- Category 3 90th Centile response time has increased by over 4mins from Jan 22
- Our deviation from target remains a significant challenge at over 40mins for Jan 23

Northern Ireland Ambulance Service
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Current Pressures – Handover Times Acute Hospitals

HANDOVER TIMES

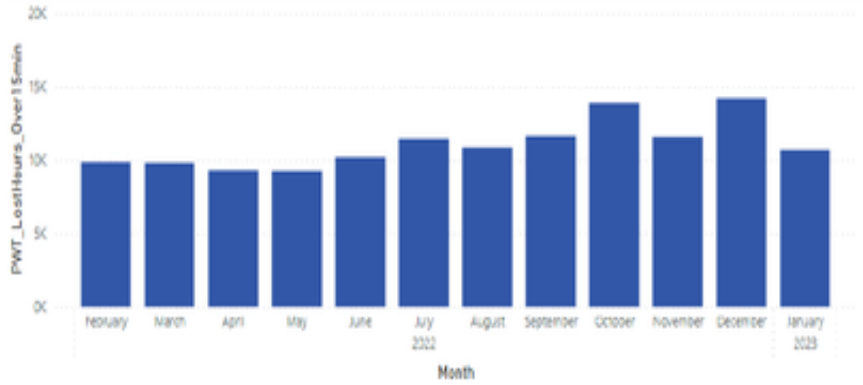
The handover time standard of 15 minutes from arrival at an ED.

In January 2023, NIAS experienced a total of 10,693 lost hours. This is the equivalent of 29 shifts per day, with crews waiting with patients outside EDs, 26% of our planned capacity. These lost hours were experienced from 10,113 instances where our crews waited longer than 15mins to handover their patient at ED. 4,122 of these instances were over 60mins in length.

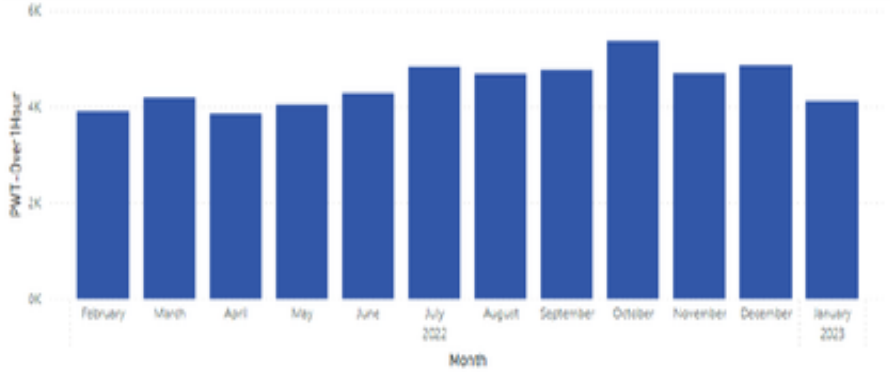
In January 23, 71% of the 10,693 lost hours occurred at the four ED sites listed below in order of volume of hours lost:

Ulster Hospital
Antrim Area Hospital
Craigavon Hospital
Royal Victoria

Total Hours Lost for Handover Over 15mins



Number of Handover Delays over 60mins



Number of Handover Delays over 15mins

Hospital Attended	Total Attendances	Handovers Over 15mins	% Over 15mins	Total Time Lost (Hours)
ALTNAGELVIN HOSPITAL	14559	14188	97%	8,604.36
ANTRIM AREA HOSPITAL	20209	20077	99%	22,880.44
CAUSEWAY HOSPITAL	7203	7114	99%	10,376.57
CRAIGAVON AREA HOSPITAL	17047	16852	99%	20,263.73
DAISYHILL NEWRY	7031	6978	99%	6,184.15
MATER INFIRMORUM	7565	7473	99%	6,023.67
R/BELF FOR SICK CHILDREN	1872	1652	88%	654.01
ROYAL VICTORIA	26020	25594	98%	25,777.45
SOUTH WEST ACUTE HOSPITAL	8264	7955	96%	3,893.95
ULSTER HOSPITAL	16981	16882	99%	28,112.94
Total	**126751**	**124765**	**98%**	**132,771.27**

Number of Handover Delays over 60mins

Hospital Attended	Total Attendances	Handovers Over 60mins	% Over 60mins	Total Time Lost (Hours)
ALTNAGELVIN HOSPITAL	14559	3457	24%	1,977.30
ANTRIM AREA HOSPITAL	20209	9641	48%	10,883.72
CAUSEWAY HOSPITAL	7203	4159	58%	5,954.41
CRAIGAVON AREA HOSPITAL	17047	7624	45%	10,491.82
DAISYHILL NEWRY	7031	2650	38%	2,253.64
MATER INFIRMORUM	7565	2601	34%	1,975.12
R/BELF FOR SICK CHILDREN	1872	171	9%	74.69
ROYAL VICTORIA	26020	12884	50%	10,388.23
SOUTH WEST ACUTE HOSPITAL	8264	1403	17%	566.07
ULSTER HOSPITAL	16981	9059	53%	17,696.89
Total	**126751**	**53649**	**42%**	**62,261.88**

In the last 12 months (February 2022–January 23), 98% of the handovers exceeded the 15min target at our acute EDs, resulting in circa 132k hours lost. The lost hours experienced in January 23 is a reduction of **25%** from December 22, whilst the number of instances of delayed handovers decreased by <1% in the same period.

The 10,693 operational hours being lost (eg. to 891 12-hours shifts per month or 29 12h shifts per day). The number of handover delays in excess of 60mins has decreased in January 23 to 4,122 occurrences during the 31 days of January resulting in 132, 60-minute delays per day during the month.

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Northern Ireland Ambulance Service
Health and Social Care Trust

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 revise the late finishes procedure in EAC to safely deploy the derogation list for Category 2 calls across both day and night shifts. The derogation list are a 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 Rotas continue to be explored with operational teams on to bolster cover further into the evenings utilising the available staff.
- 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 SPPG/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 continued 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

EMPLOYEE SICKNESS ABSENCE

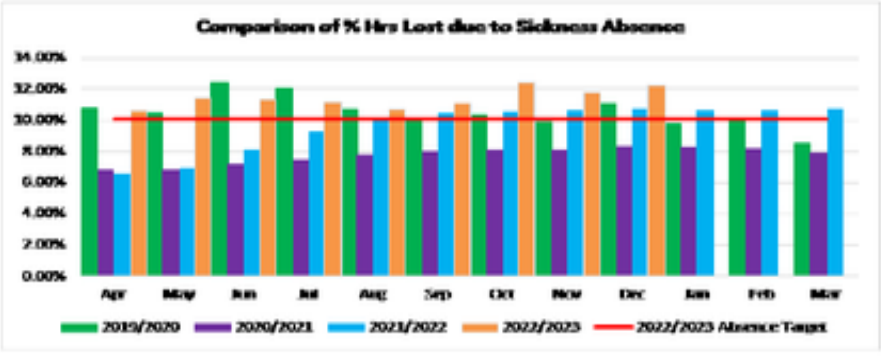
Figures demonstrate that monthly and cumulative sickness absence levels between 2022/2023 are higher than figures in the same period in 2021/2022. Cumulative figures in the last three months have increased Oct 22 11.21% (vs. 11.28% 2021), Nov 22 11.27% (vs 11.39% 2021) and Dec 22 11.39% (vs 10.78% 2021).

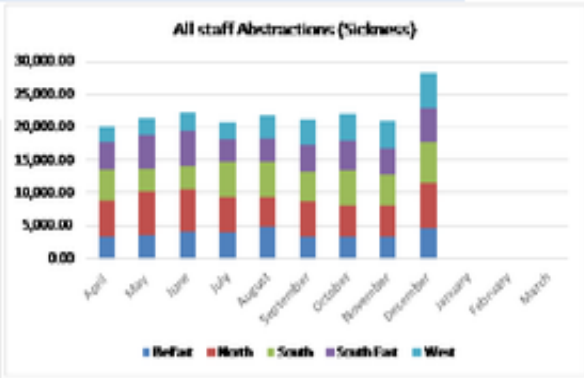
Members are aware that work continues to develop and embed changes to NIAS approaches to Attendance Management. Training has been delayed as a consequence of industrial action and managers needing to be present at Tactical Control. It is correct that attendance remains an urgent concern. This is not expected to reduce imminently as it is notable that December 2022 absence sits at 12.29%. NIAS considers that the season 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 NIAS' 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 reporting the impact of significant service 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.

SMT and senior colleagues are working with HR on developing the management of Attendance Project, with a dedicated Project Board & Project Team. Operations have arranged an Attendance Management Workshop with HR colleagues, to include all Divisions and Control Rooms for Monday 27 February 2023.

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%	11.39%			
Monthly % hrs lost (22/23)	10.62%	11.43%	11.34%	11.14%	10.68%	11.11%	12.40%	11.77%	12.29%			
Monthly % hrs lost (S/T)	2.78%	2.03%	2.00%	1.95%	2.30%	2.71%	3.55%	2.40%	4.15%			
Monthly % hrs lost (L/T)	9.74%	9.40%	9.34%	9.20%	10.29%	10.37%	8.85%	9.37%	8.24%			
Monthly % hrs lost COVID 19 (Sickness and self-isolation)	4.31%	2.37%	3.48%	3.65%	1.47%	1%	1.76%	1.73%	2.14%			
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	2.65			
Av.Estimated costs (£'000)	636	644	673	649	614	643	734	671	873			
Cumulative % Hrs Lost 2022/2023:	11.39%											



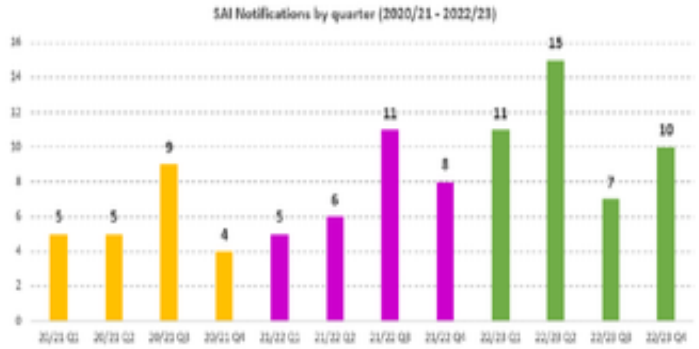


Northern Ireland Ambulance Service
Health and Social Care Trust

Service User Feedback & Serious Adverse Incidents

Serious Adverse Incidents

During January 2023, the Trust reviewed 18 potential SAIs resulting in notification of 6 SAIs. Currently we have 16 open SAIs - the majority of which 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

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. The SAI team have now booked time in all Directorate monthly meetings to progress any outstanding recommendations.

Training

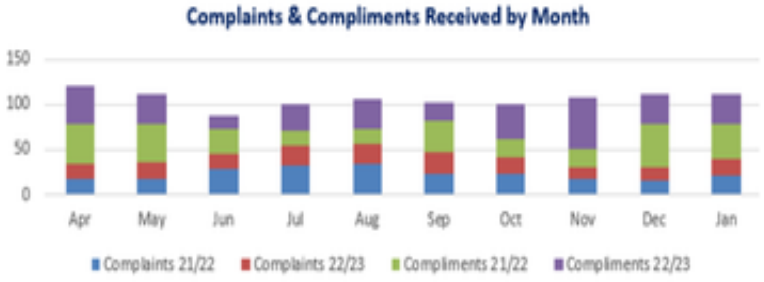
Further bespoke training specific to NIAS procedures has been booked for 16 March 2023 & 22 March 2023.
Following an expression of interest, 24 staff have now been allocated to one of the training dates.
The training will be delivered by 2 consultants from the HSC Leadership Centre in conjunction with the SAI team. A robust training package has been developed which will provide all attendees with the knowledge and skills required to complete a robust, fair, consistent, supportive and timely SAI review.

The training will include all aspects of:

- Family Engagement
- Staff Engagement
- Report Writing

Complaints, Compliments & Care Opinion

During Jan 23, **18 complaints** & **32 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

13 complaints were closed in January 2023.

Timeliness of Closed Cases	Percentage
% of complaints closed within 20 day target	23%
% of complaints that took between 20 and 40 days to close	8%
% of complaints that took over 40+ days to close	69%
Timeliness of Open Cases	**No. of Days**
Average no. days cases(x40) open at 31 Jan 2023	57

Learning

Of the 13 complaints closed, 6 complaints resulted in learning outcomes, such as: staff call reflection exercises and EMD feedback.

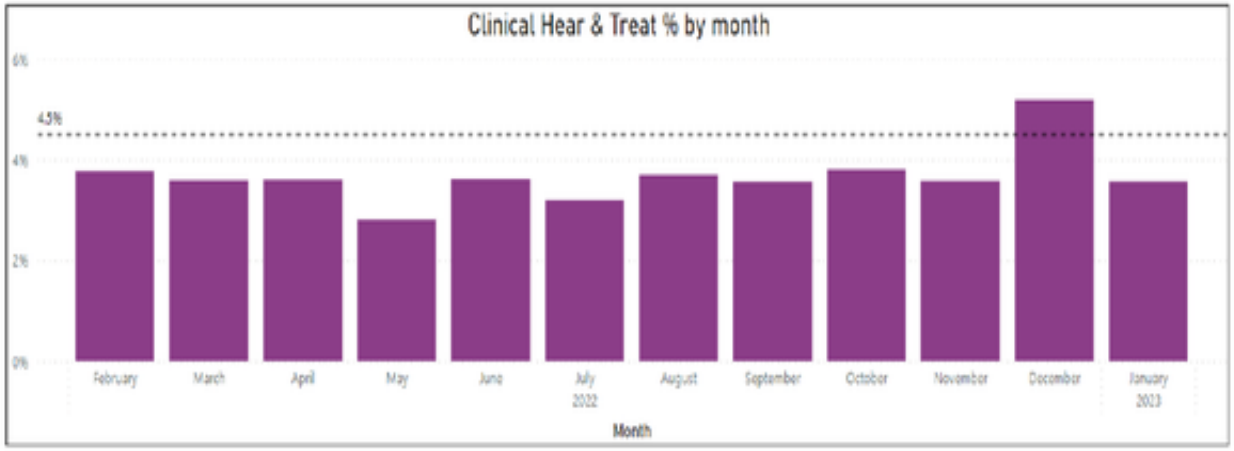
Care Opinion

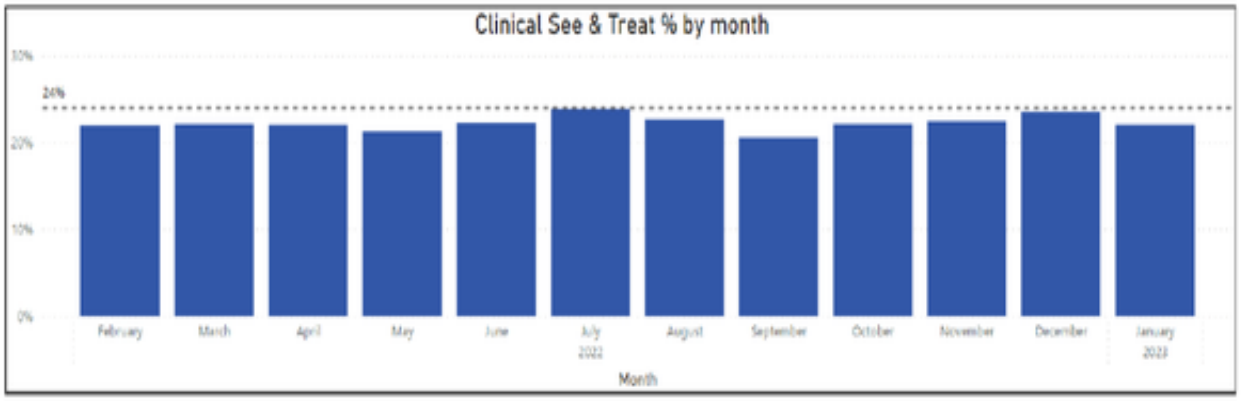
During January 2023, 15 **stories** were submitted via Care Opinion. By 1 February these stories were viewed 364 times.
The main areas of feedback were:
What's good – Care, Paramedics, staff
Improvements – More staff
Feelings – Cared for, Comfortable, Safe

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 31st January, **130** completed surveys have been returned of which **82%** were either strongly positive / positive and **10%** were strongly negative (re response times).

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.

Northern Ireland Ambulance Service
Health and Social Care Trust

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	October 2022	November 2022	December 2022	QUARTER 3	January 2023
Demand	% of Calls Answered within 5 secs	90%	Region	91.5%	91.9%	84.5%	89.0%	92.3%
Response times	Category 1 Mean	11 mins	Region	00:11:34	00:10:04	00:12:23	00:11:23	00:09:56
	Category 1 90th Percentile	21 mins	Region	00:22:56	00:19:53	00:24:31	00:22:38	00:19:19
	Category 2 Mean	22 mins	Region	00:40:43	00:32:30	00:59:37	00:44:39	00:32:31
	Category 2 90th Percentile	46 mins	Region	01:28:18	01:10:58	02:17:17	01:39:00	01:09:45
	Category 1 Mean	11 mins	Belfast	00:08:15	00:06:46	00:08:19	00:07:47	00:06:36
	Category 1 90th Percentile	21 mins	Belfast	00:13:28	00:11:46	00:14:00	00:13:25	00:10:42
	Category 2 Mean	22 mins	Belfast	00:39:12	00:31:16	00:58:48	00:43:05	00:25:58
	Category 2 90th Percentile	46 mins	Belfast	01:29:30	01:11:55	02:20:11	01:40:00	00:55:15
	Category 1 Mean	11 mins	South East	00:12:21	00:11:39	00:13:52	00:12:40	00:10:17
	Category 1 90th Percentile	21 mins	South East	00:24:23	00:22:54	00:25:34	00:24:31	00:20:26
	Category 2 Mean	22 mins	South East	00:50:27	00:41:23	01:13:44	00:55:38	00:35:17
	Category 2 90th Percentile	46 mins	South East	01:45:21	01:26:13	02:48:02	02:00:17	01:16:22
	Category 1 Mean	11 mins	Northern	00:12:49	00:12:08	00:14:20	00:13:11	00:11:31
	Category 1 90th Percentile	21 mins	Northern	00:25:59	00:23:15	00:26:41	00:26:09	00:19:59
	Category 2 Mean	22 mins	Northern	00:40:28	00:33:38	01:02:01	00:45:47	00:35:49
	Category 2 90th Percentile	46 mins	Northern	01:25:01	01:11:28	02:17:57	01:37:00	01:12:09
	Category 1 Mean	11 mins	Southern	00:14:04	00:11:51	00:14:52	00:13:40	00:12:40
	Category 1 90th Percentile	21 mins	Southern	00:26:37	00:21:20	00:28:34	00:26:37	00:22:34
	Category 2 Mean	22 mins	Southern	00:45:57	00:31:01	01:04:59	00:48:01	00:37:30
	Category 2 90th Percentile	46 mins	Southern	01:33:36	01:06:18	02:22:17	01:46:59	01:22:30
	Category 1 Mean	11 mins	Western	00:11:28	00:09:17	00:11:47	00:10:52	00:10:29
	Category 1 90th Percentile	21 mins	Western	00:23:18	00:18:38	00:22:31	00:21:46	00:21:03
	Category 2 Mean	22 mins	Western	00:28:07	00:25:14	00:38:45	00:31:01	00:28:38
	Category 2 90th Percentile	46 mins	Western	01:00:42	00:52:06	01:27:14	01:07:05	01:02:40

Northern Ireland Ambulance Service
Health and Social Care Trust

Appendix A – SPPG November 22 Submission

Pre Hospital Care and Handover Times

Performance Measure	Metric	Target	Trust	October 2022	November 2022	December 2022	QUARTER 3	January 2023
Pre-Hospital Care (Clinical Hear & Treat)	% of Calls Resolved With Telephone Advice	2.2%	Region	3.7%	3.6%	5.2%	4.2%	3.6%
Pre-Hospital Care (Clinical See & Treat)	% of Patients Seen and treated by NIAS	23%	Region	21.8%	22.4%	23.8%	22.7%	22.6%

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	October 2022	November 2022	December 2022	QUARTER 3	January 2023
Hospital Handovers	<= 15mins	27%	Region	7.52%	8.47%	1.60%	8.08%	1.62%
	<=30mins	60%	Region	27.91%	31.20%	13.29%	30.18%	13.63%
	<=60mins	87%	Region	61.46%	68.53%	54.03%	66.39%	60.80%
	>3hrs	0.25%	Region	9.18%	5.77%	12.85%	7.23%	7.73%
	No. of patients >3hrs	378 (per Annum) 32 (per month)	Region	1112	680	1365	3066	827
	<= 15mins	31%	Belfast	8.13%	8.94%	2.53%	8.78%	1.94%
	<=30mins	64%	Belfast	27.08%	31.31%	16.19%	30.24%	15.66%
	<=60mins	91%	Belfast	60.34%	70.63%	56.54%	66.41%	63.11%
	>3hrs	0.16%	Belfast	5.37%	1.70%	7.89%	3.39%	4.43%
	No. of patients >3hrs	45 (per Annum) 4 (per month)	Belfast	171	57	178	372	105
	<= 15mins	19%	South East	5.43%	7.21%	0.72%	6.40%	1.31%
	<=30mins	54%	South East	20.74%	25.43%	7.87%	24.91%	9.15%
	<=60mins	85%	South East	54.02%	56.40%	45.43%	55.04%	52.37%
	>3hrs	1.23%	South East	17.08%	14.64%	22.58%	15.77%	12.03%
	No. of patients >3hrs	213 (per Annum) 18 (per month)	South East	321	270	410	1017	221
	<= 15mins	34%	Northern	6.31%	6.14%	1.54%	6.52%	1.68%
	<=30mins	76%	Northern	21.46%	25.18%	10.45%	24.51%	11.43%
	<=60mins	96%	Northern	62.69%	58.86%	46.20%	58.41%	56.64%
	>3hrs	0.04%	Northern	13.39%	9.23%	16.27%	10.61%	11.02%
	No. of patients >3hrs	11 (per Annum) 1 (per month)	Northern	346	224	422	950	296
	<= 15mins	23%	Southern	5.77%	6.39%	1.68%	6.16%	1.57%
	<=30mins	58%	Southern	25.17%	25.98%	10.31%	26.03%	12.39%
	<=60mins	90%	Southern	59.62%	67.77%	49.41%	64.10%	62.01%
	>3hrs	0.34%	Southern	11.49%	5.93%	16.15%	8.46%	8.14%
	No. of patients >3hrs	81 (per Annum) 7 (per month)	Southern	283	129	326	686	161
	<= 15mins	25%	Western	11.74%	13.82%	1.34%	12.46%	2.36%
	<=30mins	59%	Western	43.28%	48.95%	21.87%	45.90%	20.08%
	<=60mins	91%	Western	82.04%	88.34%	74.42%	84.96%	71.09%
	>3hrs	0.13%	Western	0.51%	0.15%	1.49%	0.36%	2.41%
	No. of patients >3hrs	28 (per Annum) 2 (per month)	Western	11	3	29	41	44

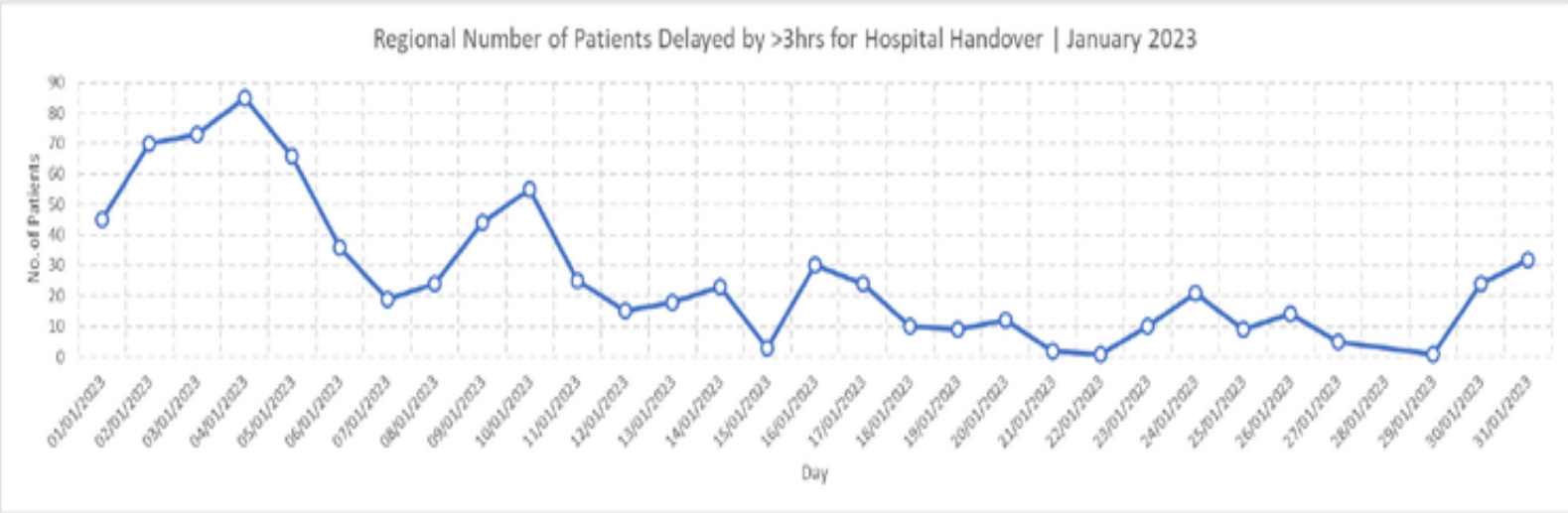
Appendix B – Regional 3 Hour Handover Performance

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 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



Northern Ireland Ambulance Service
Health and Social Care Trust

- End Of Report -

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

PRESENTATION OF PAPER

Date of SMT:	23 March 2023
Title of paper:	NIAS Communications and Engagement Strategy - 2026
Brief summary:	*This strategy is being presented to Trust Board for approval.* *The Strategy has been developed following consultation with* • *Executive Directors (prior to Covid outbreak),* • *NIAS service user group* • *Trade Unions* *and drew upon communications issues raised in the Strategy to Transform staff engagement sessions.* *The Strategy updates the previous Comms Strategy taking into account the requirement to align C&E objectives with NIAS Strategy to Transform.* *Earlier draft versions of the document had been shared with SMT, Trade Unions and NIAS service user group for comment. Comments received have been reflected in the document where appropriate.*
Recommendation:	**For Approval** ☒ **For Noting** ☐ *Click the appropriate box*
Previous forum:	*If applicable*
Prepared and presented by:	Maxine Paterson, Director of Planning, Performance and Corporate Service and Deputy Chief Executive.

	John McPoland, Media and Communications Manager.
Date:	15 March 2023

Northern Ireland Ambulance Service
Health and Social Care Trust

NIAS Communications and Engagement Strategy - 2026

V11

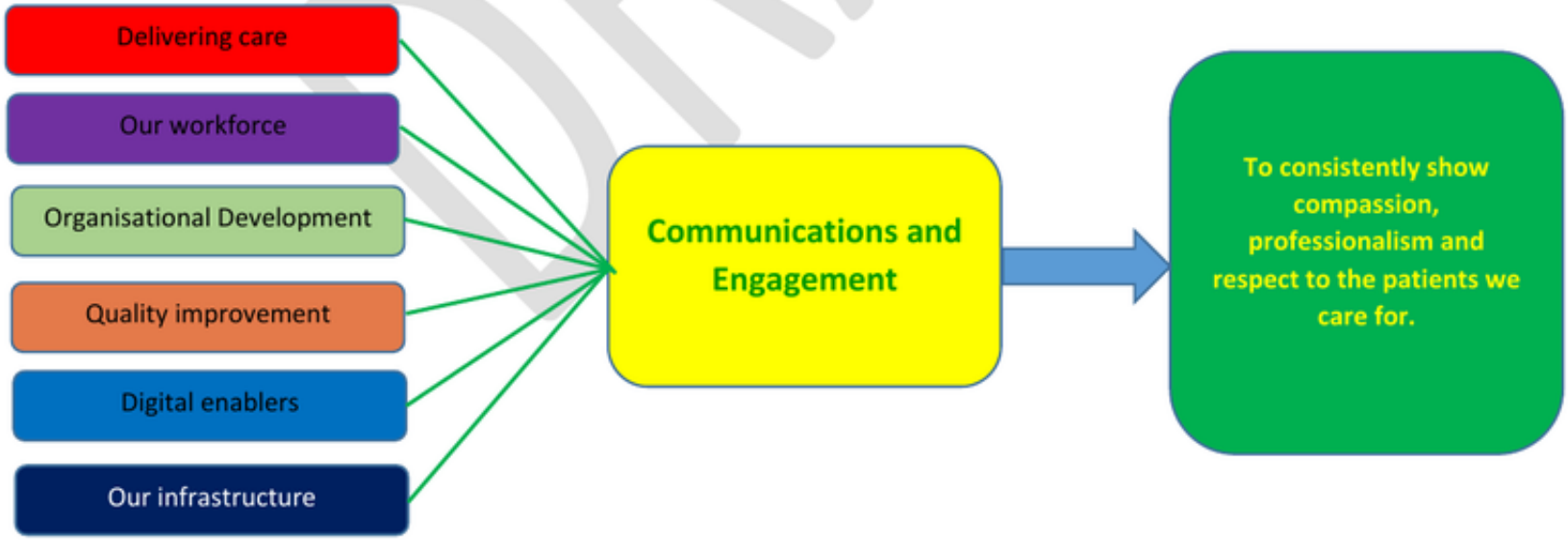
Contents

Executive Summary

The Northern Ireland Ambulance Service launched ***"Caring today, planning for tomorrow – Our Strategy to transform: 2020 – 2026"*** in March 2020.

Our Communication and Engagement Objectives align to the goals of Our Strategy to Transform and Communications and engagement has been identified as one of seven areas of priority for transformation. However, it is unique in that the delivery of the other priority areas, all require significant communications and engagement strategies, specific to each, to facilitate progress in the required elements of change and innovation. Changing circumstances and risk management require that we continually need to adapt and remain dynamic while we strive to deliver our mission – to consistently show compassion, professionalism and respect to the patients we care for.

Each of the other six priority areas will have the autonomy to develop bespoke communications and engagement strategies to ensure the effective delivery of their specific objectives, making use of the corporate communications and engagement strategy as a best practice template, where appropriate.



The continued practice of embedding Communications and Engagement principles across all NIAS activities will facilitate a shift in organisational culture. The strategy will engage staff and stakeholders to work together in effectively transforming NIAS to meet changing population health needs.

The Communications and Engagement Strategy will focus on four key areas:

1. stakeholder engagement
2. internal communications
3. media management
4. public health,

Applying proven "success factors" which facilitate high-performing communication and engagement with partners across all activities undertaken by, or on behalf of, NIAS. The factors to be applied in this regard are:

1. Embed a strategic approach to communications and engagement
2. Adopt a systematic approach to building a sustainable and effective relationship with internal and external partners/stakeholders
3. Develop a shared vision and narrative to deliver common goals
4. Embed open, transparent and two-way engagement
5. Develop communications and engagement leadership, capacity and expertise.

The rationale for the adoption of these proven success factors is detailed in Appendix 1

In summary, the desired outcomes from our Communications and Engagement Strategy are:

- ✓ Provision of services that are informed by the needs of service users

- ✓ Improved trust, legitimacy and reputation in the community
- ✓ Persuade and support staff and stakeholders to work together to transform NIAS to meet population health needs
- ✓ Everyone in NIAS will play their part in communicating to colleagues, patients and communities
- ✓ Staff will feel motivated, empowered and involved

Introduction

The Northern Ireland Ambulance Service launched its ***"Strategy to Transform: Caring today, planning for tomorrow"*** in March 2020. The strategy identifies who we are, what we do, our role in health and social care system and the challenges that we face in ensuring we deliver a quality service that is safe and seeks to constantly improve

We now find ourselves at the beginning of an intense period of organisational transformation which will shape how we care for patients; how we care for and develop our staff and, importantly, how we interact with partners in the community we serve and in the health and social care system.

As we move forward, we do so with a mission "***to consistently show compassion, professionalism and respect to the patients we care for"***. We will deliver this by putting into practice, on a daily basis and in all our interactions, those values and behaviours which will set our staff apart, namely working together, excellence, openness and honesty and compassion which will be delivered alongside an organisational cultural programme.

Key to the delivery of organisational cultural change is a robust communications and engagement strategy. This strategy will underpin and facilitate change, through the promotion of best practice communications and engagement, with particular emphasis on processes of co-production and co-design.

Purpose and aims

The Communications and Engagement Strategy 2021-26 focusses on the NIAS approach to communications and engagement with key stakeholders, with particular emphasis on our workforce, our patients, carers, Trade Unions, partners within Health and Social Care, the media and political representatives. It will ensure that robust communications and engagement systems are in place to promote a much greater degree of partnership working than before, taking into account our direction of travel relating to co-production for future service delivery.

It will promote a culture of communications, engagement and involvement within, and external to NIAS, and to detail how the delivery of NIAS vision and values will be supported through communications and engagement.

This strategy aims to place communication and engagement at the centre of all we do, and enable a greater understanding of how effective communications and engagement can;

- Support a leadership approach which is effective, ethical and collective and which places greater emphasis on engaging with partners and stakeholders as equals
- Evidence that NIAS has clinical excellence at the heart of our organisation
- Demonstrate progress towards a delivery model, the purpose of which is to ensure the most appropriate response to the sickest patients in the quickest time and thereby promoting better understanding of decision making
- Enable staff to feel motivated, empowered and involved
- Facilitate positive adjustments in behaviour and perceptions internally and externally and thereby influencing the culture of the organisation
- Assist in the achievement of strategic aims.

Strategy Objectives

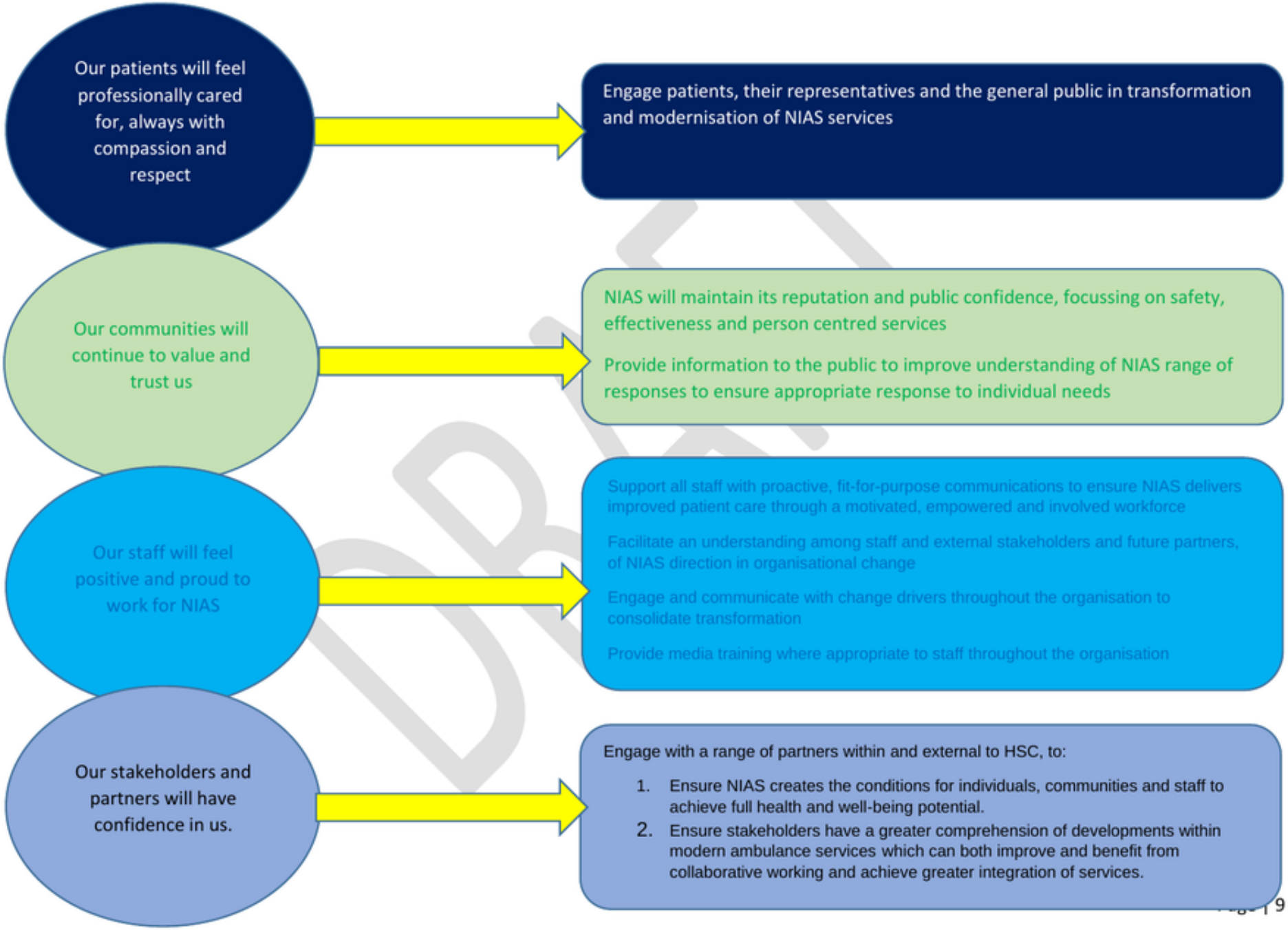
Communication and Engagement Objectives

All communications and engagement activity should be aligned to, and reflect, the goals of Our Strategy to Transform and reflect the central role NIAS occupies within the broader HSC system1.

Our objectives are, that through communications and engagement:

- Our patients will feel professionally cared for, always with compassion and respect
- Our communities will continue to value and trust us
- Our staff will feel positive and proud to work for NIAS
- Our stakeholders and partners will have confidence in us.

To deliver these objectives NIAS will actively engage with these four main stakeholders groups in processes which are meaningful and effective. NIAS will make use of communications channels which are most accessible to each, seeking, particularly, to utilise advances in digital communications


Our patients will feel professionally cared for, always with compassion and respect
Engage patients, their representatives and the general public in transformation and modernisation of NIAS services
Our communities will continue to value and trust us
NIAS will maintain its reputation and public confidence, focussing on safety, effectiveness and person centred services
Provide information to the public to improve understanding of NIAS range of responses to ensure appropriate response to individual needs
Our staff will feel positive and proud to work for NIAS
Support all staff with proactive, fit-for-purpose communications to ensure NIAS delivers improved patient care through a motivated, empowered and involved workforce
Facilitate an understanding among staff and external stakeholders and future partners, of NIAS direction in organisational change
Engage and communicate with change drivers throughout the organisation to consolidate transformation
Provide media training where appropriate to staff throughout the organisation
Our stakeholders and partners will have confidence in us.
Engage with a range of partners within and external to HSC, to:
1. Ensure NIAS creates the conditions for individuals, communities and staff to achieve full health and well-being potential.
2. Ensure stakeholders have a greater comprehension of developments within modern ambulance services which can both improve and benefit from collaborative working and achieve greater integration of services.

Review

The Communications and Engagement Strategy. Annual activity plans will be approved by Trust Board and delivered by 2026 in line with our "*Strategy to Transform*". Plans to implement changes will be endorsed by SMT and progress in delivery will be monitored by Trust Board.

Monitoring of the plan will include but will not be restricted to;

- Communications survey results
- Communications forum feedback
- Social media and digital communications metrics (hits, likes, views etc.)
- Media monitoring
- Partner/Stakeholder feedback
- Progress reports to SEMT
- Trust Board assurance framework;

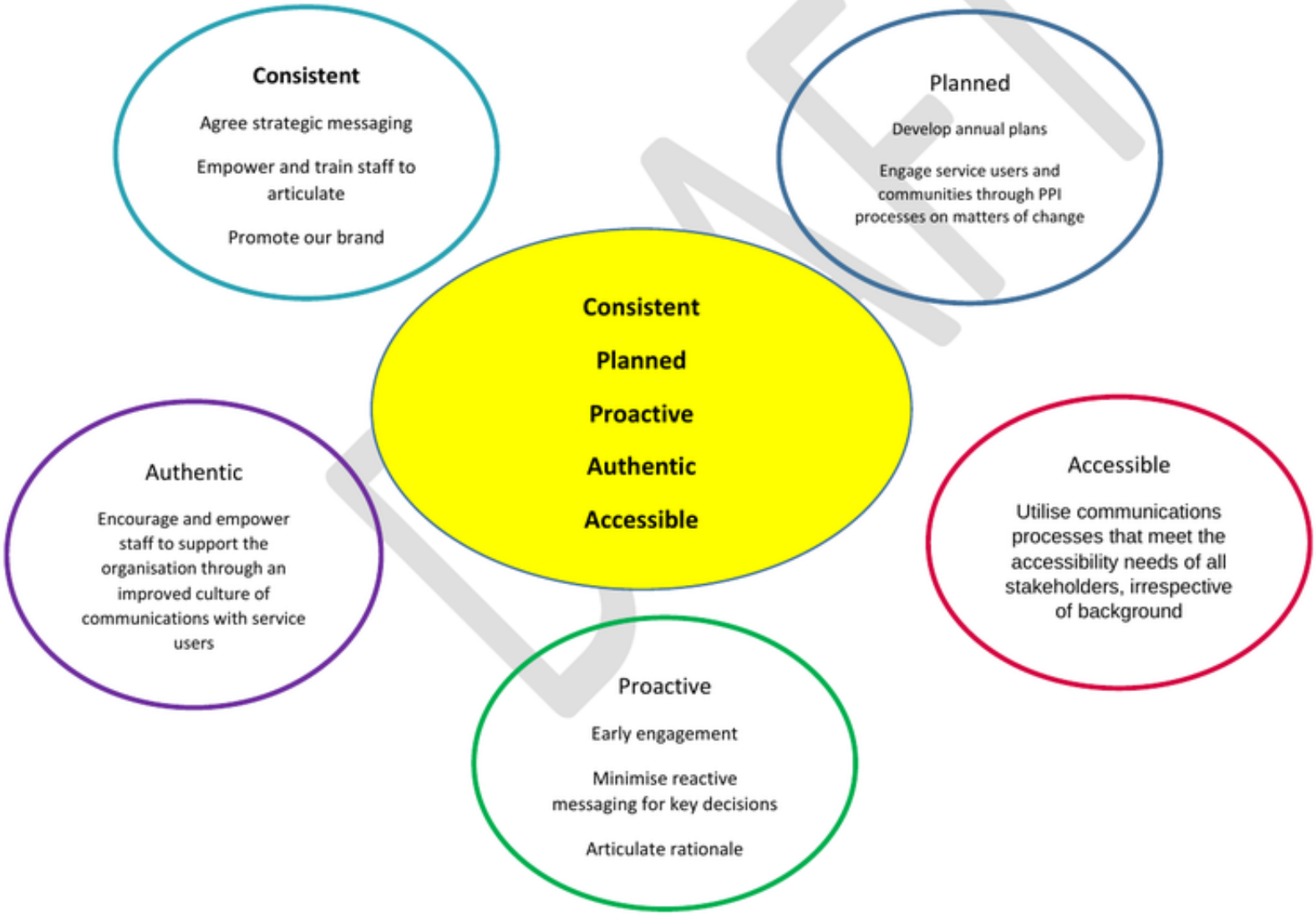
and will be delivered through annual communications plans monitored through the performance framework process. An overview of the content of these plans is attached at Appendix 2.

Measurement of success

- Internal Communications – a cultural change can be difficult to measure in a quantifiable way.
  The Trust will make use of communications survey results relating to communications as a baseline from which to measure progress towards an improved communications culture. The establishment of focus groups and the development of staff engagement plans will enable qualitative intelligence to be gathered in relation to how staff feel engaged, informed and have a voice which is being listened to.
- External stakeholders – an approach will be developed to gather external stakeholder satisfaction data which will take account of the constraints which may be experienced through use of various communication channels and which will chart a course for managing these constraints in a way which improves communications.
- Social media metrics will be key to gauging the reach of communications, internally (whatsapp) and externally (public facing social media). Subsequent Communication Surveys will point to the success of the strategy in terms of the numbers of those who engage with the survey and thei satisfaction views expressed within, compared directly with the similar results from the initial survey.

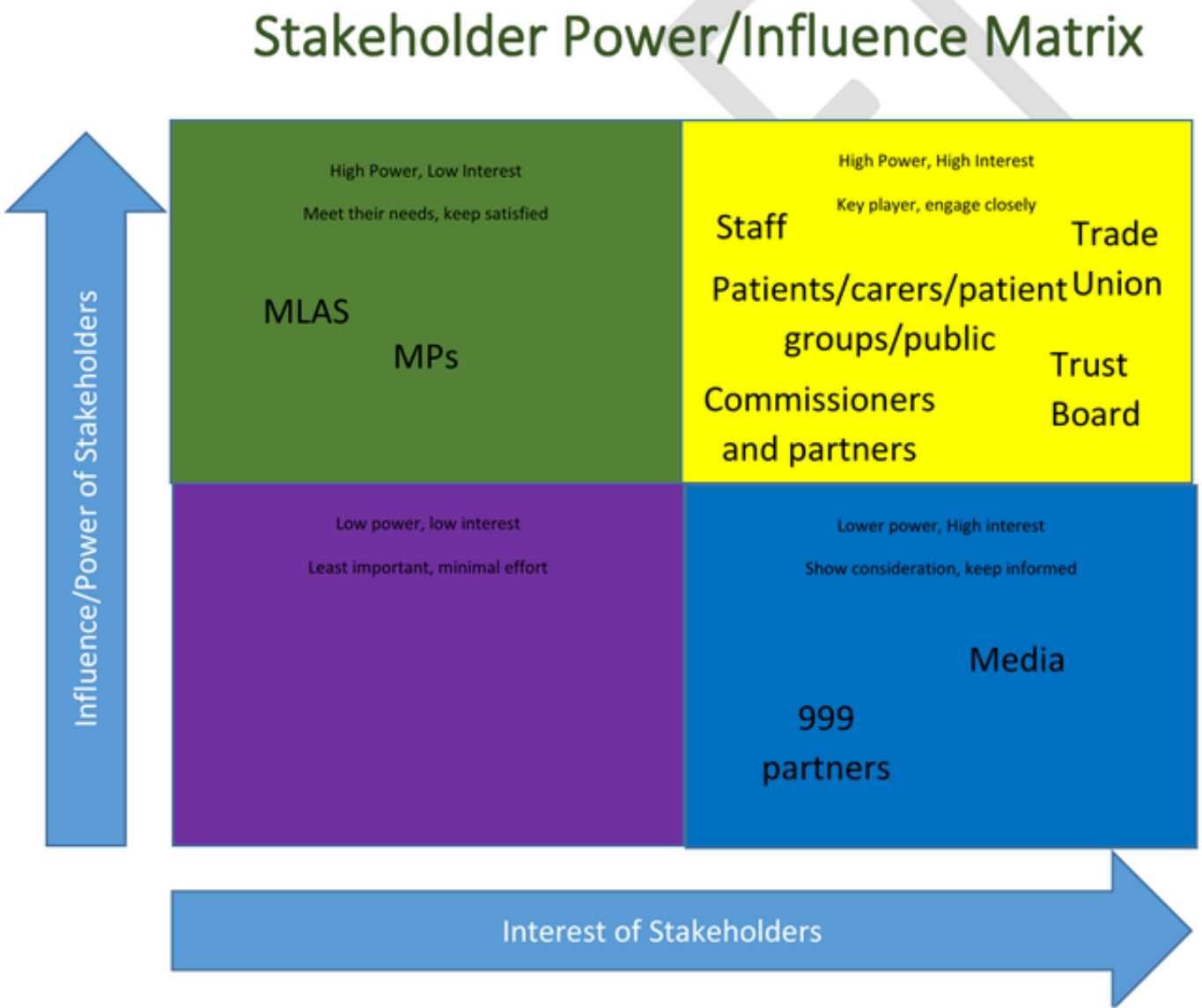
Principles and approach to communications.

To achieve our communications and engagement objectives, NIAS communications will be:



Audience segmentation and stakeholders

The Trust has identified a number of key stakeholder groups each with different needs and interests in NIAS. Our communications will be tailored to best suit their requirements. Our Strategy to Transform has identified four particular points of focus for communications and engagement, each with a number of key stakeholders as identified below:



Communications Channels

The Trust makes use of a number of communications channels to engage with internal and external stakeholders. The table below outlines each of those channels with a brief summary of its delivery and identification of the audience.

Channel	Summary	Audience
Face to face		
Staff events	Various events including, but not exclusively, • Senior manager workshops • Staff focus groups • TU engagement • Annual awards ceremony • Staff engagement sessions	Internal
Committee meetings	• Trust Board meetings • Regular Trust Board sub committees	Public/Staff/Patients & carers
Internal groups and committees	Wide range of established internal groups and committees tasked with improving patient care through models of co-production and co-design	Public/Staff/Patients & carers
External groups and committees	Wide range of established ambulance and HSC fora along with other emergency services and inter departmental fora	Commissioners/ partners/UK ambulance/999 services
Listening events	• Patient events under PPI and Patient Engagement work streams • Political representative engagement • HSC QI Network • NICON	Public/Patients and carers Political reps HSC Partners
Online/digital		
Trust website	The Trusts website which hosts corporate information, published information e.g. Trust Board papers and Annual Reports, news and relevant external info.	External
Sharepoint	The Trusts intranet (SharePoint) has been upgraded to encourage greater use by staff	Internal

Social media	Corporate presence on most popular social media platforms to promote the work of the Trust	External
Email	The most used/overused method of communication within the Trust.	All audiences
Written		
Annual Report	Corporate publication	External
Annual Quality Report	Corporate publication	External
Board Papers	Corporate publication to service public Trust Board meetings	External
Internal newssheets	These include; • NIAS news • C Ex Updates • Daily Updates	Internal
Media releases/ statements	Reactive and proactive engagement with local, regional and, at times, national media outlets re; emerging issues	External
Public Information leaflets	A range of public information leaflets	External

Roles and Responsibilities

Communication and Engagement is the responsibility of all within the Trust and, as such, every member of staff has a role to play in the implementation of the Communications and Engagement Strategy to ensure the development of a positive communications and engagement culture within the Trust and with other partners. Communications engagement impacts on our reputation and public confidence in the organisation.

The Senior Management Team will promote and support the aims and objectives of the Communications and Engagement Strategy through their engagement with staff, patients and other stakeholders.

The Director of Planning, Performance and Corporate Services will be the lead Director for Communications and Engagement within the Trust, reporting on same at organisational and Trust Board level.

The Media and Communications Manager will take lead responsibility for facilitating and promoting good communications within the Trust. The Media and Communications Manager will also be responsible for the provision of professional advice and support to the Board and other Trust representatives.

The Media and Communications Manager will be responsible for the implementation, monitoring and review of the strategy.

Specific responsibilities

All Staff	• To maintain an awareness of key issues affecting the Trust • Communicate suggestions for service/operational or strategic changes where appropriate • Engage in communications training as appropriate • To seek relevant information from line managers • Highlight areas of concern to line managers or Media and Communications Manager • To participate in suggestion and feedback schemes • To make use of communication processes provided by the Trust. • To participate in available internal communications and staff engagement opportunities • To ensure that all communications is produced and delivered to an excellent standard • To refrain from inappropriate communication which is likely to damage the reputation of, or to undermine public confidence in, the Trust
Trust Board	• Endorsing and adopting the Communications Strategy and supporting communications activities • Ensuring that clear channels of communications with the Trust's stakeholders have been established • Establishing/reviewing appropriate processes to ensure that such channels operate effectively in practice and are embedded within Trust activities and culture
Chief Executive	• To oversee the embedding of a strategic approach to communications and engagement • To develop key organisational messages with the management team and to ensure consistent support for their dissemination • To reinforce the role of communications and engagement as a key management tool and competency

	• To lead by example in terms of consistently being a communications role model making time required for effective communications and engagement with internal and external stakeholders • To lead at Board level in the implementation and monitoring of communications and engagement processes • To give confidence to the communications and engagement process • Act as spokesperson for the Trust as required, working with Media and Communications Manager on all official statements to, and interviews with, the media.
Chair of Trust Board	• To represent the views of the Board to the general public as per Northern Ireland Ambulance Service HSC Trust Management Statement section 3.8.2
Directors and managers	• To promote a strategic approach to communications and engagement • To promote and ensure effective systems are in place for two-way staff communication and engagement within area of responsibility, including ensuring that information is cascaded effectively • To lead by example in terms of consistently being a communications and engagement leader/role model, making time required for effective communications and engagement with internal and external stakeholders • To ensure that key issues are communicated to relevant staff in a manner which is timely and accurate • To seek the guidance of the Media and Communications Manager when communicating corporate messages and in the use of the most appropriate process. • Act as spokesperson for the Trust as required, working with Media and Communications Manager on all official statements to, and interviews with, the media. • To ensure consistency in style of communications

	• To ensure that opportunities for feedback are afforded to all staff.
Media and Communications Manager	• Provide expert advice on communications and engagement issues to projects and teams across the Trust • Promote best practice in communications and engagement to all parts of the Trust and lead on identifying innovation to facilitate improvement • Manage production of core publications and events • Manage Trust visual identity • Ensure processes are in place to respond to media queries and to provide communications and engagement support during Major Incidents • Ensure effective channels are in place to communicate and engage with all stakeholders and to regularly evaluate same.

Monitoring/Evaluation

Monitoring of the plan will include but will not be restricted to;

- Communications survey results
- Communications forum feedback
- Social media and digital communications metrics (hits, likes, views etc.)
- Media monitoring
- Partner/Stakeholder feedback
- Progress reports to SEMT
- Trust Board assurance framework;

and will be delivered through annual communications plans monitored through the performance framework process. An overview of the content of these plans is attached at **Appendix 2**.

APPENDIX 1 – Success factors

The "***NIAS Communications and Engagement Strategy; 2021-2026"*** will seek to build on five established factors of success:

1. **Embed a strategic approach to communications and engagement.**

   "Communications and engagement" is a strategic function; delivering an assurance that the voices of patients, the public and staff are heard and that they are involved right at the very beginning.

   Delivering success in partnership requires that communications and engagement are placed at the heart of decision-making and system transformation. In practical terms, this means that communications and engagement specialists should be involved in strategy development and implementation, included in conversations at an early stage and embedded into system transformation workstreams.

   The strategic value of communications and engagement functions is often recognized in moments of crisis but quickly shifted to being seen as purely operational once the crisis has been resolved.

   Ignoring the strategic contribution of communications and engagement runs the risk of undermining the ability to deliver transformative changes

2. **Adopt systematic approaches to continuous relationship building.**

   To make these partnerships work, it is critical to recognise the strategic importance of relationship building among the partners and the influencing skills required of leaders at all levels.

Delivering success requires building strong relationships on a planned, systematic and continuous basis. Part of the answer here is getting governance and co-production processes right so that all can see clearly how decisions are made – transparency breeds trust.

Relationship building and influencing skills are critical. Engagement and communication leaders often have good experience, knowledge and expertise to help leaders across the system do this successfully.

3. **Develop a shared vision and narrative and make it real.**

   A compelling narrative that partners buy into and which is well understood and supported by the public and staff is among the hallmarks of a successful organisation. A shared narrative and vision is a 'must-do' for effective communication and engagement at organisational level.

   There should be one story and many messengers. It is important for all partnerships, and staff within them, to have responsibility for owning and communicating the narrative and making it relevant.

   It is a key deliverable that the narrative should be made to stick, demonstrating through action that it is real. Communicating intention is one thing but stories of hope matter and staff in particular want to know they are doing the things that will make a difference. Articulating stories that demonstrate steady improvements in the lives of service users, communities and staff is among the most important roles that communications and engagement leaders play.

4. **Embed open, transparent and two-way engagement approaches**

NIAS, like all HSC bodies, belongs to the communities and the people we serve. History shows that health and care plans often succeed or fail on the strength of their engagement with staff and communities. A criticism exists for only engaging with the public on a piecemeal basis – about a particular service for example. This cycle needs to be broken and with a model of continuous engagement adopted.

A broad and strategic engagement strategy is important to build confidence and trust. This should encompass a focus on transparency and the provision of clear public information about visions, plans and progress.

It should involve working in partnership with local patient fora and the voluntary and community sector, politicians and local councilors; designing services in partnership with service users, carers and staff; reaching out to the unengaged, particular Section 75 groups.

Staff are often cited as the key audience and steps should be taken to ensure they understand the collective ambition. Using the collective experience and insight of staff to drive transformation is essential – they know what works. While leaders recognise the benefit of bringing these voices to the fore, more remains to be done at every level.

Staff are also citizens of their local communities – they have both a professional and personal stake in how services are run. They will play a key role in the public's understanding of what is going on across the health and care system

Innovative processes will be key in delivering the communications and engagement strategy as one size never fits all - enabling people to be part of the conversation, decision and solutions is mission critical to the task of transformation.

5. **Develop engagement and communication leadership capacity and expertise (take from boardroom)**

   Partnership communications and engagement is a complex, multifaceted task, requiring excellent leadership. The need is for strategic thinkers, strong relationship builders and expert story tellers that understand the nuances and commitments required to contribute to and sustain effective partnership working.

   The task is to ensure that the right resource is in place across the partnership regardless of where the capacity and expertise formally sits.

   It is important to develop the structure and resourcing of both functions and networks, ensuring roles are clear and that they have the right leadership, capacity and expertise. This should include strategic thinkers, strong relationship builders and expert story tellers that understand the nuances and commitments that are required to contribute to and sustain effective partnership working.

   Diversity of thought and leadership will be critical in these roles.

The adoption of these factors into all that we do as part of our “planning for tomorrow” will enable NIAS to build effective partnerships, providing greater opportunity in achieving the aim of joined up care and, ultimately improved population health.

The key message is that communication and engagement are key enablers of partnership working playing a key role in achieving stronger relationships, more open and transparent ways of working, greater trust, more engaged staff and, ultimately, better outcomes for the public.

APPENDIX 2 – Strategy delivery through communications and engagement plans

The Communications and Engagement Strategy 2021 – 26 will be delivered through detailed annual plans agreed by the Director of Planning, Performance and Corporate Services and the Media and Communications Manager. These plans will contain developmental plans of how, when and to whom we will communicate key messages relating to NIAS. The plans will retain a degree of dynamism to facilitate accelerated progress, or otherwise of each of the identified work-streams. The plans will be centred around key messages aimed at:

- Promoting corporate developments including successful implementation of elements of "Strategy to Transform"
- Promoting NIAS achievements across our range of services
- Raising the profile of workforce developments and performance activity
- Raising awareness of community and stakeholder engagement
- Profiling increased use of ACPs as alternative to ED attendance
- Enhance public awareness of NIAS commitment to clinical excellence

These key messages will be delivered through a number of projects or initiatives designed to assist the process of embedding a culture of communications and engagement as detailed below for Year 1 with each annual plan building upon the success of its predecessor.

Initiative	Timescale	Implementation process
Staff briefing	Year 1	The SMT of the Trust has committed to the implementation of an interactive staff briefing to include details on Operational news; clinical updates; health and safety and SOP introduction or updates. After an initial period of bedding-in, the views of staff will be sought as to the effectiveness of this as a communications tool and comments taken on board to make the briefing more accessible
Digital platforms as communications channels	Year 1	1. Work will be undertaken in the first quarter of the year to develop a social media strategy which will deliver a real time opportunity for staff to engage. Greater use will be made of social media channels, existing and additional as appropriate, with opportunities for staff involvement as Trust social media activists. 2. Continually monitor and review the Trust's website to ensure that it is up to date and relevant and a trusted source of information. 3. Upgrade Trust's Sharepoint site following which it will be continually monitored and reviewed to ensure that it is up to date and relevant and a trusted source of information.
Stakeholder engagement	Year 1	As NIAS seeks greater opportunities to adopt a more meaningful partnership approach involving key stakeholders in terms of designing future services, and improving existing service delivery, it is important that communications processes are in place to ensure regular flow of

		information. Urgent consideration will be given to how best a regular bulletin can be developed which highlights examples of best practice in terms of clinical excellence and partnership working.
Internal Communications	Year 1	To deliver meaningful staff engagement on a partnership basis a Communications Forum will be established to consider, propose and review internal communications on a regular identified basis,

APPENDIX 3 Strategic Context:

Health and Social Care in NI

NIAS continues to operate within an ever changing healthcare environment where developments within acute services and urgent care impact directly on our ability to deliver a sustainable service.

In October 2016, a report commissioned by DoH and delivered by the ***"Expert Panel"*** was published under the title of ***"Systems not Structures: Changing Health and Social Care".*** The Minister of Health then launched a 10 year plan in response to the report. ***"Health and Wellbeing 2026: Delivering Together"*** is a vison of healthcare which puts the patient at the centre of services, providing them and, importantly, staff with a voice in the change programme like never before through a system of co-production. To deliver as part of the HSC system and as an individual organisation NIAS has embraced the vision outlined in this strategy.

These changes are happening at a time when NIAS is implementing its strategy to transform. Much work has been undertaken which has identified the requirement for increased staffing levels to deliver on the year-on-year increases in demand. The most significant development within our transformation journey to date has been the introduction of a new Clinical Response Model which was introduced in 2019, following an extensive consultation and engagement process.

To seek to embed and maintain the highest standards of communications and engagement is a particularly important undertaking during periods of organisational change in order to facilitate an understanding of the Trusts direction among staff and external stakeholders and future partners.

During times of transition, it is also imperative that NIAS maintains its reputation and public confidence in the Service. The foundation of both are based on public interaction with our representatives, particularly, but not exclusively, our frontline staff.

Supporting all staff with a proactive, fit-for-purpose communications and engagement strategy will deliver a platform for delivering improved patient care through a motivated, empowered and involved workforce which is assured that it's voice is one of those being heard in the planning phases of changes to service delivery.

As such, the Communications and Engagement Strategy, in recognising the importance of culture as perhaps the singularly most important asset for corporate communications, will seek to support the delivery of the Trust's vision and values as delivered through the collective leadership programme and co-production approaches envisaged within Strategy to Transform.

The priorities and objectives of the ***NIAS Communications and Engagement Strategy*** will remain aligned to:

- *The Northern Ireland Programme for Government (2016-21) which contains strategic outcomes, touching on every aspect of government, including, of particular relevance to NIAS, the attainment of good health within confident and peaceful communities*
- *Making Life Better 2012-23 which aims to create the conditions for individuals and communities to achieve full health and well-being potential*
- *Quality 2020 which provided an agenda on safety, effectiveness and person centred services which has informed our Strategy to Transform*
- *Health and Wellbeing 2026; Delivering Together, which delivers on the recommendations emanating from the 2014 Donaldson Report (The Right Time, The Right Place) and the 2016 Bengoa Report (Systems not Structures), challenges all providers across the HSC system to work together and with other partners, external to HSC, to support people to stay well, ; physically mentally and emotionally while providing more treatment and care in the community setting.*
- *No More Silos 2020 which focusses on a greater integration of services based on lessons learned from the HSC response to the Covid19 Pandemic,*

- *The O'Hara Report (Report of the Inquiry into Hyponatraemia- Related Deaths" Recommendation 72 which recommends Trust Board scrutiny of written external communication*
- *Francis Report 2013 recommendations re openness, transparency and candour requirements on all Health Trusts*

Our priorities and objectives will dynamically align themselves to future strategic developments within HSC.

Northern Ireland Ambulance Service Health and Social Care Trust

TRUST BOARD

PRESENTATION OF PAPER

Date of Trust Board:	23 March 2023
Title of paper:	REACH Highlight Report
Brief summary:	This report provides a summary on the implementation of electronic patient care records. It gives details of hospital implementation, new technology deployment, NIAS next steps and further development work.
Recommendation:	**For Approval** ☐ **For Noting** ☒
Previous forum:	SMT – 7/3/23
Prepared and presented by: **Date:**	Maxine Paterson, Director of Planning, Performance & Corporate Services 16 March 2023

REACH Project – Background and progress to date

The REACH programme is driving forward the technologies that will better connect our clinicians, connect our patients, supporting quality and safe patient care through the implementation and use of ePCR (electronic Patient Care Records) and access for clinicians to NIECR (Northern Ireland Electronic Care Records) and clinical guides.

The software to create and access ePCR is MobiMed and its use was launched at the end of 2021. At this time, hospitals have MobiMed installed on Clinical Workstations and NIAS staff use MobiMed on personal issued tablets.

Throughout 2022 to now, a phased deployment of MobiMed has resulted in 859 NIAS staff trained in the use of MobiMed and 10 out of the 14 in scope hospitals able to receive ePCR.

However, during 2022, significant challenges have delayed the full implementation across the region. These are summarised as follows:

- Delays in implementation were largely influenced by the impact of COVID-19, continued experience of REAP 4, continued pressures on EDs and recent Industrial Action.
- As usage of the personal issue tablets and software grew, a number of first time technical issues were identified and reported. NIAS IT continue to work with technical engineering teams from the supplier to rectify and improve upon the technical solution provided.
- In order to ensure that we have sufficient technology availability and resilience for our increased workforce, including Bank staff, we planned to implement a vehicle based solution to our emergency ambulances. This involved investment in Panasonic Toughbooks which were unfortunately delayed due to global supply chain issues.

With the improvements made to the technology and software application, we have stabilised the technical issues with the personal issue tablets and the first deployment of the vehicle based solution was launched on 28 February 2023. This commenced in Belfast, prioritised due to this Division having the highest number of patient calls that receive ambulance attendance.

Full implementation to emergency ambulances (approx. 90) is anticipated to complete by end of June 2023 (supply chain dependent).

NIAS Senior Management Team have made a decision to mandate the use of ePCR once this deployment is complete.

Building on the capability of the MobiMed software, we are now in development phase that will contribute to the use of other appropriate care pathways with the benefit of reducing demand on ambulance attendance and onward ambulance conveyance to EDs. The test phase of this is expected to commence end of May 2023.

REACH Project - Status report

Project Mandate	Digital transformation and enablement will be a key focus of the NIAS Strategy "Caring Today, Planning for tomorrow: Our strategy to Transform 2020-2026". The REACH programme is driving forward the technologies that will better connect our clinicians, connect our patients, supporting quality and safe patient care through the implementation and use of ePCR (electronic Patient Care Records) and access for clinicians to NIECR (Northern Ireland Electronic Care Records) and clinical guides.			
Programme Senior Reporting Owner (SRO)	**Service Programme Lead**	**Transformation Programme Manager**	**Reporting Period**	**Project Target Completion Date**
Maxine Paterson - Director Planning Performance & Corporate Services	Ciaran McKenna– AD Operations	Neil Trelford	Progress to 22/02/2023	TBC
Points to Raise/ To be Aware (note points that should be highlighted, e.g. Interdependencies)	• A combination of factors impaired NIAS staff usage of ePCR these included REAP 4, impact of COVID-19, Industrial Action and complex technical issues. However the continuous development work with NIAS IT and suppliers has addressed a number of the complex enabling NIAS operations to focus on increasing usage from February 2023. • Vehicle based technology (Panasonic Toughbook) has been introduced from 27-02-2023. This is to supplement the existing personal issue laptops for the purpose of creating electronic patient care records. • Development work is underway with the software provider (Ortivus) in order to deliver a MobiMed software solution to support other appropriate care pathways. Testing of this solution is due end of May 2023.			
Status (R/A/G)	1. 859 NIAS staff have been trained in the use of MobiMed software/ePCR 2. From 1 March 2023, 10 out the 14 hospital sites will be receiving ePCR 3. However, full hospital roll out is tentatively delayed. This is particularly related to SEHSCT implementation that has been affected by the following: • SEHSCT IT are fully engaged in the first phase of the Encompass Programme and have no imminent opportunity to install and test the MobiMed software that was specifically designed for the virtual desktop infrastructure operating environment (VDI). An interim solution is being explored with them. • This will result in the need for continuation of paper patient referral forms (PRF) for conveyance to Ulster ED, Downe and Lagan Valley hospitals.			

REACH Project – Status Report

- **Below is the target roadmap** for further implementation and development of MobiMed and ePCR usage.

Hospitals with MobiMed Live to Date	March 2023 to July 2023	May 2023 – August 2023
• **BELFAST:** RVH ED, RVH PPCI, Mater ED and RBHSC • **North:** Antrim ED, Causeway ED • **South:** Daisy Hill ED • **West:** Altnagelvin ED and PPCI, South West Acute ED	• Regional deployment of in-vehicle technology (Panasonic Toughbooks) • Craigavon ED – staff to be trained • **South Eastern:** Implementation and training for SEHSCT	• Testing and implementation of MobiMed solution for other appropriate care pathways • NIAS reports to be live accessible on NIECR

- **Core Benefits of systems in place when used:**
  - NIAS staff can access patients' Electronic Care Records using NIECR lookup to assist with pre-hospital treatment.
  - NIAS staff can access latest clinical guidelines (JRCALC) to assist with patients' pre-hospital treatment.
  - Hospital staff have the ability to forward plan resources and treatment based on advanced knowledge of patient condition ahead of arrival.
  - Hospital staff can make real-time clinical assessment of observations/ECG data and forward plan appropriate care-pathway. This is a particular benefit to the PPCI sites at RVH and Altnagelvin.

Trust Board Finance Report

January 2023 (Month 10)

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 ten months ending 31 January 2023 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 £6.853m. 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 96.4% at 31 January 2023 (Month 10). 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 ten months ending 31 January 2023 (Month 10) 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 10 £107.546m , of which £95.227m is recurrent (previously £107.391m of which £95.227m was recurrent).
* Covid-19 Costs – The Trust has received allocations of £12.743m (previous forecast £12.660m) of Covid-19 costs across the areas of Workforce (£3.66m), Service Delivery (£7.2m), Equipment & Supply (£1.2m), Corporate Cleaning (£0.6m) and IPC (0.08m). 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 identified additional costs experienced over the winter period with a view to securing additional Covid allocations in the current year. These pressures are significant and sustained and the Trust has received a further £2m of support 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 were 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. Subsequently, the RRL was reduced by £79k.
- 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) 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 January 2023 (Month 10) 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.

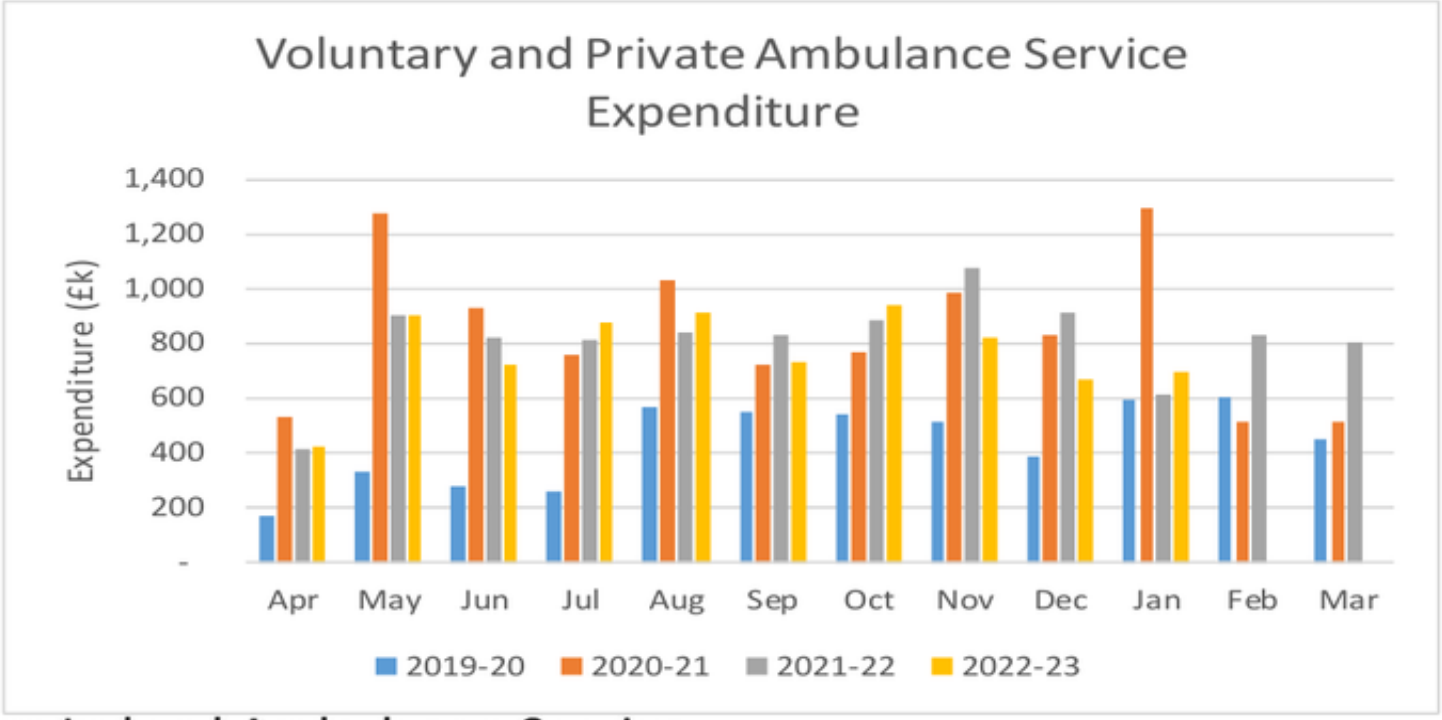
NIAS Trust Board Budget Report at January 2023

(£ 000s)		FYB	YTD Budget	YTD Actual	YTD Variance
Chief Executive's Office					
	Payroll	210	178	174	4
	Non-Payroll	154	147	143	5
Chief Executive's Office Total		364	325	316	9
Director of Finance					
	Payroll	(4,660)	(4,858)	(4,862)	5
	Non-Payroll	568	508	503	5
Director of Finance Total		(4,093)	(4,350)	(4,359)	9
Director of HR					
	Payroll	1,433	1,153	1,149	4
	Non-Payroll	679	570	565	5
Director of HR Total		2,112	1,723	1,714	10
Dir of Ops (incl Divisions & RCC)					
	Payroll	69,512	58,716	58,741	(25)
	Non-Payroll	21,064	19,140	19,167	(27)
Dir of Ops (incl Divisions & RCC) Total		90,576	77,856	77,908	(52)
Medical Director					
	Payroll	9,670	8,474	8,472	2
	Non-Payroll	1,117	1,041	1,038	3
Medical Director Total		10,786	9,515	9,510	5
Director of Safety, Qual & Imp					
	Payroll	2,991	2,639	2,632	7
	Non-Payroll	132	118	118	0
Director of Safety, Qual & Imp Total		3,123	2,758	2,750	8
Director of CRM, Fleet & Estates					
	Payroll	862	714	718	(3)
	Non-Payroll	534	444	439	5
Director of CRM, Fleet & Estates		1,395	1,158	1,157	1
Director of Plan, Perf & Corp					
	Payroll	2,801	2,335	2,330	5
	Non-Payroll	1,481	1,219	1,214	5
Director of Plan, Perf & Corp Total		4,281	3,554	3,544	10
	NIAS Total Payroll	82,818	69,353	69,353	0
	NIAS Total Non-Payroll	25,728	23,187	23,187	0
NIAS Total		108,546	92,540	92,539	0

Figures last updated: 21/02/2023 09:39

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, of the order of £1.8m for the ten months to January 2023, are also being incurred for the provision of patient taxis.



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.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Overtime	319	355	414	451	318	397	491	582	590	509		
CRRPS	341	370	268	227	514	264	137	53	10	-		

Northern Ireland Ambulance Service
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Manage within allocated Capital Resource Limit (CRL)

- The Trust has received a Capital Resource Limit (CRL) allocation of £6.853m (previously £6.315m). This includes allocations for Fleet & Estate (£5.223m), ICT (£1.133m), Backlog Maintenance (£0.250m) and IFRS16 Leases (£0.247m)
- 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 was an element of over programming on the current capital programme. This has been supported through a successful additional bid for funding.
- Provisional figures for expenditure at January 2023 (Month 10) is £2.693m against this allocation of £6.853m. The Trust currently forecasts full spend against the CRL allocation at year end, subject to the risks outlined above.

ICT Schemes	0	88	0	0	0	22	10	0	69	290			480
Backlog Maintenance	0	0	0	0	0	0	0	0	0	247			247
Actual Spend	0	164	26	6	0	48	10	277	77	2,086	0	0	2,694
Revised Forecast Profile of Expenditure	0	164	26	6	0	48	10	277	77	2,085	497	3,662	6,853

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	2,859			25,574	
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	2,787			24,643	
% bills paid on time 30 days	96.4%	95.0%	94.5%	97.0%	95.7%	96.3%	97.1%	97.1%	97.1%	97.5%			96.4%	>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	2,157			19,112	
% bills paid on time 10 days	77.0%	65.8%	71.5%	84.1%	60.9%	71.2%	82.8%	80.4%	81.4%	75.4%			74.7%	>70%

End of Report

Northern Ireland Ambulance Service
Health and Social Care Trust

'SAFETY' COMMITTEE REPORT TO TRUST BOARD 23/3/23

The Safety, Quality, Patient Experience and Performance Committee met on Tuesday 28 February 2023.

1	**Strategic Review of Clinical Education** Dr Ruddell provided the Committee with a verbal update on progress to date.
2	**Emerging Risk** Dr Ruddell briefed the Committee on the review of emergency planning within the Trust. The issue will be referred to the Trust's Audit and Risk Assurance Committee for consideration and updating of the Corporate Risk Register.
3	**SAI and Service User Feedback (including Care Opinion)** The Committee received an update from Ms Clare McVeigh, Service User Feedback Manager, on Complaints, Compliments, Enquiries and Care Opinion as well as a presentation summarising three anonymised complaints and the actions taken in response. Ms Audrey Murdoch, SAI Lead, also attended the Committee and shared with members details of an anonymised SAI and the process followed by the Trust in its investigation, including the family engagement undertaken.
4	**IAED Accreditation of Excellence** The Committee heard from Ms Hannah Maxwell, Emergency Ambulance Control (EAC) Continuous Development Manager, and Mr Steven Carson, Asst Director Operations, on the improvements EAC had made to performance and patient care over the past six months. The Committee welcomed the re-accreditation by the International Academies of Emergency Dispatch (IAED) of EAC on its standard of care.
5	**Hygiene, Cleanliness and Infection Prevention and Control:** **- Key Performance Indicators: Environmental and Vehicle Cleanliness: 1 April 2022 – 31 January 2023** **- Infection Prevention Control (IPC) and Environmental Vehicle Cleanliness (EVC) Annual Report for 2021-22** The Committee was briefed on the changes to the model of vehicle cleaning at Emergency Departments in line with returning to business as usual arrangements. The Committee also noted the IPC EVC Annual

	Report for 2021-22.
6	**Annual Quality Report 2021-22** The Committee noted the Annual Quality Report for 2021-22. Five themes This report utilises the 5 key themes of Transforming the Culture; Strengthening the Workforce; Measuring the Improvements; Raising the Standards and Integrating the Care to detail the work and efforts of the Trust in relation to transformation of quality and achieving its strategic aims for same for the year 2021/22.
7	**Quality and Service Improvement: Falls Response** The Committee received an update in relation to ongoing Falls Improvement work through a number of projects. For example, the Trust has undertaken a pilot on a range of dates in January utilising CSD clinicians to operate a dedicated Falls Response Vehicle when they are completing operational shifts. The NIAS Falls Quality Improvement Lead also participates in the HSC Quality Improvement (HSCQI) timely access collaborative which shares learning and best practice from local quality improvement projects with the aim of identifying projects for regional scale and spread.
8	**Annual Pharmacy Update** Ms Catherine Hanna, Pharmacy Lead, provided the Committee with an overview of her first year in post as well as a description of the work to be taken forward.
9	**Independent Ambulance Service Audit and Governance** The Committee were provided with details of the process and development of the processes for Independent Ambulance Services to provide assurance in relation to the compliance with the Quality & Safety aspects of the Non-Emergency Framework Scope and Service Specification in terms of inspection, assurance and governance. An update on the progress of inspects and audits carried out by NIAS on IAS providers to date was also provided as well as an outline of the plans for next steps in relation to the development of a new Framework and Specification.
10	**Safety & Quality Alerts: proposed process** Ms Katrina Keating, Risk Manager, briefed the Committee on how the Trust intended to strengthen its governance and assurance around Safety and Quality Alerts through the development and implementation of new DATIX Safety Alerts Module and the development of Trust Procedures, including 'how to guides' and training as necessary.

Northern Ireland Ambulance Service
Health and Social Care Trust

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

PRESENT:	Mr D Ashford	-	Committee Chair
	Mr W Abraham	-	Non Executive Director
	Mr T Haslett	-	Non Executive Director
IN ATTENDANCE:	Mr M Bloomfield	-	Chief Executive (joined the meeting at 9.40am)
	Ms L Charlton	-	Director of Quality, Safety & Improvement
	Dr N Ruddell	-	Medical Director
	Mr R Sowney	-	Senior Clinical Adviser
	Mrs C Mooney	-	Board Secretary
	Ms R Finn	-	Assistant Director QSI
	Mr N Sinclair	-	Assistant Clinical Director
	Mr J Wilson	-	Boardroom Apprentice
	Mr N Sinclair	-	Assistant Clinical Director (for agenda items 5, 6 & 7 only)
	Ms S Leckey	-	Community Resuscitation Lead (for agenda item 10 only)
APOLOGIES:	Ms R Byrne	-	Director of Operations

1 Apologies & Opening Remarks

Apologies were noted from Ms Byrne.

2 Procedure

2.1 Declaration of Potential Conflicts of Interest

There were no declaration of conflicts of interest.

2.2 Quorum

The Chair confirmed the Committee as quorate.

2.3 **Confidentiality of Information**

The Chair emphasised the confidentiality of information.

3 **Previous Minutes (SC12/12/22/01)**

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

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

Members **NOTED** the action list.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5 **Standing Items:**

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

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

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

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

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

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

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

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

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

Mr Sowney commented that delivery of Workstream 1 had completed.

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

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

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

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

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

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

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

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

supervision model during their period as a newly qualified paramedic.

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

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

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

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

(ii) Identification of Risk

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Mr Sinclair withdrew from the meeting at this point.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Mr Sowney sought further detail as to the monitoring applied.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Patient Care Services

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

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

Voluntary Car Services (VCS)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16 **Date of next meeting**

The Chair apologised for having to reschedule the January meeting and confirmed that the next meeting of the Safety Committee would take place on Tuesday 28 February 2023 at 9.30am (arrangements to be confirmed).

17 **Any Other Business**

There were no items of Any Other Business.

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

SIGNED: _____

DATE: 28 February 2023