NORTHERN IRELAND AMBULANCE SERVICE TRUST

TRUST BOARD - THURSDAY 14 DECEMBER 2023 AT 10AM

Boardroom, NIAS HQ, Site 30,

Knockbracken Healthcare Park,

Saintfield Road,

Belfast BT8 8SG

Agenda

1 Welcome, Apologies & Declarations of Conflict of Interest

For Information

2 Minutes of the previous meeting held on 24 October 2023

For Approval

3 Matters Arising

For Noting

4 Chair's Update

For Noting

5 Chief Executive's Update

For Noting

6 NIAS Staff Quality Improvement Group - Late Finishes

For Noting

7 Regional Co-ordination Centre (RCC) Memorandum of Understanding

For Noting

8 Getting It Right First Time (GIRFT) Report

For Noting

9 Maximising Attendance Delivery Plan

For Noting

10 Trust Corporate Scorecard & Performance Report (November 2023)

For Noting

11 Finance Report (October - Month 7)

For Noting

12 NIAS Policies:

For Noting

- Grievance Policy & Procedure

- Completion of Patient Records

- Conflict, Bullying and Harassment

For Noting

13 Committee business:

- Safety Cttee - minutes of meeting on 7 September 2023 and report of meeting on 17 November 2023;

- PFOD Cttee - minutes of meetings on 16 and 19 October 2023

For Noting

14 Date & venue of next meeting: Date and venue tbc

For Noting

15 Any Other Business

Northern Ireland Ambulance Service Health and Social Care Trust

Minutes of NIAS Trust Board held on Tuesday 24 October 2023 at 10am in the Conference Room, NIAS North Division HQ, 121-125 Antrim Road, Ballymena BT42 2HD

Present:	Mrs M Larmour	Chair
	Mr W Abraham	Non Executive Director
	Mr D Ashford	Non Executive Director (left the meeting at 11.40am)
	Mr J Dennison	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:	Ms M Lemon	Director of HR & OD
	Ms M Paterson	Director of Planning, Performance & Corporate Services
In Attendance:	Ms L Charlton	Director of Quality, Safety & Improvement
	Mr N Sinclair	Chief Paramedic Officer
	Mr A Arandia	Assistant Director, Planning, Performance & Corporate Services (rep Ms Paterson) (left the meeting at 1pm)
	Ms V Cochrane	Assistant Director HR (rep Ms Lemon)
	Mrs C Mooney	Board Secretary
	Mr B Allen	St Johns Ambulance (for agenda item 6 only)
	Mr C Clarke	Clinical Service Improvement Lead (Urgent Care) (for agenda item 6 only)

1 Welcome, Introduction & Apologies

Welcoming those present to the meeting, the Chair noted the apologies and paid a particular welcome to Mr Neil Sinclair, Chief

Paramedic Officer, who would now attend Board and relevant Committee meetings.

She 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 (TB24/10/2023/01)**

The minutes of the previous meeting held on 24 August 2023 were **APPROVED** on a proposal from Mr Abraham and seconded by Mr Haslett, subject to an amendment on page 14, fourth paragraph which should read: '*Mr Abraham said that, while he wished to record the fact there had been positive developments, it would also be important to record members' ongoing dissatisfaction that no material progress had been made….'*

3 **Matters Arising (TB24/10/2023/02)**

Members **NOTED** the Matters Arising.

Referring to the presentation of the NIAS Estates Strategy to the Trust Board, Mr Bloomfield described the complexities in developing the Strategy, for example, the fact that NIAS only owned 25% of its estate as well as the need to factor in the CRM business case and the new approach to how this would be progressed. Mr Bloomfield added that the work undertaken recently by the Reconfiguration Blueprint Group would also have to be considered.
He assured the Board that the development of a Strategy was very much work in progress and would also require input from other stakeholders as the Strategy could not be produced in isolation by the Trust's Estates Department.

The Chair pointed to the need for members to be kept appraised of the direction of travel such as whether the move from Broadway to the NIFRS site on Boucher Road was still being considered.
Mr Nicholson explained that such a move would have significant revenue consequences for the Trust and these were currently unaffordable. However, he said that he remained in discussion with NIFRS.

Responding to a question from the Chair as to the timescale for the completion of the Reconfiguration Blueprint work, Mr Bloomfield said he understood that most of the groups' work was now nearing completion with a view to producing reports by the end of November.

Mr Bloomfield noted that arrangements around the establishment of the Regional Co-ordination Centre (RCC) had moved at pace and he described in detail the structure that had been put in place. He reminded members that this initiative was being led by the six Trusts in partnership and would manage and co-ordinate unscheduled care pressures in such a way that would equalise pressures across the system over the winter period with a view to determining whether such an approach could be applied to other areas in due course.

In response to a question from Mr Haslett, Mr Bloomfield advised that the RCC would be sited at the HSC Leadership Centre. He clarified that the costs associated with the RCC would be borne by the six Trusts.

Mr Abraham advised that he had recently attended the ARAC Chairs' Forum at the DoH and said it was clear that discussions were very much hospital-focussed. However, he said he had taken the opportunity to highlight the challenges presented by delayed handovers and asked how it was envisaged the RCC could assist in this regard.

Mr Bloomfield reiterated the role of the RCC in equalising unscheduled care pressures across the HSC system and this could include a focus on reducing ambulance handover delays. He alluded to the correspondence issued by Mr Ashford, as Chair of the Trust's Safety Committee, to his counterparts in other Trusts. He acknowledged that this had been an unusual step for a Committee Chair to take and said that Mr Ashford's correspondence had raised awareness amongst Trusts of the impact delayed handovers was having on patients, particularly those frail elderly patients.

Mr Bloomfield said that, in terms of the RCC, no one Trust would have overall control and no Trust would challenge any decisions taken by the RCC. He said the focus would be on patients and patient safety rather than hospitals.

Ms Byrne advised that she sat on the RCC Project Board and was confident that it would have traction. She indicated that the Memorandum Of Understanding (MOU) had been written which would ensure the RCC had the authority and autonomy to mediate with Trusts if necessary.

Mr Ashford welcomed the ongoing work around governance and asked whether the current legislation supported the MOU. Mr Bloomfield was of the view that any RCC interventions would not cut across any legislative requirements but would very much be focussed on operational matters. He said the RCC would look across the system and challenge Trusts to ensure everything possible was being done to relieve pressure.

Mr Nicholson acknowledged that NIAS would incur expenditure relating to posts in the first instance and said that the PFOD Committee would see an increase in the costs associated with Leadership Associates. However, these costs would be covered by additional income from the other five Trusts. He noted that it involved a significant piece of work and the Trust's involvement in terms of facilitating the RCC was significant.

Responding to a question from the Chair, Mr Nicholson confirmed that NIAS would be responsible for recharging the other Trusts. Mr Bloomfield assured the Board that the six Trust Chief Executives were fully supportive of the RCC and said that he would act as the lead Chief Executive.

The Chair welcomed the whole system approach and said it was reflective of the Permanent Secretary's wish to see more collaborative working across the six Trusts. She said she hoped that the outworkings of the RCC would be positive but acknowledged the interdependencies. The Chair said the RCC would ultimately be concerned with patient care, staff and safety and was of the view that the RCC's authority and autonomy were fundamental to its success. She said that, while Mr Bloomfield had provided assurance around the governance arrangements in place, she sought further clarity in relation to the individuals within the RCC, their level of responsibility to work collaboratively with the Trust Chief Executives. She sought clarification on who would act as the ultimate 'decision maker'.

Responding, Mr Bloomfield explained that the RCC lead would make any necessary decisions and Trust Chief Executives had agreed that they would not challenge any decisions made. He said that, after a period of time, should it be determined that the RCC was not operating as had been originally envisaged, Trust Chief Executives would revisit the initiative.

The Chair welcomed this position and suggested that regular reviews would be put in place. However, she said that if the RCC operated as envisaged, there was potential to roll the model out to other areas.

4 Chair's Update

The Chair reported that, since the last Board meeting, she and the Chief Executive had had their Accountability Review meeting with the Permanent Secretary and she thanked those involved in preparing the briefing papers. She felt it had been a positive meeting and had covered a range of areas, including governance, finance and performance. The Chair said there had also been a focus on delayed handovers and the interdependencies with the other five Trusts as well as how the Trust intended to address staff absence. The Chair said that the Permanent Secretary had indicated his intention to keep the impact of handovers on future agendas.

Continuing her report, the Chair said she wished to acknowledge the significant work ongoing around the management of staff absence. She advised that she had met separately with Non-Executive Directors to discuss this important issue with a subsequent meeting held with the Chair of the People Committee, Chief Executive and Director of HR & OD to discuss the Trust approach in more detail. The Chair advised that an action plan would be developed to address the concerns at Board level in relation to managing absence and that this would be considered by the People Committee in the first instance. She added that Mr Dennison had attended the ARAC meeting on 5 October to provide an update and would continue to brief the Committee as and when required.

The Chair outlined a number of stakeholder engagement events she had attended representing NIAS, including meetings with the Chairs and Chief Executives of the Belfast and Northern Trusts. She

added that she would be meeting with the Chair and Chief Executive of the SHSCT in the coming weeks.

The Chair advised that she and the Chief Executive had recently met with their counterparts in the Regulation and Quality and Improvement Authority (RQIA) to discuss the Authority's strategic plan which was out for consultation. She said that the meeting had also touched upon the importance of ensuring flow through hospitals and the availability of beds, particularly in care homes and whether the data reflected more beds in the care home sector than were available. The Chair indicated that the RQIA Chair and Chief Executive had been very supportive of NIAS.

Continuing, she advised that she had attended a briefing on the Encompass roll-out which would commence in the SEHSCT on 9 November and subsequently rolled out to other Trusts. The Chair acknowledged that she had not previously been aware of the enormity of this project in terms of the numbers of staff involved and the impact of implementation. She said that Ms Coulter, SEHSCT Chief Executive, had been leading on the implementation of Encompass within the Trust and explained that Encompass represented one of the largest transformational IT programmes to be implemented across the HSC.

The Chair reported that she had attended a workshop, facilitated by Mr Mike Farrar and other Trust Chairs to explore further opportunities to undertake more collaborative transformational work. The Chair said she had found it to be a useful session and there was an appetite amongst attendees to identify a small number of priority areas to be taken forward through a consistent approach. The Chair said the intention was to meet again before Christmas to continue the discussion. She added that the focus was also on relationship building as well as providing an opportunity to discuss pressure points and how these might be addressed collaboratively.

The Chair reported that she had attended the Ambulance Leaders' Forum (ALF) Conference and had found it insightful to meet with Chairs from other UK ambulance Trusts and said that their focus had been on opportunities to link into best practice.

The Chair advised that she had also attended the DoH's winter planning summit where they had been briefed on cross sector plans and the establishment of the Regional Co-ordination Centre.

Continuing, the Chair said she had visited a number of stations and EDs where she had met with staff and discussed a number of issues impacting on them such as annual leave, delayed handovers, compensatory rest. She said she welcomed the opportunity to meet with staff and encouraged other Non-Executive Director colleagues to do likewise.

The Chair advised of a number of other events and meetings she had attended including meetings with the NIAS Education Team and EAC staff as well as representing the NIAS Board at the launch of the NIAS Research Public Involvement Committee. She had also attended the NICON conference where the Permanent Secretary had spoken about the current position in terms of health and social care and what Non-Executive Directors could add to discussions.

Concluding her report, the Chair said she was delighted that the Trust was very much involved in the first initiative of the Prince of Wales RCN Nursing Cadet Scheme in NI.

Mr Haslett referred to the discussions at the Accountability Review with the Permanent Secretary, particularly around absence levels within NIAS. He asked whether other Trusts had experienced similar challenges in relation to absence.

The Chair said she imagined other Trusts' agendas for their Accountability Reviews would have been similar to the NIAS agenda. However, she acknowledged that NIAS was an outlier in relation to absence levels.

Mr Bloomfield indicated that absence had increased across other organisations and agreed that NIAS was an outlier at 14.25% absence levels in comparison to other Trusts. He believed that this was as a result of the impact of pressures on the system and the challenging circumstances in which staff were working. He reminded members that, as of October 2022, Covid-19 absence was now recorded as normal sickness absence.

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

5 Chief Executive's Update

Mr Bloomfield reminded members that the staff engagement sessions had started following the August Board meeting when he and other members of the Senior Management Team had visited EDs to meet with staff. He said he had welcomed the opportunity to meet with staff and added that similar issues such as late finishes, delayed handovers, late or missed rest periods and difficulties in getting annual leave, had been raised at the sessions. Mr Bloomfield indicated that Ms Charlton's Directorate was leading on a quality improvement initiative to consider late finishes and he welcomed the approach involving staff to find potential solutions.

The Chair commented that the Board welcomed such an approach.

Referring to the Accountability Review meeting, Mr Bloomfield said the Permanent Secretary had acknowledged the Trust's comparatively stronger performance as reported to PTEB monthly and had a keen interest in what actions the Trust was taking to reduce conveyance as well as in the See and Treat initiatives being led by Mr Sinclair.

Mr Bloomfield indicated that the DoH had set the absence reduction targets at 92.5% of the previous year's figure and said that, while he had advised the Permanent Secretary that the Trust would not be able to achieve this target, he had explained the approach adopted by the Trust and the oversight of the process by the Trust's People Committee. Mr Bloomfield said that the Permanent Secretary had been interested to know whether the Trust's approach to culture and performance had been embedded and understood across the Trust. Mr Bloomfield said that he had acknowledged the challenges in ensuring a consistent approach and said the Trust continued to make every effort.

Continuing, Mr Bloomfield alluded to the significant preparations involved in respect of the industrial action which had taken place on 21 and 22 September. He advised that the Trust had established a Tactical Cell to oversee the planning and management of services across the two-day period.

Mr Bloomfield indicated that the Trust had put arrangements in place to ensure additional clinical input in EAC during the industrial action and that, as a result, conveyance to hospital had reduced by

approximately 53%. He explained that the clinicians had taken difficult decisions about patients who needed to be conveyed to hospital by ambulance and advising patients to make their own way to hospital. Mr Bloomfield said that this initiative had attracted significant interest from SPPG colleagues. He indicated that the SPPG had provided some funding to allow the Trust to explore the potential of this particular model.

Mr Bloomfield pointed out that Action Short of Strike (ASOS) continued and was becoming more impactful and difficult. He believed that, while the reason for industrial action was related to Government pay policy, action was now also being taken linked to staff not being able to finish their shifts on time. He said the Trust continued to explore how it could address this situation and had agreed that staff who had a late finish would have a 12-hour break before they commenced their next shift. Mr Bloomfield said that the provision of this additional hour was not without risk and added that it continued to be challenging.

Mr Bloomfield advised that he had recently attended an awards ceremony to recognise the Control Room staff who had recently been accredited by the IAED as a centre of excellence. He explained the detailed process involved in achieving this accreditation and the high standards that the Control Room had to maintain. He indicated that it had been considered such an achievement that the President of the IAED had visited NIAS to present the certification as well as taking the opportunity to present awards to individual members of staff to mark high compliance in certain categories, for example successful cardiac arrests, delivery of babies. Mr Bloomfield advised that the Trust had organised two different sessions so many EAC staff could attend.

Continuing his report, Mr Bloomfield advised that a few Directors had met with the BSc students who had started their course in September to talk to them about some of the developments being taken forward by the Trust. In addition to this, a further meeting took place with those students who had commenced their final year of study and who would graduate in the summer of 2024. Mr Bloomfield said he had been delighted to be able to confirm to the students that the Trust had secured funding from the DoH to employ 48 newly qualified paramedics should they wish to remain in Northern Ireland. He added that it had also been made clear to the

students that they would have to meet the recruitment criteria set by the Trust.

Mr Bloomfield advised that he had attended the Winter Summit convened by the DoH which included elected representatives and the media. He said that the Summit had been an information giving session with representatives from primary care, pharmacy, RQIA giving presentations on how they had prepared for the winter. Mr Bloomfield said that the DoH had provided an overview on Trusts' locality plans and within that had highlighted NIAS' intention to increase the clinical presence in the Control Room as well as working with other Trusts to have mental health professionals in the Control Room to support those in acute mental health distress. Mr Bloomfield said that these initiatives were viewed as a key aspect of the DoH's winter planning. He added that the DoH had clarified that it would be holding the system to account for ambulance handovers and discharges.

Continuing, Mr Bloomfield alluded to the constructive meeting with SEHSCT colleagues in relation to delayed handovers and the associated risk to patients waiting in the back of ambulances. He advised that Ms Charlton had led on the presentation and said he welcomed the SEHSCT's determination to address this issue and added that it had been agreed that a further meeting would be held in six weeks' time. He indicated that a similar meeting would be held with SHSCT colleagues in the coming weeks.

Mr Bloomfield said that earlier in the meeting, he had mentioned the correspondence sent by Mr Ashford as Chair of the Safety Committee, to his counterparts in other Trusts highlighting a number of issues in relation to patient safety as a result of delayed ambulance handovers.

Mr Bloomfield confirmed that a copy of the Trust Chief Executives' correspondence to the Secretary of State expressing their concern at the lack of a pay award had been shared with members. He acknowledged that this had been a highly unusual step but as such it had highlighted the deep concerns held by Trust Chief Executives about approaching the winter period without a pay award and the ongoing risk of industrial action. However, more fundamentally, Mr Bloomfield said that it was unfair that staff in Northern Ireland had not received any pay award. He said that the Secretary of State's response had clearly indicated his view that it was not his

responsibility while the DoH had indicated that it had not received any funding to be in a position to implement the pay award. Mr Bloomfield said that for the pay award to be implemented, the costings would be passed to the HSC to find in the form of further savings. He said that his view would be that this would have such an impact on services that it would not be an appropriate way to resolve the issue.

Mr Bloomfield said that, in his opening address at the NICON conference, the Permanent Secretary had been clear regarding the pay issue, commenting it was unfair that staff had not received the pay award and that its impact was unacceptable for patients and unsustainable for staff.

Referring to the Prince of Wales RCN Nursing Cadet Scheme, Mr Bloomfield explained that the Trust had been invited to participate in the scheme as it was a regional Trust and said that the RCN had been keen to demonstrate the breadth of posts across the HSC. He advised that the Southern Regional College had also been invited to participate as the education partner. Mr Bloomfield said that NIAS' role would be to provide placements for students on the scheme and he thanked those NIAS members of staff involved in ensuring the necessary arrangements were put in place.

Continuing his report, Mr Bloomfield advised that he, Dr Ruddell, Ms Charlton and Mr Sinclair had attended a meeting, facilitated by the Department of Justice, with PSNI colleagues to look at challenges across the ambulance and police services, particularly mental health. Mr Bloomfield indicated that the meeting had agreed a number of areas where both services could work more collaboratively. He said that NIAS had been assured by the PSNI that the service did not intend to adopt a similar approach announced by police services in England that they would not be responding to mental health calls.

Responding to a question from Mr Ashford re the escalation of industrial action, Mr Bloomfield acknowledged the significant challenges presented by the current action. However, he said that he would be extremely concerned if derogations reduced any further as significant harm could be caused to patients Mr Bloomfield acknowledged the good working relationships between the Trust and Trade Unions but cautioned that a further reduction of

derogations would significantly impact on patient safety and the Trust's ability to provide a safe service.

Mr Ashford referred to the potential to approach companies which could be hired to provide services. He asked whether there was an agreement that industrial action would cease in the event of a major incident and questioned whether this would be a potential solution.

Responding, Mr Bloomfield advised that NIAS would rely on the use of IAS in such circumstances and said that, during industrial action, the Trust had broadly maintained its use of IAS.

Ms Cochrane confirmed that there was an understanding that, in the event of a major incident, industrial action would be set aside. However, she said that to call a major incident as a mechanism to cease industrial action would be viewed by staff as a misuse of their right to strike.

Mr Haslett said he was sure other Non-Executive Directors would share his view that it was appalling that health staff had not received pay parity with the rest of the UK. He commended the Trust Chief Executives on their letter to the Secretary of State and complimented the RCN on its robust correspondence to the Secretary of State on the same issue.

Mr Ashford agreed with Mr Haslett's comments.

The Chair indicated that all Non-Executive Directors would share Mr Haslett's view.

Mr Dennison noted Mr Bloomfield's earlier comments in relation to the changing nature of industrial action and the decision only to respond to Cat 1 and upgraded Cat 2 calls during the last hour of their shift. He said that he very much appreciated that such action was as a result of concern for staff welfare.

Mr Bloomfield said that the Trust very much supported staff not having to experience late finishes and noted that NIAS staff were the only group of staff in the position of regularly not being able to finish on time and go home. He said that the Trust had been trying to address the issue for some time, including the decision to prioritise sending staff coming on shift to release those at the end of their shifts who were delayed at EDs.

He emphasised that staff should be able to go home on time at the end of their shift.

Mr Bloomfield indicated that Dr Ruddell had approved a derogation list of calls which could be held in such circumstances and said it would be important for the Trust to carefully manage the associated risks. He highlighted that, if staff were only responding to Cat 1 and upgraded Cat 2 calls during the last hour of shift, this would mean that an increasing number of Cat 2 and Cat 3 calls were waiting for response. Mr Bloomfield said it would be important for the Trust to find a way to manage this as safely as possible and identify solutions to ensure staff got home on time.

Ms Charlton said that, despite significant efforts, the likelihood of staff getting home on time was slim. She reminded members that, when relieved at an ED, staff had to return to station and carry out their medication checks before driving home, sometimes after a 16-hour shift. She advised that she hoped some members of staff would attend the December Trust Board meeting to share their experiences with the Board.

Ms Charlton said that, in discussions with Trade Union colleagues, it was clear that data around the contemporaneous impact of industrial action on patient safety would be helpful and added that it would be helpful for Trade Union colleagues to also be sighted on this data. She pointed out that staff who did not finish on time would incur compensatory rest and she highlighted the dynamic nature of this and the need for the Trust to manage this risk.

Ms Charlton said that the Trust's response times to patients with lower acuity was concerning and these issues would impact further.

The Chair highlighted the significant challenges presented by late finishes and believed that staff consistently not being able to finish shifts on time was extremely damaging to staff welfare and morale as well as posing a significant risk to patient safety.

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

6 **St John (SJA) and NIAS Falls Partnership (TB24/10/2023/03)**

By way of introduction, Ms Charlton reminded the meeting that the SJA/NIAS Falls Response pilot had been launched in September 2023 in the Belfast and South Eastern areas with further work being undertaken subsequently to develop a Memorandum of Understanding (MOU) between NIAS and SJA in respect of this project and service delivery.

She advised that, in advance of the launch in early September, there had been a trial period to test the systems and processes put in place for the project in August 2023 and she provided a brief overview of the learning from this.

Ms Charlton said the AACE Falls Response Governance Framework had been a helpful guide and had allowed NIAS and SJA to learn from other services' experiences. She alluded to the cross-Directorate work in the development of this work. Continuing, she referred to the organisational learning in relation to the experience of service users and their families when response to calls was protracted and, for that reason, acknowledged that the service was not expected to entail large volumes of calls, rather improve the experience and potential outcome for a smaller cohort. She pointed out that, at the outset, it was accepted that actions would be taken in the context and on the balance of risk.

Ms Charlton indicated that, as a result of the learning from the project so far, the MOU had been updated to incorporate minor process changes which had come to light during the test phase. She advised that the project had now moved to the next stage of full implementation.

Ms Charlton advised that the SJA/NIAS Falls Governance Group had been established and had developed the Terms of Reference and agenda for regular governance meetings. She explained that these meetings would ensure the strategic objectives of the project were being met and would include, risk management, call management, performance and Patient Report Form (PRF) review.

In terms of the success of the project, Ms Charlton reported that, to date, SJA had provided 16 periods of cover from 5 September 2023 up to and including 11 October 2023. She advised that, during this time, seven calls had been allocated and all had been responded to

within 45 minutes. Ms Charlton pointed out that cover was reliant on SJA volunteers matching their availability to CSD cover as CSD advice may be required at scene.

Ms Charlton advised that approximately 150 SJA staff had now been trained specifically on how to lift an individual off the floor on a Raizer chair. She reminded the meeting of the poor response times to falls calls and said the project aimed to improve upon these.

Mr Allen advised the meeting that SJA had over 2,000 volunteers with skills ranging from First Aid to emergency ambulance crews. He said that, as a charity, it would be important for SJA to use its charitable resources to meet a need that had been identified in society. He stressed that the project was a pilot but said that the experience of SJA volunteers had been positive. Mr Allen said it was important that SJA volunteers availed of opportunities to use their clinical skills. He explained that volunteers undertook two hours of training each week.

Continuing, Mr Allen indicated that, as mentioned earlier by Ms Charlton, over 150 SJA staff had now received training by NIAS to date. He added that SJA was still considering how best to roster and allocate shifts to volunteers as many also held full-time jobs. However, he acknowledged that many volunteers were also healthcare professionals who undertook shifts so some were available during the day.

He commended the NIAS staff involved in the project, particularly the leadership shown by Ms Charlton and said that, to date, the SJA experience had been an extremely positive one.

Ms Charlton referred to the need for pastoral care for SJA volunteers who might attend traumatic cardiac arrests, for example, and said that these arrangements were currently in place through SJA for their volunteers. She explained that consideration was also being given to consistency of shift because evidence showed that most calls took place in the morning when the majority of SJA volunteers were at their day job at this time. However, she said that efforts were being made to match shifts with demand. Ms Charlton said that work was also being progressed to organise the official launch of the project.

Mr Clarke acknowledged that falls were complex across the spectrum of illnesses and work had been undertaken to field out level 1 falls. He commended the work undertaken by SJA and said it was encouraging to note that the SJA was meeting the falls response Key Performance Indicators (KPI).

Mr Clarke alluded to the 'recontact rate' and confirmed that none of the patients responded to by SJA had recontacted NIAS within the following 24-hour period.

Ms Charlton highlighted the importance of this particular KPI.

Mr Clarke acknowledged that the service had referred a small number of patients to the Hospital@Home service. He highlighted that there had not been any need for these patients to be conveyed to ED and the Hospital@Home service would ensure the patients were cared for at home, resulting in the saving of bed days in hospital, increased flow in EDs and also ensuring ambulance were able to respond to calls in the community. Mr Clarke alluded to the governance and oversight provided by CSD colleagues and echoed Ms Charlton's earlier comments that the project had been positive.

Mr Haslett commended all involved and welcomed the collaborative nature of the project.

The Chair expressed her agreement and welcomed the innovative approach taken by SJA and the Trust in addressing what was a significant issue in terms of poor response times to patients who had fallen. She welcomed the potential to further consider the use of volunteers with particular skill sets.

The Chair asked Mr Allen to convey the Board's deep appreciation to all those volunteers participating in the project and indicated that the Board would be keen to see how the project could be extended to other areas of work.

Mr Allen said that SJA was always willing to engage and said he had appreciated the support of SJA England in progressing this work.

Mr Bloomfield echoed the comments made by the Chair and was of the view that this project demonstrated the real potential for rolling out similar projects at scale to other areas.

The SJA/NIAS Falls Partnership Update was **NOTED** by the Board. The Chair thanked Mr Allen for his attendance and he withdrew from the meeting.

7 **Internal Audit Charter (TB24/102023/04)**

Mr Nicholson explained that the Internal Audit Charter defined Internal Audit activity's purpose, authority and responsibility and said the Charter was reviewed and presented to the Trust's Senior Management and Trust's Audit and Risk Assurance Committee (ARAC) for approval every two years.

He advised that the Charter had been reviewed against Public Sector Internal Audit requirements and the Institute of Internal Audit's model Charter and, whilst there had not been any substantial changes to the content of the Charter, extended commentary had been provided in a number of sections.

Mr Nicholson pointed out that the document was consistent for all BSO Internal Audit Unit's client organisations. He advised that it had been presented to the Trust's Audit and Risk Assurance Committee (ARAC) on 5 October and the Committee had recommended the Charter to the Board for approval as required by Internal Audit.

The Chair asked what processes were in place in the event of any non-compliance of any aspect of the Charter.

Responding, Mr Nicholson explained that such issues would be raised via the Service Level Agreement (SLA) with the BSO. He advised that Internal Audit performance was measured not just by the Trust's ARAC but by the regional Internal Audit forum. Mr Nicholson added that there would be reference to such circumstances within the Committee's Terms of Reference.

Mr Abraham agreed that it would be helpful to have some detail around this and indicated that he would be content to approve the Charter in the meantime.

Mr Nicholson agreed to examine this issue further and revert to the Chair.

The Board **APPROVED** the Internal Audit Charter on a proposal from Mr Abraham. This proposal was seconded by Mr Dennison.

8 **Board Governance Self-Assessment Tool 2022-23 (TB24/10/2023/05)**

Mr Arandia drew the Board's attention to the Board Governance Self-Assessment Tool and explained that this was completed on an annual basis with a view to identifying any opportunities to enhance Board effectiveness. He advised that the documentation had been discussed at the ARAC meeting on 5 October when the Committee had recommended it to the Board for approval.

Mr Nicholson acknowledged that the Self-Assessment Tool was an extensive document which highlighted both areas for further attention as well as areas of good practice.

The Chair took the opportunity to advise that the recruitment exercise for Non-Executive Directors had now concluded and she anticipated being advised of the outcome of this by the end of the month.

Mr Haslett referred to the section on 'Balance and Calibre of Board members' and the fact that there was a red RAG rating against the prompt 'There is at least one NED with a background specific to the business of the ALB.' He hoped that the outcome of the NED recruitment exercise might assist in this regard and that this would move the RAG rating to green.

The Chair alluded to the NIAO document 'Board Effectiveness: A Good Practice Guide' and suggested this also might prove helpful in determining Board effectiveness.

The Board **APPROVED** the Board Governance Self-Assessment Tool on a proposal from Mr Abraham. This proposal was seconded by Mr Haslett.

9 **Update on Regional Electronic Ambulance Communications Hub (REACH) (TB24/10/2023/06)**

In Ms Paterson's absence, Mr Arandia drew members' attention to the schematic which provided an update on progress in implementing REACH within the Trust.

The Chair commended the use of the schematic and believed it helped members to see the progress made at a glance. She asked whether the delay in implementation in the SEHSCT had been as a result of the Trust focussing on the implementation of Encompass.

Responding, Mr Arandia acknowledged that the SEHSCT's focus and resources had been targeted on the implementation of Encompass. However, he said that SEHSCT colleagues were committed to ensuring the implementation of REACH.

The Chair sought clarification on the interface between Encompass and REACH and asked re the delay in introducing REACH in Craigavon Hospital.

Mr Arandia explained that the two systems were different but said that they would eventually interface from a patient record perspective. He advised that, while the introduction of REACH had not been a priority for the SHSCT, SHSCT colleagues were hopeful that they would soon be in a position to roll-out it out across the Trust. Mr Arandia said he remained confident that this would be achieved over the next few months.

The Chair mentioned that she would be due to meet with the SHSCT Chair in the coming weeks and undertook to discuss the issue with her.

The Chair alluded to the cultural shift amongst NIAS staff in using the REACH system and asked whether staff remained reluctant to use it. She enquired as to who was leading the implementation of REACH.

In response, Mr Arandia advised that any staff concerns in relation to using REACH had been addressed. He confirmed that staff had been trained and opportunities for refresher training had also been provided to staff. Mr Arandia believed that the focus should now be on continuing to implement the system within the Trust.

Mr Arandia confirmed that the Trust's Operations and Clinical Team were now leading on the implementation. He explained that dashboards had been developed to provide information to monitor the usage of the system.

Ms Byrne said that, from an Operations perspective, the monitoring of the usage of the REACH system would form part of the 1:1 discussions with staff. She confirmed that training had been provided to staff and, in those instances where uptake had not been sufficient, the focus would be on identifying the reasons for this and additional training provided.

Mr Sinclair agreed with the points made by Mr Arandia and Ms Byrne. He said that the dashboards would prove helpful to determine uptake on a station by station basis and the 1:1 discussions could then be used to discuss in more detail.

The Chair suggested that it would be helpful for the Board to receive an update on progress with a view to meeting the target of full REACH implementation by March 2024.

Mr Arandia advised that the Trust was moving to benefits realisation monitoring and said he was confident that the necessary technology and processes had been put in place to enable this.

The Board **NOTED** the REACH Update provided by Mr Arandia.

10 **Trust Corporate Scorecard and Performance Report (October 2023) (TB24/10/2023/07)**

Mr Arandia explained that the Performance Report set out the key measures to demonstrate the health of the organisation and added that the detail behind each measure was set out within the report. He reminded the Board that the Trust's performance monitoring and recording would continue to evolve.

Mr Dennison acknowledged the wealth of information within the report and suggested it was extremely beneficial to a reader who was close to the operational detail. He suggested it would be helpful to have some analysis in future papers, for example, highlighting areas where there were increasing risks/challenges and opportunities as well as unforeseen/unpredictable issues. He commented that he was uncertain what actions were required from the report.

The Chair noted Mr Dennison's comments and acknowledged the depth of information within the Board papers. She suggested that it

would be possible to highlight a short overview in the cover papers to Board documents.

Mr Bloomfield said it would be important to highlight NIAS' performance compared to the rest of the UK, but mainly England. He drew members' attention to slide 4 which set out the 999 response time performance which showed that NIAS had fallen behind its counterparts in terms of performance. He reminded the meeting that, over the last few years, the Trust had made considerable progress in relation to Cat 2 and 3 responses. However, this progress had now deteriorated to the point where English counterparts had improved and had also seen some progress on handover times. Mr Bloomfield acknowledged that this information did not make for satisfactory reading.

Ms Byrne advised that this information had been shared with SEHSCT and SPPG colleagues. She reminded the meeting that the SPPG had regular performance meetings with Trusts and had asked NIAS to highlight any areas of concern that should be raised.

The Chair highlighted the importance of such data being shared with Trusts to demonstrate the impact of delayed handovers on NIAS performance.

Ms Charlton said it would be important to understand that, where responses are particularly protracted, there were occasions when staff were arriving at calls when it was too late to help. She acknowledged the importance of understanding the detail but in the context of the NIAS position in comparison with improved response times in England. She noted that, between July 2022-2023, there had been circa 60% improvement nationally in waits over one hour while NIAS only saw a 18% improvement. Ms Charlton said she had taken the opportunity to share this information with other Trusts as well as at the Chief Nursing Officer's business meeting, noting that NIAS had not seen a similar improvement as its English counterparts.

Mr Haslett welcomed the evolution of the Trust's Performance Report and commented that it had transformed significantly over recent years. He said it provided a robust platform to enable Non-Executive Directors to seek additional assurance. Mr Haslett said he agreed with Mr Dennison's earlier point re providing further analysis in the cover paper.

The Chair noted that, on average, 102 patients per day were waiting more than 60 minutes outside EDs and said this needed to be highlighted. She noted that, while the volume of duplicate calls had decreased by 3% from August to September for the first time since April 2023, duplicate calls had increased by 13.5% on the same period last year. The Chair suggested that it would be important to understand whether this increase represented additional demand as well as the steps being taken by the Trust to address the increase.

Ms Charlton pointed out that approximately 40% of those waiting over two hours for handover to ED were over 80 years of age.

Referring to duplicate calls, Mr Bloomfield explained that these were largely due to callers phoning back to check on the arrival of an ambulance due to increased response times.

The Chair enquired whether the Trust was exploring the potential for any IT solutions to address the increase in duplicate calls.

Ms Byrne confirmed that the new Computer Aided Despatch system currently being procured by the Trust would have a mechanism to assist in this regard.

Ms Charlton explained that there was potential for a patient's condition to deteriorate whilst waiting for an emergency response and Standard Operating Procedures (SOPs) would require patients to be escalated to ED should this be the case. She referred to an escalation earlier that morning in Clinical Safety Plan and explained that this had resulted in the use of different scripts within EAC.

The Chair commented on the human-intensive nature of this and said it would be important to consider technology-assisted processes.

Mr Sinclair agreed with the concept of a technological solution. However, he said he believed that ensuring additional clinicians within the EAC who would proactively contact patients would reduce the incidence of patients making duplicate calls to EAC.

The Chair sought further clarification as to the timescale for this.

Mr Sinclair confirmed that the Trust had received funding from the SPPG for an additional 13 members of staff up until the end of March 2024 and added that the necessary arrangements had been made to fill these posts through an Expressions of Interest process. He added that he was hopeful that the service would be in place by the end of December.

The Chair commented that it would be beneficial to increase clinical presence within the Control Room at the same time as the Regional Co-ordination Centre became operational.

She alluded to Mr Bloomfield's reference to page 4 of the report and the deterioration in the Trust's response time performance and expressed her disappointment.

Continuing, the Chair referred to page 7 which set out the Trust's performance in respect of Clinical Hear & Treat and Clinical See & Treat. She said that the Board had previously been briefed that 15 of the 21 clinical support posts had been filled and asked if the position had changed.

Mr Sinclair explained that this tied into the previous discussion around increasing clinical presence within the Control Room.

Ms Byrne confirmed that the SPPG had provided additional funds and the Trust was undertaking a recruitment exercise.

Mr Bloomfield advised that the target for Clinical See & Treat was 15.2% and acknowledged that there had not been much movement over the last few months.

Mr Sinclair referred to the Chair's update meeting with the Clinical Education Team and the briefing around the regional work being taken forward in terms of ensuring staff had the best knowledge of pathways and frameworks within which to make the optimum decisions and to ensure they were comfortable in leaving patients at home.

The Chair noted that the equivalent of 24 shifts per day (8,748 lost hours) were lost as a result of crews having to wait outside EDs while more than 75% of lost hours occurred at four ED sites.

Ms Charlton pointed out that recent data analysis over a three-month period had shown that 60% of ambulance handover delays greater than two hours occurred at two Trusts.

The Chair referred to the report following the regional review of Urgent and Emergency Care undertaken by the Getting It Right First Time (GIRFT) Team and said members would appreciate early sight of this when it became available.

The Chair also noted the increase in absence levels from 12.3% in March 2023 to 14.64% and expressed surprise at the level of increase.

Ms Cochrane explained that 12.3% represented the cumulative figure across the previous year, not in the month of March.

The Chair thanked members for their comments and the Trust Corporate Scorecard and Performance Report (October 2023) was **NOTED** by the Board.

11 **Finance Report (September – Month 6) (TB24/10/2023/08)**

Mr Nicholson reported that the Trust had forecast a deficit of £2.2 million at year end and advised that this was in line with the Financial Plan submitted to the DoH at the start of the year. However, he reported that, following discussions with SPPG colleagues, the Trust had been informally advised of a £0.6 million allocation to support its deficit position.

Mr Nicholson explained that, following a review of indicative allocations received at the start of financial year, the Trust had been able to identify a further £1.3 million which could be used to offset the deficit. He added that Trust officers would continue to explore every opportunity to bring the Trust back into a balanced position at the end of March.

Mr Bloomfield said that, at a recent meeting with Trust Chief Executives, the Permanent Secretary had advised of some additional allocations which would reduce the overall deficit. However, he had made it clear that he would look to the HSC system to continue to make every effort towards reducing the deficit.

Mr Nicholson welcomed this updated position and said that it had been made possible through the significant efforts of staff and those involved in the Delivering Value Programme, particularly the Resource Optimisation project and the management of expenditure within funded levels. He referred to the thoughtful and focussed work being taken forward in that area through the use of overtime and VAS/PAS which, he said, was reported in further detail within the overall Finance Report.

He said that, whilst being able to deliver on the management of expenditure, the Trust had been able to release staff to take annual leave as well as releasing them to undertake continuing clinical education. He acknowledged that it would require a significant effort for the rest of the year to maintain that position and achieve the financial balance while maintaining performance and quality. Mr Nicholson indicated that the Trust was currently trialling the use of a data warehouse in terms of the uptake of overtime and noted overtime costs for October were approximately £533,000. He advised that this had only been affordable given the additional allocations received by the Trust.

Mr Nicholson alluded to the Executive Summary within the report and indicated that, due to the recently received allocations, the RAG status against achieving financial breakeven would now show as amber.

Mr Nicholson reported that the Trust's Capital Resource Limit allocation was just over £7 million with only approximately £300,000 having been spent in the first six months of the year. He explained that the Trust continued to experience global issues which impacted on the Trust's supplier capacity and therefore the ability of the Trust to deliver within the financial year. Mr Nicholson indicated that the Trust had been advised of some additional resources to replace defibrillators but said that this was dependent on the approval of the related business case.

Mr Nicholson reminded the meeting that expenditure on fleet was profiled to the end of the financial year to maintain a smooth fleet age profile.

In keeping with Mr Nicholson's comments regarding quality aspects of the service, Ms Charlton commented on the importance of ensuring quality and safety remained at the fore when looking at

cost containment exercises. She acknowledged that all these aspects were wedded to resource optimisation.

Continuing, Ms Charlton said that, in terms of the Trust's responsibility in the context of discharge and flow through hospitals, it would be essential to ensure that individuals received the right treatment, at the right time and in the right place. She was of the view that the Trust had a responsibility to ensure there was a clear focus and understanding that this was the case as well as ensuring a concerted focus on the outcome for the patient and the patient experience.

Ms Byrne alluded to the interdependencies with other aspects of the Delivering Value Programme.

Agreeing, Ms Charlton referred to the high absence levels and suggested that efforts around other aspects of the Programme would be futile unless absence was reduced.

Mr Haslett advised that the financial position had been discussed in detail at the finance-focussed People Committee on 19 October. He pointed out that there were six months of the financial year remaining with £0.8 million to yet be identified to achieve the Trust savings. He said that, while he welcomed this position, there remained a significant number of issues to be addressed.

Mr Bloomfield clarified that the forecast financial position was after the delivery of £1.975 million of savings.

The Chair thanked Mr Nicholson for the Finance Report (September – month 6) which was **NOTED** by the Board.

12 **Committee Business:**

- **Safety Committee – minutes of meeting on 8 June & report of meeting on 7 September 2023;**
- **Audit & Risk Assurance Committee – minute of meeting on 22 June ad report of meeting on 5 October 2023**
- **People, Finance & Organisational Development Committee – minutes of meeting on 4 July 2023; (TB24/10/2023/09)**

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

Mr Abraham explained that the ARAC had included a standing item on the agenda around 'Business As Usual' to ensure the Committee monitored the position. He advised that, following a recent presentation by Ms Paterson, this item had now been removed.

Mr Dennison advised that the People Committee had met on 16 October with a specific agenda item on Managing Attendance. He explained that the Committee had considered four key elements, namely information and data and how this would be used; the Delivery Plan; reporting timeline and way forward and the application of existing procedures.

Mr Dennison said that the Committee had been reassured by the level of information available to monitor attendance across the Trust and there was agreement on how this would be instilled into red zones. Continuing, he reported that the Committee had approved the Delivery Plan and said there had been some comments in terms of outcome focus and qualification of outcomes. He said that the Committee had commented on the significant number of actions against the 6-7 objectives and had asked for these to be reviewed with a view to prioritising/reordering them.

Mr Dennison said there was a commitment that the revised Delivery Plan would be brought to the December Trust Board for noting. He also noted that Ms Byrne had undertaken to ensure that all existing procedures were being robustly applied in a supportive way. Mr Dennison said that the meeting had been helpful and productive.

Mr Bloomfield said he would like to provide some further assurance around the prioritisation of this work. He advised that he, Ms Charlton, Ms Byrne and Ms Cochrane had recently met with the senior team from the Operations Directorate including Assistant Directors, Area Managers and senior EAC managers to reinforce the importance of the Managing Attendance work and ensure everything possible was being done to address this issue. He explained that Ms Charlton had attended the meeting as she had recently assumed temporary responsibility for Patient Care Services.

The Chair welcomed this reassurance. She noted that the Delivery Plan had now been approved by the People Committee and asked that Mr Dennison would continue to brief the ARAC when required

so as to avoid duplication at Committee level. She also noted that it would be helpful for the Board to receive regular updates.

The Chair acknowledged the level of work ongoing at Committee level and believed that the Board had started to clarify and prioritise those areas where, from a strategic perspective, it could support, empower and progress.

Ms Charlton referred to the AACE Safeguarding Review which had been presented to the Trust's Safety Committee and reported that this had now been finalised. She added that points of concern around the Trust's low referral rate still applied and added that the action plan had been presented to the Committee. Ms Charlton said that she intended to present this to a future meeting of the Board.

Referring to handover delays, Ms Charlton acknowledged that, when engaging with HSC Trusts recently, there had been an increased focus on the patient in the back of the ambulance. She advised that she, Mr Bloomfield and other Directors had met with the senior teams of both the Southern and South Eastern Trusts to discuss frail elderly patients in particular. Ms Charlton advised that, while 40% of patients in the back of ambulances at EDs were frail elderly, 11% of these patients were over 90 years old. She advised that there had been some regional discussion with the DoH Director of Nursing in relation to the fundamentals of care in the back of an ambulance and avoidable elements of harm.

Ms Charlton believed that this highlighted the need within winter preparedness plans for frail elderly destinations for each Trust with a view to working to bringing frail elderly patients into EDs and added that having frail elderly patients wait in the back of ambulances put them at significant risk.

13 **Date of Next Meeting**

The next NIAS Trust Board will be held on Thursday 14 December 2023 at 10am in the Boardroom, NIAS HQ.

14 **Any Other Business**

(i) Visits to Stations

Concluding the meeting, the Chair encouraged NEDs to meet with staff whenever possible.

THIS BEING ALL THE BUSINESS, THE CHAIR CLOSED THE PUBLIC MEETING AT 1.40PM.

SIGNED: _____

DATE: _____

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD – 24 OCTOBER 2023

		INDIVIDUAL ACTIONING	UPDATE
	PUBLIC		
1	Clarify process whereby any issues of non-compliance with the IA Charter could be raised	PN	Response e-mailed to Chair on 13/11/23
2	Present Safeguarding Action Plan to future TB meeting	LC	To be scheduled
3	REACH implementation: - discuss with SHSCT Chair; - Board to receive update on progress	Chair MP	Raised at meeting with SHSCT Chair on 7/11/23 Update to be provided under Matters Arising

Northern Ireland Ambulance Service
Health and Social Care Trust

REACH Project
–
electronic patient care record update

Trust Board – 14th December 2023

Northern Ireland Ambulance Service
Health and Social Care Trust

Last Update (Oct 2023(

Implemented:

- 71% in-scope Hospitals use MobiMed (10/14)
- All staff trained (over 830 staff)
- Personal Issue Tablets deployed
- 25% (40) Emergency vehicles fitted with high performance Panasonic Toughbooks
- Policy for Completion of Patient Records revised to make electronic patient care records (ePCR) standard practice
- Performance Dashboards implemented for Operations management in order to support staff

Benefits Realised:

- Over 15000 electronic patient care records to date created
- i. Over 10000 have Patient Information such as HCN, Contact Details, GP details pre-populated by using Person Demographic Service
- ii. Pre-arrival patient personal and clinical information transmitted to Hospital to enable Emergency Department readiness and triage
- iii. ECGs transmitted to full screen-size for easy reading by PPCI labs
- iv. Automated notification back to EAC for patient handover / discharge times, identifying crews that are clear.
- Clinical Team Access to electronic records for purposes such as
  - Drug monitoring

Since Last Update (Oct 2023) To Date (30-11-2023)

Implemented:

- All in-scope Hospitals now receiving electronic patient care records.
  - RVH, RVH PPCI, Mater, RBHSC, SWAH, Altnagelvin, Altnagelvin PPCI, Antrim, Causeway, Daisy Hill, Craigavon, Ulster, Lagan Valley, Downe.
- Policy for Completion of Patient Records launched by Dr Ruddell on 6th November, making electronic patient care records the standard format.
- Instruction to Operational Staff to transition to the electronic patient care record as their standard practice issued by Assistant Director of Ops on 13th November
- NIAS Staff supported with online training videos – over 1100 views
- 46% (74) Emergency vehicles fitted with high performance Panasonic Toughbooks

Benefits Realised:

- First time ever that the NIAS Care report features as part of patients' digital medical records history on EpicCare (SEHSCT from encompass go live 09-11-2023).
- Since the introduction of Panasonic Toughbooks to emergency vehicles and the Policy directing electronic patient care records as standard has resulted in an increase in adoption across the five NIAS Divisions. The baseline Divisional usage average was 6% and is now 37%

Now to 31-March-2024

Planned Implementation:

- Communication campaign to embed ePCR as standard practice
- Automated referral process to urgent care pathways (e.g. Falls)
- Notification to GPs
- 100% Emergency vehicles to be fitted with Panasonic Toughbooks (All Emergency ambulances and Rapid Response Vehicles, total 161)
- Full adherence by Ops staff to create electronic patient care records as standard practice

Benefits to come:

- NIAS care report on NIECR to inform the continuum of patient care
- Automated referrals to urgent care pathways, reducing demand on EDs and directing patients to the most appropriate point of care
- Bank staff (approx. 98) able to complete ePCR using Toughbooks
- GP notification informing the continuum of patient care, particularly for patients that are not conveyed to hospital.
- Safeguarding referrals used to assist patients requiring a network of care
- Clinical audit / research and development / clinical reporting

April 2024 onwards

Planned:

- Expanded use of referral process to more urgent care pathways
- Explore implementation with other hospital sites e.g. Royal Jubilee Maternity
- Implementation of the Clinical Measures Framework
- ePCR fully embedded as standard practice.

Benefits to come:

- Automated referrals to urgent care pathways, reducing demand on EDs and directing patients to the most appropriate point of care
- Targeted use of ePCR data to inform clinical reporting and clinical development against the Clinical Measures Framework.

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

PRESENTATION OF PAPER

Date of Trust Board:	14 December 2023
Title of presentation:	Late finishes – NIAS Staff Quality Improvement Group
Brief summary:	Presentation to explain the actions that have been taken in relation to late finishes within NIAS and to outline future steps regarding this issue. NIAS staff will attend to discuss their personal experiences of late finishes. The NIAS QSI Directorate will present the actions taken/future actions to be taken in relation to late finishes.
Recommendation:	**For Approval** ☐ **For Noting** ☒
Previous forum:	SMT
Prepared and presented by: **Date:**	Ruth Finn, Asst Director, Quality, Safety & Improvement Lynne Charlton, Director Quality, Safety & Improvement 7 December 2023

Northern Ireland Ambulance Service
Health and Social Care Trust

NIAS Trust Board

14.12.23

Late Finishes – NIAS Staff Quality Improvement Group

Many lenses to look at this issue through

How did we know that this was an issue?

- Our staff have been telling us
  - at ED engagements
  - at Chief Executive/ SMT engagements
  - through line managers/ line management structures
  - through informal conversations
  - through official reporting via Datix
  - through our EAC control room
- Through looking at other 'signals' in the system
  - through claims for overtime arising as a consequence of late finishes
  - through compensatory rest arising as a consequence of late finishes
  - through discussion with staff in respect of sickness absence where late finishes (amongst other issues) are cited as impacting wellbeing
- Issue is being experienced by other UK ambulance services and is being reported through umbrella group AACE as a significant issue for staff
- Our Trade Union colleagues have been telling us about this too from the perspective of their members

What have we changed?

- Change to compensatory rest protocol where impacted by a late finish beyond 1hr from 12 hrs from 11 hrs between shifts
- Introduction of a start of shift protocol
- Receiver shifts introduced
- Dashboard to support monitoring of late finishes
- Bespoke 'late finish' management tool built to support EAC
- Staff engagements during month of Nov
- Recruitment of staff to QI Group to look at late finishes, 25 staff recruited, 1st meeting 07/12/23
- Monitoring of late finishes now built into standing agenda of new AD Forum for oversight

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What have we changed? – Suite of measures 15.09.23 aimed at reducing the incidence of late finishes

Caring Today, Planning for Tomorrow

Compensatory Rest & Late Finishes

15 September 2023

Colleagues,

As you will be aware, delayed ambulance handovers at ED sites continue to impact on our operational capacity, not least on our ability to ensure that crews finish their shifts on time. The Trust continues to be concerned about the impact that these late finishes have on the health and well-being of our staff.

We have been working across the Health and Social Care System to address the factors that are causing delayed turnaround times. Some measures, introduced previously, have provided temporary improvements but it is clear these have lacked consistency and sustainability. We continue to impress upon our colleagues the importance of introducing Ambulance Handover Zones to provide areas for cohorting their patients.

However, we must continue to look internally for ways to mitigate this issue for staff and how we can manage this with minimal impact on our already pressurised control room. Therefore NIAS has recently introduced a suite of measures aimed at reducing the incidence of late finishes including;

- The implementation of a derogation protocol which maximises the number of call categories which can be safely held to facilitate crew release at end of shift;
- Opportunity for crews to hand patients over to colleagues at station;
- Maximising Clinical Support Desk and Clinical Support Manager in Control to manage hear and treat;
- Ensuring implementation of Clinical Safety Plan actions to mitigate and prioritise the safety of patients;
- Ensuring the end of shift protocol is implemented consistently.

We do recognise that these measures, on their own, will not guarantee that every member of staff will finish on time, therefore we have also been engaging with Trade Unions to explore what other measures we can introduce to address the issue.

To consistently show compassion, professionalism and respect to the patients we care for

Northern Ireland Ambulance Service
Health and Social Care Trust

Caring Today, Planning for Tomorrow

We are considering a range of actions, including the use of hospital receivers and identifying an effective model to facilitate the release of crews at end of shift.

Whilst we work with Trade Unions on developing these measures, we have responded to a request to consider how we might mitigate the impact on the health and well-being of our staff in the intervening period.

Therefore, we have reviewed the Compensatory Rest Process and have agreed to introduce a temporary change to ensure that staff, who have a late finish of more than one hour, will have a compensatory rest period of 12 hours between shifts. **This is an additional 1 hour to the current process and this will be effective as of 16th September 2023.**

This temporary process is not without risk to patients and will be subject to ongoing review to consider any escalating impact on them. This will be managed in partnership with Trade Unions.

We hope that the actions we intend to introduce will go some way towards ensuring that late duties are minimized. Meanwhile, we will continue to impress upon colleagues in the other Trusts the need to ensure that ambulances are always available to respond to 999 calls in the community, rather than being delayed at EDs as a result of the significant pressures across the system.

We appreciate that you have, over a period of years, provided huge amounts of goodwill to ensure that we can deliver our service in the challenging environment in which we find ourselves across the health and social care system. We do not take this goodwill for granted and will continue to work towards providing a service which takes account of your health and well-being and the needs of our patients.

Michael Bloomfield
Chief Executive

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Northern Ireland Ambulance Service
Health and Social Care Trust

What have we changed? – Compensatory Rest 01.10.23

Northern Ireland Ambulance Service
Health and Social Care Trust

NIAS Standard Operating Procedure

Management of Compensatory Rest

SOP Reference:	Ops/02/001	**Version:**	1.3
With effect from:	01.10.2023	**Review Date:**	To be advised
Related SOP:	Ops/02/006 Management of Late Finishes EAC Standard Operating Procedures – Section 32 (as amended October 2023		
Superseded SOP:	Interim Guidance document February 2013 Ops/02/001 version 1.1 Ops/02/001 version 1.2		
For Action:	Regional Control Manager DCMs Control Officers, EAC & NEAC		
For Information:	Operational Managers Resource Centre Manager All Operational Staff		

Impact on 11 Hour Break	Overtime Payable	Action
< 60-minute late finish and no reduction in 11-hour break.	Yes	Employee will commence their next shift at the rostered time
Late finish of > 60 minutes but < 2 hours (with reduction in 11-hour break).	Yes	Employee will contact the DCM to request compensatory rest. DCM will advise of revised start time. No allowance will be made for travel time home from current location. The period of compensatory rest will provide for 12 hours rest prior to the start of the next shift. The DCM will: • Advise RMC of the revised start time • Update the record of compensatory rest
Late finish of > 2 hours (with reduction in 11-hour break).	Yes	Employee will contact the DCM to request compensatory rest. DCM will advise of revised start time. An allowance will be made for travel time home from current location. The period of compensatory rest will provide for 12 hours rest plus the travel time allowance agreed with the DCM prior to the start of the next shift. The DCM will: • Advise RMC of the revised start time • Update the record of compensatory rest

What have we changed ? - Start of shift protocol 13.11.23

Northern Ireland Ambulance Service
Health and Social Care Trust

NIAS Standard Operating Procedure

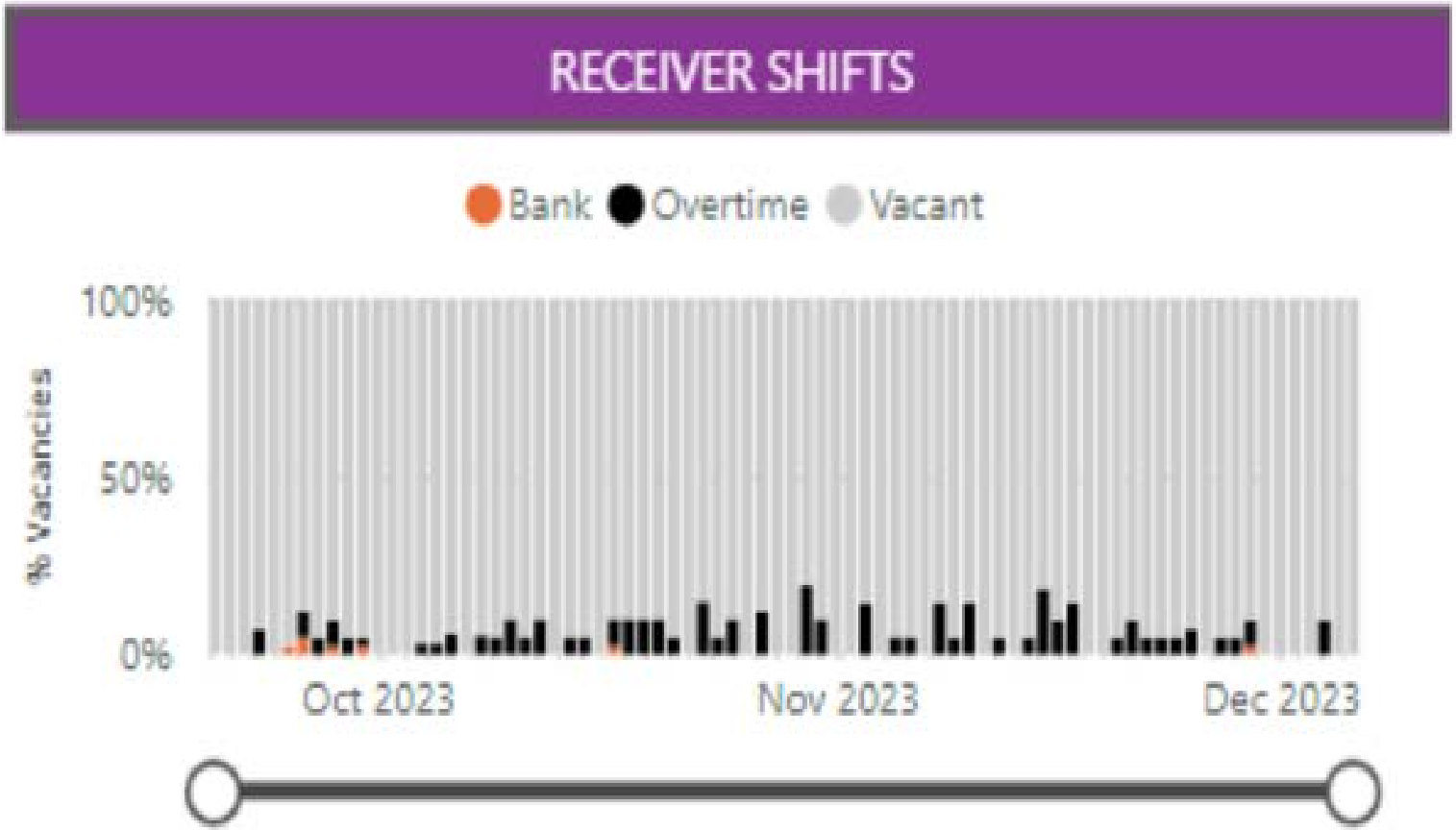
Management of Late Finishes

SOP Reference:	Ops/02/006	**Version:**	2.3
With effect from:	13/11/2023	**Review Date:**	TBC
Also refer to:	*Ops/02/001 Management of Compensatory Rest* *Ops/02/026 Booking On, Booking Off* *EAC Standard Operating Procedures – Section 6*		
Superseded SOP:	Version 2.2 of 26.02.2018		
For Action:	(N)EAC Manager DCM/DPM Control Officers, EAC & NEAC		
For Information:	Operational Managers Resource Centre Manager All Operational Staff		

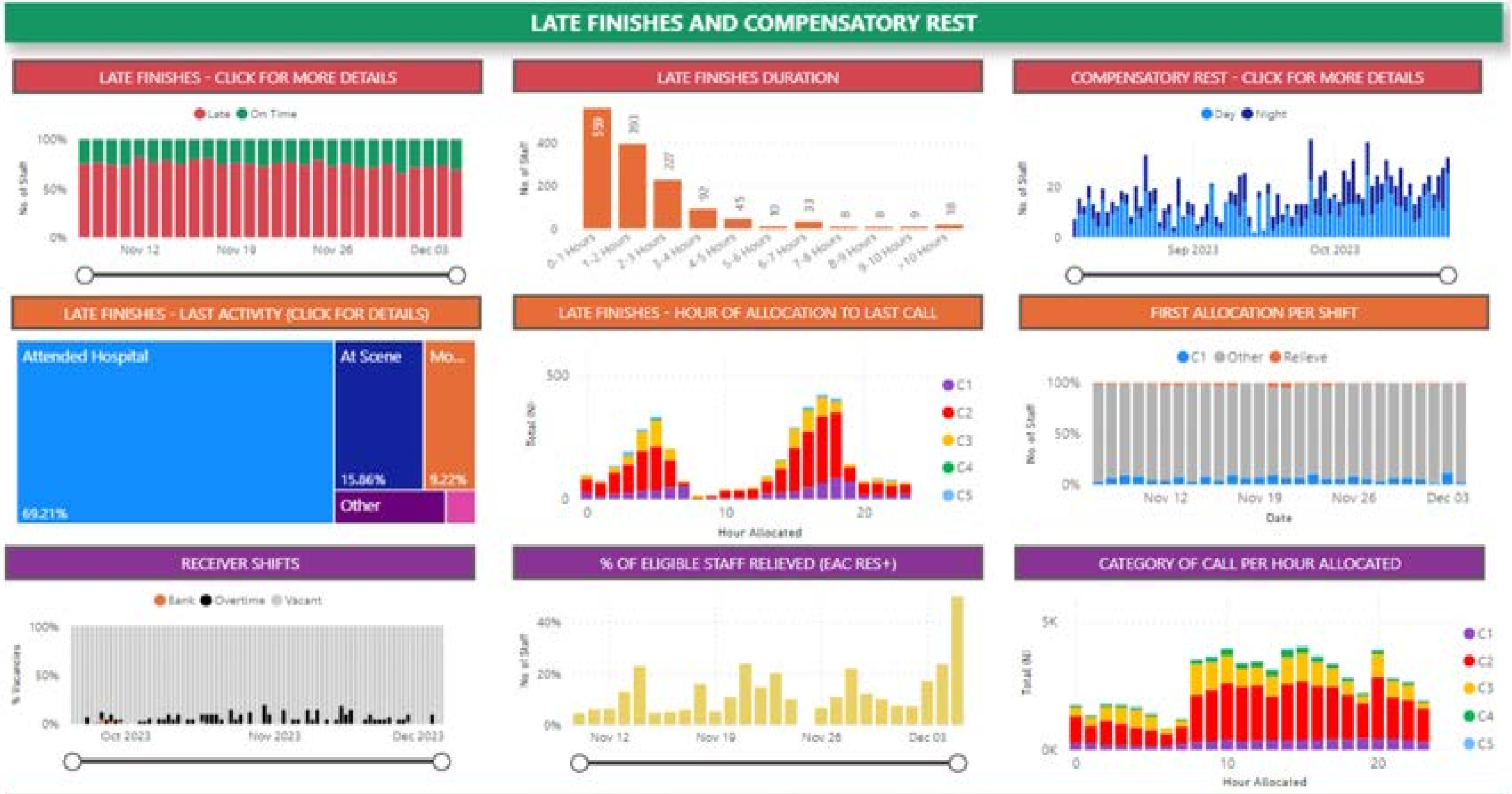
	Name	Position
Author:	Mark Cochrane	Assistant Director of Operations

Northern Ireland Ambulance Service
Health and Social Care Trust

What have we changed? – Introduction of Receiver shifts



What have we changed? – Development of a dashboard for monitoring late finishes (06.12.23)



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What have we changed? – Development of bespoke 'late finish' management tool for EAC

First Shift Allocation Support Tool

12/6/2023 9:18:12 AM

CAT 1 Calls on Stack by HSC Trust Area (Bl...

HSC Trust Area

CAT 1 Calls on Stack - Detail

HSC Trust Area	Chief Complaint	GovtStd TOC	Age	TimePerf Override	Time From Commenced (Mins)

No. Crews on a Late Finish by Station

No. Crews on a Late Finish - Detail

Minutes Over Shift	Callsign	Pin	Hospital	Crew_Status	Status_Text
78.00	S322	2334	CRAIGAVON AREA HOSPITAL	Waiting_Handover	[EMG] CRAIGAVON HOSPITAL - RESUS, ROAD
78.00	S322	3537	CRAIGAVON AREA HOSPITAL	Waiting_Handover	[EMG] CRAIGAVON HOSPITAL - RESUS, ROAD
78.00	N821	2091	ANTRIM AREA HOSPITAL	Waiting_Handover	[EMG] ANTRIM ARE HOSPITAL - ED EME DEPARTME
78.00	N821	4077	ANTRIM AREA HOSPITAL	Waiting_Handover	[EMG] ANTRIM ARE HOSPITAL - ED EME DEPARTME
78.00	E922	4021	ULSTER HOSPITAL	Waiting_Handover	[EMG] ULSTER HOS ED EMERGENCY DEPARTMENT, U
78.00	E922	4362	ULSTER HOSPITAL	Waiting_Handover	[EMG] ULSTER HOS
78.00					

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What have we changed? – Monitoring of late finishes weekly through AD Forum

Agenda - Assistant Director Forum

Wednesday 6th December at 10.00am via Teams

Meeting ID: 365 685 398 112

Passcode: Mydvgc

CHAIR: TBC

#	Agenda Item	Who	Notes
1.	Welcome • Apologies • Actions from previous meeting	Chair	
2.	Strategic Implementation Group • REACH • PCS • CAD	Andoni	Charlie to join 10:15-10:45
3.	Formal Request for Impact from Service Changes, Southern Trust	Andoni	
4.	Staff Feedback – Process and Monitoring	Tracy / Ruth	
5.	SAI process change	Ruth	
6.	ED Visits	Ruth	
7.	Operational Efficiencies: • Late finishes • Rest periods	Ciaran / Mark	
8.	Discussion re Policies: • Annual leave management • Emergency leave process • Carers leave process • Overtime management	Ciaran	
9.	Transformative Leader Programme	Ruth	
10.	Internal Audit: Organisational response	Brona	
10.	AOB		

What have we changed? – Improved Welfare Facilities

What else have we been doing?- Staff Engagement Nov 2023

Engagement undertaken with 63 staff during Nov/ Dec 2023

5 Focus Groups held – 5 attendees in total

Online Questionnaire – 49 responses

Face to face engagement – 9 Staff at ED Altnagelvin

What have we changed?- Staff Engagement Nov 2023 – Survey 49 Responses

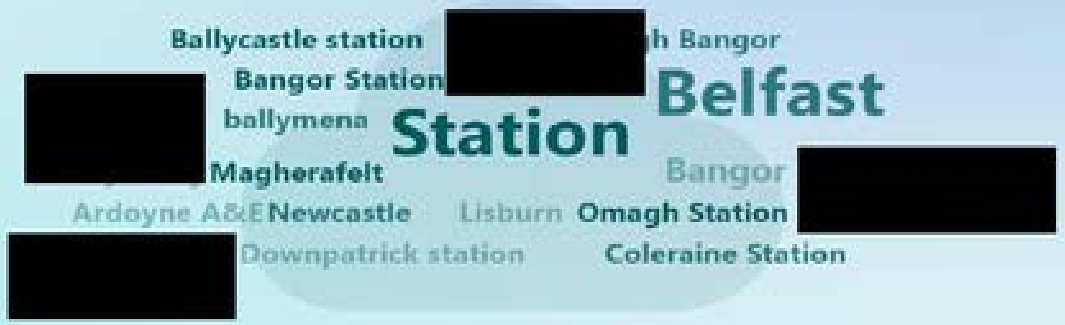
Staff views: Late finishes

NIAS are taking forward a piece of planned improvement work in relation to the late finishes which are being experienced by our staff. In order to ensure that the views and ideas for improvement of those affected by late finishes are heard and developed into improvement actions, we are undertaking different methods of engagement.

This questionnaire is one method to support staff to share their views.

CLOSING DATE: Friday 24th November

Provide name, email and/or location of work e.g Coleraine



49 responses submitted

What is your directorate?

49 responses submitted

Do you have any recommendations to support improving late finishes?

49 responses submitted

Do you have any recommendations to help support staff wellbeing?

49 responses submitted

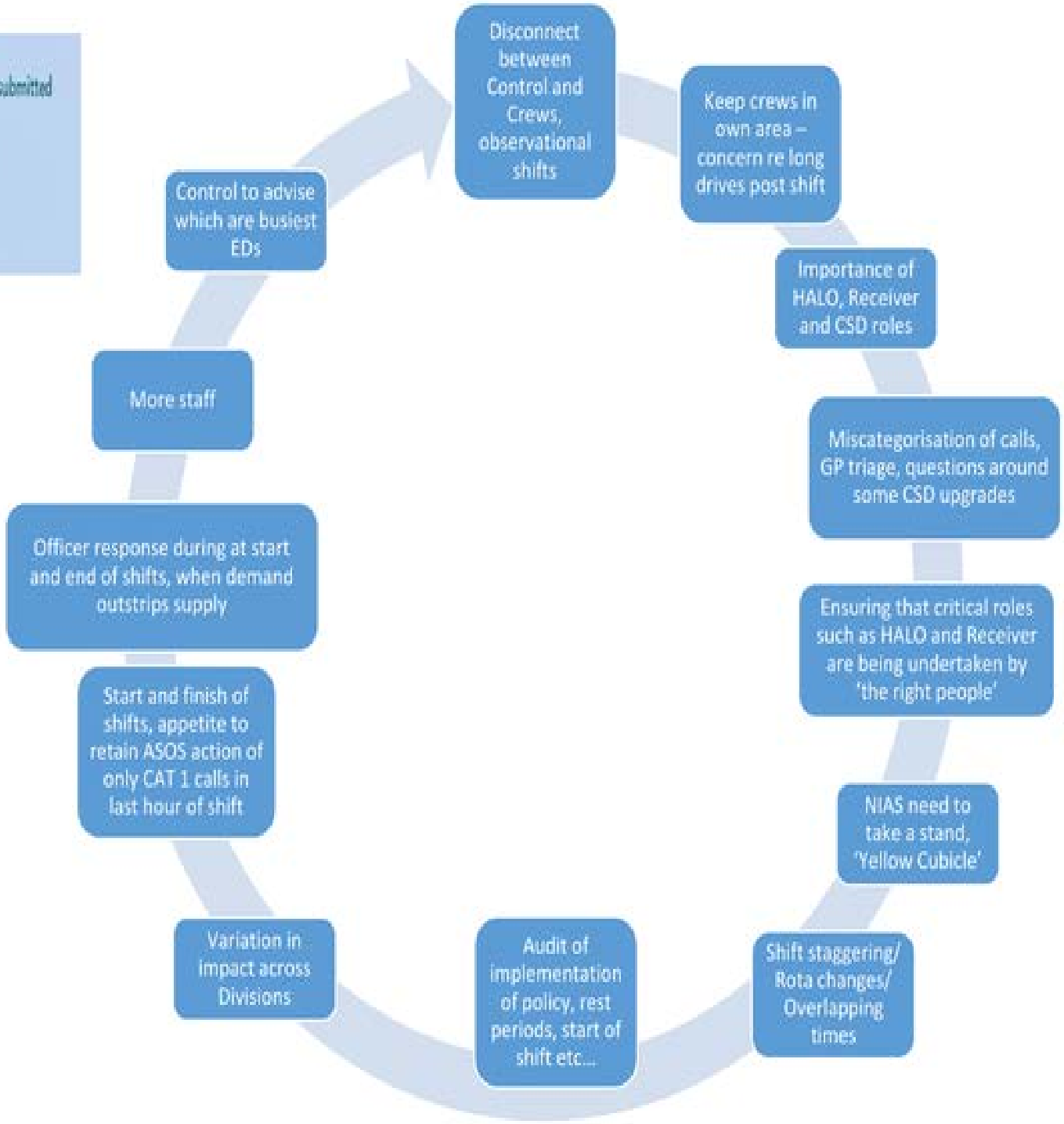
Do you have any recommendations to help support with future staff engagement opportunities?

49 responses submitted

Any other suggestions?

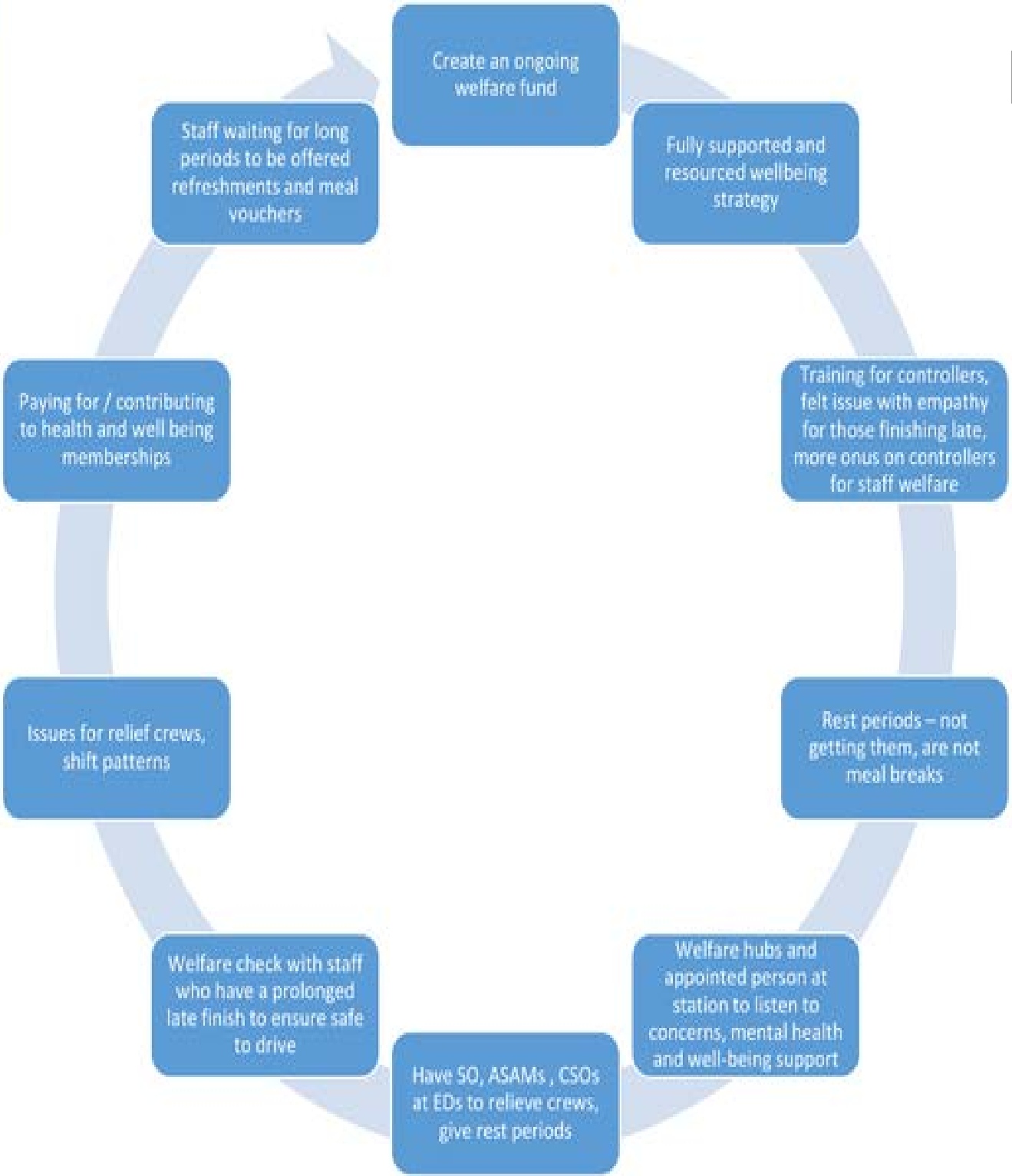
49 responses submitted

Do you have any recommendations to support improving late finishes?



49 responses submitted

Do you have any recommendations to help support staff wellbeing?



What have we changed? – Staff QI Group

Agenda

NIAS Late Finish Quality Improvement Group

Date: 07/12/23

Time: 1400 - 1600

Location: via TEAMS

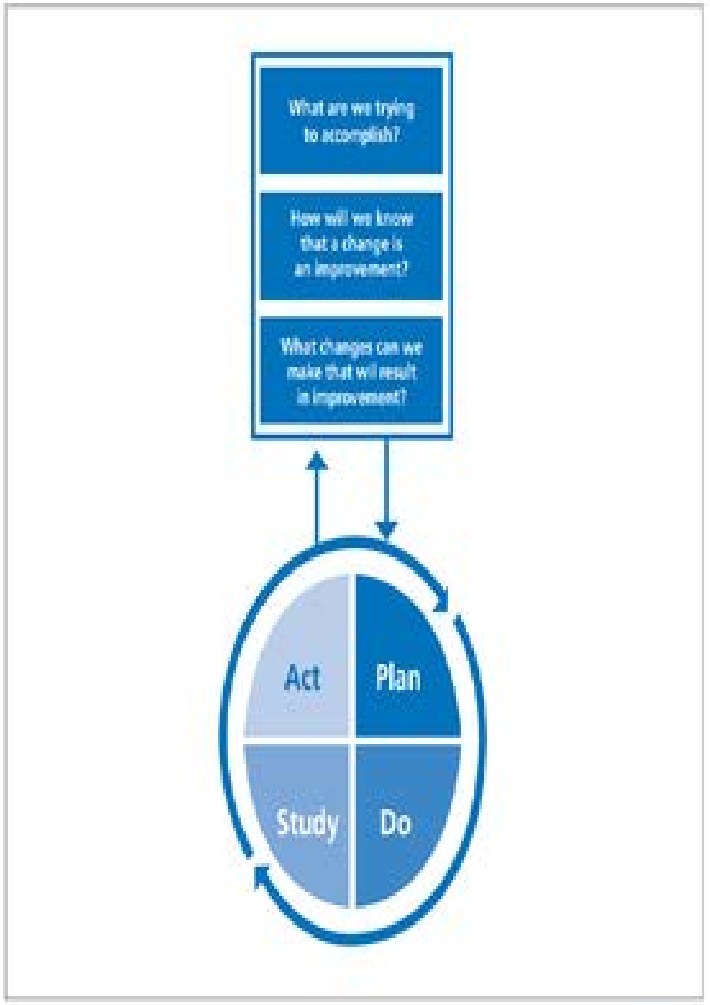
Meeting ID: 330 442 135 780

Passcode: jebbjy

*This meeting will be recorded to enable notes of the meeting to be written up, following this it will be deleted.

1. Welcome
2. Apologies
3. Introductions
4. Purpose of Group
5. Ground Rules
6. Discussion about Quality Improvement as a methodology and how we will use it for our group
7. Overview of the work that has been happening to date
8. Dashboards
9. Improvement Ideas
10. Next Steps
11. A.O.B
12. Date of Next Meeting

- 25 Staff have joined
- 11 attended first meeting
- Project aim agreed, will require some finessing = Prevent and Reduce late finishes/ Increase the number of staff that finish shift on time
- List of change ideas formulated and prioritise
- Group would like to consider 'Receiver' and 'CALO' in South East Division as a change idea using quality improvement methodology/model for improvement



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Next steps

- NIAS AD Forum to provide ongoing oversight in relation to late finishes
- BI Team and Ops Directorate to undertake further work in relation to Late Finish Dashboard
- QSI Directorate to progress with late finish QI group, improvement projects to be developed from same
- Proposal to be worked up for NIAS AD Forum re 'feedback' box for staff
- NIAS AD Forum taking forward ongoing ED engagements, to augment those already undertaken by SMT, will foster relationships between NIAS AD tier and operational colleagues within service (getting to know you)

Questions?

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

PRESENTATION OF PAPER

Date of Trust Board:	14 December 2023
Title of paper:	Regional Co-ordination Centre (RCC) Memorandum of Understanding
Brief summary:	In August 2023, the Trust Chief Executives Group commissioned the establishment of an RCC. The RCC will operate from 4 December 2023 to 31 March 2024 under the remit of the attached Memorandum of Understanding (MoU). The initial scope of the RCC is to support the improved management of winter pressures and extending to include elective care as appropriate. On behalf of the Trust Chief Executives, the RCC's aim is to oversee and drive improved hospital flow to improve patient access, care and experience. This will also support the delivery of in-year priority Trust improvements mandated in the DoH "Preparing for Winter" letter. The attached MoU sets out the extent of the delegated authority and devolved responsibilities and accountabilities mandated to the RCC by the six Trusts. Arrangements have been made for the Board to visit the RCC (which is located at NIAS HQ) on 14 December to meet with the RCC leadership team and better understand the role and planned impact on NIAS in terms of improving handover delays.

Recommendation:	**For Approval** ☐ **For Noting** ☒
Previous forum:	If applicable
Prepared and presented by:	Rosie Byrne, Director of Operations
Date:	7 December 2023

DRAFT v1

MEMORANDUM OF UNDERSTANDING IN RESPECT OF THE ROLE OF THE REGIONAL COORDINATION CENTRE AND NI PROVIDER TRUSTS

1. Context

The Regional Coordination Centre (RCC) is established as a collaborative arrangement mandated by the Chief Executives of the following Northern Ireland Health & Social Care Provider Trusts on 25 August 2023:

- Belfast HSC Trust
- Northern HSC Trust
- Northern Ireland Ambulance Service
- Southern HSC Trust
- South Eastern HSC Trust
- Western HSC Trust

The RCC will operate from 4 December 2023 to 31 March 2024 under the remit of this Memorandum. The initial scope of the RCC is to support the improved management of winter pressures and extending to include elective care as quickly as possible.

2. Purpose of Memorandum of Understanding (MoU)

The purpose of this MoU is to set out the extent of the delegated authority and devolved responsibilities and accountabilities mandated to the RCC by the Trusts named in (1) above.

3. Terms of Agreement

Under this MoU, the Chief Executive of each named Trust agree that the RCC will operate at NI provider system level and to give delegated authority via the Director of the RCC to take operational decisions on behalf of the provider system of unscheduled care flow in order to manage and balance system-level risks across Trusts. This includes directing Trusts to take actions to reduce demand pressures and to mandate the system level, Trust-specific actions necessary to improve hospital flow and patient safety, and scrutiny or mitigation at a system level of any significant negative impacts on the delivery of hospital planned care services.

The RCC will be accountable to the Trust Chief Executive Group and will operate within the approved governance arrangements outlined in 'Regional Coordination Centre (RCC) Governance Arrangements' approved on 25th September 2023 and appended to this MoU for reference.

To ensure and evidence good corporate and clinical governance, with effect from week commencing 11th December 2023, the action and decision logs from the previous week(s) RCC actions will be made available for Trust Chief Executives Group formal and informal meetings, which is the agreed forum for RCC escalation, notwithstanding emergencies or crises which will be addressed in real time directly with the relevant Trust Chief Executive and/or his/her executive team.

Signatories

Michael Bloomfield,
Chief Executive
NIAS

Maria O'Kane
Chief Executive
SHSCT

Neil Guckian
Chief Executive
WHSCT

Roisin Coulter
Chief Executive
SEHSCT

Jennifer Welsh
Chief Executive
NHSCT

Cathy Jack
Chief Executive
BHSCT

Appendix to Memorandum of Understanding

Regional Coordination Centre (RCC) Governance Arrangements

Approved by Trust Chief Executives Group 25 September 2023

1. Context for RCC

In August 2023, the Trust Chief Executives Group commissioned the establishment of a Regional Coordination Centre (RCC), initially to support the improved management of winter pressures and extending to include elective care as quickly as possible. The evidence base for RCC impact will inform a Trust Chief Executives Group decision on a more permanent arrangement.

The Trust Chief Executives Group have agreed to give delegated authority to RCC to take decisions on behalf of the provider system. This is to be detailed in a Memorandum of Understanding (see Section 4), and will include the extent to which the RCC can take decisions to manage and balance system-level risk across Trusts, direct Trusts to take actions to reduce demand pressures and to mandate the system-level and Trust specific actions necessary to improve hospital flow.

Northern Ireland Ambulance Service (NIAS) has been agreed as the Host Trust for the RCC, and the NIAS Chief Executive as Lead Chief Executive. The Host Trust will act of behalf of the Trust Chief Executives as the employing authority for RCC staff, managing a delegated budget for salary and accommodation costs. The Lead Chief Executive will provide guidance and direction from Trust Chief Executives to the Programme Leadership Group charged with the establishment of the RCC and be the initial point for contact and escalation to the Trust Chief Executives Group. The Host Trust and Lead Chief Executive's role is to facilitate and support the RCC, but do not have authority to direct the RCC's operation or decision making. This is the responsibility of the Trust Chief Executives Group pending the establishment of a Provider Collaborative Board.

2. Agreed Aims of RCC

The RCC will deliver:

- Regional oversight, near real time situational analysis and prospective view of emerging pressures, with daily and 'real time' system and provider risk assessment.
- Monitoring of Trust or system-level issues impacting on flow, with the delegated authority to intervene by directing Trusts to take appropriate actions and escalating as required.
- Whole system tactical management and effective escalation to balance and/or reduce risk across the system.

- A single point of contact for Trust requests for mutual aid, such as for ambulance diverts. The RCC will receive and coordinate Mutual Aid requests across and between Trusts and direct the delivery of Trust recovery/de-escalation plans. The current Regional Escalation Protocol will be amended accordingly.
- A single version of the truth by standardising and coordinating data flows into an agreed Regional Minimum Data Set (MDS), initially for unscheduled care and out of hospital community capacity to manage discharge demand, but quickly progressing to elective care. These data flows should be automated where possible to reduce the reporting burden on Trusts.
- Regionally agreed standardised measures of hospital pressures with a suite of regional protocols and Standard Operation Procedures that define the expected response at Trust and regional level.
- Clinical standards for expected response times at key points of the patient's hospital journey, and monitoring of agreed Trust escalation actions where these standards are not being achieved.
- Resolved recommendations for action and timely escalation of system-level risks to delivery to the Trust Chief Executive Group. Operational Trust-level risks and performance issues will be escalated to that Trust's Chief Executive where not appropriately resolved with the Trust Lead Director.
- System wide single point of contact for provider intelligence on effective delivery of DoH priorities as set out in 'Preparing for Winter 2023/23' letter of 17 August 2023.

The role of the RCC will be enabled by the development and enactment of a standardised and resilient network of Hospital Control Centres at Trust level, responsible for managing internal Trust hospital pressures, with daily reporting to RCC and escalation of pressures beyond Trust control to RCC for consideration and action as appropriate.

3. Initial Scope of RCC

On behalf of the Trust Chief Executives, the RCC will oversee and drive improved hospital flow to improve patient access, care and experience. This will also support the delivery of in-year priority Trust improvements mandated in the DoH Preparing for Winter letter which are:

- **Maximising Ambulance Capacity.**
- **Reducing Time Spent by patients in ED awaiting Clinical Decision and Next Stage of Care.**
- **Timely Discharge for Patients who are Medically Fit for Discharge (in line with previously agreed targets).**

The RCC will also focus on protecting and maximising capacity for elective care activity to support reduction of patient waiting times for planned care, including the

timely access to and repatriation from tertiary and very specialist services, providing input and advice to the DoH Elective Care Management Team as appropriate.

The RCC will focus on equity of population access and where possible take action to ensure that risk and pressures are equalised across providers.

4. Governance Framework for RCC

The RCC's authority to act and to direct Trust actions will be underpinned by a Memorandum of Understanding (MoU) where each Trust will commit to a limited delegation of authority to the RCC Director and senior staff to allow the taking of tactical decisions to manage risk across the provider system.

This MoU will be developed and agreed before the establishment of the RCC. The ceding of Trust autonomy provided to the RCC through the MoU will be rigorously overseen though the governance arrangements set out overleaf.

The RCC's daily system-level coordination of the tactical response to system pressures will identify common and recurring tactical/systemic barriers that need to be addressed though focused improvement programmes. It is proposed that, building on the membership of the Regional Steering & Delivery Group established by Trust Chief Executives to inform and guide the development of the RCC, a Regional Delivery & Improvement Group (RDIG) is established to drive the system wide actions and change to capacity, policy or protocols needed to drive improved hospital flow and improve patient access, care and experience. The governance framework for RDIG is also included below, and a Terms of Reference is included in Appendix 1.

Governance Framework for Regional Coordination Centre

Trust Chief Executives have approved the formation of a Regional Delivery & Improvement Group, with cross-Trust and key stakeholder representation. The Terms of Reference are included in Appendix 1. The establishment of a regional Trust Clinical

Standards Group* to agree 'good practice' clinical response times, initially for unscheduled care pathway, was also agreed.

This Governance Framework will be further enhanced by the establishment of formal links with:

- DoH Elective Care Management Team
- DoH Information Standards Board

This Governance Framework provides a clear process for raising any concerns about the operation of the RCC, in that such concerns should be initially raised with the organisation's representative on the Regional Delivery & Improvement Group, discussed by the Group where appropriate and a decision made as to the appropriate response which could include escalation to the Trust Chief Executives Group (pending the establishment of the Provider Collaborative Board).

Where there are issues in relation to the response of individual Trusts to the actions required by the RCC, these issues will be raised by the RCC Director with the individual Trust Chief Executive in the first instance.

5. Evaluation of Impact of RCC

The Regional Steering & Delivery Group will establish the metrics for measuring the impact of the RCC.

Appendix 1

Regional Delivery & Improvement Group (RDIG)

Terms of Reference

Approved by Trust Chief Executives Group 25 September 2023

Aims

The Regional Delivery and Improvement Group is commissioned by Trust Chief Executives to:

- Receive direction from Trust Chief Executive Group, based on recommendations from Regional Coordination Centre (RCC), to lead and manage the of delivery of a programme of in-year tactical, policy and protocol reform, prioritising and driving the in-year system improvements necessary to deliver the system priorities for winter. This will be delivered through the commissioning of short-life (3 month) Task and Finish Groups to agree and drive tactical improvement and consistency of approach for unscheduled care across the HSC System.
- Bring forward these Improvement Proposals for Trust Chief Executive Group approval and, where appropriate, endorsement to seek DoH policy review.
- Provide a strong leadership team across the HSC through a lead team of Executive and Professional/Clinical lead(s), providing advice and input to the RCC and ensuring a collaborative approach to decision making which ensures all key system partners are represented in the membership of the Group and appropriate engagement with key stakeholders.
- Identify gaps in unscheduled care provision, based on evidenced population need and patterns of presenting demand, and provide resolved advice to Trust Chief Executives Group to inform commissioning decisions and Trust prioritisation of resources.
- Oversee the HSC system delivery of the in-year performance requirements of the 23/24 Winter Plan, ensuring consistency of implementation and delivery across Trust Winter Plans to improve patient flow through the NI hospital system, and to ensure shared learning and good practice across Trusts.

Scope

On behalf of the Trust Chief Executives Group, the RD&IG will work collaboratively in support of the aims of the RCC, tackling systemic barriers prioritised by the RCC. The RD&IG will commission and deliver at pace a change programme of system-level improvements to practice, protocols, policies, and prioritisation of resources necessary to deliver improved hospital flow to improve patient access, care and experience. This will also support the delivery of in-year priority Trust improvements mandated in the DoH Preparing for Winter letter which are:

- **Maximising Ambulance Capacity.**
- **Reducing Time Spent by patients in ED awaiting Clinical Decision and Next Stage of Care.**
- **Timely Discharge for Patients who are Medically Fit for Discharge (in line with previously agreed targets).**

The RD&IG will focus on system-level actions necessary to protect and maximise capacity for elective care activity to support reduction of patient waiting times for planned care, including delivery of any new regional policies and protocols for the timely access to and repatriation from tertiary and very specialist services for Chief Executive approval.

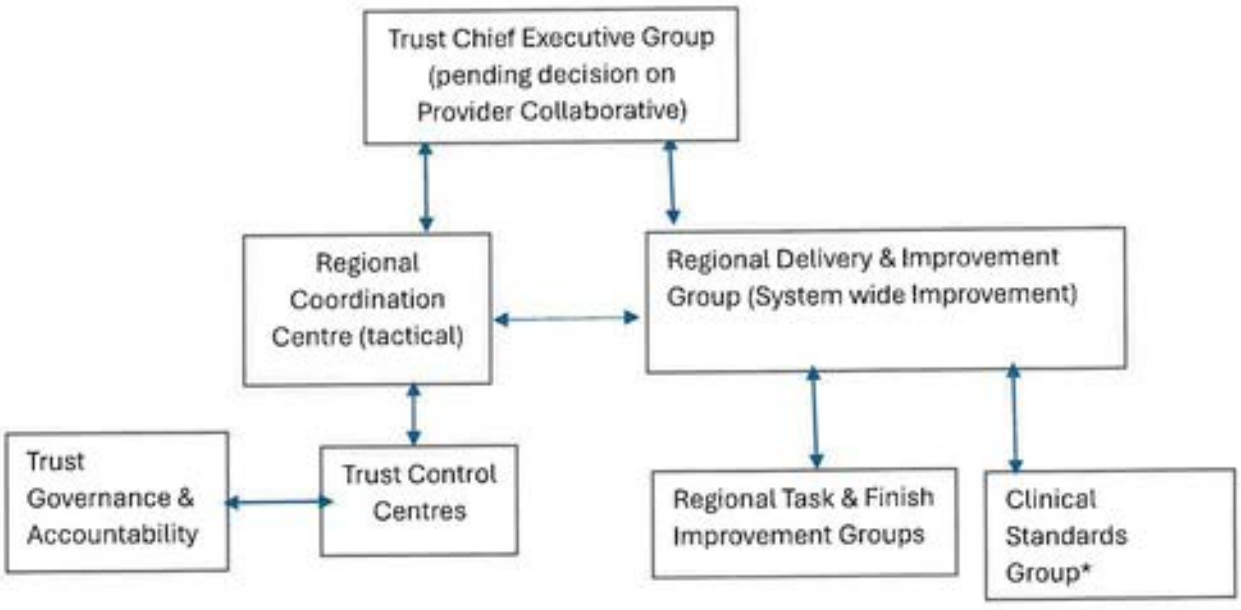
The RD&IG will also provide resolved advice on:

- The metrics and thresholds for the decision-making framework to balance risk across the HSC system.
- Recommended actions to address equity of population access and where possible take action to ensure that risk and pressures are equalised across providers.

Governance Framework

The RDIG sits within the HSC governance framework as described in the diagram below:

Governance Framework for Regional Delivery & Improvement Group



Trust Chief Executives have approved the establishment of a regional Trust Clinical Standards Group* to agree 'good practice' clinical response times, initially for unscheduled care pathway, proposing these standards for ratification by the RD&IG.

RD&IG will establish formal links with:

- DoH Elective Care Management Team
- DoH Information Standards Board

This Governance Framework provides a clear process for raising any concerns about the operation of the RCC, in that such concerns should be initially raised with the organisation's representative on the Regional Delivery & Improvement Group, discussed by the Group where appropriate and a decision made as to the appropriate response which could include escalation to the Trust Chief Executives Group (pending the establishment of the Provider Collaborative Board).

RDIG Membership and Operating Principles

RDIG will meet bi-weekly and **the Chair is the RCC Director** to ensure close collaboration across both RCC and RDIG functions, and to direct a focused workplan for RDIG. RDIG will report progress on a monthly basis through a highlight report to Trust Chief Executive Group and RCC. Where Chief Executive approval is required to mandate significant changes or escalation to SPPG/DoH, this will be communicated directly into the Lead Trust Chief Executive and necessary papers produced.

Proposed Core Membership (to be reviewed/finalised)

Title	Name
Chair	Director, Regional Coordination Centre
Professional & Clinical Lead(s) nominated by Trust CXs to represent the Provider system: • Medical Director • Director of Nursing • Director of Adult Social Care • Director of AHP services	
NIAS Lead Director	
Provider Directors of Unscheduled Care, Scheduled Care, Adult Community Care and Mental Health Services, Childrens Acute Hospital and Childrens Community Care	Trust CXs to decide if they wish to nominate a single representative or for each Trust to be represented.
Provider Director of Planning	Trust CXs to decide if they wish to nominate a single representative or for each Trust to be represented.

DoH Policy and Commissioning Leads for: • Acute Hospital Care • Adult Social Care/Chair of Social Care Collaborative • Mental Health	
Lead for SPPG Unscheduled Care Head of SPPG Strategic Intelligence	
Regulator (RQIA, Other)	
Regional Communications lead	
Other (TBA)	

Individual Delivery/Task & Finish (T&F) Improvement Groups will be sponsored by RD&IG and have a nominated SRO from RD&IG membership to provide guidance and ensure the necessary support. These T&F Groups should meet at least once a week, this frequency may be increased at times of heightened escalation, to discuss progress against planned actions, activity data, and escalations for RDIG. Updates are provided to the RDIG via highlight reporting on a weekly basis.

The meetings of the RDIG will be considered quorate when the Chair or Deputy Chair is present and over 50% of attendance of members (or nominated deputies).

Terms of Reference Review

The RDIG and its terms of reference will be reviewed in April 2024.

Arrangements and Running order Regional Co-ordination Centre

The RCC will be established on Monday 4th December at 08:00.

The RCC will operate 7 days per week as follows

Monday to Friday :	08:00 until 18:00 / on-call to 2000
Saturdays and Sundays	08:00 until 13:30 / on-call to 2000
Bank and Public Holidays	08:00 until 13:30 / on-call to 2000
Christmas Day	no service

The RCC, situated at NIAS will be physically staffed from 08:00 to 18:00 Monday to Friday and virtually from 08:00 to 13:30 at weekends, holidays and Bank Holidays.

Staffing will be

1) Chair : rotated through all available senior staff.

   Role : Chair of the day, meeting management, SPoC for Trust contacts. Check and challenge, RCC directions as required.

2) Deputy Chair : rotated through all available senior staff

   Role : supporting meeting actions, recording issues and actions logs, support for Chair, maintaining constant presence and immediate contact availability should the Chair be unavailable or on a break.

3) Clinical advisor : initially provided by RCC leadership team but may, in due course be resourced through a remote on call. NB the Clinical Advisor may undertake either the Chair or Deputy Chair role.

   Role : to ensure that all decisions made in the RCC, support requests and offers are clinically resonant, and patient centred. Supports the Chair with clinical advice where required or indicated.

4) BI Expert : NIAS team until other arrangements are agreed.

   Role : provision of business intelligence, visual presentation of dashboards and reports, real time and tactical analysis, support with daily reports and CEO briefings.

5) Admin / Loggist : rotation of admin staff appointed w/c 20 Nov

   Role : maintaining records and actions logs, responsible for receiving and distributing communications, working with the Deputy Chair to collate reports for Chair sign off. NB in due course, admin and loggist staff may/ should be trained to, and adopt EPRR loggist standards.

On-call arrangements

As an initial trial, an on call arrangement will be in place from close down time until 8pm each night. Contact with the on call "Chair of the day" will be by telephone, contact details will be shared in due course. The SBAR approach, commonly used in major incident situations (SBAR Tool: Situation-Background-Assessment-Recommendation | Institute for Healthcare Improvement (ihi.org)) should be used to communicate the issue at hand.

Where RCC support is requested out of hours, the requesting Trust must complete and submit an SBAR within 24hours.

Daily timetable 7/7

08:00 to 08:30

1) RCC team review the NIASBI Sitrep for exceptional issues requiring attention before the formal 10:30 call below

2) Where exceptional pressures are evident by way of either

   a. A direct contact from a challenged Trust

   b. Concerns arising from available data intelligence, the Chair may convene a direct contact call with affected Trust(s) and as required with Trusts who appear to have potential support capability.

   to ensure that support and potential external assistance is expedited, prior to formal 10:30 meetings.

08:30 to 09:30 (but no later than 10am)

3) Trusts aggregate / validate and submit the RCC Minimum Dataset (SITrep) to the email address nias.regionalposition@nias.hscni.net

   Where data are auto aggregated by the NIASBI team, data will be shared with Trusts and RCC simultaneously. (All Trusts should identify a single email inbox to receive auto aggregated data). In the interim an agreed Single Point of Contact will be agreed

4) Standing agenda plus exceptional items agenda published to Trusts in advance of the 10:30 meeting where possible, based on first (preferably validated) cut of the SITrep.

10:30 to 11:00. RCC formal ***Teams call :*** SBAR approach (verbal).

(NB short minutes and action logs will be maintained and retained for all meetings. All action logs will be PDF'd at RCC close of play to protect records and action logs to EPRR standards, meeting minutes, action logs will be made available to CEOs at the next available joint CEOs meeting.)

Standard Meeting Agenda

a. Key issues arising from SITRep : Chair
b. Additional context (non PID data only please) : Provider leads
   i. Acute Providers
   ii. Critical Care network

iii. Mental Health providers
iv. Children's network
v. Community Providers

c. Support requested or indicated SBAR format : Provider leads
d. Support offered : Provider leads
e. Collective assessment of risks and capacity to mitigate : All
f. Actions, follow-up actions required and summary : Chair
g. Other key information e.g. CMO / SPPG directions, PHA Outbreak notices, notification of mass gatherings that may affect flow, attendance at ED or impact travel, etc. : Chair

NB the Chair, at their discretion, may, even in the absence of a request for support, negotiate or direct support to a challenged Trust in fulfilment of the objective of sharing and equalising system pressures across N. I.

11:00 to 12:00 : RCC Comms and action log distributed to all Trust CEOs and Control Room Directors

Follow-up on 10:30 actions and impact assessment.
"As required calls" to Trusts Directors and escalation where necessary.

14:30 to 15:00 Monday to Friday and by exception weekends and BHs : Formal 2nd RCC via MS Teams

Standard Meeting Agenda

1) Follow up on 10:30 action completion : Chair
2) Review of key current changes to SITrep : Chair
3) Support and mutual aid requested and (SBAR) / standdown of aid provided, new and emerging issues : Trust leads

4) Readiness for out of hours period: Trust leads
Readiness for weekend period (Thursday specific item) : Trust leads
Readiness for Bank Holiday/ long weekend period : Trust leads

17:00 to 17:30 Monday to Friday and by exception weekends and BHs : Formal 3rd RCC
Teams call : link here.

Standard Meeting Agenda

1) Follow up on 14:30 action completion : Chair
2) Review of key current changes to SITrep : Chair
3) Support and mutual aid requested and (SBAR) / standdown of aid provided, new and emerging issues : Trust leads

4) Outlook and additional actions for the evening and night.
5) Communications to CEOs and SPPG for overnight period.

This call can be "stood down" by collective agreement at the 14:30 call should all Trust pressures be equalised and actions that allow a safe overnight, be in place.

Where circumstances require RCC support outside formal meetings, Trusts should contact the RCC Chair of the day by telephone AND by email using the attached proforma.

In every case, where RCC support is requested out of hours, it is expected that the request will be made by a Director On Call. (Director or minimum deputy Director) who has the authority to make Trust wide decisions, without delay.

Day to day Role of the RCC : initial arrangements

- Chair the daily system calls and negotiating and directing actions arising as required.
- Optimise patient and population safety within the available collective resources and ensuring equity of access and equalisation of risk and pressures across all Provider organisations.
- Ensure Providers are supported to optimise the services within their individual control and where support from other organisations or sectors is required that these are expediently brought together to that effect.
- Highlight gaps in actions to individual organisations where current ways of working and current resource will not sufficiently mitigate risk.
- Manage inter Trust support requests. *Requirement that all requests are preceded by an assessment that all internal actions are exhausted prior to RCC support request.*

  Reference Patient Flow Standards – CH1.1.
- Co-ordinate the development of achievable recovery initiatives and plans to manage, mitigate and smooth out risk and pressures.
- Ensure Providers are supported to optimise the services within their individual control and where support from other organisations or sectors is required that these are expediently brought together to that effect.

- Provide tactical support or direction to all service providers with regards to non-elective services, mindful of the impact on planned care.

- Tactically co-ordinate system wide provider activities and interdependencies and provide operational advice and guidance to colleagues at all levels, where required.

- Ensure providers across all sectors work together as required to solve individual provider and system wide pressures and crises and where necessary take System wide responsibility for directing escalation, mutual aid and inter organisational support.

- Provide early warning of the need to implement formal escalation across partnerships and within providers and directing providers accordingly.

- Request, receive and evaluate escalation plans, weekend and holiday plans, extreme pressures mitigation plans and requesting adjustments where needed and where possible : achieved through support, check and challenge of provider plans and provider activities across pathways, using a "balance of risk" judgement.

- Contribute to providers across N Ireland meeting their obligations under major incident/EPRR rules and requirements including managing escalation activities, maintaining logs and action plans.

- Communicate and implement directions from SPPG, DH N Ireland and Provider CEOs Group as required.

- Acting as the conduit for direction and information sharing with SPPG and DH.

- High level co-ordination and evaluation of the impact of improvement initiatives.

- Provide and develop intelligence and planning tools, web-based resources and planning and modelling capability .

- Maintain and review of decision logs, activity logs, risks and escalation logs and develop thematic analysis.

- Any other duties and responsibilities as directed by CEOs group.

Example SBAR template.

Date : 1/1/24 Time : 23:50 Name : Jane Hope Designation : DOps/ Dir Oncall

SBAR	
Situation	The MAU at St James has declared a lab confirmed C Diff outbreak @ 11:20 and is unable at this time of night, to transfer any patients to wards due to all wards and side rooms being occupied. With only 3 available beds for ED admissions, the 45 DTAs in ED over occupy majors as follows 45/ 28 = 17 additional potential corridor patients before the 3 beds are occupied, We have no current ability to step down from resus.
Background	2 patients with LoS > 3 days in MAU showed +CDiff yesterday. These patients were isolated. Today 14 additional patients in MAU have +CDiff. MAU cannot isolate or cohort. Hence ED cannot decompress. Our NIAS attendance profile at ED suggests another 14 potential admission arrivals between now and 8am. Without external support, occupancy in ED by 8am is likely to exceed 59 DTAs. From 2am onwards we expect only 4 of the expected 14 NIAS admission arrivals/
Assessment	With 59 potential DTAs in ED, first assessment ability is significantly compromised. We assess that with the capacity to raise 6 more additional extra ward beds and through bedding down the the current 45 DTAs on ED corridors we can maintain critical safety. We can maintain critical safety with the expected overnight admission arrivals.
Recommendation	Consider a NIAS divert to neighbouring hospitals to provide us with a firebreak and reduce overnight risk by at least 10 patients who cannot be easily accommodated on corridors or extra beds. Advise if a limited time divert can be authorised until 2am, in the context of risks that we may not be aware of at the other Trusts.

Jane Hope email : Jane.Hope@stjames.nhs.ni mobile : 07575 757575

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

PRESENTATION OF PAPER

Date of Trust Board:	14 December 2023
Title of paper:	Getting It Right First Time (GIRFT)
Brief summary:	GIRFT is a national programme that aims to enable a rapid improvement in the delivery of urgent and emergency care and the adoption of GIRFT principles to ensure best outcomes for patients, by reducing unwarranted variation and maximising the use of existing resources and assets. SPPG commissioned GIRFT to undertake a review of emergency medicine in Northern Ireland. The GIRFT N.I. regional report was shared in November 2023 following visits to all the Type 1 Emergency Departments in June 2023 by the GIRFT emergency medicine team – Professor Chris Moulton and Mr Darren Best. The team identified three main problems for Urgent & Emergency Care in Northern Ireland: 1) Patient handover delays from ambulance staff and consequent poor ambulance response times; 2) ED exit block for patients requiring hospital admission; 3) Poor patient flow within hospitals and exit block for patients requiring social and community care.

	Of the three main identified problems, the report notes that patient handover delays are clearly the biggest single risk to patients in the emergency care system of Northern Ireland. The report also notes that the lost capacity as a result of delays in handovers at EDs - both staff and vehicles - is the main cause of poor ambulance response times for patients. Cognisant of the significant impact delayed handover times have on patients' experience and potential poor outcomes, and the impact on our staff, NIAS has had a continued focus on highlighting our concerns regarding this issue and has taken forward a wide range of actions to highlight and address this issue. This includes (not exhaustively): • Engagement with SPPG & DoH colleagues to influence introduction of 3-hour backstop from December 2022, reducing to 2-hour backstop from February 2023 for ambulance turnarounds; • Permanent Secretary invited to join Board meeting to discuss turnaround challenges and impact on NIAS; • Raised by Chair & Chief Executive at accountability meetings; • Raised by SMT colleagues at Ground Clearing meetings; • Chief Executive level meetings with Trusts with the longest handover delays; • Letter from Chair of NIAS Safety Committee to counterparts in other five Trusts raising concerns and seeking details of the actions being taken in their Trust to address the risks associated with handover delays; • Range of correspondence with DoH/SPPG & Trusts regarding NIAS concerns associated with ambulance handover delays. This includes most recent correspondence to SPPG November 2023, requesting meeting to discuss which has been arranged.

	In addition, the Winter Plan published by the Department of Health in October 2023 includes specific actions to ambulance handover times, and ambulance handover performance is one of the four matrices published fortnightly via the Departmental website. The Regional Co-ordination Centre established by all six Trusts with effect from 4 December 2023 has a specific focus on reducing ambulance handover delays. The GIRFT report makes recommendations across a range of areas in urgent & emergency care including for NIAS: • The Northern Ireland Ambulance Service should reduce the overall ambulance conveyance rate and in particular, the rate of conveyance to EDs. However, the rate of conveyance to alternative UEC facilities should be increased. "Hear & Treat" and "See & Treat" rates should also be increased. Linked to this is a recommendation for acute Trusts to facilitate this recommendation, the report notes: • This will require improvements to both the content and the utilisation of the directory of services (DoS), combined with an increase in the availability and accessibility of alternatives to ED attendance for NIAS (eg alternative patient pathways). The GIRFT report makes a very clear statement in relation to the risk associated with delayed ambulance handovers. SPPG has indicated that they will be developing an implementation plan to address the findings and recommendations and we await details of this.
Recommendation:	**For Approval** ☐ **For Noting** ☒

Previous forum:	If applicable
Prepared and presented by:	Rosie Byrne, Director of Operations
Date:	7 December 2023

GETTING IT RIGHT FIRST TIME

For Emergency Medicine

The Emergency Departments of Northern Ireland

Report following visits in June 2023

This report has been produced by the Getting It Right First Time (GIRFT) Project Team at the Royal National Orthopaedic Hospital (RNOH/GIRFT). It aims to enable a rapid improvement in the delivery of urgent and emergency care and the adoption of the GIRFT principles to ensure best outcomes for patients, by reducing unwarranted variation and maximising the use of existing resources and assets.

Written by:

Professor Chris Moulton: National Clinical Lead for GIRFT for Emergency Medicine

Darren Best: GIRFT Senior Specialist Clinical Review Manager (UEC Specialties)

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1. Foreword

Getting It Right First Time (GIRFT) is a national programme, under the direction of Professor Tim Briggs, designed to improve the treatment and care of patients by in-depth review of services, benchmarking, and the presentation of data-driven evidence to support change. GIRFT aims to reduce unwarranted variation – the variation that is bad for the patient, bad for the healthcare system and bad for the economy – whilst accepting that some variation can be beneficial.

The programme undertakes clinically led reviews of specialties, combining wide-ranging data analysis, with the input and professional knowledge of senior clinicians, to examine how things are currently being done and how they could be improved.

GIRFT is part of an aligned set of programmes within NHS England. The programme has the backing of the Royal Colleges and professional associations.

This report is based on the observations and discussions from visits to all ten of the type 1 (major) emergency departments in Northern Ireland, in June 2023, by the GIRFT for emergency medicine team (Professor Chris Moulton and Mr Darren Best). The Northern Ireland Ambulance Service (NIAS) was also visited. Comparative data were shown to staff, using the Summary Emergency Department Indicator Table for Northern Ireland (the SEDIT-NI).

The SEDIT-NI was built, and the visits conducted, at the request of the Department of Health, Northern Ireland (DoH NI), Strategic Planning and Performance Group (SPPG), following discussions that started in 2021. The aim was to bring GIRFT methodology to Northern Ireland and to allow comparison of the Northern Ireland emergency care system with the much larger dataset of English emergency departments.

The GIRFT for Emergency Medicine team would like to thank our colleagues from the DoH, NI, SPPG team who have been extremely positive and supportive throughout the Northern Ireland GIRFT Emergency Medicine process. Gratitude is also due to the clinical and executive healthcare staff from across Northern Ireland who have been candid and honest in sharing their experiences and their knowledge.

This work should provide a real stimulus to restart and embed the recovery of emergency care services in Northern Ireland and should encourage shared learning between the two countries involved in it.

Professor Chris Moulton: National Clinical Lead for GIRFT for Emergency Medicine

Darren Best: GIRFT Senior Specialist Clinical Review Manager (UEC Specialties)

2. Introduction

This report summarises the overall recommendations for Emergency Medicine in Northern Ireland as well as specific recommendations for the 10 Type 1 EDs that the RNOH/GIRFT emergency medicine team visited during two trips to Northern Ireland in June 2023.

A more comprehensive presentation, which includes more detailed descriptions of the SEDIT-NI and shows the data sets for each of the Type 1 EDs visited, can be found in the appendix of this report. The intent of the presentation is that it can be used by the SPPG and members of the Department of Health, Northern Ireland (DoH NI) to present to key stakeholders, either in full format or in parts, as necessary.

3. The SEDIT for Northern Ireland

The Summary Emergency Department Indicator Table for Northern Ireland (SEDIT-NI) was the main source of data for the GIRFT for Emergency Medicine visits. It is a repository of GIRFT emergency care information that is available online to all healthcare staff and is updated monthly. It is a development of the GIRFT SEDIT for England. Information about the EDs of Northern Ireland is compared with the large, combined data set of Northern Ireland and England.

Both SEDITs also address the issue of unwarranted variation in access to urgent and emergency care information. The data metrics are presented in an intuitive and helpful way, in order to show why problems are occurring, rather than providing an operational dashboard of current patient flow. The SEDITs are constantly evolving and responding to a changing NHS and the requirements of their 57,000 registered users. The SEA-IT (the Summary Emergency Ambulance Indicator Table) is now available as a tab on the SEDITs.

4. The three main problems for urgent and emergency care in Northern Ireland

The RNOH/GIRFT team identified three main problems for UEC in Northern Ireland, which are:

1. Patient handover delays from ambulance staff to ED staff and consequent poor ambulance response times
2. ED exit block for patients requiring hospital admission
3. Poor patient flow within hospitals and hospital exit block for patients requiring social and community care

These problems are greatly accentuated by staffing and other capacity deficits in community services, in primary care, in social care and in most of the hospital services. Positive benchmarking against England does not negate these issues; all of the UK has failing UEC systems, with insufficient capacity to meet the demands of its growing and ageing population.

4.1 Ambulance to ED patient handover delays

- Delays in the handover of emergency patients from ambulance staff to ED staff wastes many hours per month of valuable emergency ambulance time. In fact, it consumes over 25% of the Northern Ireland Ambulance Service's emergency capacity.

- This loss of emergency capacity - both staff and vehicles - is the main cause of poor ambulance response times for patients. As a consequence, people who require urgent help are often left at home in pain or short or breath for long periods.
- This is clearly the biggest single risk to patients in the emergency care system of Northern Ireland.

4.2 ED exit block and hospital exit block

- The main reason for ambulance to ED patient handover delays is over-crowded EDs, with very large numbers of patients waiting for admission to a hospital inpatient bed. These people are often in beds and chairs in ED corridors and there is frequently no space for ED staff to examine and treat new patients. This is called ED "exit block" (or "access block" in some parts of the world).
- The lack of space on hospital wards is usually due to large numbers of patients who are "medically fit for discharge" but who cannot be found a space in a care / nursing home or allocated suitable social or community care.

5. Overall recommendations for Urgent and Emergency Care in Northern Ireland

The overall recommendations for UEC in Northern Ireland are based on two important premises:

1. The current situation in emergency care in Northern Ireland is unacceptable, untenable, and unsustainable. It is wasting Health and Social Care Northern Ireland (HSC NI) money, paralysing the emergency ambulance service, and preventing ED staff from doing their jobs. Most significantly of all, it is harming patients, increasing their risk of dying and giving them very poor experiences of hospital care.
2. Small improvements to emergency processes, whilst still important, have not been sufficiently effective in England and will not remedy the situation in Northern Ireland either. Significant and uncomfortable changes in many different areas are required to deliver the level of improvement that patients and staff require and, more importantly, deserve.

RNOH/GIRFT's recommendations fall into four categories as follows:

KEY: Group **S** = Recommendations about **S**OCIAL CARE

Group **C** = Recommendations about urgent care in the **C**OMMUNITY

Group **H** = Recommendations about the **H**OSPITAL emergency care system

Group **A** = Recommendations about the emergency **A**MBULANCE service

All hospitals and local UEC systems in Northern Ireland should look at these overall recommendations. As there was only a limited amount of time to visit each of the 10 EDs, the recommendations for each department (see later in the report) are brief and limited. Therefore, these overall recommendations, not all of which of course, will apply to each locality, are more comprehensive and may sometimes be more helpful.

5.1 Recommendations S: Improve the social care system

The difficulty in discharging patients from the hospital in a timely and efficient way is the most significant factor that causes a lack of bed availability, ED exit block and ambulance handover delays:

1. The timely flow of urgent and emergency care patients through the hospital system is absolutely dependent on effective and available social and community care. Similarly, avoidance of hospital admission depends on the same out of hospital services. Therefore, trusts should consider all options to alleviate backdoor pressures which could include internal processes, trust run nursing homes and terms and conditions of domiciliary care workers.

5.2 Recommendations C: Improve the community care system

The difficulties in obtaining a timely appointment in primary care or in finding an alternative to ED attendance or an alternative to hospital admission are the factors that increase patient attendance and ambulance conveyance to hospital:

1. The importance of primary care in the provision of an effective urgent and emergency care system cannot be underestimated. This is true both in and out of hours. Consequently, primary care staffing and availability should be considered in all discussions concerning UEC.
2. The commissioned services in the community and the directory of services (DoS) should be examined to ensure that they meet local needs and provide services when and where they are of maximum benefit to patients.

5.3 Recommendation C (i): Consider urgent care centres in specific situations

Urgent care centres and similar facilities are not the solution to ED exit block and ambulance handover delays, but they do have a definite place in the urgent and emergency care system:

1. The current urgent care centres and other type 3/4 facilities provide a valuable service to patients who live in areas that are not well-served by the 10 type 1 EDs of Northern Ireland.
2. There may be a place for similar facilities in some other areas with a high demand for UEC or with a particular geographical requirement.
3. Call before attendance and similar systems should be carefully evaluated to ensure equitable and effective access across the region.

5.4 Recommendations H: Improve the hospital system

Long stays in EDs and prolonged waits for definitive care harm patients, prevent EDs from functioning properly and paralyse the ambulance service.

1. Each area hospital should have an adequate range of medical specialties. For specialties that are not present on site, there should be clear, time-specific transfer agreements, bypass arrangements (including "stop and x-ray") and helicopter transfers for very sick patients. The range of specialties, and any transfer arrangements, should be reviewed regularly in the light of the changing patient demographics of a growing and ageing population.

2. Any "dominant constraints" to good patient flow in the hospital should be addressed or mitigated (Dominant constraints are staffing (consultants and registered nurses) and space available to treat patients).
3. All acute specialties should have "elastic" reception facilities for both external and internal acceptance of patients. This will require staffed specialty receiving areas.
4. The elasticity of the ED should be used to eliminate ambulance handover delays, rather than to accommodate large numbers of patients waiting for a hospital bed.
5. Internal professional standards should be implemented throughout each hospital. In the right situation, for instance, referrals from the ED can occur by electronic notification, without the need for negotiations over the telephone.
6. A frailty in-reach team should cover both ED and the acute wards. Occupational therapists should be included in the frailty team.
7. There should be a good range of Same Day Emergency Care (SDEC) and urgent clinics, with a focus on admission avoidance and complex patients.
8. An acute medical in-reach model to ED should be considered.
9. Access to MR imaging 24/7 should be regarded as essential aim for all hospitals that have a Type 1 emergency department.
10. Reported ultrasound scans should be available to the ED for a large period of the working week, to help to avoid unnecessary referrals and admissions.
11. Timely access to endoscopy for all hospital patients should be ensured.
12. Access to HDU and ICU services should be timely and hurdle-free.
13. Provision of transfer teams to move ED patients rapidly to the wards and to the imaging departments should be considered.
14. In all the EDs of Northern Ireland, large numbers of ED nurses are engaged for long periods in caring for patients who are waiting for an inpatient bed. There should be a formalisation of these arrangements with a senior nurse responsible for a dedicated (and sufficiently large) team of nurses who rotate into and out of this particular duty. (This, of course, is a temporising measure for reasons of patient safety, until the problems of delays for inpatient admission can be resolved.)
15. More support staff should be employed to free-up the main clinical staff groups and allow them to concentrate on direct patient care.
16. The installation of time - and labour-saving devices, such as automated drug dispensers (e.g., the Omnicell), ambulance trolley weighbridges and ceiling-mounted bariatric hoists should be considered for all EDs.
17. The use of ED reception / waiting room patient-operated streaming systems should be trialled.
18. There should be an aim to make the estate of each type 1 ED ready for another pandemic resulting from an unknown pathogen. Preparedness for an incident requiring decontamination is also necessary.

19. Staff facilities in EDs require improvement. Adequate provision of toilets, for instance, can obviously save valuable staff time.

20. Many EDs are dependent on locum doctors, especially for their middle grade rotas, and also bank nurses. Conditions of service should be offered that tempt these staff to accept longer-term contracts, wherever possible, cognisant of trust financial pressures.

21. Senior and junior rotas for both medical and nursing staff should be reviewed to ensure adequate out-of-hours cover for EDs at all times.

22. Seven-day working for all acute specialties should be considered as normal practice; rotas should ensure adequate out-of-hours cover.

23. Emergency medicine trainee disposition throughout Northern Ireland should be re-evaluated to ensure variety of ED experience and service provision, as well as excellence in training. This will require discussion with NIMDTA.

24. GIRFT reports from other medical specialties should be reviewed in conjunction with this report, especially those from general surgery, urology and orthopaedics. A GIRFT for acute medicine team visit should be considered. Their tools – the "six to help fix" (for acute medical flow), for instance, may prove to be very helpful.

25. All parts of the UEC system should aim to improve the quality and usefulness of their data and to ensure its alignment with other services. The GIRFT-EM SEDIT and SEA-IT may be useful in this respect and should be used to drive improvement.

26. The leaders and managers of every service should aim to limit "internal demand" on their staff, such as poorly functioning IT and unnecessary non-clinical tasks.

5.5 Recommendation H (i): Implementation of equitable and effective call before attendance and ED appointment systems

1. Urgent and emergency care appointment systems are based on a false premise: that ED attendance is unpredictable and needs to be regulated somehow. In actual fact, demand for emergency care is highly predictable and for any particular ED, the busiest time of the day and even the busiest day of the year are almost always the same and change very little over time.

2. A streamlined attendance system should be implemented to ensure equal access for all patients, especially those people who already suffer from poor access to healthcare and other health inequalities. Appointment systems in EDs should be set up to ensure they don't lead to a parallel queue that cannot be serviced in a timely way.

5.6 Recommendation H (ii): Do not underestimate the effect of hospital attitudes, behaviours and cultures

1. The style of leadership of a hospital, and the attitudes, behaviours and cultures that it engenders, is perhaps the most important factor affecting the care of emergency patients.

2. The best hospitals have a highly visible top team who encourage the rest of the hospital staff to see lengthy delays for patients as everybody's responsibility. They regard threats to patient safety as problems that must and can be improved.

3. Seven-day working in such hospitals is normalised and internal professional standards become imbedded into everyday practice.

4. For reasons that we do not fully understand, there is a strong positive correlation between contented staff (in the whole hospital) and good ED patient flow. Hospital culture is therefore of paramount importance and should be considered an area for continuous review and improvement.

5.7 Recommendations A: Improve the emergency ambulance system

Delayed emergency ambulance response times are almost certainly the greatest risk to patients throughout the UK.

1. The Northern Ireland Ambulance Service should reduce the overall ambulance conveyance rate and in particular, the rate of conveyance to EDs. However, the rate of conveyance to alternative UEC facilities should be increased. "Hear & Treat" and "See & Treat" rates should also be increased.

2. This will require improvements to both the content and the utilisation of the directory of services (DoS), combined with an increase in the availability and accessibility of alternatives to ED attendance.

3. Patients who have been recently discharged from hospital or who are being admitted from clinics, dialysis units or chemotherapy centres should go directly to the appropriate ward, rather than being taken to the ED.

4. Patients who have fallen in care or nursing homes and patients with a care plan in place should be referred to community services, whenever possible.

5. Ambulances should not leave patients at hospitals that do not have the specialties that are required for their anticipated condition. There should be hospital bypass and "stop and x-ray" agreements in place.

6. For severely ill or injured patients who have been admitted to hospitals where the required specialties are missing, helicopter transfers should be arranged.

7. The Northern Ireland Ambulance Service (NIAS) should improve the quality and usefulness of its data and ensure that it aligns as well as possible with ED and other hospital data.

8. The Northern Ireland Ambulance Service (NIAS) should consider the possibility of setting up urgent care-coordination hubs.

6. Specific local issues and recommendations for the 10 EDs of Northern Ireland

The following hospitals with Type 1 EDs (10 in total) were visited and the RNOH/GIRFT team have made recommendations for each.

Hospital Name	Acronym	HSC Trust Name
Royal Victoria Hospital	RVH	Belfast Health and Social Care Trust (BHSCT)
Mater Infirmorum Hospital	MIH	Belfast Health and Social Care Trust (BHSCT)

Royal Belfast Hospital for Sick Children	RSC	Belfast Health and Social Care Trust (BHSCT)
Antrim Area Hospital	AAH	Northern Health and Social Care Trust (NHSCT)
Causeway Hospital	CAU	Northern Health and Social Care Trust (NHSCT)
Ulster Hospital Dundonald	UHD	South Eastern Health and Social Care Trust (SEHSCT)
Craigavon Area Hospital	CAH	Southern Health and Social Care Trust (SHSCT)
Daisy Hill Hospital	DHH	Southern Health and Social Care Trust (SHSCT)
Altnagelvin Area Hospital	ALT	Western Health and Social Care Trust (WHSCT)
South West Acute Hospital	SWAH	Western Health and Social Care Trust (WHSCT)

All hospitals and local UEC systems should look at the overall recommendations (laid out earlier in this report) for Northern Ireland, as well as the specific recommendations for their own ED. These four groups of overall recommendations apply to social care, primary and community care, the hospital system and the Northern Ireland Ambulance Service. As there was only a limited amount of time to visit each of the 10 EDs, the recommendations for each department are brief and limited. Therefore, the overall recommendations, not all of which of course, will apply to each locality, are more comprehensive and may sometimes be more helpful.

6.1 The Royal Victoria Hospital (RVH): Belfast Health and Social Care Trust (BHSCT)

Local issues

- The ED has multiple areas – probably too many - to cover and this, together with the many patients waiting for an inpatient bed, gives a chaotic and unhappy feel to the department.
- The department is used as a receiving area for patients from other EDs who require specialist treatment, and this adds to the over-crowding and severe pressure on space. Patients who are transferred from other hospitals, with for example hip fractures and urology conditions, experience particularly long waits in the ED.
- The ED also holds patients for long periods who are deemed too sick for standard wards, but not sick enough for the intensive care unit (ICU).
- The urgent care centre (UCC) is really a revamped "minors" area, staffed with ENPs together with some GP input. It has limited opening hours. A lot of the work is triaging GP referrals.
- Both an observation ward and an SDEC are run by ED staff, with little acute medical input to the emergency service. There is no acute medical receiving unit (AMU).
- Nursing skill-mix is not good and there are too few ENPs and ANPs in the ED. Triage cover and the number of nurses at night are particular problems.
- Senior ED medical cover is very limited at night and during weekend evenings.
- The large number of patients waiting for an inpatient bed (40 to 60 on a typical day) require a dedicated team of nurses, under band 7 leadership, to ensure their ongoing care.
- There are many paper-based systems in the ED and a high level of "internal demand".

- In a large specialist hospital, areas are often at a distance from each other (e.g., the CT scan room is two floors above the ED at the Royal Victoria Hospital). A dedicated patient transfer team would greatly improve patient flow and reduce nursing workload.

Recommendations

Patient reception facilities: As the central teaching and specialist hospital for the whole of Northern Ireland, the functioning of the Royal Victoria Hospital has a profound effect on emergency care throughout the country.

It is therefore essential that the RVH has the facilities to receive patients from other hospitals, without them passing through (and waiting for lengthy periods) in the ED. Such patients must also have their operative care and other treatment performed in an efficient and timely way. This is especially true of orthopaedic and urology patients.

ED and hospital staffing: Out-of-hours staffing for the ED should be improved. More Emergency Nurse Practitioners (ENPs) and Acute Nurse Practitioners (ANPs) are required in the ED and the level of evening and weekend cover by the senior ED medical staff should be reviewed. Seven-day working practices should be normalised for the whole hospital. The provision of a patient transfer team should be considered.

ED patient care and flow: The patient reception and flow issues described above should all be considered and addressed. The current delays for patients are unacceptable and are almost certainly causing patient harm. As a result, staff surveys show that the staff are unhappy and discontent.

ED litigation: The high cost of litigation per ED attendee should be explored, with the help of staff who are experts in this field.

6.2 The Mater Infirmorum Hospital (MIH): Belfast Health and Social Care Trust (BHSCT)

Local Issues

- The ED has a cramped and old estate, with a small waiting area and only one patient toilet, apart from those in the waiting room. Just two of the ED cubicles have doors, rather than curtains. The resuscitation area is also small.
- There are no medical specialties on site, except general medicine, elderly medicine and the anaesthetic airway team.
- Transfers from ED to inpatient beds and to other hospitals are delayed, with long waits for patients.
- There is an out-of-hours primary care centre, just across the road, that sends patients to the ED but does not accept referrals from the department.
- The whole hospital is very dependent on locums, there is no rotation of ED trainees to the ED and the ENPs are not properly funded.
- There is poor integration of the ED with the rest of the trust.

Recommendations

ED staffing and facilities: The use of temporary staff should be reduced; better rotations with staff from other EDs in the trust would help considerably. The ED estate requires modernisation. Dedicated ED x-ray facilities would be a step forward.

ED patient care and flow: The current delays for patients are unacceptable and are certainly causing patient harm. As a result, the staff are unhappy and discontent. The availability of alternatives to ED attendance should be explored. Emergency ambulances should bypass the ED when they have patients who almost certainly require services that are not available in the Mater Infirmorum Hospital. It is unsatisfactory that there is an out-of-hours primary care service very close to the ED that will not accept referrals of low acuity patients from the ED staff; this issue should be discussed with the relevant managers.

ED litigation: The high cost of litigation per ED attendee should be explored, with the help of staff who are experts in this field.

6.3 The Royal Belfast Hospital for Sick Children (RSC): Belfast Health and Social Care Trust (BHSCT)

Local Issues

- The estate of the ED is less than ideal. There is no ligature-proof room.
- The work of the children's ED is very centred around primary care work. Although there is a UTC on-site, it does not accept children as patients.
- The ED has no middle grade cover overnight.
- There are lengthy delays for children who require inpatient admission. Patients also wait for long periods to be assessed by CAHMS staff.

Recommendations

ED staffing and facilities: The use of temporary staff should be reduced; better rotations with staff from other EDs in the trust would help considerably.

ED patient care and flow: The availability of alternatives to ED attendance should be explored. It is unsatisfactory that there is an out-of-hours primary care service very close to the ED that will not accept referrals of low acuity patients from the ED staff; this issue should be discussed with the relevant managers.

ED litigation: The high cost of litigation per ED attendee should be explored, with the help of staff who are experts in this field.

6.4 The Antrim Area Hospital (AAH): Northern Health and Social Care Trust (NHSCT)

Local Issues

- There is no on-site trauma and orthopaedics service in Antrim. Patients with fractured hips (and other severe injuries) often wait for several days in the ED corridor before transfer to the ED at the Royal Victoria Hospital in Belfast, where there is no timely reception system and the wait for operative fixation begins again.

- Urology care in the area is fragmented and disorganised; patients wait in the ED for long periods with urosepsis.
- Many of the patients waiting in non-clinical spaces are elderly. There is no front door geriatric in-reach service or use of a clinical frailty score.
- There is limited access to out of hours MR imaging in the hospital.

Recommendations

Hospital inpatient specialties and imaging: The provision of medical and surgical specialties in the Antrim Area Hospital should be urgently reviewed, in the light of a growing and ageing population. An on-site orthopaedic service would seem to be essential. The recommendations of the GIRFT report into urology services in Northern Ireland should be implemented. There must be an aim to obtain access to MR imaging for the hospital – ideally with 24/7 availability.

The acute medical model would be improved by having a seven-day working pattern, which may require input from other medical specialists. The access to SDEC services (such as cardiology) should be increased, with a focus on admission avoidance. Frailty specialist input to the ED and the acute wards is essential. Urgent endoscopy should be available in an agreed timeframe and HDU care should be readily accessible, without difficult negotiations.

Ambulance patients, transfers and referrals: Ambulances that are carrying patients with conditions that cannot be definitively treated at the Antrim Area Hospital should bypass it and go directly to Belfast. "Stop and x-ray" practices should be reviewed and improved. Any required transfers should occur within a short, agreed timeframe. Proper (non-ED) reception facilities for referred patients in Belfast should be mandated.

Patients who have been recently discharged should be returned to the discharging hospital or ward and patients who are referred for admission from clinics, dialysis units and chemotherapy centres should be transferred directly to assessment areas on wards and not be sent to the ED. Patients with care plans and people who have fallen at home, without apparent injury, should be referred to appropriate community services, wherever possible.

ED patient care and flow: The current delays for patients are unacceptable and are almost certainly causing patient harm. Understandably, the results of patient surveys are poor. Patient flow could be improved by moving to post-pandemic standards of isolation and practice.

ED litigation: The high cost of litigation per ED attendee should be explored, with the help of staff who are experts in this field.

6.5 Causeway Hospital (CAU): Northern Health and Social Care Trust (NHSCT)

Local Issues

- The ED of Causeway Hospital has to undertake around 60% of all its clinical work in the small and cramped "Majors One" area, because the other two main clinical areas are full of patients who are waiting for an inpatient bed.
- Therefore, all the nurses in these areas are unable to perform proper ED work. Patients are also kept in corridors and other non-clinical spaces.
- The line of sight in the ED of patients for nurses is poor and there are only five rooms with proper doors, rather than curtains. This is a potential infection and control issue. Portable x-ray facilities are rather inadequate.

- Causeway Hospital is bedevilled by the lack of a trauma and orthopaedics service and by very poor arrangements - and long delays - for urology patients. Catheter care is hard to obtain.
- There is no MR scanning in house and no arrangements for referral to MR out of hours.
- The ED has no trainees in emergency medicine and, as a consequence, is very dependent on locum doctors.
- The hospital has many patients in beds on wards who are medically fit for discharge.

Recommendations

Refer also to the recommendations for Antrim Area Hospital (Northern Health and Social Care Trust).

ED staffing and facilities: The large number of patients who are waiting in the ED for an in-patient bed is preventing the staff from attending to new patients and accessing clinical space.

ED patient care and flow: The current delays for patients are unacceptable and are almost certainly causing patient harm; patient surveys reveal negative experiences of care. Arrangements for orthopaedic patients and urology patients should be reviewed urgently. The recommendations in the GIRFT reports for the surgical specialties in Northern Ireland should be implemented. There must be an aim to obtain access to MR scanning for the hospital – ideally with 24/7 availability.

ED litigation: The high cost of litigation per ED attendee should be explored, with the help of staff who are experts in this field.

6.6 Ulster Hospital Dundonald (UHD): South Eastern Health and Social Care Trust (SEHSCT)

Local Issues

- Patients often wait for very long periods in the back of ambulances, before being finally admitted into the ED.
- There are very long waits in the ED for patients with mental health conditions. (A patient had been in the ED for more than 96 hours at the time of the GIRFT-EM visit.)
- The hospital constantly has two full wards of patients awaiting inpatient beds that are under the care of ED nurses. (There are a total of 71 such beds, including 20 on the ED short stay ward.)

Recommendations

ED staffing and facilities: The management and status of the two wards of patients "waiting for admission" who are under the care of the ED nurses should be formalised. These patients have clearly already been admitted to hospital and the facilities on the two wards are sufficiently good to allow patients on the wards to be taken off the "four-hour clock". The medical care of these patients is already under the inpatient specialties and the nursing team should be separated from the ED team and led by a dedicated senior nurse. If necessary, these ward nurses could rotate in and out of the ED nursing team.

ED patient care and flow: The problem of long waits in ED for patients with mental health conditions should be discussed with the responsible managers, The risk of looking after such patients must not fall entirely on the ED staff. There should be some elastic capacity in the mental

health assessment units where these people can be safely looked after until a definite care plan can be implemented.

6.7 Craigavon Area Hospital (CAH): Southern Health and Social Care Trust (SHSCT)

Local Issues

- The first impression of the ED at Craigavon Area Hospital is one of gross overcrowding. At the time of the GIRFT-EM visit, there were 51 patients in various spaces, waiting for a hospital inpatient bed, and patients waiting outside the ED in ambulances for many hours too. The nurses were running the equivalent of a ward of medical and surgical patients in a cramped corridor, some of the patients on trollies but many of them having to sleep overnight on chairs.
- Surgical patients who are transferred during the night from Daisy Hill Hospital fill up the surgical wards and so surgical admissions from the ED are then unable to be moved to an inpatient bed.
- There are some good facilities in the ED (including two Omnicell automated drug dispensing machines), but there are too many clinical areas to cover.
- The medical SDEC seems to be relatively under-used.

Recommendations

ED staffing and facilities: The working practices of the staff between the two sites of the trust should be discussed, with an intention of reducing the amount of travel between the two hospitals.

ED patient care and flow: The current delays for patients are unacceptable and are almost certainly causing patient harm. Understandably, the results of patient surveys are very poor. The medical SDEC should be used to prevent avoidable patient admissions. In addition, there is a large, almost vacant surgical assessment area, adjacent to the ED, which is currently used as an ED minor's area and also as a storage area. This could be used as an admissions area for surgical (and medical) patients, with its own team of nurses. If necessary, these nurses could be rotated out of the ED team in the short term (as they are already doing the job of caring for patients who are waiting for specialty assessment).

6.8 Daisy Hill Hospital (DHH): Southern Health and Social Care Trust (SHSCT)

Local Issues

- Daisy Hill hospital has a Type 1 ED. There is no general surgery, no trauma & orthopaedics, no urology, no ENT and no stroke service.
- The hospital has no acute medical receiving unit or acute medical in-reach service.
- There are constant problems with recruiting nurses for the ED.

Recommendations

ED patient care and flow: The current delays for patients are unacceptable and are certainly causing patient harm. As a result, surveys show that both patients and staff are unhappy and discontented. The availability of alternatives to ED attendance should be explored. Emergency ambulances should bypass the ED when they have patients who almost certainly require services that are not available in Daisy Hill Hospital.

6.9 Altnagelvin Area Hospital (ALT): Western Health and Social Care Trust (WHSCT)

Local Issues

- The ED of the second main hospital in Northern Ireland is rather cramped with many different clinical areas. Consequently, it has poor lines of sight for the nurses who are caring for the patients. This is greatly accentuated by the large number of patients in various spaces who are waiting for an inpatient bed.
- Only five of the major cubicles have doors; the rest are curtained. Infection prevention and control is thus a constant potential problem.
- The portable x-ray facilities are poor.
- Timely access to specialties, such as ENT, has not been reinstated to pre-pandemic levels. Specialty assessment areas no longer accept ED referrals directly, and the resulting poor patient flow impedes the work of the ED and delays patients.

Recommendations

ED staffing and facilities: Efforts should be made to improve the infection prevention and control facilities in the ED. This would also positively influence the levels of privacy and dignity available for patients and would help with nursing care.

ED patient care and flow: The current delays for patients are unacceptable and are almost certainly causing patient harm. As a result, both patients and staff are unhappy and discontented. There is a high catchment attendance rate and so the availability of local alternatives to ED attendance should be explored. The availability of SDEC, urgent clinics and timely patient assessment in specialty areas should all be increased, with a view to reducing the pressure on the ED and improving patient experiences.

6.10 Southwest Acute Hospital (SWAH): Western Health and Social Care Trust (WHSCT)

Local Issues

- There is no onsite general surgical service in the hospital (since December 2022) and this necessitates transfers of patients by ambulance to Altnagelvin Area Hospital.
- There are no trainees in emergency medicine in the hospital and lots of locum doctors instead.
- More than a third (72 on the day of the visit) of the hospital's G&A beds are occupied by patients who are fit for discharge. Many of these patients are elderly people in difficult phases of dementia. Community and social care are not available to support timely discharge from the hospital.

Recommendations

ED staffing and facilities: The use of temporary staff should be reduced. Rotations with staff from the other ED in the trust would help considerably and would demonstrate the advantages of two far-apart hospitals being in the same trust. The use of screens in the many glass-fronted ED cubicles should be replaced by the installation of external curtains.

ED patient care and flow: The current delays for patients are unacceptable and are almost certainly causing patient harm. As a result, both patients and staff are unhappy and discontented. The availability of local alternatives to ED attendance should be explored. Helicopter transfers

should be standard practice for severely ill or injured patients who are at risk of harm during long road transfers by ambulance.

7. Conclusions and Next Steps

The current situation in emergency care in Northern Ireland is badly affected by long delays at all stages. This paralyses the emergency ambulance service, makes the EDs crowded and dysfunctional, and worst of all, harms patients and gives them poor experiences of the healthcare system. We hope that the information in this report, and its subsequent recommendations, will help to change this paradigm rapidly and efficiently. We know that resources are not endless and so our recommendations focus on improved processes and better cooperation between specialties. Most of the things that we suggest are relatively easily achievable and have already been agreed with many people from both clinical and managerial groups of staff.

The final "Getting it Right First Time for Emergency Medicine Report" will be shared with the Urgent and Emergency Care Implementation Programme Board, DoH NI.

Further "implementation sessions" are also planned. The specific content and purpose of, and participation in, these meetings will be determined by the DoH NI, SPPG team.

Finally, we have great confidence in the future of urgent and emergency care in Northern Ireland. The levels of dedication and enthusiasm that we found in all types of staff that we met will ensure that patients finally get the service that they require and deserve.

8. Appendix: Important supporting information for the GIRFT- EM recommendations for the 10 EDs of Northern Ireland

8.1 GIRFT EM report for Northern Ireland

The full GIRFT EM report for the 10 EDs of Northern Ireland is in MS PowerPoint and can be accessed here by clicking on this icon.

GIRFT-EM report
for the EDs of NI (Ju

The full report contains all the information in this summary report, and the following additional information:

- Details of the Northern Ireland Summary Emergency Department Indicator Table (SEDIT – NI).
- Evidence and observations to support the national and local recommendations, including the SEDIT NI data for each of the 10 Type 1 EDs.

8.2 GIRFT-EM report for England

The GIRFT for Emergency Medicine National Report for England made 17 recommendations to address three key priorities:

- Match emergency care capacity to local demand more effectively
- Improve patient flow in EDs (using solutions based on data and GIRFT-EM metrics)
- Reduce unwarranted variation in the resources available to EDs

It can be accessed by clicking on this link:

Layout 1 (gettingitrightfirsttime.co.uk)

8.3 Internal Professional Standards

Internal professional standards are important to ensure good ED functioning and timely patient flow through the UEC system. An example of them can be accessed by clicking on this link:

rig-making-internal-prof-standards-work.pdf (england.nhs.uk)

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

PRESENTATION OF PAPER

Date of Trust Board:	14 December 2023
Title of paper:	Maximising Attendance Delivery Plan
Brief summary:	Trust Plan to support the health and wellbeing of the workforce and reduce sickness absence within the organisation. The DoH target is to reduce absence rates to 92.5% of the sickness absence levels reported in 2022/23, by the end of the 2023/24 financial year. This represents a target for NIAS of 11.24%. This is a challenging target for NIAS in the context of a legacy of high levels of absence. The delivery plan is based on an approach that focuses on the following: • Information-led identification of hotspots to inform prioritisation of actions. • Central role of the line manager with related systems, processes, training and support. • Implementation of the Trust Health and Wellbeing Strategy, Healthy People, Healthy Place. • Improved governance arrangements with appropriate accountability and reporting mechanisms.
Recommendation:	**For Approval** ☐ **For Noting** ☒
Previous forum:	People, Finance and Organisational Development Committee – 6/12/23

Prepared and presented by:	Michelle Lemon, Director of Human Resources and Organisational Development
Date:	7 December 2023

					Measurement	Outcome	Lead/Owner	Start Date	Due Date	RAG	Progress Update
1	To mainstream and support line manager role in the effective management of absence	i	Establish process to mainstream absence reporting directly to line managers	New reporting process in place	Performance information from GRS	Effective line management leadership and accountability	ML/MC/RB	01-Sep-23	31-Mar-24		Revised reporting system in place but work underway to strengthen and measure compliance
		ii	Deliver line manager training workshops	Workshops delivered	Report of workshops delivered and assessment of participant feedback	Effective line management leadership and accountability	LG/LOC	01-Sep-23	31-Jan-24		Workshops have been delivered across the organisation. Further sessions on qualitative skills around e.g. having difficult conversations and case management approaches in development
		iii	Develop and publish Line Manager Toolkit, including process maps and FAQ's.	Published toolkit	Toolkit in place	Effective line management leadership and accountability	LG	01-Sep-23	31-Mar-24		Guidance notes and flow charts in place. Work underway in respect of toolkit and since last report process mapping has been undertaken to inform
		iv	Ensure appropriate resource for specialist HR advice, guidance and support	HR resource in place	Business Partnering Report to be developed with related measures	Managers are supported in managing attendance	ML	01-Aug-23	31-Mar-24		additional advisor and related HR capacity focused on MA. Approval for permanent recruitment to HR advisor posts granted and recruitment in progress
		v	Ensure appropriate resource for specialist Occupational Health advice	Effective Occupational Health resource in place	Occupational Health KPIs to be agreed in December 2024 workshop.	Managers are supported in managing attendance and staff receive effective OH support and advice	ML	01-Sep-23	31-Mar-24		OH Meeting has taken place to agree new framework approach. Workshop in December to agree KPIs, management helpline and quality reports.
		vi	Assess options for and identify case management solution	Case Management solution in place	Case management reporting measure under development to inform escalation meetings. Intermin GRS measures in place	Effective performance management and accountability	LG/MC	01-Sep-23	31-Mar-24		Collaborative work on case management approach underway. Escalation to Director level meeting. Work progressing around related standardisation of recording and reporting against measures.
2	To establish an information-led approach to attendance management that supports managers in undertaking timely and outcome-focused actions and interventions	i	Establish Information Task & Finish Group reporting to the Maximising Attendance Project Board; identify information requirements and data sources;	Information group in place and related work completed	Dashboard in place including related measures developed	Information -led identification of hotspots and targeted /prioritised action and reduction of absence	VC/TA	01-Sep-23	31-Mar-24		Information work stream has established initial dashboards developed. HROD have produced target baseline and trajectory reports to SMT/PFOD.
		ii	Establish information baseline and improvement target at department/division level	Visible target for improvement with related accountability at managerial level	Baseline and performance trajectory report	Improved performance management and measurement in targeting and reducing sickness absence	VC/TA	01-Sep-23	31-Mar-24		Initial data analysed, hotspots identified, related target established and prioritised accountability meetings in place
		iii	Develop, test and publish Maximising Attendance manager and corporate dashboards	Maximising Attendance manager and corporate dashboards	Evolution of dashboards	Improved access to timely, meaningful and user friendly management information in relation to sickness absence	VC/TA	01-Sep-23	30-Nov-23		Work is progressing as above
		iv	Identify trends and hotspots to inform targeted interventions and associated action plans	Action plans at prioritised areas to address trends and hotspots	Performance Reports with related highlighted trends	Reduced sickness absence due to targeted interventions	VC/TA	01-Sep-23	31-Mar-24		Weekly Director level meetings and monthly Director/Chief Executive meetings taking place
		v	Review information outputs at Maximising Attendance Project Board to ensure timely performance management and escalation as appropriate	Information reviewed and actions agreed	Ongoing evolution of information and dashboards as work streams develop	Effective governance and performance management	ML/MC	01-Sep-23	30-Nov-23		Ongoing work
3	To ensure effective Attendance Management Policy, Procedure and associated employment processes are in place	i	Contribute to regional work stream to develop and deliver a new regional HSC Managing Attendance Policy and Procedure	Regional HSC Managing Attendance Policy and Procedure for implementation at Trust level	Policy in place	Corporate assurance that Managing Attendance Policy and Procedure is fit for purpose and consistent with legislative requirements, terms and conditions and best practice	ML/LG	01-Sep-23	31-Dec-23		Draft Policy and procedure in place due to be issued for HSC wide consultation in January 2024.
		ii	Implement regional HSC Managing Attendance Policy and Procedure within NIAS once signed off at regional level	Trust Managing Attendance Policy and Procedure	Implementation plan with associated measure due 01/04/2024	Corporate assurance that Managing Attendance Policy and Procedure is fit for purpose and consistent with legislative requirements, terms and conditions and best practice	ML	01-Jan-24	31-Mar-24		Work on current systems and processes underway as outlined in progress report in line with extant Policy and Procedure
		iii	Review processes to ensure that applications for Injury Allowance are given appropriate and timely consideration	Injury Allowance process established	Report of proceedings of IA meetings and related data to be presented to SMT and PFOD.	Staff injured at work receive appropriate and timely support. Reports provided to SMT and PFOD as appropriate	ML/RB	01/010/2023	30-Nov-23		Panel meetings taking place. Reports of proceedings will be provided on a quarterly basis.
		iv	Review processes to ensure that appropriate and timely consideration is given to the potential for redeployment of staff who are unable to fulfil their substantive role for health reasons	Redeployment process established	KPIs under development for Redpeloyment Processes to include timescales and outcomes. Related reporting to SMT and PFOD.	Staff who are unable to fulfil their substantive role for health reasons receive appropriate, timely and compassionate support and have an opportunity for reasonable, suitable alternative employment and appropriate related employment processes undertaken	VC/MC/ML	01-Sep-23	30-Nov-23		Redeployment processes are being undertaken with progress reports to be issued from Q4.
		v	Review processes to ensure that applications for Ill Health Retirement are processed to Superannuation Branch in a timely manner	Ill Health Retirement process established	KPIs under development for ill health retirement processes to include timescales and outcomes. Related reporting to SMT and PFOD. Important to note this is a DoH-led process	Staff applying for ill health retirement receive appropriate and timely support	VC	01-Oct-23	31-Mar-24		Current backlog with Superannuation branch. NIAS are engaged in order to highlight delays
		vii	Line management performance management arrangements to ensure appropriate accountability and support	Performance management in place	Initial focus within operations to establish managerial KPIs. This is ongoing work within the directorate.	Effective management of absence to reduce levels by managers who are appropriately supported and managed	MC/RB	01-Sep-23	31-Mar-23		Focus on operations directorate in first instance but wider workshops with other directorates have been undertaken.
4	To deliver a range of proactive Health and Wellbeing initiatives in line with the Trust Health & Wellbeing Strategy to promote a healthy workforce	i	Deliver a range of initiatives to improve physical health, eg, Couch to 5K, support for gym membership	Initiatives in place and pro-actively promoted throughout the Trust	Measures related to projected outcomes identified including qualitative staff assessments	Improved workforce physical health assessed via sickness absence figures, health & wellbeing surveys	ML/AMMcS	01-Sep-23	31-Mar-24		range of wellbeing initiatives in place including Couch to 5k, walking groups and discounted gym membership.

		ii	appropriate, timely and accessible mental health pathways for staff who have been exposed to trauma and/or are experiencing stress or mental ill health	in place. Reporting of progress developed to include monitoring of timeliness.	ace for NAS pathways, work H for December 2023 re: OH KPIs. Progress to be reported in next PFOD report.	Staff feel appropriately supported when exposed to trauma and/or dealing with mental health issues; improved workforce mental health assessed via sickness absence figures, health & wellbeing surveys	ML/AMMcS	01-Sep-23	30-Nov-23		Triage assessment for mental health referrals in place with onward referral as appropriate. Reporting tool under development. Inspire learning report to be presented to SMT and PFOD December 2023.
		iii	Ensure a proactive and preventative approach to addressing MSK issues through, eg, the timely delivery of effective manual handling training, direct referral to physiotherapy services	Manual Handling sessions delivered	Record of access to Physiotherapy and MH training with related outcomes	Staff are better equipped to avoid workplace injury; staff receive appropriate and timely specialist care. Reduction in MSK absence and personal injury claims	NR/NS/ML/MC	01-Sep-23	31-Mar-24		This has been formally escalated to Education Steering Group for urgent consideration
		iv	Ensure a proactive and preventative approach to potential and actual staff assaults through prioritising Care & Responsibility Training for operational staff and ensuring timely and appropriate leadership and corporate support to impacted staff	Care & Responsibility Training is delivered; Managers are equipped to provide necessary support to impacted staff	Record of access to training with associated staff assessment of related benefits	Staff are better equipped to deal with potential aggressive situations; staff feel supported; reduced sickness absence due to staff assaults; Staff report that they feel supported in related pulse surveys	NR/NS/ML/MC	01-Sep-23	31-Mar-24		This has been formally escalated to Education Steering Group for urgent consideration
		v	Deliver recommendations associated with NAS/Unison Partnership work stream	Partnership model established for improving workforce Health & Wellbeing with related news letter and progress reporting	Measures to be reviewed at Partnership meeting Q4	Improved industrial relations and partnership working; improved workforce health and wellbeing assessed via sickness absence figures, health & wellbeing surveys	ML/AMMcS	01-Sep-23	31-Dec-23		Previous work undertaken to be revisited and newsletter progress re-established.
		vi	Implement "Dragons' Den" scheme to support staff to access charitable funds in delivering workforce-led	Scheme in place; staff submissions to access identified streams of charitable funds	Report of applications, allocations and assessment of Post Project Evaluations	Staff feel involved and empowered to deliver initiatives to support their health & wellbeing. Reflected in	ML/AMMcS	20-Nov-23	31-Jan-23		Draft proposal developed and approved by SMT November 2023.
		vii	Analyse data related to absence due to work-related stress to identify any patterns and develop associated	Analysis of data and case management information and report of clear actions to target	Measurement of absence levels against HSE Stress management processes undertaken and delivery of related action plans mainstreamed	Improved understanding of work-related stress causal factors to inform targeted, preventative	ML/NC/AMMcS	01-Nov-23	31-Dec-23		Information work stream established.
5	**To establish robust governance and performance management mechanisms for the delivery of a reduction in sickness absence and associated improvements in attendance**	i	Establish a discrete Maximising Attendance Project; Project Board chaired by a senior leader and to	Project Board, with associated Terms of Reference and schedule of weekly meetings, established	Project Board Reports	Senior level accountability for delivery of focused project to deliver improvement	ML/NC	01-Sep-23	31-Mar-24		Project board established led by ML and NC. Meetings take place on a weekly basis.
		ii	Provide regular performance reports and progress updates to SMT, Delivering Value Project	Performance reports and progress updates	Project Board Reports	Senior level accountability for delivery of focused project to deliver improvement	ML/NC	01-Sep-23	31-Oct-23		DVP weekly project board highlight report to SMT.
		iii	Provide Delivery Plan and associated monthly reporting against target to DOH	Delivery Plan and monthly reports	DoH Reports	focused monitoring of trajectory against the target to ensure accountability and targeted improvement actions.	ML	30-Sep-23	31-Mar-24		Delivery plan provided to DoH by 31/08/23 as required. Regional discussions around reporting arrangements not yet complete.
		iv	Develop and deliver improvement plan to address Internal Audit recommendations associated with the Attendance Management Audit 2022/23	Improvement Plan that outlines progress against recommendations	IA Reports, Reports to ARAC, updates to PFOD	Closed recommendations and improved governance and assurance	ML	01-Sep-23	31-Oct-23		Plan has been developed and under implementation and being reviewed in light of September mid-year position.
6	**To ensure effective communication to trade unions, staff and other key stakeholders of Trust plans and available support related to health and wellbeing and sickness absence**	i	Develop and implement a Communication Plan under the Maximising Attendance Project	Communication Plan	Report of Communications issued	Staff, Trade Unions and Managers are fully informed of the support available and the expectations in respect of health and wellbeing and sickness absence.	ML/NC	01-Sep-23	31-Dec-23		Communications Plan developed in line with OVP workstreams. Further required on organisational communication including podcasts/ surveys/newsletters

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

PRESENTATION OF PAPER

Date of Trust Board:	14 December 2023
Title of paper:	Trust Corporate Scorecard and Performance Report (November 2023)
Brief summary:	The Trust Board Corporate Scorecard and Performance report are presented to Trust Board for noting. Contained within these reports are the Trust's performance trends against the Key Performance Metrics across the organisation. Outlined below is a summarisation of some of the Key Performance Indicators that are outlined in the Trust Performance Report for November 2023, based on outturn data for October 2023. **Demand** • Demand for our services remains at a steady state, when comparing a year-to-date position between 2022 and 2023, we see a 2% decrease in demand levels. • October 2023 however has seen a small increase from September 2023, with EAC answering 656 calls per day on average. **Response Times** • Response time In October were a significant challenge across all categories and NIAS continue to underperform against national targets for all Categories. • Category 1 Mean was nearly 12mins with Category 2 mean over 50mins, against and 8mins and 18mins targets respectively.

Clinical Hear & Treat and See & Treat

- The Clinical H&T rate for October 23 was 3.9%, which was an increase from August 2023. Clinical See & Treat was static in October 2023 at 14.6%.

Handover

- October 2023 saw the Trust lose >12.1k hrs with handover delays>15mins. There were 130 patients per day within October who waited >60mins to get into Hospital Emergency Departments.
- The 2hr backstop is still not showing any signs of improvement in some Trusts and the trend through October continues to illustrate a process out of control.

Patient Care Service:

- Patient facing KPIs continue to show progress when compared against the same period last year, with the new dispatch guidance having a positive impact on arrivals and departures to and from hospital sites.
- Productivity and efficiency in October 2023 show another improvement from September with average number of patients per shift transported increasing to 4.29 through October 2023.

Serious Adverse Incidents, Complaints, Compliments and Care Opinion:

- There have been 21 potential SAIs reviewed, with the Trust notifying 6 during October 2023.
- The Trust currently has 24 open SAIs and they are all at level 1 review.
- During October the Trust received 23 complaints and 31 compliments.
- There were also 14 stories submitted via Care Opinion during October 2023.

Sickness absence:

- The YTD sickness absence rate continues to be a challenge across the organisation, with October performance at just over 14% against a target of 11.2%

Recommendation:	**For Approval** ☐ **For Noting** ☒
Previous forum:	SMT – 28/11/23
Prepared and presented by:	Neil Walker, Head of Performance Maxine Paterson, Director of Planning, Performance & Corporate Services
Date:	7 December 2023

Northern Ireland Ambulance Service CORPORATE SCORECARD 2023/24

October 2023

Northern Ireland Ambulance Service Health and Social Care Trust

Indicator	Measure	Detail	Latest Reported Period													2023/24 Target	Reporting Frequency	Comments
Our Patients will be professionally cared for; Always with compassion and respect			Outturn 22/23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24			
1.01	Category 1 Mean Response Time	The Average Time taken to respond to a Category 1 Call	10	9	10	10	11	11	11	11						10 mins	Monthly	
1.02	Category 1 90th Centile Response Time	The time taken to respond to 90% of Category 1 Calls	21	19	20	20	21	21	22	22						21 mins	Monthly	
1.03	Category 1T Mean Response Time	The Average Time taken to respond to a Category 1 Call with Transport	13	13	14	14	14	15	15	16						19 mins	Monthly	
1.04	Category 1T 90th Centile Response Time	The time taken to respond to 90% of Category 1 Calls with Transport	27	26	27	25	27	30	29	31						30 mins	Monthly	
1.05	Category 2 Mean Response Time	The Average Time taken to respond to a Category 2 Call	36	35	35	37	38	44	47	50						36 mins	Monthly	
1.06	Category 2 90th Centile Response Time	The time taken to respond to 90% of Category 2 Calls	80	68	69	81	84	106	105	111						80 mins	Monthly	
1.07	Category 3 90th Centile Response Time	The time taken to respond to 90% of Category 3 Calls	233	183	196	262	280	360	328	483						233 mins	Monthly	
1.08	Call Answering Performance	% of calls answered within 5 Secs	89.5%	86.9%	85.3%	82.4%	80.7%	80.2%	82.2%	85%						N/A	Monthly	
1.09	No. of Calls Answered within Emergency Ambulance Control	Number of Calls Answered within EAC each month (Emergency 999 calls)	20,789	16,595	18,106	18,440	18,939	19,666	19,187	20,106						N/A	Monthly	
Our Staff will feel positive and proud to work for NIAS																		
2.01	Cumulative % Hours lost from Sickness	Total Hours lost due to sickness absence/Total hours available (%). Year to Date 2023/24	12.15%	14.25%	14.20%	14.25%	14.27%	14.64%	14.60%	14.65%						11.2%	Monthly	
2.02	Cumulative % Hours lost from Short Term Sickness	Total Hours lost due to Short Term sickness absence/Total hours available (%). Year to Date 2023/24	2.72%	2.37%	2.20%	2.10%	2.09%	2.55%	2.61%	2.63%						N/A	Monthly	
2.03	Cumulative % Hours lost from Long Term Sickness	Total Hours lost due to Long Term sickness absence/Total hours available (%). Year to Date 2023/24	9.43%	11.88%	12.00%	11.92%	11.92%	12.09%	11.99%	12.02%						N/A	Monthly	
2.04	Organisational Vacancy rate	Percentage of vacancies within the Trust															Monthly	
2.05	Cumulative Staff Turnover rate	Percentage of turnover of staff within the Trust over the past 12 months		5.19%	5.06%	5.77%	5.95%	6.39%	6.00%	5.80%							Monthly	
2.06	Staff Engagement Survey	Number of Staff Engagement Surveys Complete																Staff Satisfaction Surveys carried out every 3 years
2.07	Statutory and Mandatory Training	Percentage of Staff that have completed Statutory and Mandatory training	20.0%														TBC	Work in progress as moved to LMS in April 23
Our Stakeholders and partners will have confidence in us as a reliable provider at the centre of UEC																		
3.01	Average Handover Time at Type 1 ED	The average time it takes to hand a patient over to a Type 1 Hospital ED	64	56	53	57	60	60	66	85						15 mins	Monthly	
3.02	Lost Hours from Handover delays >15mins	The Hours lost from handovers exceeding the 15min target at Type 1 EDs	8,967	9,780	9,861	7,686	8,425	8,976	6,748	12,035						N/A	Monthly	
3.03	Number of Patients >2hrs for Handover	Number of Patients that wait >2hrs to be handed over at Type 1 EDs	16,286	991	880	1,024	1,205	1,369	1,310	1,687						0	Monthly	
3.04	Hear & Treat Rate	The percentage of patients being clinically treated via the Clinical Hub within Emergency Ambulance Control	4.2%	3.5%	3.2%	4.1%	4.0%	3.4%	4.0%	3.9%						5.2%	Monthly	
3.05	See and Treat Rate	The Percentage of patients being clinically treated at Scene by the Ambulance Crews	14.2%	14.0%	14.4%	14.8%	14.8%	14.5%	14.3%	14.6%						15.2%	Monthly	
3.06	Conveyance Rate	The Percentage of patients being conveyed to Hospital	81.6%	82.50%	82.40%	80.70%	81.20%	82.10%	81.70%	81.48%						N/A	Monthly	
3.07	Number of Scheduled journeys made	The number of journeys to and from a Healthcare facility by NIAS Patient Care Service resources	117,507	12,167	13,341	13,885	12,840	13,256	12,426	12,661							Monthly	
3.08	Average Number of Patient Journeys per shift	The Average number of patients transported by PCS resources within each shift	3.61	3.58	3.70	3.80	3.89	3.90	3.84	4.39						N/A	Monthly	
3.09	Average Number of Patient transported per Run	The Average number of patients transported to a healthcare facility per Run	1.19	1.19	1.19	1.23	1.25	1.23	1.23	1.36						N/A	Monthly	
3.10	The Percentage of patient Journeys that arrive on time	The percentage of PCS journeys that arrive within 60mins of the patients appointment time	30%	39%	36%	36%	39%	37%	37%	34%						95%	Monthly	
3.11	The Percentage of patient Journeys that start on time	The Percentage of journeys that start within 60mins of the patient being booked ready by the healthcare facility	56%	70%	71%	70%	70%	68%	67%	68%						95%	Monthly	
Our Communities will continue to value and trust us																		
4.01	Number of potential SAIs reviewed	The number of potential SAIs that have been reviewed by the Trust	101	13	9	11	14	13	13	21						N/A	Monthly	
4.02	Number of SAIs notified	The number of SAIs that have been notified to SPPG	62	0	3	2	0	5	4	6						N/A	Monthly	
4.03	Number of Complaints	The number of complaints that have been received within the month by the trust for investigation	148	17	15	11	16	15	22	22						N/A	Monthly	
4.04	Number of Compliments	The number of Compliments that have been received within the month by the Trust	273	58	41	36	32	29	36	31						N/A	Monthly	
4.05	Number of patient stories received	The number of patient stories submitted within the month to the Trust	128	21	20	14	16	20	12	14						N/A	Monthly	
4.06	Forecast Revenue Expenditure	Forecast Deficit / Surplus for YE against total revenue resource limit (000s)	£ -	[redacted]	-£ 500	-£ 550	-£ 731	-£ 917	-£ 1,100	£ -						£ -	Monthly	

TRUST PERFORMANCE REPORT

NORTHERN IRELAND AMBULANCE SERVICE

November 2023

for October 2023 Data and Performance

Northern Ireland Ambulance Service
Health and Social Care Trust

Executive Summary

Resource Escalation Action Plan (REAP)

- At the time of writing of this report the Trust is in REAP 3 Major Pressure, although it must be noted that pressures are building across the system which is reflected in some of our performance measures in this paper. Action short of strike continues with full industrial action expected through winter.

Clinical Safety Plan (CSP)

- In keeping with National Ambulance Trusts, NIAS has implemented a Clinical Safety Plan (CSP) to operationally support the REAP position of the trust.
- The simple and dynamic plan is 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 response as soon as identified triggers are met.
- Implementation of the plan has been enacted on a number of periods since last performance report at times of spikes in pressures , and required the re-profiling of existing resources with input from senior management and clinical support with good effect
- Following a review of CSP escalation plan, it has been updated to be more responsive to surges in demand. The plan now reflects the demand surges within divisions, so that responses can be tailored and actions executed accordingly.
- The effectiveness of the procedure is monitored by the EAC Senior Leadership Team and colleagues from the Clinical Team from the medical directorate identified to support

Demand

- Demand for our services remains at a steady state, when comparing a year to date position between 2022 and 2023, we see a 2% decrease in demand levels. October 23 however has seen a small increase from September 23, with EAC answering 656 calls per day on average.

Response Times

- Response time In October were a significant challenge across all categories and NIAS continue to underperform against national targets for all Categories. Category 1 Mean was nearly 12mins with Category 2 mean over 50mins.

Clinical Hear & Treat and See & Treat

- The Clinical H&T rate for October 23 was 3.9%, which was an increase from August 23. Clinical See & Treat was static in October 23 at 14.6%.

Handover

- October 23 saw the trust lose >12.1k hrs with handover delays>15mins. There were 130 patients per day within October, that waited >60mins to get into Hospital Emergency Departments.
- The 2hr Backstop is still not showing any signs of improvement in some trusts and the trend through October continues to illustrate a process out of control.

Patient Care Service

- Patient facing KPIs continue to show progress when compared against the same period last year, with the new dispatch guidance having a positive impact on arrivals and departures to and from Hospital sites.
- Productivity and efficiency in October 2023 shows another improvement from September with average number of patients per shift transported increasing to 4.29 through October 2023.

Serious Adverse Incidents, Complaints, Compliments and Care Opinion

- There have been 21 potential SAIs reviewed, with the Trust notifying 6 during October 2023.
- The trust has currently got 24 SAIs open and they are all at level 1 review.
- During October the Trust received 23 complaints and 31 compliments.
- There were also 14 stories submitted via care opinion during October 23

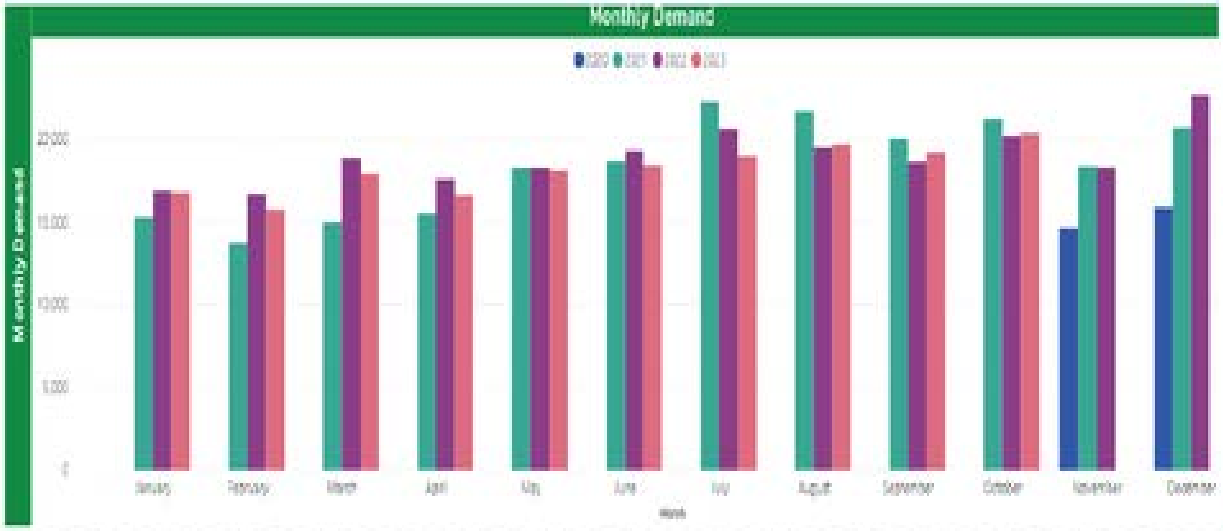
Northern Ireland Ambulance Service
Health and Social Care Trust

Our Patients | Emergency Demand Performance | Operational Demand

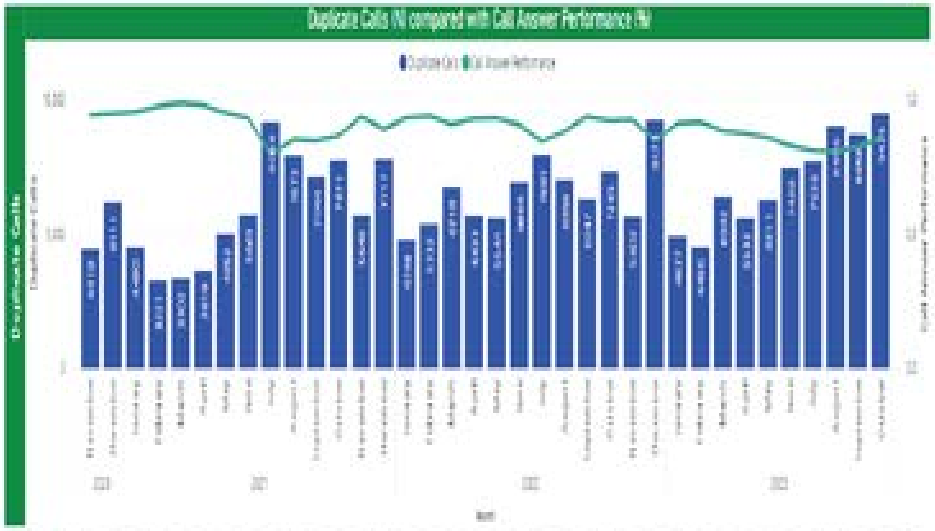
The level of demand each month has a direct relationship on our performance metrics. Ensuring we make the most appropriate response is critical to managing demand effectively and therefore making the most of our resources and capacity to respond to our most critical patients.

The analysis below describes: Calls Answered and Call Answering Performance

999 Calls Answered



Call Answering Performance and Duplicate Calls



- **October 23** has seen a **1% Increase** in demand levels within our control room compared to **October 22.** Year to Date 2023-24 has saw a decrease in demand of 2% when compared to same period 2022-23. In the same period, **Incidents** the trust has had to respond to have remained static Year to date 2023-24 to 2022-23.
- **October 23** saw an increase in the call demand from September 23, this was around 16 calls per day into EAC and this increase was mirrored across ambulance services in England.
- **Call Answering performance** continued to be a challenge through October 23 as staffing challenges within the control room particularly at weekends caused performance to drop **below 60%** on occasion. **October23 call answering performance** was **85.1%** for the month. There is currently a training course running in the trust to address some of these challenges with a further course to commence September 23.
- **Duplicate Calls** Increased in October from September, reaching over 9,000 for the first time since December 2022, an increase of 9% from September 2023. Year to date, the volume of duplicate calls has grown by 16% on the same period last year.

Northern Ireland Ambulance Service
Health and Social Care Trust

Our Patients | 999 Response Time Performance | Response Times Scorecard

Latest Month	Oct-23

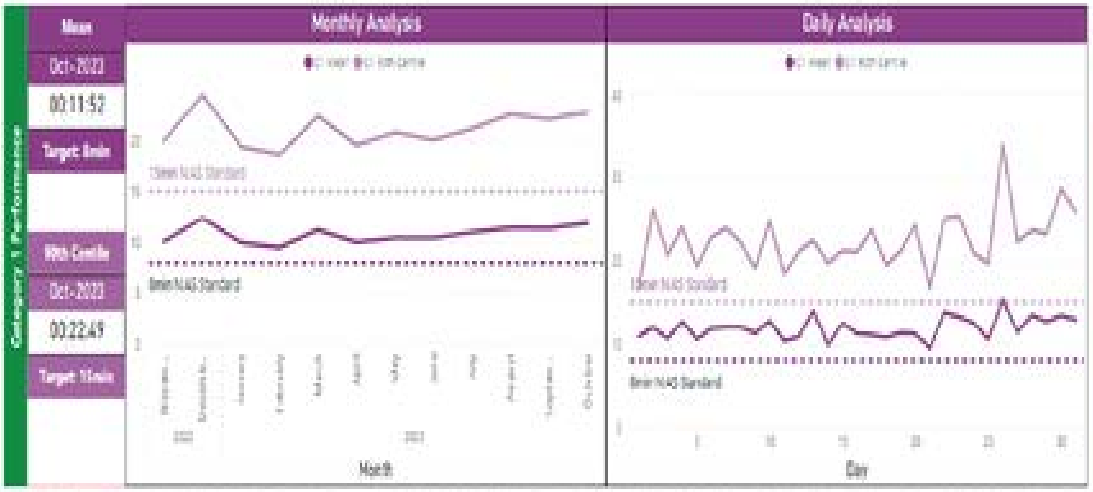
	Target	Current Performance: Latest Month	Current Performance: YTD (from April)	Current Performance: Rolling 12 Month	Benchmarking (Latest Month): National Data	Benchmarking (Latest Month): Best in Class	Benchmarking (Latest Month): Ranking (out of 12)
Category 1 response - Mean	8 Minutes	00:11:52	00:10:57	00:10:51	00:08:40	00:07:09	12
Category 1 response - 90th Centile	15 Minutes	00:22:49	00:21:25	00:21:20	00:15:28	00:12:27	12
Category 1T response - Mean	19 Minutes	00:15:48	00:14:23	00:14:01	00:10:54	00:08:10	12
Category 1T response - 90th Centile	30 Minutes	00:31:29	00:29:07	00:28:01	00:20:06	00:14:18	11
Category 2 response - Mean	18 Minutes	00:51:36	00:40:07	00:39:22	00:41:40	00:28:02	9
Category 2 response - 90th Centile	40 Minutes	01:51:20	01:28:41	01:26:54	01:30:02	00:55:26	9
Category 3 response - Mean	Not a target	03:02:41	01:55:19	01:48:04	02:31:05	01:18:09	9
Category 3 response - 90th Centile	2 Hours	08:03:21	04:50:22	04:29:48	06:06:46	03:12:55	10
Category 4 response - Mean	Not a target	03:06:56	03:40:14	02:50:45	02:50:10	01:54:45	8
Category 4 response - 90th Centile	3 Hours	04:33:11	10:55:36	08:03:27	06:55:40	04:30:46	1

Please be aware, Benchmarking Data for the previous month is not released until the middle of the current month, and so data may not always be available.

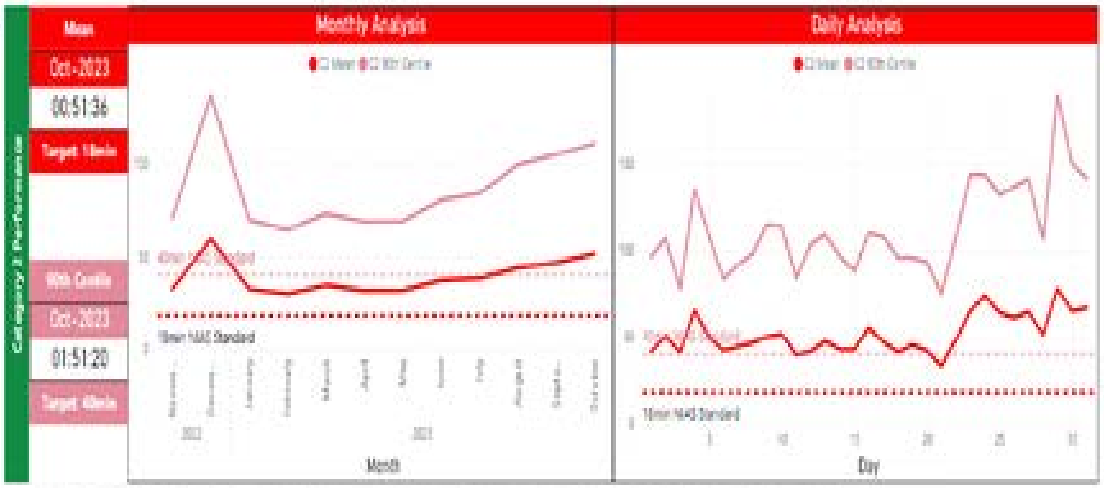
Our Patients | 999 Response Time Performance | Response Times

CATEGORY 1 and CATEGORY 2 Response Times are measured based on the mean and the 90th centile of the response time provided.
The target for a CATEGORY 1 call response time is 8 minutes (15 minutes for the 90th centile).
The target for a CATEGORY 2 call response time is 18 minutes (40 minutes for the 90th centile).

CATEGORY 1 Performance



CATEGORY 2 Performance



Category 1

- October 23 Category 1 mean response time was 11 minutes 52 seconds; while the Category 1 90th centile was 22 minutes 49 seconds.
- October 23 saw the Category 1 mean response marginally deteriorate from September 23. The 90th Centile response time also marginally deteriorated from September 23

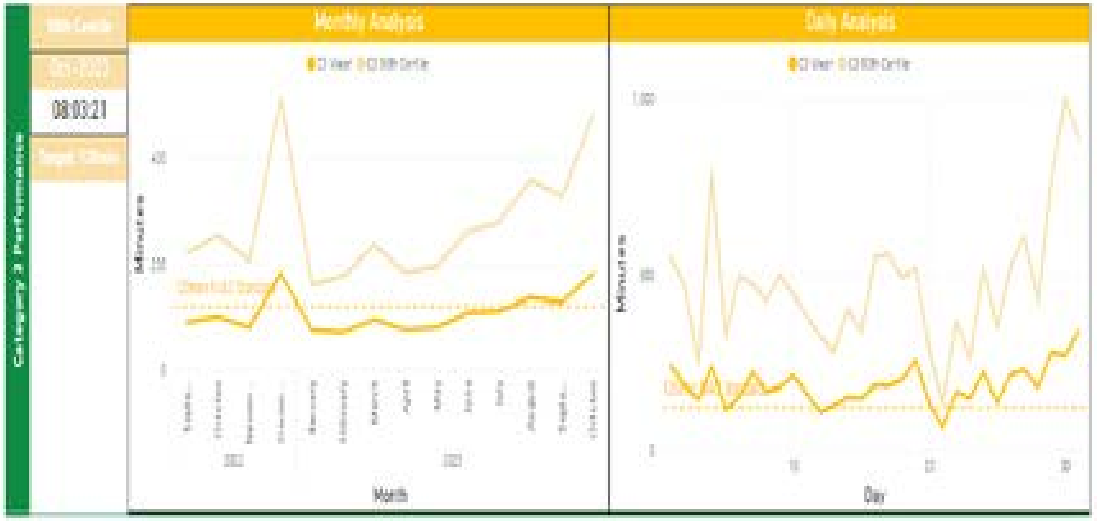
Category 2

- October 23 Category 2 mean response time was 51 minutes 36 seconds; While the Category 2 90th Centile was 1hour 51 minutes and 20 seconds.
- The Mean Category 2 mean response time again declined through October 23 when compared with September 23. The mean response time increased by 5 minutes, whilst the 90th Centile increase by 6 minutes.

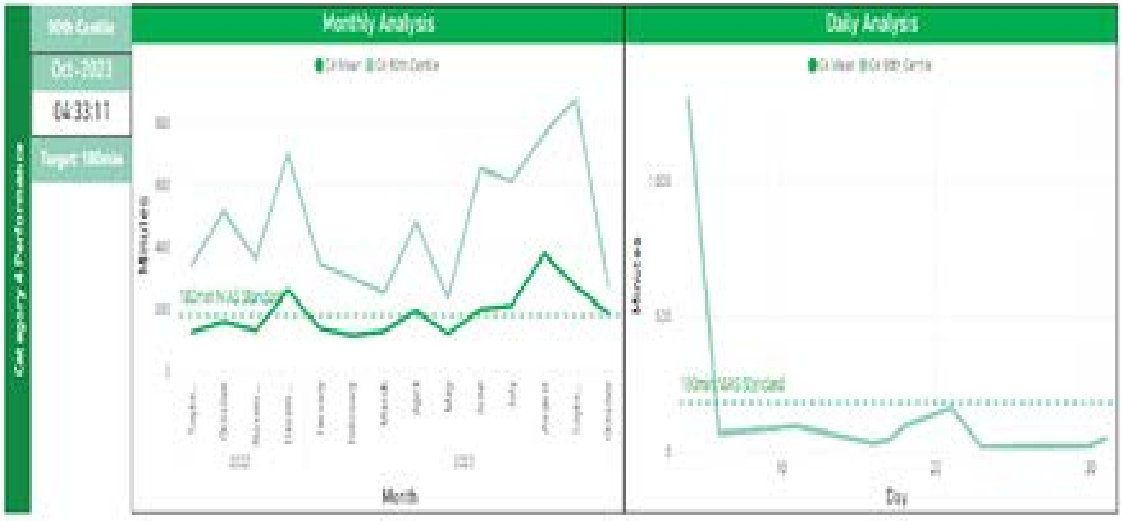
Our Patients | 999 Response Time Performance | Response Times

CATEGORY 3 and CATEGORY 4 Response Times are measured based on the 90th centile of the response time provided.

CATEGORY 3 Performance



CATEGORY 4 Performance



Category 3

- October 23 Category 3 mean response time was 3 hours 2 minutes 41 seconds; while the Category 3 90th centile was 8 hours 3 minutes 21 seconds.
- October 23 saw a significant decline in category 3 mean response time when compared to September 23. However, the 90th Centile response time, saw the greatest impact with a deterioration for the month of over 3hours.

Category 4

- August 23 Category 4 mean response time was 3 hour 6 minutes 56 seconds; While the Category 4 90th Centile was 4 hours 33 minutes and 11 seconds.
- It must be noted that the volume of Category 4 calls received by NIAS is very low and response times can be impacted significantly on a daily basis.

Northern Ireland Ambulance Service
Health and Social Care Trust

Our Patients | Emergency Demand Performance | Clinical Response

The level of demand each month has a direct relationship on our performance metrics. Ensuring we make the most appropriate response is critical to managing demand effectively and therefore making the most of our resources and capacity to respond to our most critical patients.

The analysis below describes: NIAS Clinical Hear & Treat and Clinical See & Treat

Clinical Hear & Treat

Clinical See & Treat

The targets for both Hear & Treat and See and Treat will be re-baselined for 2023-24. This is to support the organisations focus on Clinical Decision making in these areas. The targets will be adjusted in line with the Service Delivery Plans (SDP) submitted to SPPG in April 2023.

To support this, we have developed a revised dashboard which will support an quality and improvement approach to Hear and Treat outcomes.

An updated recruitment campaign has been launched to support the implementation of the Integrated Clinical Hub (ICH). There has been a very positive reaction to this campaign and the recruitment process is currently progressing. It is hope that all funded positions within the ICH will be appointed to early in December 2023.

Improvement trajectory is to increase Hear and Treat by a further 1.5% by 31st March 2024.

As with Hear and Treat, a revised See and Treat dashboard has been finalised, 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 a further 1.5% by 31st March 2024.

Our Patients | Emergency Performance | Hospital Handover Performance

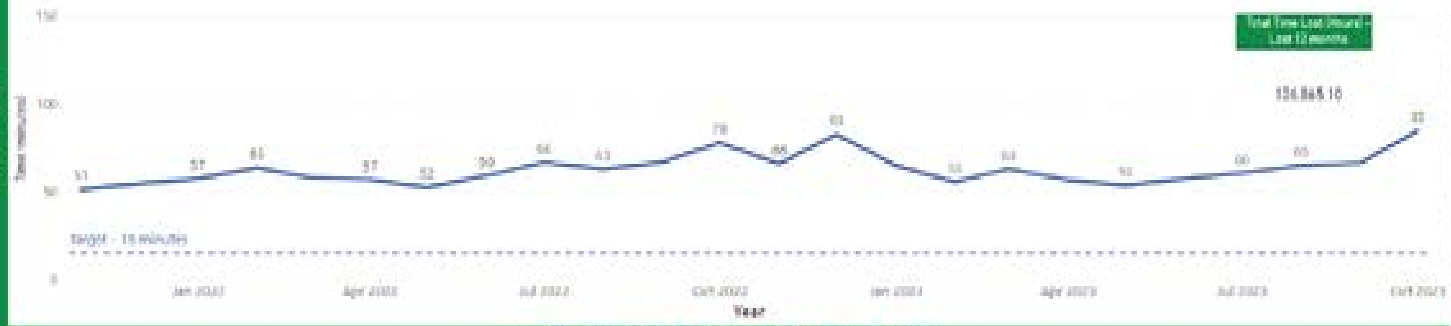
Our operational efficiency is critical to our success and whilst one of our key dependencies is the ability to successfully handover if a patient is conveyed to hospital we must ensure we strive to be as efficient as possible whilst always delivering the very best care for our patients.

Arrival at Hospital to Patient Handover last month

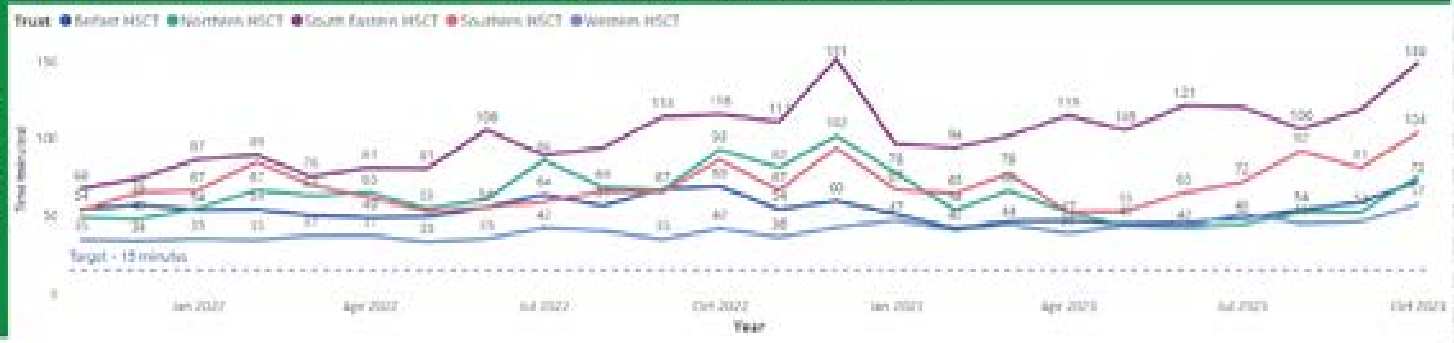
Hospital Attended	Total Attendances	Total Handovers	Total Handovers Over 15mins	% Over 15mins	Total Handovers over 60mins	% Over 60mins	Total Time Lost (Hours)	Average Handover Time (Minutes)
ULSTER	1342	1342	1240	96.15%	784	58.42%	2,991.74	148.65
CRAIGAVON AREA	1178	1178	1106	93.89%	579	49.15%	2,078.24	120.60
ROYAL GROUP	2231	2231	2040	93.59%	950	42.16%	2,355.16	79.86
CAUSEWAY	694	694	581	91.84%	249	39.27%	650.02	76.10
ANTRIM AREA	1700	1700	1582	93.05%	617	34.32%	1,600.53	75.07
ALTNAGELVIN	1208	1208	1130	94.21%	469	36.74%	1,102.42	69.50
DAISYHILL	532	532	502	94.36%	183	34.77%	457.28	60.37
MATER	570	570	527	92.46%	155	28.84%	387.39	53.46
LAGAN VALLEY	93	93	65	75.12%	5	5.60%	35.63	36.38
SOUTH WEST	614	614	526	85.99%	60	9.77%	199.07	33.64
RBSC	122	122	93	69.67%	5	3.92%	20.72	23.70
BELFAST CITY	54	54	39	72.22%	1	1.85%	9.92	23.69
DOWNE	39	39	25	64.10%	0	0.00%	3.97	19.17
Total	10385	10385	9631	92.74%	4060	39.09%	12,104.01	84.57

Hand Over Delays

Monthly Handover Times



Monthly Handover Times for Type 1 EDs, by Trust



In October 2023, NIAS experienced a total of 12,104 lost hours. This is the equivalent of 32 shifts per day, with crews waiting with patients outside EDs, 29% of our planned capacity. These lost hours were experienced from 9,631 instances where our crews waited longer than 15mins to handover their patient at ED. 4,060 handovers took longer than 60mins in October 2023

In October 23, >75% of the 12,104 lost hours occurred at the four ED sites listed below in order of volume of hours lost:
Ulster Hospital
Craigavon Hospital
Royal Victoria
Antrim Area

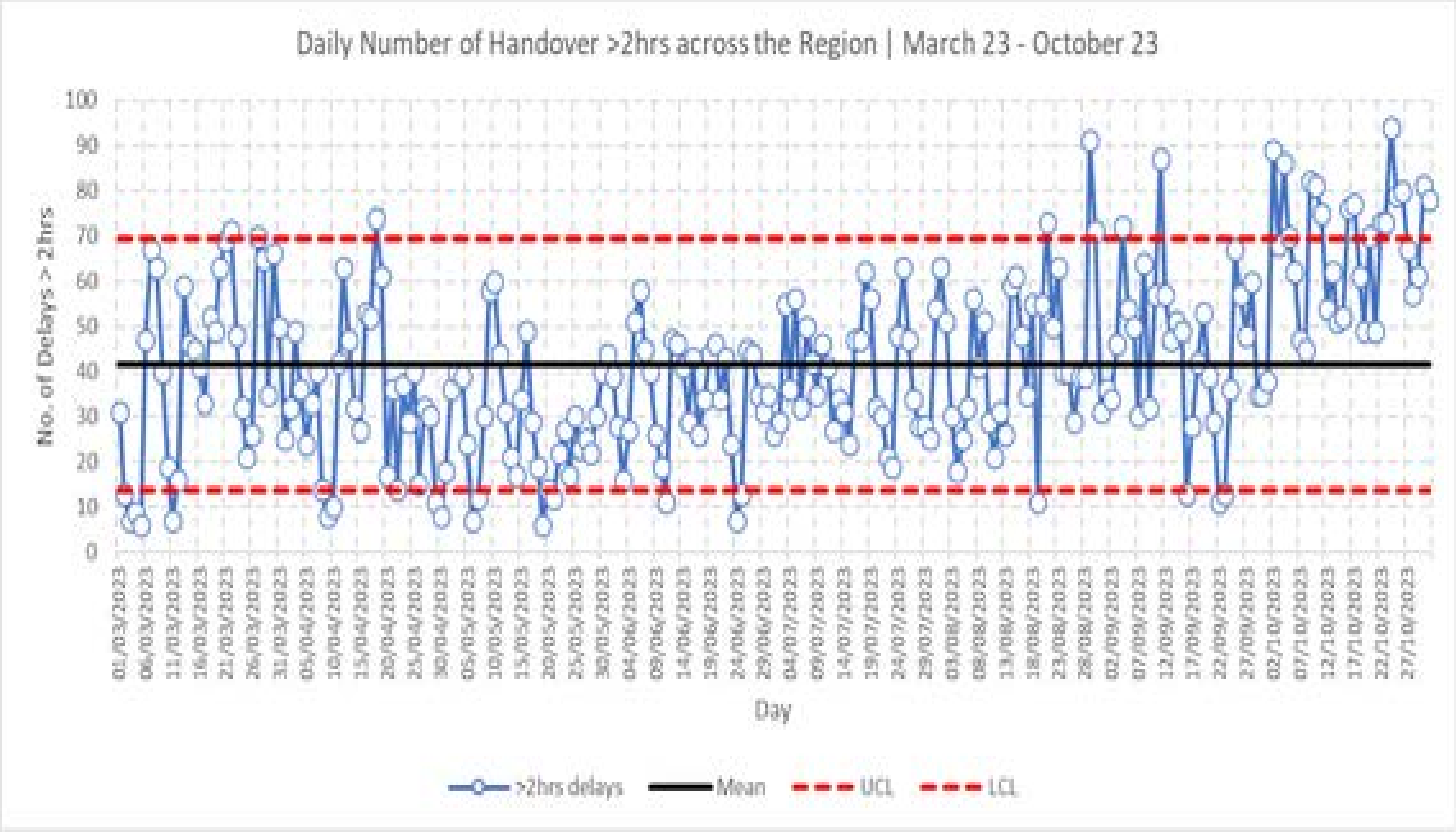
In the last 12 months (November 22–October 23), >92% of the handovers exceeded the 15min target at our acute EDs, resulting in circa 106k hours lost. The lost hours experienced in October 23 is an increase of 3,356hrs or 38% from September 23, whilst the number of instance of delayed handovers increased by 2% in the same period.

The 12,104 operational hours being lost (eq. to 1,008 12-hours shifts per month or 32 12h shifts per day). The number of handover delays in excess of 60mins has increased in October 23 to 4,060 occurrences during the 31 days of October resulting in 130, 60-minute delays per day during the month.

Northern Ireland Ambulance Service
Health and Social Care Trust

Our Patients | Emergency Performance | 2hr Back Stop Performance Regionally

Our operational efficiency is critical to our success and whilst one of our key dependencies is the ability to successfully handover if a patient is conveyed to hospital we must ensure we strive to be as efficient as possible whilst always delivering the very best care for our patients.



On the 1st March 2023, all trusts committed to delivering a maximum handover delay of 2hrs.
The next slide outlines the weekly performance by receiving hospital for the 2hr Maximum handover delay.

The chart to the left is a statistical Process Control (SPC) chart, outlining the variation in the handover process. October 23 saw a significant number occasions of special cause variation leading to the number of handover delays >2hrs exceeding the upper control limit. During October some days the process was significantly above the upper control limit

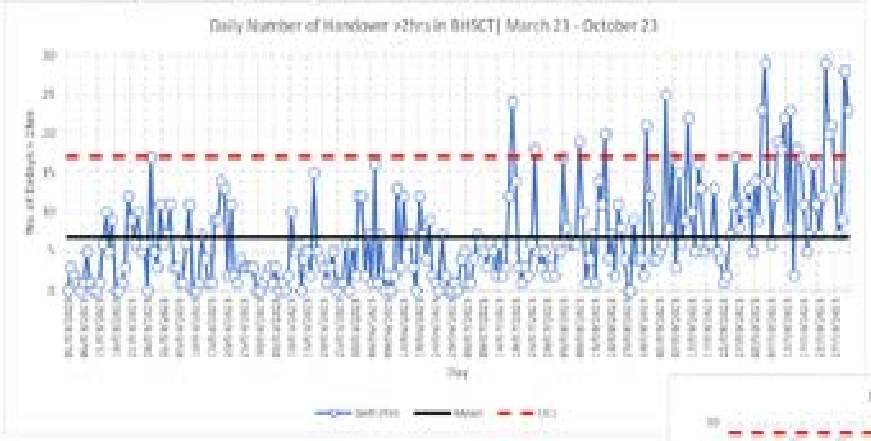
Since July 23 there are a significant number of days the handovers >2hrs has exceeded the centre line. The 2hr target has not shown any signs of improvement through October 2023. A substantial number of days have either been above the upper control limit (special cause variation) or very close to it. This indicates that the processes to reduce the 2hr handover delays are showing no signs of control over the past number of months.

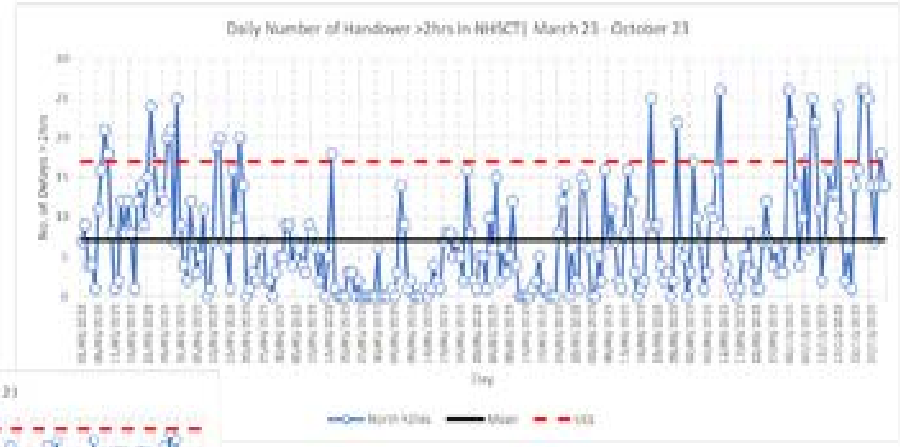
The desirable trend would be one that shows a sustained run of data points below the centre line, trending towards zero driving an outcome of sustaining zero handovers >2hrs.

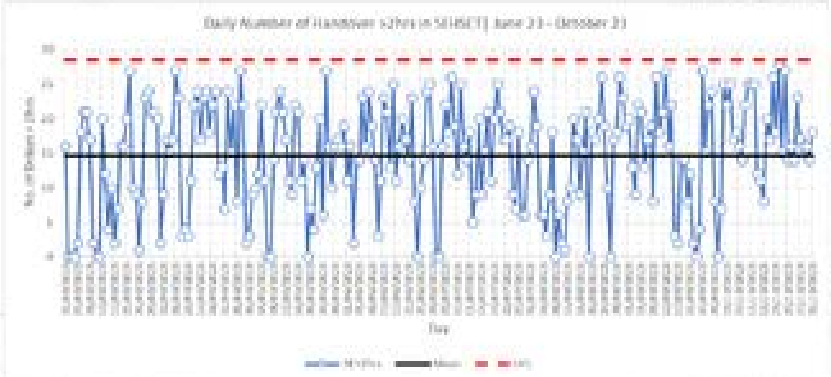
Northern Ireland Ambulance Service
Health and Social Care Trust

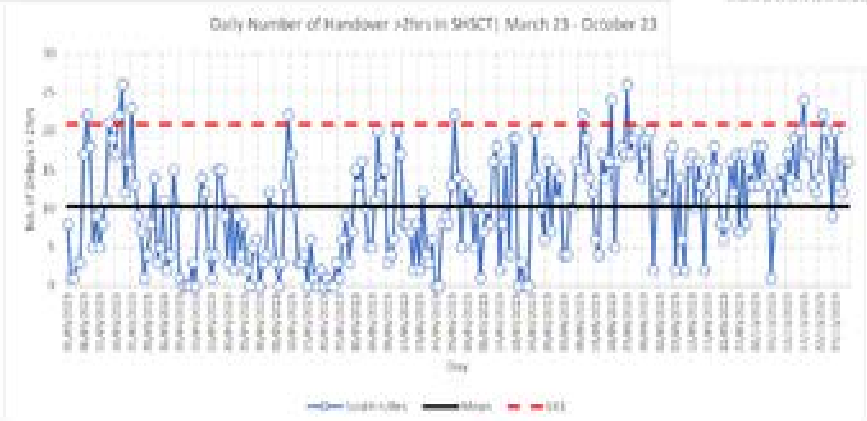
Our Patients | Emergency Performance | 2hr Back Stop Performance at Trusts

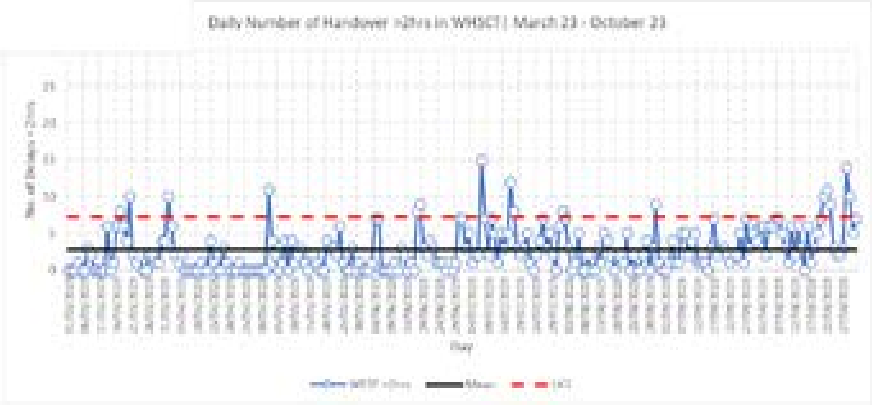
Our operational efficiency is critical to our success and whilst one of our key dependencies is the ability to successfully handover if a patient is conveyed to hospital we must ensure we strive to be as efficient as possible whilst always delivering the very best care for our patients.











Northern Ireland Ambulance Service
Health and Social Care Trust

Our Patients | Non-Emergency Performance | Productivity Performance

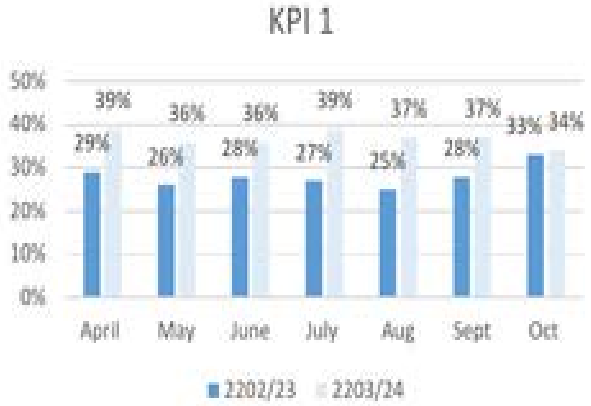
Patient-focused KPIs

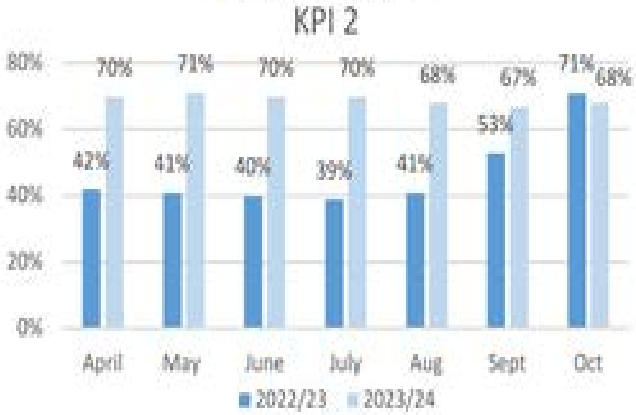
KPI 1 - That 95% of inward journeys will arrive within the 60mins prior to an appointment time.

KPI 2 - That 95% of outward journeys will start within 60 minutes of the patient being booked as ready by the clinic/hospital

In both of these measures it is noticeable that for the 1st time month to month comparison shows near parity between 2022/23 & 2023/24 there is likely 2 factors at play here.

- October 2022 was the month of the Perfect Day Trial where NIAS and the trailing Trusts took additional measures to improve compliance.
- The significant upturn in NIAS activity in Oct 23 has had a knock-on detrimental impact on the more Qualitative KPI performance.





Productivity & Efficiency KPIs (NIAS crews only)

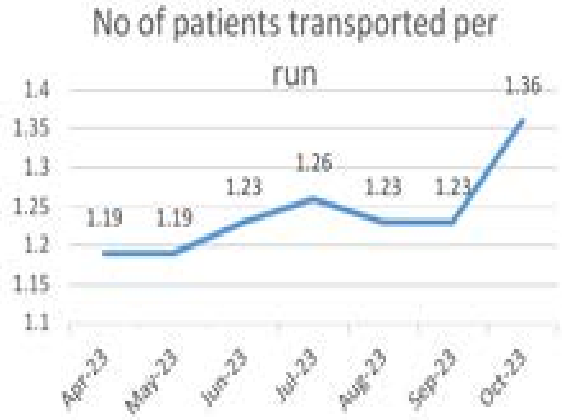
KPI - Average Number of Patients Transported per Shift

The steady, improvement in this indicator of activity throughout 2022/23 showed a significant upturn in Oct both in relation to this year and when compared to Oct 22. This can largely be attributed to the commencement of Destination Focused Planning.

KPI - Average Number of Patients Transported per Journey (Run)

As above there has been a significant improvement in this measurement of activity in the past month, for the same reason.

To underline these figures NIAS crews carried out over 1000 more patient journeys in Oct '23 compared to Oct '22



Points to Note

- Compliance against KPIs 1 & 2 relates to Ambulance Journeys (both NIAS and Independent) where timestamps have been completed.
- We don't currently have a comprehensive set of productivity indicators and while these are being worked on in the PCS Improvement Project, we will continue to report on Patients transported and Patients per journey.
- It remains the aim to be able in the near future to report on more specific utilisation and productivity indicators such as productive time v unproductive time.

Northern Ireland Ambulance Service
Health and Social Care Trust

Our Patients | Emergency Performance | Actions to improve Performance

- Through the delivering value programme, service improvements are being identified and implemented through the operational efficiencies project. Further information can be found within the Delivering value programme update.
- Additional mitigation has been employed at the end and start of shifts to reduce the impact of late finishes on staff. The Trust is using overtime to source up to 20 6hour shifts per day to act as relieving crews at ED. This essentially means that these crews coming on shift are tasked to make their way to Emergency Departments to allow those crews finishing to get away as close to their finish time as possible.
- Funding as now been agreed to proceed with scaling up the Integrated Clinical Hub pilot through the Winter. Posts are out for recruitment and the response to the internal recruitment campaign has been very positive. An implementation plan is being built that will be used to roll out the new ways of working across the team to maximise the impact of the clinical hub through Winter 23/24.
- The trust is currently in the process of employing additional HALO at Emergency departments to support crews during handover of patients at EDs.
- The Trust has launched a recruitment campaign for Newly Qualified Paramedics, Qualified Paramedics and qualified Emergency Medical Technicians. This will generate a waiting list of qualified staff that will allow the trust to be more responsive as and when funding is made available for additional resources.
- Work is being prioritised to develop principles and approaches to introducing enhanced rotas to support staff health and wellbeing, along with delivering operational cover during times patients require the Trusts services.
- Introduction of new logistics post within EAC to reduce some of the administrative burden for EAC DCM staff to protect capacity for focus on performance and staff welfare.
- Improved utilisation of alternative care pathway and destinations to support 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 alternatives to ED conveyance (including direct access to Urgent Care Centres/Phone First etc). Discussions with acute trusts regarding the potential to improve the functionality of their handover areas , as well as potential for their provision of "cohort" areas continue and we anticipate direction from SPPG to all trusts regarding cohorting in November 2023
- A continued focus on Patient Care Pathways to maximise opportunities, signpost patients appropriately, and contribute to reducing conveyance rates. Work is ongoing with the Northern Trust to align the Hospital @ Home models for all Trusts.

Northern Ireland Ambulance Service
Health and Social Care Trust

Our Patients | Emergency Performance | Actions to improve Performance

- NIAS has been heavily involved as a key stakeholder in the development of the Regional Control Centre, including the "Mini RCC" to be established for the encompass "Go Live" in November 23, and in advance of the regional "Go Live" RCC planned for 4 December 2023
- Challenges with Duplicate Call activity in EAC have been highlighted earlier in the performance report. EAC have reviewed the process and how we can address this and have plans to mitigate
- A new CAD SMS module (Advanced Contact Caller Module) has been developed and is envisaged to go live late November. The system will enable EAC to send an SMS to mobile phone numbers providing more information regarding the 999 call and not to contact 999 again unless the there is a change in the patient's condition. This will be automated via C3 CAD and supporting information/awareness will be made available for staff.
- Social media to support the introduction will be communicated via platforms to inform the public as well as again providing information stressing the need to only contact 999 again if there is a change in the patient's condition.
- Trust Board were previously updated on the engagement of GIRFT colleagues by SPPG to undertake a regional review of Urgent and Emergency Care that would include NIAS, and that an update would follow. The final GIRFT report has now been received (November 2023) and will be agenda item at December Trust Board

Northern Ireland Ambulance Service
Health and Social Care Trust

Our Patients | SAIs & Complaints

Serious Adverse Incidents

During October 2023, the Trust reviewed 21 potential SAI's resulting in 6 notifications to SPPG. All incidents were notified as Level 1 reviews. Currently there are 24 open SAIs all of which are Level 1 reviews.

Themes

The 3 key National Ambulance Risk and Safety Forum themes remain unchanged and are as follows:

- Delays in call answering and dispatch
- Clinical Assessment and or treatment on scene
- Non-conveyance

The top NIAS themes are as follows:

- Misinterpretation of ECG
- Delayed response associated with a patient outcome of death
- Deteriorating Patient – community
- Non-convey associated with patient outcome of death

Recommendations & Learning

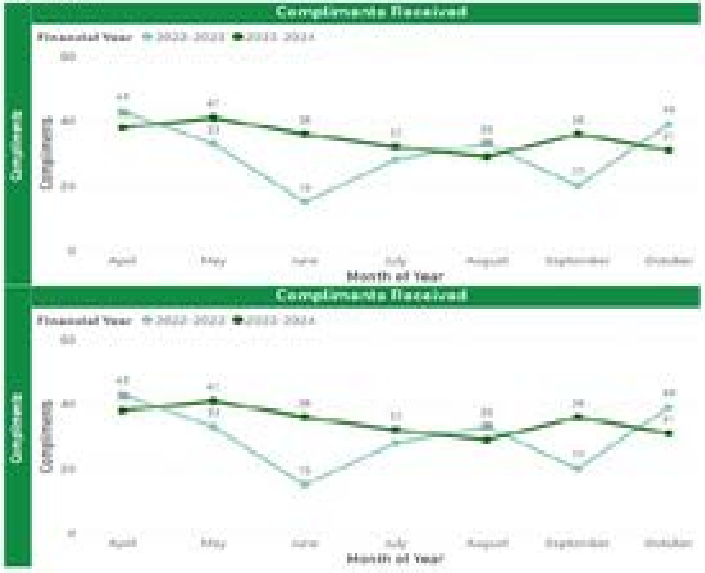
Work is continuing on completion of historical and recent SAI recommendations with 281 evidenced and closed, and 139 in progress. This represents a completion rate of 66%.

1 SAI was closed in October with the following learning identified:

- ECG recognition particularly ECG's which meet referral criteria for PPCI
- Consideration for amendment of STEMI pathway to include reference to the potential of silent MI in diabetic patients.

Complaints, Compliments & Care Opinion

During October 2023, **23 complaints** & **31 compliments** were received.



Timeliness of Process

13 complaints were closed during October 2023.

At the end of October 2023, 32 complaints remained opened with the average number of days opened being 20 working days.

Learning: Of the 13 complaints closed, 92% were upheld/ partially upheld with the following learning outcomes identified: Patient assessment; documenting decisions; Communication; Call handling (NEAC & EAC)

Service Improvement Plans

- feedback leaflet for frontline staff to issue to service users (under development)
- development of learning outcomes action dashboard (completed)
- refresh of public facing feedback sections of external website (completed)
- feedback survey for complainants & staff to complete following resolution of the complaint.

Care Opinion

During October 2023, 14 **stories** were submitted via Care Opinion. By 1st of November these stories were viewed 756 times. The main areas of feedback were:
What's good – Ambulance Crew, Compassion, Level of Care
Improvements – Waiting time, Availability, Ambulance Response time
Feelings – Thankful, Grateful, Reassured

Our People | Absence | Sickness

A Project Board has been established to ensure direct oversight and monitoring of the Maximising Attendance Project. The project is co-led by Michelle Lemon, Director of HR & Organisational Development and Mark Cochrane, Assistant Director of Operations.

A new methodology has been established to deliver a prioritised case management approach (each case triaged to Level 1, 2, 3) to the management of sickness absence.

The Line Manager role has been established for sickness absence reporting, recording and management. Training workshops are being rolled out across all Directorates.

The Department of Health (DoH) have issued a target for sickness absence reduction in 2023/24[1]. The Maximising Attendance Project methodology includes distilling this target out to managers across the Trust to inform management and reporting.

A separate workstream has been established to develop and roll-out a sickness absence information dashboard. The roll out of this dashboard and performance management of the target is designed to ensure an information-led approach to identify hotspots and ensure appropriately prioritised and targeted interventions. This scope of this workstream includes consideration of working environment factors that have the potential to impact on sickness absence levels, eg analysis of data associated with: late finishes; rest periods and annual leave allocation; and assaults on staff.

The DoH requires an action plan for the delivery of the target to be developed and submitted to DoH by 31/08/23. This was submitted to DoH in draft pending PFOD approval. It was presented to PFOD and approved in principle subject to some requested amendments.

Health and Wellbeing actions are targeted to key reasons for sickness absence, eg. the creation of mental health pathways. A request for manual handling training has been raised formally with the Clinical Training Team in order to pro-actively target MSK-related absence and for Care and Responsibility Training to support staff in the context of dealing with assaults. A direct referral route to Physiotherapy is in place.

2023/24 Cumulative Sickness Absence by Month including Comparison with Previous Reporting Year

	Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
1.	Absence Target (2023/24)						11.24%[1]						
2.	Current Status against Target						14.65% ↑						
3.	Cumulative % hours lost (22/23)	10.62%	10.64%	10.88%	10.94%	10.89%	10.93%	11.12%	11.19%	11.58%	11.91%	12.07%	12.30%
4.	Cumulative % hours lost (23/24) (Total)	14.25%	14.19%	14.25%	14.27%	14.64%	14.60%	14.65%					
4.1	Cumulative % hours lost (23/24) (Non-Covid)	13.15%	13.27%	13.40%	13.46%	13.71%	13.33%	13.44%					
4.2	Cumulative % hours lost (23/24) (Covid)	1.1%	0.95%	0.85%	0.81%	0.93%	1.02%	1.04%					
4.3	Cumulative % hours lost (23/24) Short-Term	2.57%	2.20%	2.33%	2.35%	2.55%	2.61%	2.63%					
4.4	Cumulative % hours lost (23/24) Long-Term	11.68%	12.00%	11.92%	11.92%	12.09%	11.99%	12.02%					
5.	Average standard working days lost per employee per month	2.78	2.98	3.01	2.93	3.60	2.94	3.19					
6.	Average estimated cost per month (£'000)	860	859	859	822	£911	£820	£840					

[1]To reduce absence rates to 92.5% of absence levels reported in 2022/23 (based on annual re-run) by end March the 2023/24 financial year.

↑ Above target and increase from last month
↓ Above target and decrease from last month
↑ Below target and increase from last month
↓ Below target and decrease from last month

Our Patients | SPPG Service Delivery Plan | Trajectories and Performance

The information below sets out the Trajectories agreed with SPPG for 2023-24 and our performance against these trajectories

Call Answer Performance:

	April 23	May 23	June 23	July 23	August 23	September 23	October 23	November 23	December 23	January 24	February 24	March 24
Call Answer Outturn	86.9%	85.3%	82.4%	80.7%	80.2%	82.2%	85.1%					
Trajectory	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%

Hear and Treat and See & Treat

	April 23	May 23	June 23	July 23	August 23	September 23	October 23	November 23	December 23	January 24	February 24	March 24
Hear & Treat Outturn	3.5%	3.2%	4.5%	4.0%	3.4%	4.0%	3.9%					
Hear & Treat Trajectory	4.2%	4.2%	4.2%	4.4%	4.4%	4.6%	4.6%	4.6%	4.8%	4.8%	5.0%	5.2%
See & Treat Outturn	14.0%	14.4%	14.8%	14.8%	14.5%	14.4%	14.7%					
See & Treat Trajectory	14.2%	14.2%	14.2%	14.4%	14.4%	14.6%	14.6%	14.8%	14.8%	15%	15%	15.2%

Our Patients | SPPG Service Delivery Plan | Trajectories and Performance

The information below sets out the Trajectories agreed with SPPG for 2023-24 and our performance against these trajectories

Response Times

	April 23	May 23	June 23	July 23	August 23	September 23	October 23	November 23	December 23	January 24	February 24	March 24
Category 1 Mean	9mins	10mins	10mins	11mins	11mins	11mins	12mins					
Cat 1 Mean Trajectory	10mins	10mins	10mins	10mins	10mins	10mins	10mins	10mins	10mins	10mins	10mins	10mins
Category 1 90th Centile	19mins	20mins	20mins	21mins	23mins	22mins	23mins					
Cat 1 90th Centile Trajectory	21mins	21mins	21mins	21mins	21mins	21mins	21mins	21mins	21mins	21mins	21mins	21mins
Category 1T Mean	13mins	14mins	14mins	14mins	15mins	15mins	16mins					
Cat 1T Mean Trajectory	19mins	19mins	19mins	19mins	19mins	19mins	19mins	19mins	19mins	19mins	19mins	19mins
Category 1T 90th Centile	26mins	27mins	29mins	27mins	32mins	28mins	31mins					
Cat 1T 90th Centile Trajectory	30mins	30mins	30mins	30mins	30mins	30mins	30mins	30mins	30mins	30mins	30mins	30mins

Northern Ireland Ambulance Service
Health and Social Care Trust

Our Patients | SPPG Service Delivery Plan | Trajectories and Performance

The information below sets out the Trajectories agreed with SPPG for 2023-24 and our performance against these trajectories

Response Times

	April 23	May 23	June 23	July 23	August 23	September 23	October 23	November 23	December 23	January 24	February 24	March 24
Category 2 Mean	31mins	31mins	37mins	38mins	44mins	47mins	52mins					
Cat 2 Mean Trajectory	36mins	36mins	36mins	36mins	36mins	36mins	36mins	36mins	36mins	36mins	36mins	36mins
Category 2 90th Centile	68mins	69mins	81mins	84mins	100mins	105mins	111mins					
Cat 2 90th Centile Trajectory	80mins	80mins	80mins	80mins	80mins	80mins	80mins	80mins	80mins	80mins	80mins	80mins
Category 3 90th Centile	183mins	196mins	262mins	280mins	360mins	328mins	483mins					
Cat 3 90th Centile Trajectory	233mins	233mins	233mins	233mins	233mins	233mins	233mins	233mins	233mins	233mins	233mins	233mins

Northern Ireland Ambulance Service
Health and Social Care Trust

Our Patients | SPPG Service Delivery Plan | Trajectories and Performance

The information below sets out the Trajectories agreed with SPPG for 2023-24 and our performance against these trajectories

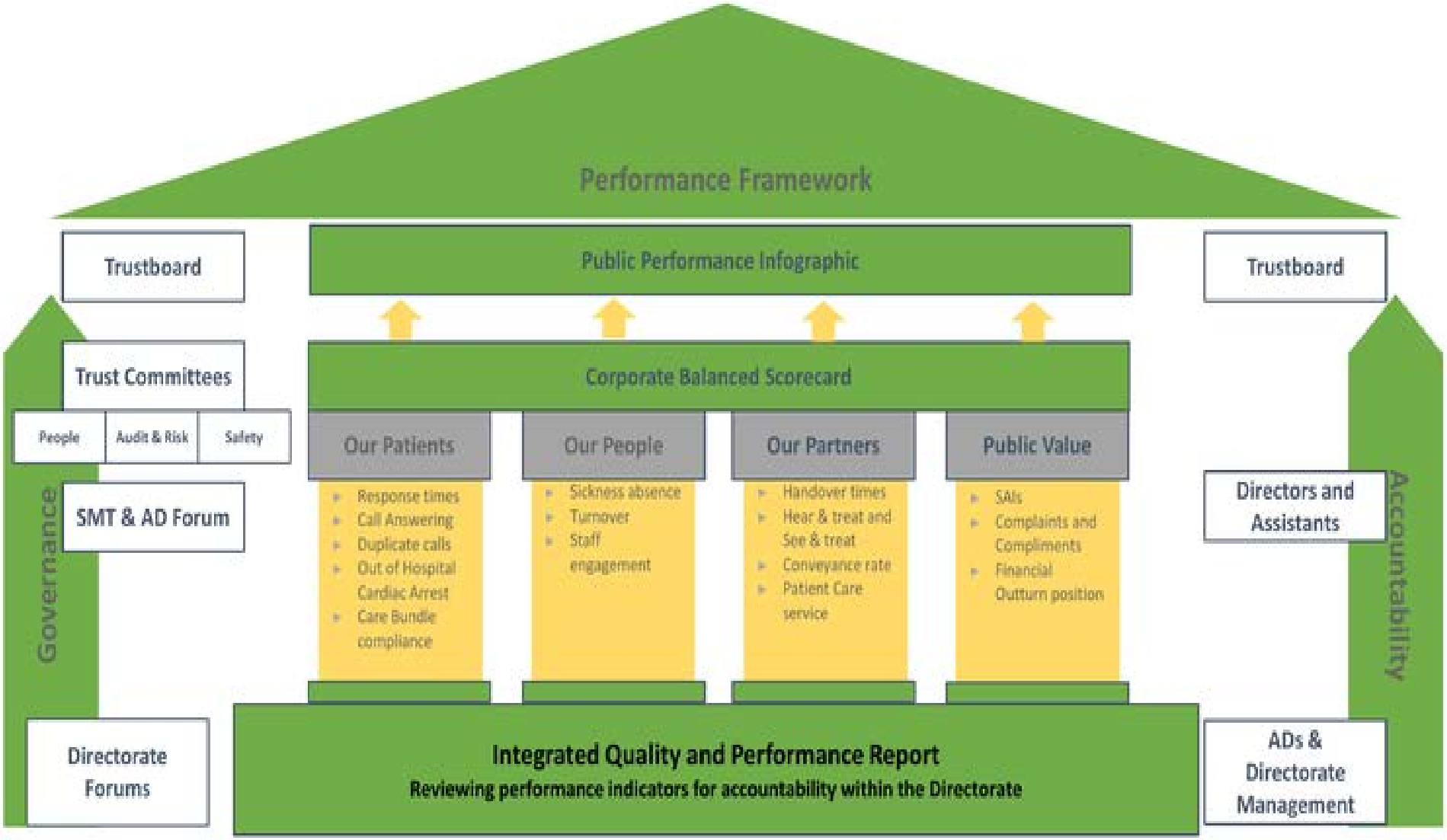
Handover Performance

	April 23	May 23	June 23	July 23	August 23	September 23	October 23	November 23	December 23	January 24	February 24	March 24
<=15mins	8.8%	8.8%	8.7%	9.0%	8.3%	7.8%	7.3%					
<=15mins Trajectory	2%	4%	8%	8%	12%	15%	17%	19%	22%	25%	25%	25%
<=30mins	38.4%	36.5%	38.2%	36.1%	33.5%	33.2%	28.6%					
<=30min Trajectory	14%	14%	20%	25%	30%	35%	35%	40%	40%	45%	55%	60%
<=60mins	74.8%	76.1%	75.6%	73.1%	69.6%	69.7%	60.9%					
<=60mins Trajectory	59%	65%	65%	70%	70%	70%	75%	75%	80%	85%	90&	95%
>2hrs	9.2%	7.67%	9.6%	10.9%	12.7%	13.1%	20.1%					
>2hrs Trajectory	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
No of Patients >2hrs	997	881	1,040	1,206	1,371	1,334	2,090					
No of Patients >2hrs Trajectory	0	0	0	0	0	0	0	0	0	0	0	0

Northern Ireland Ambulance Service
Health and Social Care Trust

Appendix A

Performance Reporting Schematic



Northern Ireland Ambulance Service
Health and Social Care Trust

Appendix B

Public Facing Performance Infographic

Our Patients

20,336 calls answered within Emergency Ambulance Control

On average 656 calls per day

Category 1 average response time was 11mins (8min target)

Category 2 average response time was 51 mins (18min target)

85% calls answered in 5 secs (90% target)

Public Value

The Trust is on track to breakeven at the end of the financial year

The Trust received 23 complaints last month that will be learnt from

31 compliments were received from patients that experienced our care last month

A total of 6 Serious Adverse Incidents were notified

OCTOBER 2023

Our Partners

12,035 hours lost to delays handing patients over at Emergency Departments

Over 106,000 hours lost in the last 12 months
It take 85mins on average to hand a patient over at Emergency departments

Hear & Treat rate is 3.9%: 26 patients a day redirected to more appropriate service by our clinicians in our control room

See & Treat rate is 14.6%: 95 patients a day referred to other services or treated by our clinicians in patient homes

Our People

14.65% of hours have been lost to sickness, so far this year (13.7% target)

12.02% of these hours are due to long term sickness and 2.63% due to short term sickness

11 members of staff left the organisation.

The turnover rate for staff was 5.8%.

Trust Board Finance Report

November 2023 (Month 8)

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 will be reporting a breakeven position at 30 November 2023 (Month 8) and forecasting a breakeven position for the year ending 31 March 2024.	
Manage within allocated Capital Resource Limit (CRL)	
The Trust has received a Capital Resource Limit (CRL) allocation of £6.381m. This includes allocations for Fleet & Estate (£5.7m), ICT (£0.555m), Leases (£0.1m) and Backlog Maintenance (£0.026m).	
Prompt payment target-95% of suppliers within 30 days	
Cumulative performance is 97.0% for the eight months ending 30 November 2023 (Month 8).	

Manage within allocated Revenue Resource Limit (RRL) / Achieve financial break-even

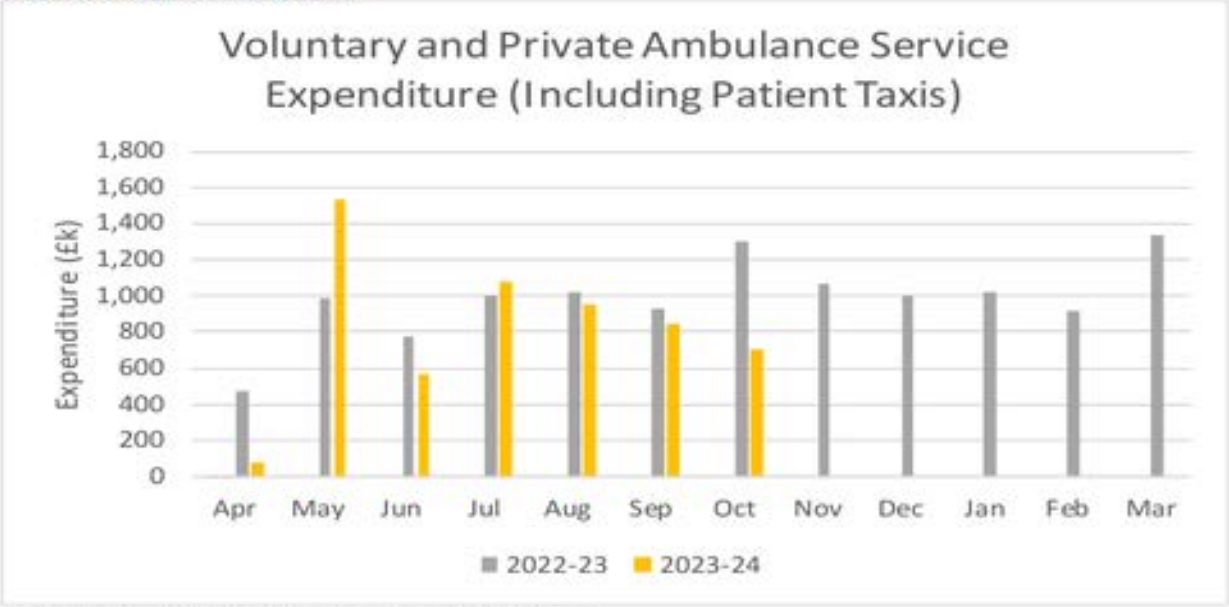
The Trust will be reporting a breakeven position at 30 November 2023 (Month 8) and forecasting a breakeven position for the year ending 31 March 2024. This is a change to the previously reported position and the summary financial plan submitted to DoH/SPPG on 30 June 2023. This is due to a review of the initial allocations and assumptions identified in the financial plan and also further allocations notified by DoH/SPPG.

There are a number of assumptions and key factors underlying this position, specifically:

- Allocations - These will be in line with those notified to the Trust as part of the financial planning process.
- Savings Plans – The Trust has been set a target of £1.975m. Initial estimates are that these will be challenging to deliver and will require specific action and monitoring during the year. Importantly, all the proposals identified are non-recurrent in nature and a number are not repeatable.
- Resource Optimisation – Expenditure during the year on overtime and third party providers will be managed within available resources. This has to be balanced against demand, performance and quality considerations as expenditure in these areas is lower than previous years but the service remains under significant pressure.
- Accounting Treatment – Assuming no unsupported major in year changes to accounting treatment.
- Regional financial planning for 2023-24 with Trusts and DoH/SPPG continues against a backdrop of a seriously constrained financial position across the public sector. Planning for 2024-25 has also commenced.

Voluntary & Private Ambulance Services (VAS/PAS)

- The Trust has benefited from significant additional funds 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, 2021-22 was £9.7m and 2022-23 was £9.2m. This level of expenditure was 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.
- The sustained impact of Covid-19 has resulted in the continued reliance on VAS/PAS to maintain services. The Trust has largely been operating at the highest levels of escalation and VAS/PAS spend remains significant. In 2022-23, further costs of the order of £2.6m were also incurred for the provision of patient taxis. Monthly expenditure in 2022-23 and the year to date are shown below.

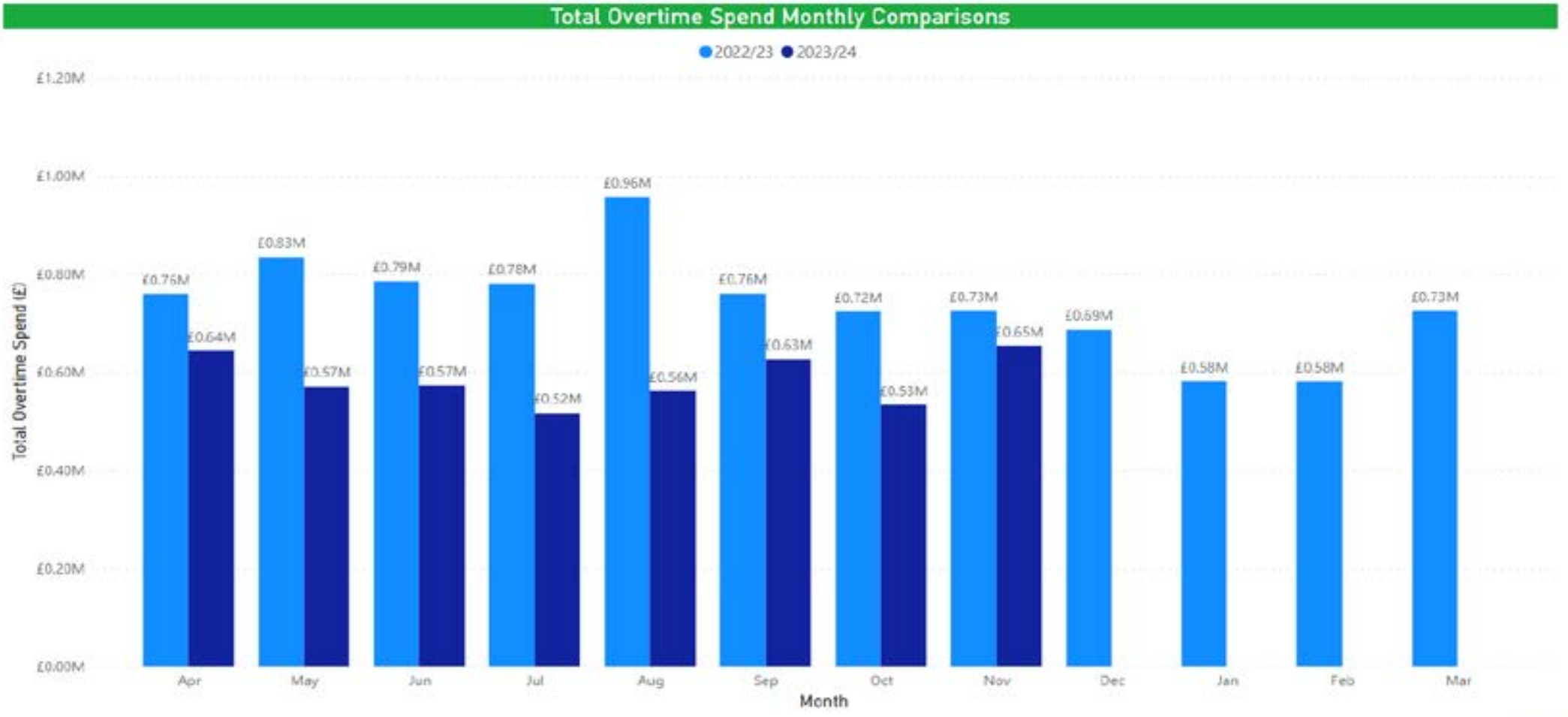


Overtime Expenditure

- The Trust relies 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 at 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. This, combined with other changes between years, can mean that expenditure between years, and particularly between months between different years, may not be directly comparable.
- However, even with this variability, overall overtime has been remarkably consistent in prior years averaging circa £6m per annum. Costs in 2022-23 increased to £7.9m which was affordable with additional Covid allocations. Expenditure showed a slight downward trend for the last three months of 2022-23 (figures for March 2023 include pay award arrears estimated to be in the order of £300k). This downward trend has broadly continued for the first eight months of the 2023-24 financial year, with the exception of a slight upturn in September and November 2023. This control of expenditure will need to be maintained and sustained for the rest of the financial year to manage within currently available resources.
- The Trust has largely completed a programme of work to recruit substantively to positions that have historically been filled with overtime. There was 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 on overtime should reduce. Levels of sickness absence are also a major driver of overtime spend.

Overtime Expenditure

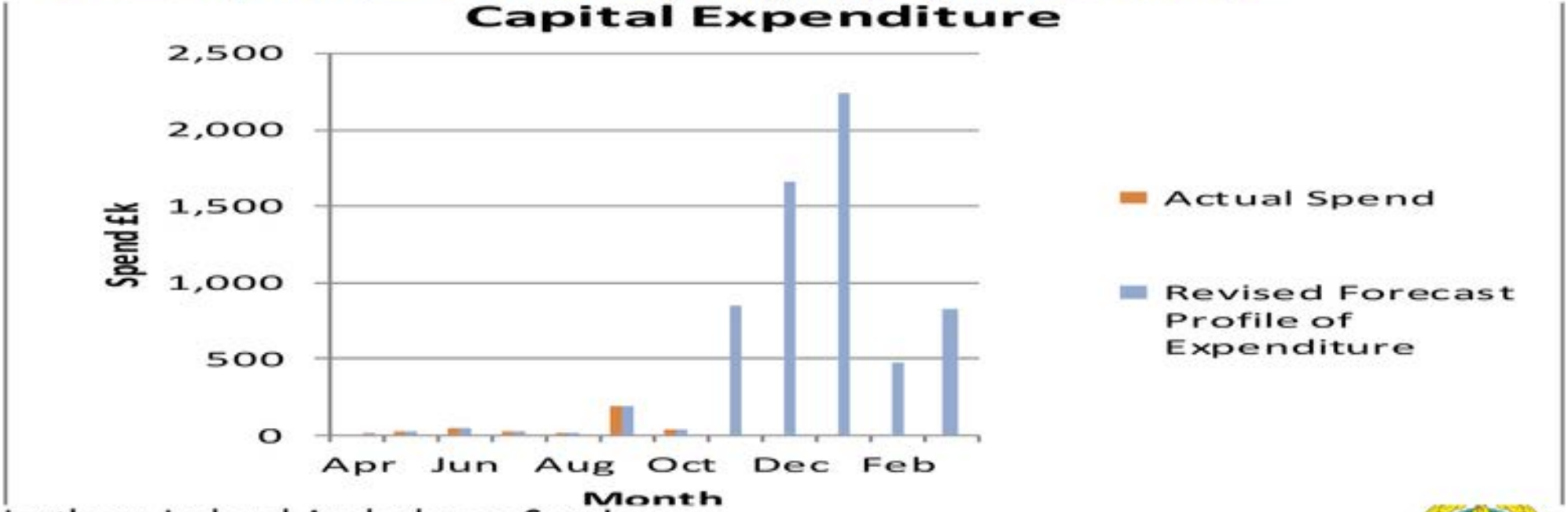
Total Overtime Spend Monthly Comparisons (£)



Manage within allocated Capital Resource Limit (CRL)

The Trust has received a Capital Resource Limit (CRL) allocation of £6.381m (previously £7.099m). This includes allocations for Fleet & Estate (£5.7m), ICT (£0.555m), Leases £0.1m and Backlog Maintenance (£0.026m). The reduction relates to slippage in ICT schemes. Additional funding has also been identified in year for replacement defibrillators. This is subject to business case approval, procurement timelines and supplier capacity.

- 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.
- Provisional figures for expenditure at October 2023 (Month 7) is £0.326m against the allocation of £6.381m.



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% 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 measures are in place to improve and maintain performance in this area. As aged invoices are cleared and paid, performance between months can vary.

- The Trust has achieved both the 95% and 70% targets for the last three years and continues with efforts to maintain this level of performance in 2023-24.

Number	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD Cum	Target
Total bills paid	1,940	2,425	2,348	1,974	2,252	2,283	2,608	2,302					18,132	
Total bills paid within 30 calendar days of receipt of undisputed invoice	1,900	2,316	2,280	1,876	2,193	2,226	2,569	2,219					17,579	
% bills paid on time 30 days	97.9%	95.5%	97.1%	95.0%	97.4%	97.5%	98.5%	96.4%					97.0%	>95%
Total bills paid within 10 working days (14 calendar days)	1,745	1,629	1,854	1,621	1,919	1,858	2,087	1,790					14,503	
% bills paid on time 10 days	89.9%	67.2%	79.0%	82.1%	85.2%	81.4%	80.0%	77.8%					80.0%	>70%
Targets			30 days	>95%	>90%	<90%		10 days	>70%	>65%	<65%			

End of Report

Grievance Policy and Procedure

Table of Contents

1.0 Summary of Policy and Procedure

The purpose of this policy is to explain the Trust's response to employees who, during the course of their employment wish to raise grievances. This policy provides an approach to ensure the concerns are dealt with quickly, fairly and constructively. The policy aims to encourage positive employee relations and to secure constructive and lasting resolutions to workplace concerns. This is in line with the HSC values and the Trust expects all staff involved in the grievance process to consistently demonstrate the values of compassion, openness and honesty, working together and excellence.

The Trust recognises that in the course of work, an employee may feel aggrieved and expects that normal day to day management should deal with the majority of work issues without the need to resort to formal procedures. The Trust would always encourage and promote early resolution although it recognises that there are times when a more formal approach is necessary. This will be done in line with current legislation and best practice guidance outlined by the Labour Relations Agency Code of Practice on Grievance Procedures.

1.1 Definitions

The Trust	NIAS Health and Social Care Trust
Employee	Anyone employed by the Trust, including those on fixed term contracts and bank workers.
Employee Representative	Any employee of the Trust who is an accredited representative of a trade union, professional organisation or staff organisation, a full time official of a Trade Union or a fellow Trust employee
Trade Union	Nationally recognised NHS negotiating body
Management Representative	A manager who is familiar with the concern raised in the grievance. The manager may be invited to the grievance hearing or related meetings to provide information to the grievance panel, if considered necessary to clarify any points raised.

Grievance Panel	The persons with the appropriate authority to resolve the grievance
LRA	Labour Relations Agency

2.0 Responsibilities

Director of Human Resources – The Director of Human Resources has a responsibility to ensure that robust systems are in place, to ensure compliance with the policy and employment legislation. They will also ensure that all Directors, Managers, Human Resources staff and employees are fully aware of their roles and responsibilities in relation to this policy.

Managers – Managers will attempt to resolve workplace concerns raised by employees informally, fairly, consistently and within the agreed timescales.

All Employees – All employees are required to participate and co-operate with others in ways aimed at resolving workplace concerns and to state what would be seen as a suitable outcome.

Employee Representative – Employee representatives have an important role to play in both the handling and resolution of workplace concerns and should work in partnership with the Trust to support prompt and satisfactory resolution.

Employees should be advised of their right to be accompanied at all formal stages in the procedure by a Trade Union representative or workplace colleague.
Legal representation, that is solicitors and/or professional legal counsel, will not be permitted at any stage of this Grievance Procedure

Under the Section 75 equality categories, employees who require additional support to help resolve grievances should seek advice from their trade union representative or Human Resources Department.

Human Resources – The Human Resources Team will work with managers, Trade Unions and all employees to ensure the policy is followed and complies with employment legislation. They will provide support and advice to managers, employees and Trade Union representatives. Human Resources are responsible for advising all parties on the grievance process, including providing advice on any options that may facilitate early resolution of employee's workplace grievances. Human Resources staff may be directly involved at any stage of the grievance process and will help to maintain consistent and uniform standards throughout the Trust.

Grievance Panel – The Panel will consist of two senior managers at the appropriate level who have the authority to make a decision based on the concerns raised. The Panel Chair will take the lead responsibility for ensuring the hearing is conducted appropriately. He/She/They will also ensure that a decision is reached and a written response is provided.

Management Representative – Will represent the position of management and may be invited to attend the hearing, or any subsequent meetings at the request of the grievance panel if considered necessary to clarify any points raised

3.0 Policy Statement

3.1 Scope

This policy applies to all Trust employees including medical and dental staff and bank workers. Other staff e.g. contractors, locums and agency staff employed to carry out duties within the Trust premises on behalf of the Trust will be covered by the protocols specified in contractual arrangements with third party organisations.

Any concerns should be treated in a fair and consistent way and dealt with quickly and supportively. This approach can be used for individuals and groups when there is a collective complaint.

This policy is aimed at securing constructive and lasting resolutions to workplace concerns. It is suitable for the following types of issue;

- Concerns about how the allocation or distribution of resources affects the employee
- Concerns about the actions or inactions of the Trust that may impact the employee
- Concerns about the application of a policy

The following are excluded from this procedure and the appropriate policy/procedure should be referred to;

- Disciplinary matters
- Outcomes of Job Evaluation/Banding Reviews
- Terms and conditions of employment that are either set nationally or by local collective bargaining procedures, that an employer does not have the authority to change
- Pension issues
- Policy on Concerns at Work about Patient Care or Matters of Business Probity/Conduct
- Where there is general interpersonal conflict within the workplace or when a member of staff believes they have been subject to bullying or harassment this should be dealt with under the Conflict, Bullying and Harassment Policy
- Complaints arising from the Recruitment and Selection process (excluding Expression of Interest applicant pools)
- Policies that already include an appeal process

Where a policy does not have an appeal process in its own right then an appeal may be considered under the appeal stage of the Grievance Procedure.

3.2 Principles

a) All grievances must be dealt with through the informal process in the first instance as outlined in Section 3.4.2.

b) If a grievance cannot be resolved informally, a formal hearing will be arranged. This can either be in person or virtually if necessary. For collective grievances,

two lead persons should be nominated to attend the grievance hearing on behalf of the group.

c) All grievances should be raised as close to the issue/ event as soon as is practically possible. This should not normally be later than four months after the issue/ event other than in exceptional circumstances.

d) All parties are expected to take all reasonable steps to participate fully with the grievance procedure. Section 3.3 advises on the arrangements when an employee is unable to attend the Hearing.

e) At all stages of the process, all parties will endeavour to progress meetings, hearings and outcomes on a timely basis in line with the timescales laid out in the policy and procedure.

f) At all formal stages during the grievance procedure the employee will have the right to be accompanied and/or represented by an employee representative as defined in Section 1.1.

g) An employee who has a grievance must exhaust each stage before proceeding to the next. The matter will not normally be progressed until the previous procedural stages have been concluded.

h) The Grievance Panel will consist of two managers at an appropriate level. The panel must have the authority to make any decision in relation to the grievance, but must have no involvement in the decisions that led to the grievance and not be impacted by the outcome of the grievance. In most instances this will require someone removed from the managerial unit impacted by the grievance.

i) To expedite and inform the grievance process, both the employee and management representatives are expected to commit to providing relevant information to the grievance panel on a timely basis. For the employee raising

the grievance this will mean completing the Notice of Grievance Form in full, sharing relevant documents in advance of the Hearing and attending the Hearing prepared to present the case with the relevant information available. The Management Representative should also be prepared, when meeting with the panel to have all the necessary information available in response to the grievance.

j) The Grievance Panel and/or Appeal Panel may seek additional information/clarification in the pursuit of resolution of the grievance. If new information is provided to the panel after the grievance hearing which will impact the outcome of the grievance, it is important that all parties are given the opportunity to respond/comment on this information.

k) Managers should retain written records of all meetings with employees under the informal process including outcomes.

l) Panel members should ensure they take/have a note of the key factors and considerations of the grievance hearing and related meetings. After issuing the outcome of the grievance these notes should be forwarded to HR for filing.

m) Reasonable adjustments will be made throughout the grievance procedure to ensure accessibility for staff who fall within the DDA 1995 legislation or, due to their ethnicity need additional support.

n) In cases where the Chief Executive is the line manager, the employee may raise the grievance with the Chair of the Trust Board or his/her/their nominee.

3.3 Meetings/Hearings

If an employee cannot attend a meeting/hearing through circumstances outside her/his control and unforeseeable at the time the meeting/hearing was arranged they must notify the HR Department and provide reasons. The Trust will arrange one further meeting/hearing. Failure to attend this rearranged meeting/hearing will, unless there are exceptional circumstances conclude the process.

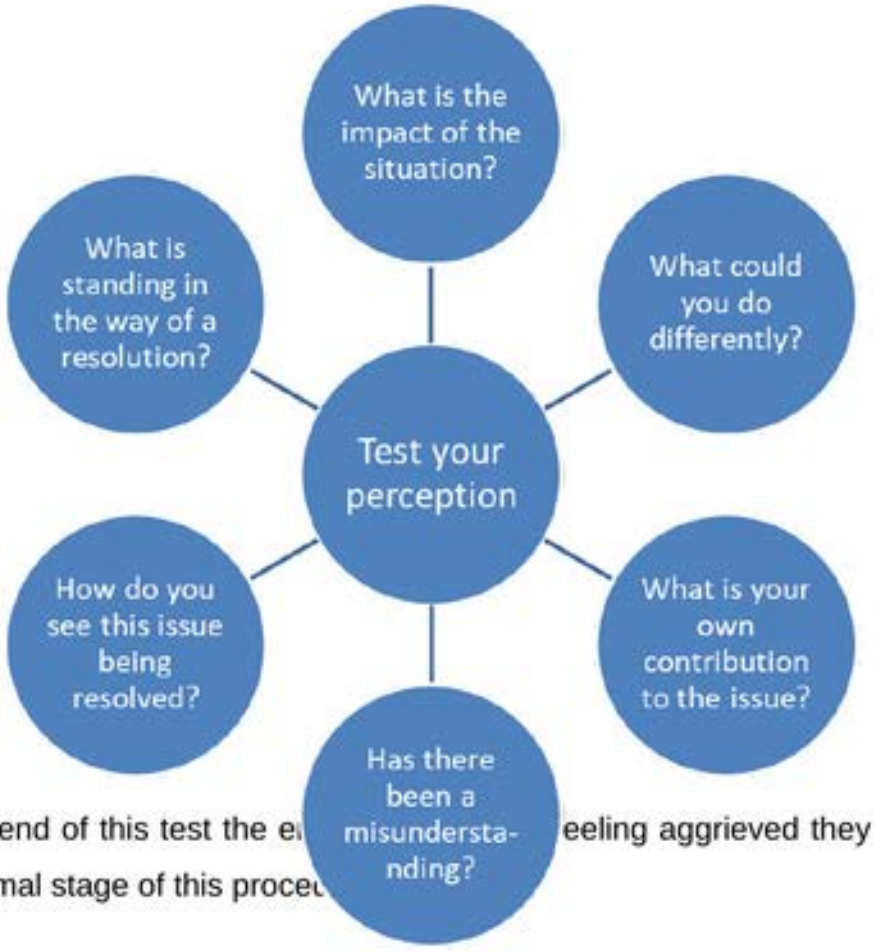
3.4 Grievance Procedure

This procedure details the appropriate steps to be followed when pursuing and dealing with a grievance.

Before using this procedure, an employee should test their perceptions, explaining their understanding to a trusted colleague, manager or trade union representative. The aim of doing this is to gain greater clarity and perspective on the concern.

3.4.1 Testing your Perceptions

The diagram below outlines some key questions to help an employee test their perceptions of their grievance.



If at the end of this test the e eeling aggrieved they can move to the informal stage of this proce

3.4.2 Stage 1: Informal Stage

All grievances must be dealt with through the informal process in the first instance.

Every attempt should be made by both the manager and the employee to resolve the issue in an informal manner where possible through discussion.

An employee can raise the matter either verbally or in writing, with their immediate line manager. The line manager should respond in writing to organise a resolution meeting to take place as soon as practicable and within 10 working days of receipt of the request.

Where the grievance lies with the line manager, then the employee should raise the matter informally with the next level of management. In these circumstances, advice and support can be sought from the Human Resources Department by either party.

3.4.3 Informal Resolution Meeting

Grievances are often resolved quicker and more satisfactorily through discussion between the relevant parties on a timely basis. Before raising a formal grievance, employees are required to participate in an informal resolution meeting with an outcome reached. This meeting will involve all parties (two representatives in group grievances) and should focus on working together to identify, agree and resolve issues. The resolution meeting must be approached and conducted in accordance with HSC Values and behaviours and should be structured to;

- Allow adequate time for parties to explain and listen to each other's concerns, provide any evidence or information relating to their concerns and discuss the impact these concerns are having on them, their role or service provision.
- Explore possible reasons/specific problems.
- Explore how issues can be addressed and what the employee is seeking in terms of a resolution.

It is important that all parties make every effort to listen and try to understand each other's perspective on the issue of concern. To help resolve the issue, it may also be appropriate for parties to discuss the issue with a trusted colleague or peer in another service area who will challenge and help them understand the different perspectives using a coaching approach.

It is not usually necessary for HR or trade union colleagues to attend these meetings, but that does not preclude their attendance or that of a facilitator if necessary.

The line manager will inform the employee in writing of the conclusions reached in the resolution meeting as soon as practicable and within 10 working days of the meeting. This letter will outline the nature of the grievance, the steps taken to resolve the issue and conclusions/resolutions reached. Managers should retain written records of all meetings with employees under the informal process including outcomes.

3.4.4 Additional Support for Resolution

There may be additional options outside this informal resolution meeting which staff may want to consider that will help them to resolve the grievance including;

- Facilitated Conversations

A facilitated conversation provides an opportunity for parties with concerns to explore the issues and find positive ways to address them. A timely and well managed facilitated conversation may offer a breathing space and opportunity to resolve matters without moving to a more formal intervention. The facilitator speaks to each person in advance and agrees the ground rules and boundaries of the conversation. The facilitator keeps confidential what they have heard from each person and the content of the facilitated conversation. The facilitator will help the parties to understand each other's perspective, explore options for moving forward and consider practical solutions.

- Coaching

Through coaching, people are able to find their own solutions, develop their own skills and change their own behaviours and attitudes. The process typically lasts for a defined period of time or forms the basis of an on-going management style. Coaching is essentially a non-directive form of development. It is a skilled activity, which should be delivered by people who are trained to do so.

- Mediation

Mediation is a tool to resolve workplace disputes or concerns. Mediation seeks to give a speedy solution to individual workplace concerns. The process aims to create a safe, confidential space for those involved to find solutions that are acceptable to each individual. It follows a structured approach and seeks to provide fuller solutions that address underlying causes and are more genuinely win-win than adversarial approaches. A trained mediator's role is to act as an impartial third party who facilitates a meeting between two or more people with concerns to help them reach an agreement. Although the mediator is in charge of the process, any agreement comes from the participants.

Your HR Department will be able to provide further information.

These options enable employees to be supported to resolve their issues without needing to go through a formal process. If the issue isn't satisfactorily resolved and informal options to resolve the grievance have been fully exhausted, employees can at this stage request to go to formal resolution.

3.4.5 Stage 2: Formal Stage

Where it is not possible to resolve a grievance informally through the resolution meeting, an employee may raise a formal grievance.

Employees should raise their formal grievance by completing the Notice of Grievance Form in Appendix 1 and advise their line manager they are raising their grievance formally.

Employees must clearly state the reason for the grievance, who the matter was raised with informally, the outcome of the informal stage and why the employee remains aggrieved.

All supporting documentation including the outcome of the informal resolution meeting must be included. If all relevant information is not received, the grievance will not be progressed and timescales will not take effect until all relevant information is received. Employees must provide an email address for communication.

Once submitted, the appropriateness of the issue will be assessed by Human Resources to determine whether or not the issue is suitable for formal grievance. Human Resources will liaise with the relevant parties to inform this decision.

The Human Resources Department will acknowledge receipt of the grievance in writing and will arrange for a Grievance Panel to hear the grievance, normally within 20 working days from the date it is in receipt of all information or as soon as reasonably practicable. If it is not possible to hold the hearing within 20 working days the employee should be provided with an explanation for the delay by the Human Resources Department.

The decision of the Grievance Panel will normally be conveyed in writing to the employee within 10 working days from the date of the hearing, stating clearly the reasons for the acceptance or rejection of the case. If the Panel is unable to provide a response within the required timescales, the employee should be advised accordingly. This letter will also provide details of how to appeal this decision, should the employee believe the matter has not been resolved.

3.4.6 Stage 3: Appeal Stage

An employee wishing to appeal the Stage 2 decision should submit a Notice of Grievance Appeal (Appendix 2) to the Director of Human Resources or a duly designated member of the Human Resources Department within 10 working days of being notified of the decision. The Notice will include details of the grounds for the appeal and all relevant documentation.

The Human Resources department will acknowledge receipt of the appeal letter in writing and will arrange for a Grievance Appeal Panel to hear the grievance within 20 working days or as soon as reasonably practicable.

The Director of Human Resources or a duly designated member of the Human Resources department will be responsible for organising an appeal hearing. The panel for the hearing will normally comprise the relevant Director or suitable Senior Management delegate from the directorate and a senior member of the Human Resources department, neither of who should have had previous involvement with

the case. In circumstances where the Director has been previously involved in the case, the Human Resources department may seek a senior nomination from another directorate.

Where appropriate, the appeal panel may invite a suitably qualified and experienced senior officer in the same profession as the aggrieved employee(s) from the Trust or outside the Trust to attend the hearing as an assessor. The assessor is there to provide professional advice to the panel as required and has no decision-making role.

The Grievance Appeal panel may invite a management representative and/or other employees associated with the grievance to be present at the hearing, if considered necessary to clarify any points raised.

The decision of the Grievance Appeal Panel will be conveyed in writing to the employee within 10 working days from the date of the hearing, stating clearly the reasons for the acceptance or rejection of the case. The decision of the Grievance Appeal Panel is final.

3.5 Time Limits

It is recognised that due to competing demands on all members and the complexity of the issues raised, the deadlines may not be achievable. If a delay is anticipated, employees will be provided with an explanation for the delay and what is being done to expedite the matter. Updates should be provided regularly to the employee raising the grievance

3.6 Implementing Outcomes

The decision of the grievance panel should be confirmed in writing in accordance with the timescales specified in the procedure. If the decision requires actions to be taken, these should be implemented without any unreasonable delay. If the decision is the final stage of the process this should be made clear to the employee.

After the grievance outcome has been issued, panels may also want to feedback to Human Resources any insights on how the issue(s) could have been resolved at an earlier stage or any potential learning for the parties involved and/or the organisation.

3.7 Documentation

At the formal stages of the procedure, all evidence in support of the grievance must be submitted with the Notice of Grievance and Notice of Grievance Appeal for circulation to all parties involved.

3.8 Overlapping Grievance and Disciplinary Cases

Where a formal grievance is raised during a disciplinary process, the appropriate action regarding progression of these processes will be determined on a case by case basis by the Director of Human Resources or nominee, taking into consideration all relevant factors and the nature of the proceedings. This will be communicated to the employee.

3.9 Status Quo*

The use of status quo provides existing arrangements to continue while attempts are made to resolve the grievance.

Wherever possible, the status quo should remain in place until the grievance process has concluded.

The status quo will be set aside where:

- a continuation of the status quo will result in a breach of statutory or other mandatory regulations,
- the grievance is about a decision taken by management following consultation with the Trade Unions
- it is considered detrimental to health, safety and welfare of patients, staff or members of the public
- where there is a delay or failure of the employee raising the grievance to appropriately engage in the grievance process by resolution of the grievance in a timely manner
- or for some other substantial reason

The decision that the above apply and there is a need to vary the status quo will be made by the Director responsible for the service in conjunction with the Director of HR, whose decision is final. The reasons for not maintaining the status quo will be provided in writing to the employee.

4.0 Evidence Base/References

Labour Relations Agency Code of Practice on Disciplinary and Grievance Procedures: https://www.lra.org.uk/sites/default/files/2019-05/Code%20of%20Practice%20on%20Disciplinary%20and%20Grievance%20Procedures%20-%203rd%20April%202011.pdf

5.0 Personal & Public Involvement (PPI)/Consultation Process

This policy was developed and consulted upon with Trade Union colleagues and LRA colleagues.

6.0 Equality, Human Rights & DDA

Equality Impact Assessment conducted with no adverse impact identified.

7.0 Rural Needs Impact Assessment?

N/A

8.0 Additional Considerations

No additional considerations

9.0 Alternative Formats

This document can be made available on request on disc, larger font, Braille, audio-cassette and in other minority languages to meet the needs of those who are not fluent in English

10.0 Sources of advice in relation to this document

The Policy Author, responsible Assistant Director or Director as detailed on the policy title page should be contacted with regard to any queries on the content of this policy.

11.0 Monitoring

The operation of this policy will be monitored and reviewed regularly (every 3 years) to ensure its relevance and effectiveness.

12.0 Policy Sign Off

Signed on behalf of Trade Union Side:

Signed on behalf of Employer:

Date:

*The inclusion and application of this Status Quo paragraph will be kept under review. Management reserve the right to amend or withdraw this paragraph from this procedure.

13.0 Appendices

Appendix 1: Notice of Grievance Form

This form is submitted as I wish to raise my grievance formally at Stage 2 of the Grievance Procedure, as my grievance was not resolved at Stage 1 (informal stage).

You are required to complete this form and send it to the next level of management and [insert relevant HR Department] within 10 working days of receipt of the written outcome of the Informal Grievance procedure (Stage 1).

Full Name:	Staff Number:
Job Title:	Department:
Email:	Contact Number:
Name of Immediate Line Manager:	Contact Number/Email of Immediate Line Manager:
Name of Employee Representative:	Contact Number/Email of Representative:

Note: For collective grievances, on a separate sheet, please list the staff numbers, names, job titles, department, contact details including emails, along with signatures for each individual involved and nominate two lead persons who will be invited to attend the grievance hearing on your behalf.

Please describe the nature of your Formal Grievance

Please provide a description of your concerns, including precise information such as dates of events, meetings or correspondence, whether this is a one-off issue or part of a sequence of events, names of those involved and any reference to relevant documents or policies. You may attach additional sheets if required.

Please attach relevant documentation in support of your grievance securely and list below:

-
-
-

Please state the steps you have taken to resolve your concerns and attach copies of relevant documentation

Please provide full details of the informal resolution meeting to include the date of the meeting, with whom the discussion took place, and the outcome of the discussion

Please state your desired outcome and how you believe this will resolve the issue

Signed…… Date Submitted……
(Employee raising grievance)

Manager's Signature…… Date Received……

NB: Please ensure you have attached a copy of the outcome of stage 1 informal resolution meeting

Please retain a copy of this form and attachments for your records

Appendix 2: Notice of Grievance Appeal

You are required to complete this form and send it to the Director of Human Resources or designated contact in your Human Resources Department within 10 working days of receipt of the outcome of your Stage 2 (formal) grievance.

Full Name:	Staff Number:
Job Title:	Department:
Email:	Contact Number:
Name of Immediate Line Manager:	Contact Number/Email of Immediate Line Manager:
Name of Employee Representative:	Contact Number/Email of Representative:

I am writing to formally appeal against the decision taken on my recent stage 2 formal grievance which was notified to me on .....[date]

Note: For collective grievances, on a separate sheet, please list the staff numbers, names, job titles, department and contact details including emails, along with signatures for each individual wishing to appeal the stage 2 decision. Please nominate two lead persons who will be invited to attend the appeal hearing on your behalf.

My reasons for appeal are as follows:
[Set out the basis for your appeal including any new evidence that you feel should be considered. You may attach additional sheets if required].

Please provide the outcome letter from your stage 2 formal grievance and any other documents or detail relevant to the appeal and list below • • •

I have attached the relevant information in support of my grievance appeal including the outcome of my stage 2 formal grievance ☐

I give my consent for this information to be circulated to relevant members of staff on a need-to-know basis for the purpose of investigating my formal grievance appeal ☐

I have advised my line manager that I am submitting a formal appeal against my stage 2 grievance outcome ☐

Signed…… Date Submitted……
(Employee appealing stage 2 grievance outcome)

Manager's Signature…….. Date Received……

NB: Please ensure you have attached a copy of the outcome of stage 2 formal grievance

Please retain a copy of this form and attachments for your records

Northern Ireland Ambulance Service
Health and Social Care Trust

Title:	**Policy for Completion of Patient Records**		
Author(s):	Neil Sinclair, Assistant Clinical Director (Paramedicine)		
Ownership:	Dr Nigel Ruddell, Medical Director		
Date of SMT Approval:	11th July 2023	**Date of SQPEP Committee Approval:**	7th September 2023
Operational Date:	8th September 2023	**Next Review Date:**	7th September 2024
Version No:	3.2	**Supersedes:**	3.1
Key Words:	Patient Report Form, PRF, ePCR, electronic patient care records		
Links to Other Policies / Procedures:	General Data Protection Regulations (GDPR), Data Protection Act 1998, Freedom of Information Act 2000 Policy, Code of Practice Protecting the Confidentiality of Service User Information 2019, Staff Guidance Leaflet -Code of Practice Confidentiality of Service User Information, Information Governance Policy. Policy for safeguarding, movement and transportation of Records and Files, HCPC Standards of Conduct Performance and Ethics, HCPC Standards of Proficiency for Paramedics, Staff Guidance Caldicott principles, NIAS Patient Report Form User Guide (Paper records), Access to Health Records (NI) Order 1993. Clinical Documentation Update – Interim Guidance on Clinical, Documentation Standards, NIAS ST Myocardial Infarction Pathway v4 HCPC Standards of Conduct Performance and Ethics (2016) HCPC Standards of Proficiency for Paramedics (2023) NIAS Disciplinary Policy & Procedure.		
Monitoring	The Policy Author will be responsible for monitoring the need for policy revision.		

Version Control:			
Date:	**Version:**	**Author:**	**Comments:**
May 2016	1.0	Projects Development & Implementation Manager REACH Programme Lead	Initial draft for comment
October 2020	1.1	Projects Development & Implementation Manager	Complete review
January 2022	1.2	Clinical Training Manager	Feedback tracked in document
Feb 2022	1.3	Assistant Clinical Director	Review and comment
February 2022	1.4	Line Management & TUs	Comments / additions
Mar2022	1.5	Clinical Data group	Stage approval
April 2022`	1.5	IAG by email circulation	Stage Approval
April 2022	1.5	SMT	Stage Approval
June 2022	2.0	ARAC	Final Approval
11-07-2023	3.0 draft	SMT	Stage Approval
15/08/2023	3.0 Draft (0.9B revision)	TU (Unison, Unite, NIPSA, GMB)	Stage Approval
23/08/2023	3.0 draft	Policy Owner and Policy Author	Stage Approval
29/9/2023	3.0	Senior Management Team	Addendum re DDA commitment and Stage Approval
07/09/2023	3.1	Safety, Quality, Patient Experience & Performance Committee	Approval subject to minor change
07/09/2023	3.2	-	Final version after minor change enacted

1.0 INTRODUCTION:

This policy provides guidance on the completion of Patient Records by the Northern Ireland Ambulance Service Health and Social Care Trust (NIAS).

1.1 Background:

The reliable recording of information is key to the successful treatment of people needing emergency, urgent or non-urgent care. Patient records support direct patient care as an aide memoire ensuring effective patient care and provide communication between multidisciplinary teams helping to ensure continuity of patient care. The Patient Report Form herein is referred to as the PRF and the ePCR for electronic Patient Care Record, is an important medical and legal record of assessments, observations, treatments and actions undertaken by NIAS staff; it is essential in providing evidence that the NIAS duty of care has been met. The patient record (either paper based or electronic) is a medicolegal document which records the treatment, care and support provided to a patient. The records will be used, for example, to inform the Coroner's Office and for any inquests or investigations.

NIAS has now introduced a software and hardware solution for the creation and secure record keeping of electronic patient care records across the Trust. Going forward this will be the primary method for creating NIAS care records. Vehicle based tablets and personal issued tablets enable ePCR to be created and the contingency solution will be a written PRF. Using the software enables the patient information to be transmitted securely to the next HCP (Health Care Professional) during the NIAS point of care.

1.2 Purpose:

The Northern Ireland Ambulance Service (NIAS) recognises its professional, legal and moral duty to ensure that appropriate patient records are completed for all patients who are assessed, treated and/or referred irrespective of being conveyed or not. The purpose of this policy is to ensure that all staff involved in the assessment, treatment, and/or referral of patients comply with their professional, legal and moral duties in the documentation of patient records. A patient record (electronic or paper) must be completed for every call where a patient has been seen and assessed by NIAS personnel. Staff must create an ePCR as standard practice.

This policy updates the previous document Policy for Completion of Patient Records (2022) and is supported by the current Patient Report Form User Guide for paper records and the provision of training materials for the new MobiMed electronic patient record software and associated processes.

1.3 Objectives:

The completion of the patient care records, whether electronic or paper will meet the following objectives:

- To ensure a clear record of assessment and treatment of the patient.
- To provide accurate information about pre-hospital patient care so that it informs continuity of care for the next healthcare professional and is shared securely and appropriately across digital platforms for the benefit of the patient and their care.
- To provide information for clinical audit (both quantitative and qualitative data) and clinical research and development.
- To support clinical supervision, appraisal, recognise good practise and assist with reflective learning.
- To support staff training needs and quality improvement through clinical audit.
- To inform evidence-based practice for Continuing Professional Development.
- To provide comprehensive records for any legal /medical disputes or complaints.
- To provide standardisation in the capture, secure record keeping and documentation of patient records.
- To comply with any legal requirements and professional standards.
- To provide organisational assurance against National Ambulance Quality Indicators and clinical outcomes.
- To inform any investigation of patient safety incidents.

2.0 SCOPE:

2.1 Electronic records and paper-based records:

The scope of the policy covers both written and electronic patient records. Regardless of how data is captured, the purpose and objectives will remain the same.

2.2 When does the policy apply?

All patients that have been attended to and assessed / treated by NIAS must have an electronic patient care record completed in alignment with this policy. This will be for patients conveyed to hospital and for patients not conveyed to hospital.

The primary format for patient records is the electronic patient care record (ePCR).

When patients are not conveyed an electronic patient care record must be completed and the record must include appropriate worsening care and safety netting advice. The patient must be provided with the NIAS Non-Conveyance Advice Leaflet with the appropriate sections completed.

When the ePCR is created, a photograph of the completed Non-Conveyance Advice Leaflet should be taken for inclusion within the electronic patient care record.

In all incidents whereby a NIAS resource has arrived on scene but there is no patient contact, the crew must document all actions taken to try and locate the patient e.g., confirm location is correct, check with neighbours, request PSNI if appropriate to gain entry and record this information with EAC or a clinical record. This is not an exhaustive list. Responding crews must be assured that there is no patient at the location prior to clearing scene. Where the origin of the call is a HCP, the HCP must be contacted to advise that the patient cannot be located.

This policy is supported by the User guide for electronic patient care records and related training materials.

The written PRF will be only used as a contingency on occasions that hardware / software is unavailable to produce the electronic patient care record and will be directed by Medical Directorate, Operations Directorate or IT notifications, directly to all operational staff via existing processes (for example MDT bulletins).

The policy is supported by a PRF User guide for paper records which also documents the procedure for completion where multiple resources are on scene. The user guide remains appropriate for instances of contingency which may necessitate the use of paper records.

An exception for the completion of patient care records is for routine Patient Care Service (PCS) calls e.g. Outpatients, Renal Clinic attendance, Discharges.
Note: Independent Ambulance Service (IAS) providers working for or on behalf of NIAS should also ensure that a patient record is completed.

Note:
It is noted at the time of writing that the PCS service is undertaking assessment review of its service and this policy may be updated where appropriate by any recommendations made including a requirement to record any clinical observations.

2.3 Directions for creating patient care records.

The standard practice for creating patient care records is ePCR (electronic patient care records).

The standard practice is applied to all hospital conveyances. At the time of writing this policy the hospitals in scope for receiving electronic patient care records is as detailed below, however other hospitals may be on-boarded to receive ePCR through the lifetime of this policy. Any hospitals added will be communicated by Operations Directorate and / or IT whenever this is appropriate.

Hospitals in scope for receiving electronic patient care records are:

Belfast: Royal Victoria Hospital (RVH) ED, RVH PPCI, Mater Infirmorum Hospital ED, Royal Belfast Hospital for Sick Children ED.
North: Antrim Area Hospital, Causeway Hospital ED
South: Craigavon Area Hospital ED, Daisy Hill Hospital ED
South East: Ulster Hospital ED, Lagan Valley Hospital and Downe Hospital.
West: Altnagevin Hospital ED, Altnagelvin PPCI, South West Acute Hospital ED.

The standard practice is applied to all non-conveyances which will include referrals into Urgent Care Pathways and other appropriate care pathways. Staff will be informed by the Medical Directorate whenever a care pathway is created for referral using the software and ePCR.

On occasion all staff will be informed when an exception to creating the electronic patient care records is required. On these occasions the paper PRF must be completed.

Exceptions will include but are not limited to, for example, the need for regular IT system outages (example, Windows Updates, BSO Server maintenance); prolonged issues with NIAS and HSC network connections; circumstances when Hospital IT systems unable to receive electronic records.

3.0 ROLES AND RESPONSIBILITIES:

3.1 Chief Executive Officer

- The Chief Executive Officer has overall responsibility for Information Lifecycle Management (ILM).
- The Chief Executive Officer is responsible for ensuring the full implementation of this policy, and that clinical records are managed according to legislation. This responsibility is delegated to the Medical Director.

3.2 Trust Board

The role of the Trust Board is to:

- Set the strategic direction of NIAS within the overall policies and priorities of the Health and Personal Social Services (HPSS), define its annual and longer-term objectives, and agree plans to achieve them.
- Ensure high standards of corporate governance and personal behaviour are maintained in the conduct of the business of the whole organisation.

3.3 Senior Information Risk Owner (SIRO)

The Senior Information Risk Owner (SIRO) has overall responsibility for ensuring appropriate mechanisms are in place to support the ILM function. The SIRO is the Director of Performance, Planning and Corporate Services.

3.4 Data Protection Officer (DPO)

The DPO is a mandatory role that will ensure NIAS can demonstrate its compliance with Data Protection legislation. The role is appointed within the Planning, Performance and Corporate Services Directorate.

3.5 Information Asset Owner (IAO)

An Information Asset Owner (IAO) will be identified for each information asset (system). IAOs will have overall responsibility for managing the risks to the assets and provide assurance to the Information Governance Group. The IAO role for patient data is assigned to the Assistant Clinical Director within the Medical Directorate.

3.6 Caldicott Guardian:

The Caldicott Guardian will act as the 'guardian' of patient identifiable information and will ensure appropriate mechanisms are in place to support the ILM function relating to patient information. The Caldicott Guardian is the Medical Director.

3.7 Informatics Assurance Group (IAG)

The Informatics Assurance Group (IAG) is a delegated authority group accountable to the Audit and Risk Assurance Committee (ARAC). Its purpose is to support and drive the Trust wide informatics assurance agenda, and provide the Trust Board with the assurance that effective policies and processes are in place within NIAS in relation to the following discreet specialisms:

- Data Quality and compliance.
- Information Governance, including data protection, records management, Freedom of Information and UK GDPR.
- Information security, including cyber security.
- Data and Digital Services.
- Management of Security Level Information.

3.8 Information Governance Group (IGG)

The IGG (Information Governance Group) is a delegated authority group accountable to the Informatics Assurance Group.

Its purpose is to support and drive the information management and information governance agendas and provide the Trust Board with the assurance that effective policies and processes are in place within NIAS in relation to these fields.
It will consider and approve proposed changes to the processing of data and review compliance with national and local requirements relevant to data processing.

3.9 Medical Director / Medical Directorate:

The Medical Director, as owner of the policy, will be responsible for the revision and documentation control of this policy.
The Medical Director is responsible for providing clinical guidance on the full implementation of this policy.
The Medical Directorate is responsible for all Medical Directorate staff to comply with this policy and processes within it for the creation of NIAS patient care records.
The Medical Directorate is responsible for all Medical Directorate staff that perform operational duties create electronic patient care records as standard practice.
All staff are responsible for the upkeep and safety of their personal issue tablet, ensuring that they have their device charged and ready for use whilst on shift and for the duration of the shift. In the unlikely event of a device being stolen, the IT department must be informed immediately so swift action can be taken to disable the device.
The Clinical Quality Manager from within the Medical Directorate will be responsible for development of suitable policies and procedures compliant with legislation and guidance relating to medical records.
The assigned clinical function within the Medical Directorate will ensure that regular audits are carried out to ensure compliance with legislation, policy and relevant clinical standards. Compliance to this policy include a focus on using ePCR as the standard practice for all NIAS patient care records.
The Clinical Education Department within the Medical Directorate will support the development of staff, so they are trained and supported to the appropriate standards and processes.

The Clinical Quality Manager from within the Medical Directorate will be responsible for overseeing the development, testing and implementation of software revisions that affect electronic patient care records, ensuring that all changes and procedures are compliant with legislation and guidance relating to medical records. The Clinical Quality Manager will liaise with all stakeholders with regards to training and awareness needs related to electronic patient care records and the associated software and hardware.

3.10 Director of Operations / Operations Directorate

The Director of Operations is responsible for all operational staff to comply with this policy and the processes within it for creation of NIAS patient care records.
The Director of Operations is responsible for ensuring that all applicable operational staff create electronic patient care records as standard practice.
All staff are responsible for the upkeep and safety of their personal issue tablet, ensuring that they have their device charged and ready for use whilst on shift and for the duration of the shift. In the unlikely event of a device being stolen, the IT department must be informed immediately so swift action can be taken to disable the device.
The appropriate management functions within Operations Directorate are responsible for identifying and signposting staff for training or re-familiarisation / awareness requirements in relation to this policy and processes.
The appropriate management functions within Operations Directorate are responsible for monitoring compliance to this policy, in particular the creation of the electronic patient care records.
Operations will be supported by other functions such as Informatics, Divisional Training Officers and Clinical Support Officers when required.
Where non-compliance is identified then appropriate action will be taken with support from Human Resources. Refer to appendix 1.

3.11 Human Resources

HR will provide support and guidance to line managers in the event that non-compliance to the policy is identified as an issue of capability and / or conduct. Non-compliance will be considered in the event when a staff member regularly does not complete ePCR for patients that they attend to, assess and / or treat; when the software and hardware is readily available for them to do so.

3.12 Director of Quality, Safety & Improvement:

The Director of Quality, Safety and Improvement is responsible for ensuring that there is continuous improvement supported by sharing learning identified at the Rapid Review Group meeting related to completion of patient records with relevant stakeholders and where appropriate at the Learning Outcomes Group.

3.13 Planning, Performance & Corporate Services Directorate:

ICT Department is responsible for managing the supply, maintenance and development of the software and hardware that is provided for the creation of electronic patient care records.
ICT Department will maintain all relevant documentation related to technical updates such as software versions, operating updates and hardware changes that provide the solution for the creation of electronic patient care records.
IT Users service desk will be responsible for the triage of any technical issues reported in relation to the creation of the electronic patient care records or the use of the software and hardware.
ICT Department will inform this Policy Owner if an update to this policy is required.
ICT Department will manage existing third-party supplier interfaces (e.g. NIECR) and coordinate future regional system integration (e.g. Encompass).
Informatics and Information Governance is responsible to ensure that the processes, maintenance and control of patient records comply with GDPR.
Informatics and Information Governance is responsible is responsible for providing business intelligence support to enable clinical data reporting and ensuring that accurate data is extracted for audit purposes, policing matters, Coroner requirements and investigations into serious adverse incidents.
Clinical Informatician will provide leadership and carry out complex scientific and information assessments to support NIAS Clinical Indicators, public health policies and practices, including community health improvement, decision support, and stakeholder engagement.
Performance Management will be responsible for any oversight required when monitoring compliance to the use of electronic patient care records is enacted.

3.14 Directors & Assistant Directors are responsible for:

- Understanding and implementing this Policy and any associated guidance applicable to their Directorate.
- Ensuring arrangements are in place for monitoring and compliance with this Policy.
- Ensuring that there are suitable resources available for the implementation of this Policy.
- Ensuring that patient records are used in compliance with GDPR.
- Promote and encourage the use and benefits of electronic patient care records.

3.15 All Staff Involved in Treating / Assessing / Transporting Patients:

All staff involved in assessing and treating / transporting patients must maintain appropriate records as detailed in this policy with the primary format being electronic patient care records.
Where staff have received a personal issue tablet and or have access to a vehicle-based tablet and are a licenced MobiMed user then an ePCR must be completed for their patient.
If a staff member as part of a crew does not have access to a tablet and is not a licenced user on MobiMed then the creation of the electronic patient care record is done through the use of the available tablet.
Any staff member that does not have a MobiMed licence should report this to their Station Officer.

When an electronic patient care record is being created, the patient's HCN must be inputted (note that some patients will not have an HCN, in which case it is important to capture as much patient details as possible or use the unknown patient reference).
All staff must comply with this policy and their training.
All staff must comply with Trust information security policies and procedures. Information must not be used for any purpose other than that which is legitimate under the relevant policies and procedures.
If staff experience any technical issues with personal issue tablets or with vehicle-based tablets, then they should report this to IT Users and not through DATIX.
If staff require any assistance with the completion of clinical records, then their allocated Clinical Support Officer should be contacted.

4.0 KEY PROCESSES:

4.1 Patient report Form User Guide:

The policy is supported by a user guide for paper records which can be electronically accessed on the NIAS SharePoint site. The user guide was developed to support changes to the PRF and documents the procedures and guidelines for completion of a PRF.

4.2 eLearning Resources for Electronic Patient Records:

With the introduction of electronic patient records a number of materials (including an ePCR User Guide) have been developed to support users and any changes to how patient data is recorded. These are available through the MobiMed software and on SharePoint.

Resources available are supported by practical patient scenarios developed to support practical application of the training.

4.3 Creation of a contemporaneous ePCR:

With the introduction of electronic patient records, the policy is that there should be a **single** record for a patient. In the event that there is more than one response resource to the patient, it will be the lead clinician treating the patient at that time who will be responsible for opening and completing the record.

Where there is an incident attended by a Rapid Response Vehicle (RRV) and the patient is handed over to a receiving crew, the RRV responder should proceed to electronically handover the patient following the relevant processes within the system.

This can be achieved by performing a 'Discharge for Handover' and the responding crew then retrieving this record from the server or a direct transfer of the record from device to device using 'Discharge for Handover via WLAN'.

In some instances, an emergency ambulance crew or RRV using ePCR may handover to a crew using a paper record or vice versa. The documented procedure is highlighted within the ePCR user guide and should be referred to.

4.4 Patient Health & Care Number & NIECR:

It is essential to record the patient's HCN in the required data field within the patient's electronic record.

This can be done automatically through the MobiMed software by using the search function that directly links to the Personal Demographic Service (PDS).

The HCN is the key identifier in allowing access to the Northern Ireland Electronic Care Record (NIECR) patient summary record where this is available, enabling patient history review to inform NIAS clinicians' and other HCPs' decision making for patient care and treatment.

Access to the NIECR is READ ONLY and staff will have user accounts set up for this.

In normal circumstances the patient's consent is required for NIECR access, however, should the NIAS clinician deem that access is vital and is in the patient's best interests then this requirement is overridden and the rationale documented in the patient record.

4.5 JRCALC Access:

JRCALC clinical guidelines are available on every personal issue tablet and vehicle-based device and is built into the MobiMed software to assist with clinical information and clinical decision making.

4.6 Use of Camera Function & Images:

Each personal issue tablet and vehicle-based tablet has a camera function. This functionality can only be accessed when a patient record is open. Any images taken must only relate to the incident and patient attended. This will include clinical images and any written documentation left with patients that are not conveyed to hospital (for example, the worsening care advice leaflet). Clinical images captured should only be taken when required to enhance the care provided to the patient.

At all times only the NIAS personal issue tablet and the vehicle-based tablet with the MobiMed software should be used to record clinical images and only within the patient record.

Patients must be fully informed and consent given prior to clinical images being taken. When a patient is not able to provide consent, there must be a clearly documented rationale to support and enhance the care provided to the patient. Staff should refer to the NIAS Policy for Use of Clinical Imagery within NIAS Electronic Patient Care Records.

4.7 Training

All operational staff identified as potential users will be trained.

Any further requirement for training in relation to this policy should be assessed at the monthly Education Learning and Development meeting with representation from the Medical Directorate, Operations Directorate and Clinical Education Department.

Any staff already trained and require re-familiarisation then signposting to applicable training materials such as e-learning will be provided.

4.8 Governance & Assurance:

Information recorded in a patient care record is the cornerstone of clinical care underpinning the safety and quality of care.

Existing governance reporting and assurance structures will also be utilised in order to ensure due information governance, for example oversight by Information Governance Group, Informatics Assurance Group, Clinical Data Group, Audit and Risk Assurance Committee and / or Trust Board as appropriate.

4.9 Personal Issue Devices:

Staff are issued with a personal issue Windows tablet with the MobiMed software installed in order to record electronic patient records.

Individuals receiving devices are bound by the condition of use, issued by NIAS ICT Department.

Staff are responsible for ensuring that they have their device charged and ready for use whilst on shift and for the duration of the shift. Staff are responsible for reporting any defects/loss/or damage to the device via informed reporting procedures.

4.10 Documentation Standards:

The patient record has been designed in line with professional guidance on the structure and content of patient records produced by the Royal College of Physicians.(Ambulance Electronic Patient Report (AEPR) standard specification ISB 1516 and the National Ambulance Documentation standard specification (NADS) Adherence to the standards will ensure that information that is documented allows for appropriate sharing of meaningful data across care settings to support patient care and inform performance management, and clinical audit.

ISB1516 AEPR standard states that Systematized Nomenclature of Medicine -- Clinical Terms (SNOMED CT) should be used for encoding concepts within the ambulance patient report. The development of patient records and data captured will maintain a watching brief on the pilot work in England for adoption of ambulance data sets and developments within HSCNI and adopt coding standards in line with DHCNI data strategies.

4.11 Compliance & Effective Implementation:

All staff involved in attending to, assessing, treating and transporting patients must maintain appropriate records as detailed in this policy.

Paramedics should comply with this policy in alignment with the Health and Care Professions Council (HCPC) standards of proficiency.

4.12 Loss / Theft of Device

In the unlikely event of a device being stolen, the IT department must be informed immediately so swift action can be taken to disable the device.
In the unlikely event of a device being stolen the information cannot be accessed or viewed by any other person due to the level of encryption on the device used to access and record the information.
All records are stored on the server and not on the device. Only a record that is in use is available on the device. Once closed, the record is transferred to the server.
The Medical Directorate, Information Governance and line management must be informed immediately in the event of a device being lost / stolen.
In the event of a loss of a device all reasonable attempts must be made to trace the device by the staff member. A DATIX must be completed immediately on return to station listing the Risk Manager as the line manager and detailing the movement of the staff member and approximate time and location of the loss. If the device is connected to the network, IT can track the last known location.

5.0 IMPLEMENTATION OF POLICY:

5.1 Dissemination:

With regards to dissemination this procedure will be:

- Issued to all Board Members, Chair, Non-Executive Directors, Chief Executive, Directors and Assistant Directors.
- Disseminated to the required staff by Assistant Directors.
- Made available on the Internet and SharePoint so that all employees and members of the public / stakeholders can easily have access.
- Discussed during Corporate Induction and training.

5.2 Resources:

The policy updates the previous policy for the completion of patient records. Its implementation should not require additional resources and will be supported by existing operations staff DTOs, CSOs, SOs and ASAMs where appropriate.

Digital Support will be provided by the ICT department and the REACH programme in the initial stages of roll out of the electronic hardware and software.

5.3 Exceptions:

Non-operational staff, office-based staff and non-patient facing roles who are not required to use devices are exempted from the requirement to create records in line with this policy.

6.0 MONITORING:

NIAS Clinical governance group (in development June 2023), in collaboration with the education and standards team will monitor the completion of the EPCR via digital dashboards and provide appropriate feedback and assurance.
This Policy will be reviewed every three years or amended as appropriate if other organisational changes impact. Feedback from stakeholders will be taken into consideration, along with a review of systems and processes with ongoing analysis of the management of electronic patient records.

Back to Agenda

7.0 PROVISION FOR DISABILITY

NIAS is committed to fully supporting staff and will ensure appropriate education and training to enable implementation of this policy. In line with the Trust's responsibilities under legislation such as The Disability Discrimination Act 1995 we will work to support those who may have particular needs and give full consideration to reasonable adjustments.

8.0 EQUALITY STATEMENT:

8.1 In line with duties under Section 75 of the Northern Ireland Act 1998; Targeting Social Need Initiative; Disability Discrimination Act 1995 and the Human Rights Act 1998, an initial screening exercise, to ascertain if this policy should be subject to a full impact assessment, has been carried out.

8.2 The outcome of the equality screening for this procedure undertaken on pending 2022 is:

Major impact	☐
Minor impact	☐
No impact.	✓

9.0 SIGNATORIES:

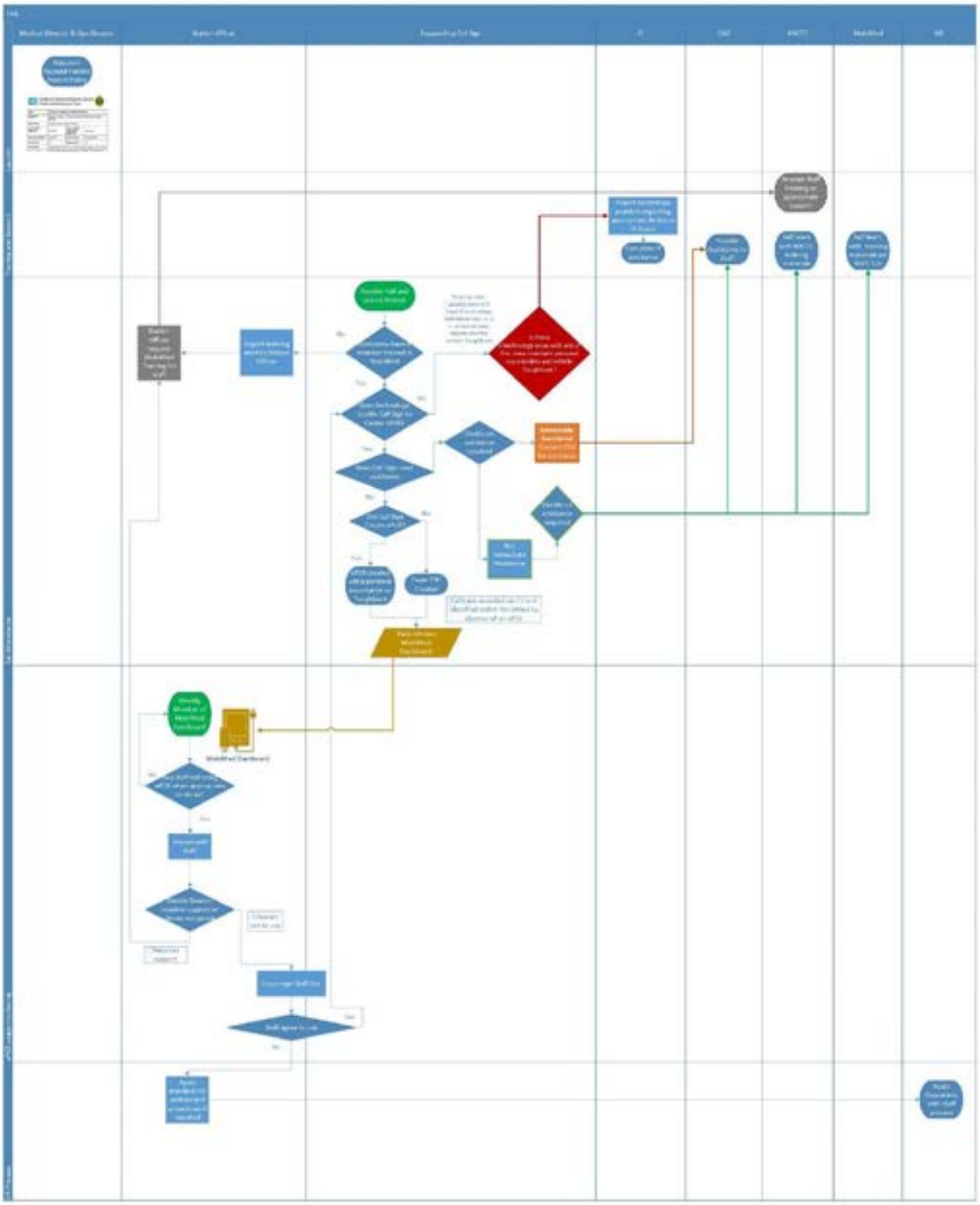
NEIL SINCLAIR **Date: 3 July 2023**
Lead Author

Nigel J. Ruddell

Dr Nigel Ruddell **Date: 3 July 2023**
Lead Director

10.0 APPENDICES:

APPENDIX 1: Process for compliance of use and performance management of ePCR



WORKFORCE POLICY DIRECTORATE

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Chief Executives of HSC Bodies[1];

For information:
Director of Human Resources of each body

Castle Buildings
Stormont Estate
BELFAST BT4 3SQ
Tel: 028 9052 2680
Email: P&E@health-ni.gov.uk

Reference: HSC (AfC) (5) 2023

Date: 9 November 2023

Dear Colleagues

Implementation of Conflict, Bullying and Harassment Policy

Summary

1. The Conflict, Bullying and Harassment Policy was launched in 2019 after extensive review and consultation which resulted in the amalgamation of the regional Working Well Together Policy and local Harassment Policies.

2. In 2022 a review of the policy was commenced. Consultation with Trade Unions took place both locally and regionally and a revised draft was also shared with the British Medical Association in November 2022. Changes to the policy were agreed with Trade Union counterparts in November 2023.

3. A copy of the model policy is attached.

4. Changes to the policy include:

[1] HSC Trusts, the Public Health Agency, the Business Services Organisation, the Northern Ireland Blood Transfusion Service Agency, The Children's Court Guardian Service Northern Ireland, the Northern Ireland Practice & Education Council for Nursing, Midwifery & Health Visiting (NIPEC), the Northern Ireland Social Care Council (NISCC), the Patient & Client Council, the Northern Ireland Regulation and Quality Improvement Authority and the Northern Ireland Medical and Dental Training Agency (NIMDTA)

- Inclusion of an open, just and learning culture.
- More information on the formal process.
- Introduction of a screening tool.

5. All HSC organisations are required to adopt the revised regional policy.

Enquiries

6. **Employees should direct personal enquiries to their employer**.

7. **Employers** should direct enquiries about the contents of this Circular to, Workforce Policy Directorate, Room D1, Castle Buildings, Stormont, Upper Newtownards Road, Belfast BT4 3SJ (or email: P&E@health-ni.gov.uk)

Further Copies

6. Copies of this Circular can be obtained from the Department's website at Workforce Policy Guidance

   A copy of the NHS Terms and Conditions of Service Handbook can be downloaded from the NHS Employers website at: https://www.nhsemployers.org/your-workforce/pay-and-reward/agenda-for-change/nhs-terms-and-conditions-of-service-handbook

CHRIS WILKINSON
Head of Pay and Employment

HSC Health and Social Care

CONFLICT BULLYING & HARASSMENT IN THE WORKPLACE

October 2023

Table of Contents

Our Commitment

The (Name of organisation) is an equal opportunities employer. As such, we will comply with the spirit and letter of the law, including equality legislation. We strive to create and promote an inclusive and harmonious working environment, where all staff feel safe at work, and are treated with civility, respect and dignity, regardless of their age, disability status, marital or civil partnership status, political opinion, race, religious belief, sex (including gender reassignment), sexual orientation, dependant status.

We all have different experiences, background and perspectives which mean that we often see the world in different ways. This means we can all react differently to situations at work, which can also affect relationships we have. This diversity of experience and thought is a good thing, but on occasion it can also lead to misunderstanding and conflict.

Poor working relationships unresolved conflict, bullying and harassment can have a detrimental effect on personal wellbeing, as well as the wider working environment. Evidence shows that effective team working, supported by good communication and responsive line management, impacts positively on patient and client care. Issues which affect the ability of staff to work well together will be taken seriously and addressed promptly. Bullying and harassment in the workplace is unacceptable and will not be tolerated or condoned under any circumstances.

We will work to create and maintain an organisation with an inclusive, just and learning culture where people feel proud to work. This will be achieved by fostering a climate of dignity and respect amongst staff at all levels, and in demonstrating our commitment to deal with conflict, bullying and harassment effectively and promptly.

A Just and Learning approach centres on the desire to create an environment where all staff are accountable and supported and empowered to learn when things do not go as expected.

2 Purpose and Aims

The purpose and aims of this policy and associated procedure are:

- To provide all staff, particularly managers, with clear guidance on how to handle conflict, bullying and harassment in accordance with best practice and relevant employment legislation.
- To outline to all staff their rights and their collective responsibility to create and maintain a safe, harmonious, positive and enabling working environment for all.
- To provide a mechanism to facilitate prompt resolution of issues that may arise.
- To prevent bullying of all staff members, including agency workers.
- To prevent harassment of all staff members, including agency workers.
- To contribute to building and maintaining a just and learning culture focusing more on supporting staff and managers in the early resolution of concerns and the restoration of working relationships.
- To facilitate learning from situations where there has been conflict, bullying or harassment in order to prevent re-occurrence.

3 Scope

3.1 This policy applies where there is general interpersonal conflict within the workplace or when a member of staff believes they have been subject to bullying or harassment, as defined in this policy. Where group conflict exists, the same principles laid down in this policy will apply. All staff have a responsibility to comply with this policy.

We expect our staff to both receive and show courtesy and respect to and from colleagues, patients, service users and anyone else with whom they come into contact in the course of their work. There is a particular obligation on managers to ensure the effective application of this policy and to work to cultivate and maintain a safe and positive working environment within their teams.

3.2 This policy also applies to events which could reasonably be regarded as an extension of the workplace, such as Christmas parties and conferences, the use of social media or any other situation which is an extension of the working environment. This policy should be read in conjunction with any related social media policy.

3.3 This policy should be read in conjunction with any relevant codes of conduct, and Maintaining High Professional Standards (applicable to medical and dental staff only).

3.4 It is expected that staff members will raise concerns of conflict, bullying or harassment in a timely manner and as close as possible to the alleged issue(s) or event(s). This should not normally be later than four months after the alleged issue(s) or event(s), other than in exceptional circumstances.

3.5 This policy must not be interpreted, or applied in such a way as to detract from the legitimate right and obligation of those in management roles to manage their staff in accordance with other Human Resources (HR) and Trust organisational policies. Constructive and fair criticism of behaviour or performance is not bullying or harassment. Management has a right to identify and address unacceptable standards of behaviour or performance and must do so in a fair, respectful and measured way and

in accordance with this policy. Failure to do this in a fair and respectful way may be considered and addressed under this policy and any other relevant HR policy.

3.6 This policy is not applicable where a member of staff believes they are being bullied or harassed by a member of staff from another organisation or a patient, client or member of the public. In such instances, staff should first seek advice from their line manager and HR and/or their trade union as appropriate, in order to progress their concern and receive the right support. Where a concern of bullying or harassment is raised by a member of staff from another organisation or a patient, client or member of the public against a staff member, this policy may be applied, and in all cases advice must be sought from HR.

3.7 If a staff member raises a concern against an agency worker or an agency worker raises a concern against a staff member, the line manager will liaise with the employment agency to work towards an effective resolution of the issues. The agency should have their own policies and procedures for dealing with concerns about their employees. The line manager will liaise with the employment agency to ensure there is an effective resolution of the concern.

This policy will apply where a concern is raised by an agency worker against a member of staff. The line manager, in conjunction with HR, will work with the employment agency, using this policy, towards an effective resolution of the issues.

4 Definitions and Legal Context

4.1 What is general conflict?

4.1.1 General interpersonal conflict can take many forms, for example; colleagues who simply do not work well together, as a result of different styles of working, someone changing their behaviour causing an unpleasant atmosphere, differing opinions and perceptions, personality clashes, or an overspill of personal issues outside of work. Most of us will experience an issue or level of conflict with someone at work at some point of our careers. However, these issues have the greatest chance of resolution if addressed locally and quickly through the dialogue and all staff are encouraged to 'test their perception' (see page 16) before labelling their experience or attempting to pre-determine the pathway for resolution.

4.2 What is bullying?

4.2.1 Bullying occurs 'where one person or persons engage(s) in unwanted conduct in relation to another person which has the purpose or effect of violating that person's dignity or creating an intimidating, hostile, degrading, humiliating or offensive environment for that person.

The conduct shall be regarded as having this effect only if, having regard to all the circumstances and in particular the alleged victim's perception, it should be reasonably considered as having that effect. [2]

[2] 'Harassment and Bullying in the Workplace' – A joint publication by the Equality Commission for Northern Ireland and the Labour Relations Agency.

4.2.2 Unlike harassment, bullying need not be related to any of the protected characteristics outlined in Section 4.3.1. Examples of bullying at work may include:

- Subjecting an individual to humiliation or ridicule;
- Inappropriate shouting or use of abusive language;
- Spreading malicious rumours or telling untruths;
- Constantly undermining effort, competence or confidence;
- Deliberately withholding information to affect a staff members' performance or reputation;
- Persistent adverse criticism in public or in private;
- Isolation or exclusion at work or from work related events;
- Intimidating body language or physical behaviour;
- Changing of work responsibilities unreasonably or without Justification.

This is not an exhaustive list, and all cases will be considered individually.

4.3 What is harassment?

4.3.1 Harassment bears very broad similarities to bullying and the behaviour described in Section 4.2.2. However, the crucial difference is that harassment is based on, motivated by or related to one of the equality grounds laid down in anti-discrimination legislation, and summarised in the table below. Harassment can also constitute a civil or criminal offence.

Legislation	Protected Equality Groups

Sex Discrimination (NI) Order 1998 as amended	Gender Gender identity and expression Marital or civil partnership status Pregnancy or maternity Carers
Fair Employment and Treatment (NI) Order 1998 as amended	Community background Religious and philosophical beliefs Political opinion Trade union membership
Employment Equality (Age) Regulations Northern Ireland 2006 as amended	A particular age or range of ages
Disability Discrimination Act 1995 as amended	Disability (Disability is defined as a physical or mental impairment which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities)
Employment Equality (Sexual Orientation) Regulations Northern Ireland 2003 as amended	Sexual orientation (Whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes)
Race Relations (NI) Order 2007 as amended	Race Colour Nationality Ethnic or national origin Irish Travellers

4.3.2 Harassment can be a single serious incident or an ongoing campaign. Conduct shall be regarded as harassment only if, having regard to all the circumstances and in particular the alleged victim's perception, it should be reasonably considered as having that effect. Where it is not mutually acceptable behaviour, this may constitute harassment. Harassment on the grounds of, or related to, a protected characteristic is unlawful discrimination and may constitute a criminal offence.

4.3.3 It is not necessary that a person possesses a particular characteristic themselves, as outlined in the table at 4.3.1, to be a victim of harassment. It can be as a result of their association with a person who falls into one of these categories, or a mistaken belief that they possess one of these characteristics.

4.3.4 Harassment can take many forms, as per the table below. This is not an exhaustive list of examples of behaviour that may amount to harassment or indeed bullying, if it does not relate to one of the equality grounds listed in 4.3.1.

- **Physical conduct**, ranging from touching to assault or making obscene gestures;
- **Verbal and written harassment** through jokes, racist, sexist, sectarian, homophobic or transphobic comments, comments about a person's disability, offensive language, gossip and slander, sectarian songs, mobile ring tones, threats, use of social media, letters and emails;
- **Visual displays** of posters, screensavers, downloaded images, graffiti, flags, bunting or emblems or any other offensive material;
- **Isolating** a person, including exclusion from social events;
- **Overloading** a person with unreasonable work activities;
- **Forcing** a person to offer sexual favours or to take part in religious or political activities;
- **Intrusion** by pestering, spying or following.

4.3.5 Causing or contributing to conflict, bullying and harassment is unacceptable behaviour which will not be permitted, accepted or condoned. Notwithstanding the legal implications of engaging in such behaviour, bullying and harassment are contrary to the standards of conduct that we expect of our staff and have the potential to impact on the delivery of safe, effective and compassionate care to patients, clients and service users. Such behaviours are detrimental to a productive, harmonious working environment, as well as the confidence, morale and performance of those affected by it, including anyone who witnesses or knows about the unwanted behaviour.

4.3.6 If you are experiencing conflict at work, but remain unsure as to whether it is general interpersonal conflict or bullying or harassment, you can seek advice from a trusted colleague, trade union representative or HR, so that the most appropriate course of action is taken to deal with your concerns quickly and effectively. If you believe your concern may constitute harassment as defined in this policy, you should report this to the appropriate manager immediately, to enable prompt resolution and ensure any relevant statutory time limits, such as those of the Employee Tribunals, can be adhered to.

4.3.7 If a staff member's behaviour is found to be in breach of this policy, consideration will be given to screening the matter under the Disciplinary policy.

5. The Rights and Responsibilities of All HSC Staff

5.1 As HSCNI staff, we have the right to work in an environment that is free from conflict, bullying and harassment, where all staff feel safe, and are treated with respect and courtesy. HSCNI fully recognises your right to complain about harassment or bullying and as such all concerns will be dealt with seriously, promptly and

confidentially. In matters relating to interpersonal conflict, it is expected that all staff participate in efforts to resolve their issues locally and promptly and without the need for formal investigation.

5.2 The Trust's internal procedures do not negate the right of an aggrieved staff member to also pursue complaints through an Industrial Tribunal, the Fair Employment Tribunal or through the courts. If you wish, you can obtain advice from your trade union representative, the Equality Commission and the Labour Relations Agency. There are strict time limits for making complaints to a tribunal and complainants normally will be expected to have raised their concerns under the relevant HSCNI procedure first, though it is not necessary for the matter to have been brought to a conclusion.

5.3 Line Managers and HR will ensure that any staff member who raises a concern under this policy, or who gives evidence or information in connection with such cases will not be victimised, i.e. they will not be discriminated against, harassed or bullied in retaliation for their actions. Victimisation is also discrimination contrary to equality laws and this policy, will be treated as misconduct which may warrant disciplinary action, up to and including dismissal.

5.4 It is appreciated that it may be difficult to report or deal with bullying or harassment, however, it is expected that staff will report or deal with bullying or harassment as failure to do so may be viewed as condoning this behaviour.

6. The Role of the Board/Senior Management Team

The Board and/or Senior Management Team have a responsibility to act as role models supporting and encouraging an open, just and learning culture and monitoring the effectiveness of this policy and procedure.

7. The Role of HSC Staff

All staff have a responsibility to familiarise themselves with this policy, and to ensure that their behaviour complies with what is expected. Staff must recognise that they have a vital role to play in the creation, promotion and maintenance of a good and harmonious working environment, where the dignity of all is respected.

7.1 Staff are expected to participate in any relevant training to support this policy and adhere to all relevant procedures including professional codes of conduct where applicable.

7.2 If you raise a concern, you are required to participate in any process that is invoked as a result to resolve the issue. This includes, for example, facilitated meetings (reference section 2.2 of procedure) or investigation (reference section 4 of procedure), where this has been deemed necessary. You will also be expected to give due consideration to mediation, where appropriate. Failure to participate in attempts to resolve the issue you have raised may result in the matter being deemed closed.

7.3 If a concern is raised about you, you will be required to participate in any facilitated meetings or investigations, where appropriate, as well as giving due consideration to mediation, if applicable. Failure to meaningfully participate in attempts to resolve the

issue may result management considering the best way forward and other actions in conjunction with HR.

7.4 Where group conflict exists, staff should work with management to agree an appropriate way forward to progress the matter on behalf of the group.

7.5 Staff must not allow situations of misunderstanding to develop into conflict situations. Instead, staff should be proactive in dealing with issues as they arise, so long as they feel confident enough to do so. Where staff lack confidence, they should seek advice from a trusted colleague, trade union representative, manager or HR.

7.6 Any staff member who is aware of or witnesses any instances of conflict, bullying or harassment should support their colleagues and alert a manager or supervisor to assist all parties to work towards swift and effective resolution. Where the behaviour in question is that of a manager, the staff member should either report it to the manager's line manager or seek advice from HR or a trade union representative.

8. The Role of Managers

8.1 Line Managers have a specific responsibility in the prevention and resolution of conflict, bullying and harassment. They are responsible for creating a safe, harmonious and enabling working environment, setting a good example for other staff members to follow, intervening when conflict arises and ensuring that their teams are aware of their obligations and relevant policies.

8.2 Managers should ensure they are fully aware of their responsibilities under the relevant policies and are alert to potential issues of conflict, bullying and harassment; and that they intervene and take appropriate action quickly when issues of conflict, bullying or harassment occur.

8.3 Managers have a responsibility to be responsive and supportive to any member of staff who raises an issue of conflict or makes an allegation of bullying or harassment. They must provide clear advice on the procedure, maintain strict confidentiality throughout the process and actively seek to bring matters to a timely conclusion. They should also seek to prevent a reoccurrence of the same problem, either whilst the concern is being resolved or after it has been dealt with.

8.4 Managers must also take particular care to ensure their behaviour sets an example and must be mindful of their interactions with their team, particularly during sensitive but necessary conversations, for example during appraisals, performance reviews or attendance management meetings.

9. The Role of Trade Unions

9.1 Trade union representatives can help support and guide members towards the most appropriate course of action in a situation of conflict, bullying or harassment. It is best to involve your trade union representative at the earliest possible stage so they can help you test your perception and advise appropriately. Trade union representatives can also provide valuable support, advice and representation in relation to bullying and harassment and formal processes as detailed within this procedure.

9.2 Trade union representatives also have a role in supporting and educating members on their rights responsibilities under this policy.

10. The Role of Human Resources

10.1 HR has a key role to play in the resolution of conflict, bullying and harassment in the workplace. HR is firstly responsible for raising awareness of this policy and procedure, and ensuring that managers are confident and competent to deal with conflict locally and at an early stage.

10.2 It is expected that cases of general interpersonal conflict will be addressed locally by line managers. HR is available for advice and guidance and can assist managers and staff members to test their perceptions and triage an issue as appropriate. HR may participate in or facilitate a meeting to progress resolution. Where conflict involves the line manager, advice should be sought from your line manager's manager or HR. Staff may also wish to seek advice from a trade union representative.

10.3 HR will work with management, the complainant and their trade union representative, if applicable, to identify the most appropriate process for handling the concern.
10.4 Where management and HR determine that a formal procedure is not required management will meet with the employee to clearly explain the next steps under the informal procedure. The employee has the right to be accompanied at this meeting. HR will remain available for advice and guidance to all parties on the relevant informal process.
10.5 Where it is agreed that a formal procedure is necessary to consider bullying or harassment, HR will support the parties concerned by providing advice and guidance on process and policy application, signposting to sources of support for staff, liaising with legal representatives where necessary and case- managing the process in accordance with best practice and employment legislation. HR, in conjunction with the relevant line manager, has a responsibility to progress the formal procedure and bring such matters to a timely conclusion.
10.6 HR will also monitor trends in turnover, sickness absence rates and take particular note of the working lives of rotational staff in order to surface any underlying workplace issues.

Procedure

1 Test your perceptions

This procedure outlines the steps that should be followed where an employee raises a concern about conflict, bullying or harassment. Before using this policy, you should always test your perceptions. In other words, you should explain your version of events to a trusted colleague, manager or trade union representative. The aim of doing this is to gain greater clarity and perspective on the incident or behaviours and prevent rash decision making. The diagram below outlines some key questions to help you do this.
Test your perceptions

1.1 If at the end of your test you feel you are being bullied or harassed, then report this **immediately** to either your line manager, or their manager, if the concern relates to your own manager. You can also seek support from your trade union representative or HR.

1.2 In terms of conflict, staff should bear in mind their personal responsibility to promote good relations and attempt to resolve conflict where there are instances of staff members not working well together, so long as they feel confident enough to do so. For example, approaching the other individual at an early stage to discuss your concerns, your perceptions, the impact and how you would like to move forward working together. It is advisable to keep a written record of your discussion(s).

2 Self- Resolution

If you simply want the behaviour to stop and where the incident was not very serious, then the informal procedure is likely the most appropriate approach to effect swift, confidential resolution to an issue. If you feel confident and able to do so, you should try and resolve conflict yourself, by approaching the person concerned, outlining the event or incident that you are referring to, describing how you felt and explain why you would not wish it to happen again and what steps you will take if it does reoccur. You can do this with the support of a colleague or a trade union representative if you wish.

3 Informal Procedure

3.1 Where self-resolution has not successfully resolved your concerns, or where you do not feel able to approach the person, you should discuss the matter with your line manager as soon as is reasonably possible. Should the concern be against the line manager, it should be brought to their line manager who will take it forward.
3.2 The manager should act promptly and listen to what has happened and using the 'test your perception' model where appropriate discuss the most appropriate way of addressing the matter; maintaining strict confidentiality at all times.
3.3 It should be noted that in most cases, it is expected that parties will engage in informal resolution in the first instance, with the exception being in cases of serious bullying and/or harassment (as defined at section 4.3.1).
Good practice encourages an informal, restorative approach to conflict, bullying and harassment in place of or prior to a formal process for a number of reasons including:

- A formal process may cause an immediate emotional and potentially further harmful impact on all parties involved.
- A formal process is often more lengthy and this can further impact on the health and wellbeing of those involved.
- A formal process may lead the parties to become entrenched and the working relationship may be broken for good.

3.4 The informal process takes the form of a facilitated discussion where the manager will:

- **Meet[3] with the complainant,** and also meet with the person against whom the concerns has been made to make them aware. Both parties should be informed that the other person involved is also having an individual meeting. The manager should listen out for other contributory factors, recurring and common themes which could be used to direct dialogue when parties are brought together. The manager should remind the parties of their obligation to resolve matters locally and promptly.

- **Meet with the parties together**, this should be a future-focused meeting, with common themes being drawn down out and discussed. The meeting should ideally end with an agreement to draw a line under the matter or, where appropriate, with the completion of an action plan detailing how the parties propose to work well together in future. The manager should make a note of any

[3] It is not usually necessary for HR or trade union colleagues to attend these meetings, but that does not preclude their attendance if necessary.

outcomes or action plans and follow up on these within a suitable time period. Again, it is not usually necessary for parties to be accompanied at these meetings.

- **Monitor the situation** and be alert to any deterioration of the situation or any patterns of behaviour emerging. Equally, staff should make genuine efforts to embed what was agreed at the meeting and to work well together.

3.5 After the joint meeting has taken place and action plan agreed, the matter will be considered closed. Where there are new issues or where the situation deteriorates HR together with the appropriate manager, will triage the issue, making a decision on the way forward by reviewing information and circumstances of the case. It may be the case that a further facilitated discussion is required or formal mediation may be offered as a final opportunity to resolve the conflict and restore the working relationship.
Where management and HR are satisfied that the issue(s) constitute interpersonal conflict, there is no automatic right to a formal process.
The staff member may wish to seek advice from their trade union representative.
3.6 Where there are new issues or where the situation deteriorates the appropriate manager together with HR, will screen the issue, making a decision on the way forward by reviewing information and circumstances of the case. It may be the case that a further facilitated discussion is required or a formal mediation may be offered.
(see Screening Tool at Appendix 1)

3.7 Where there is evidence that one or other of the parties has failed to comply with the previous agreement reached through facilitated discussion, consideration should be given to the appropriateness of other policies and procedures, including the Disciplinary Procedure, in relation to conduct. It is also important at this stage, in line with an open, just and learning culture that the manager reflects on the information gathered and shared through the process and identities and implements any learning.

4 Mediation

4.1 In cases where informal resolution has not been successful, you will be expected to consider mediation. Whilst it is not mandatory that you participate, you will be expected to give it due consideration.

4.2 Mediation is not about placing blame or making judgements. It is designed to help parties gain clarity around the claim of conflict, bullying or harassment. Mediation provides the potential to:

- Help parties to hold open conversations that would normally be too difficult to have constructively.
- Help parties to understand and empathise with each other's emotions and situations.
- Explore all parties' issues and concerns and use joint problem solving to find a solution that each side feels is fair.

- Encourage communication and re-establish workable relationships

4.3 Trained mediators will facilitate open and honest communication, in a safe and impartial environment in order to foster better relations, and ultimately help the parties come to an agreement as to how they will work together in the future. This will be written and signed by all concerned. The manager concerned will not be privy to the details of what was said or agreed. They will only know if the mediation was successful or not, unless the parties to the mediation agree for particular information to be shared.

4.4 Where mediation is agreed, you will take part in the mediation process within 4 weeks (or as soon as is reasonably practicable in view of leave arrangements) of the mediation having been agreed.

4.5 Where management and HR have determined that it is a matter of general interpersonal conflict, mediation will be the last stage of the process. If you refuse to participate in mediation or where mediation fails, the manager reserves the right to take action as necessary to ensure that a harmonious and safe working environment is achieved.

Action may include:

- Reminding staff of the HSC values and the associated behaviours expected of them, advising that it is not unreasonable that they should work together.
- Moving either or both parties
- Changing working patterns of either or both
- Screening the matter under the Disciplinary Procedure

Senior management and HR will make the final decision on any redeployment, ensuring this is in line with the relevant terms and conditions, and will not put the employee at a substantive detriment.

5 Formal Procedure

If a concern of bullying or harassment is serious, it may be appropriate to go to a formal process. However, it is important to note that even harassment can take place across a very wide spectrum of behaviour and be unintentional, and there could be circumstances where an informal approach or mediation may be helpful.

5.1 Concerns should be raised as soon as possible (and not later than 4 months) following an alleged act of bullying or harassment and, where possible, should be set out in writing to the appropriate manager or HR, making it clear which protected characteristic the alleged harassment relates to, if appropriate. Concerns may be

raised by a staff member, or someone on their behalf such as a colleague or a trade union representative and should be discussed with HR immediately.

a. Following screening (see appendix 1), if the incident(s) reported is so serious the issue will be addressed through the formal procedure. It is accepted that in making this determination discussion will have taken place with the affected staff member(s) and/or their trade union representative where appropriate to ensure understanding. Following determination of the next steps by management and HR, the staff member will be advised of this in writing within 5 working days. In relation to concerns raised about Medical or Dental staff, consideration must also be given to procedures and timescales laid out within Maintaining High Professional Standards and advice sought on how to proceed.

b. Whilst this is a more formal process, the possibility of mutual resolution in instances of bullying or harassment through mediation at any stage of the process may be considered with the agreement of HR, management, the employee and their trade union representative, if applicable.

This will be considered in the context of the case and the seriousness of the incident which gave rise to the concern.

c. In some instances, there may be clear evidence of misconduct that is so serious that it may be appropriate to move straight to disciplinary proceedings. Where there is concern that conduct may constitute a criminal offence, advice should be sought immediately from HR.

d. At this stage, a senior manager will need to decide whether it is necessary to keep the complainant and the respondent separated up and until the investigation is completed. This should be discussed with HR and in most cases will be facilitated by moving one or both parties to alternative duties, an alternative reporting arrangement or alternative role. Every effort should be made to ensure that the staff are moved to a similar role at the same substantive grade. However in the event that all options have been exhausted and there is only a post available at lower grade or in a different role, the staff member must retain the pay and conditions of their substantive grade for the duration of the investigation. Managers must ensure that it is communicated to both parties that this is a neutral act and in no way infers wrong doing or guilt on the part of the staff member who has been moved. The decision of who is moved should be considered on a case by case basis taking into consideration the needs of the service.

e. If management feel that there is a need to place a staff member on precautionary suspension, this decision must be taken in conjunction with HR and the relevant

professional lead where appropriate. The staff member will continue to receive their usual pay and conditions while on Precautionary Suspension. Precautionary Suspension must only be considered in extreme circumstances as a last resort.

f. Managers have a responsibility to regularly (no less often than every 4 weeks) review the decision as to whether a staff member should be moved to alternative duties, an alternative role or placed on precautionary suspension and communicate their decision in writing to the employee.

g. Both the complainant and the respondent should receive written confirmation of the formal investigation and any alternative arrangements/precautionary suspension.

Step One: Appointment of the Investigating Officer/Team and clarifying the process

- Following screening by management and HR, where it is determined that a formal investigation is required, management, guided by HR where necessary, will appoint an investigating officer or team and set up Terms of Reference without undue delay and normally within two weeks. Terms of Reference are essential in providing clear guidance to the investigating officer or team on the subject and scope of the investigation.

- The team will be required to establish the facts and decide how the matter should be progressed. The investigating officer/team should be clear at the outset about how information will be used and shared throughout the investigation and where necessary HR should provide guidance on this.

- It is anticipated that most investigations should be completed within a period of 8-12 weeks. The investigating officer/team should draw up an action plan at the outset of proceedings, outlining how the investigation will be conducted. This action plan will be flexible, as relevant parties may need to be interviewed on more than one occasion. It is the responsibility of the investigating officer/team to update the parties on the status of the investigation and provide an explanation for any delays. In any case, the investigating officer/team **must** provide an update to all relevant parties at the six week mark.

- Decisions to refer the respondent to a relevant professional body, e.g. NMC, GMC, DBS, NISCC and HCPC and also to the Police Service of Northern Ireland

(PSNI) should be taken in conjunction with HR. The employer is also required, under the Protection of Children and Vulnerable Adults (NI) Order 2003, to make a referral to the Department of Health if a person working in a child care or vulnerable adults position has been dismissed, would have been dismissed, or considered for dismissal had they not resigned, or has been suspended, or transferred from a child care or vulnerable adult position.[4]

- At regular intervals, the manager and HR should remind all staff about the support and counselling services that can be accessed at any stage in the process.

Step Two: Initial meeting with the complainant

- The investigating officer/team will interview the complainant to clarify and formally record the nature of the concern and ensure it is being handled under the correct procedure. The complainant has the right to be accompanied by a work colleague or trade union representative at this stage.

- The investigating officer/team may ask the complainant to identify any key witnesses that they may need to interview. The investigating officer or team will advise the complainant that there may be a need to meet with them again for clarification.

- The investigating officer/team will, in a timely manner and normally within two working weeks, send the complainant a written note of the meeting, for confirmation that it is an accurate account of what was discussed. Notes of a meeting are not a verbatim account of what was said but should provide a broad summary of matters discussed. Notes of a meeting are not a verbatim account of what was said but should provide a broad summary of matters discussed. The complainant should agree the note or alternatively may wish to highlight 'factual errors' or 'omissions' and should do so within two weeks of receipt or sooner.

- The investigating officer/team will advise the complainant that the issue is being dealt with strictly confidentially, but that the details of the concern will be shared with the respondent. They will be advised that the outcome of the investigation will be confirmed in writing.

[4] For medical and dental staff, MHPS will also apply.

- The complainant will receive a written note of the meeting to ensure it is an accurate record of what is discussed.

Step Three: Informing the respondent

- The investigating officer/team will meet with the respondent who will be given an opportunity to answer the concern. This meeting should be scheduled within the action plan to take place as soon as is reasonably practicable after the initial meeting with the complainant. They have the right to be accompanied to this meeting by a work colleague or trade union representative. They will also be informed that they should not contact an alleged victim and that the outcome of the investigation will be communicated

- The investigating officer/team may ask the respondent to identify any key witnesses that they may need to interview.

- The investigating officer/team will advise the respondent that there may be a need to meet with them again for clarification.

- Where a written complaint has been received, the respondent has a right to see it, but should be made aware that it may be redacted to remove information that is of a personal or sensitive nature or irrelevant to them or the investigation.

- The investigating officer/team will, in a timely manner and normally within two working weeks, send the respondent a written note of the meeting, for confirmation that it is an accurate record of what was said but should provide a broad summary of matters discussed. The respondent should agree the note or alternatively may wish to highlight 'factual errors' or 'omissions' and should do so within two weeks of receipt or sooner.

- Should the respondent make or indicate that they wish to make a counter complaint, the investigating officer or team should take a separate note of these concerns and forward them to management for screening in conjunction with HR. This may result in the concerns being incorporated into the existing investigation or being the subject of a separate investigation.

Step Four: Meeting with other parties/witnesses as part of the investigation

- The investigating officer/team will also meet with those who they have deemed important in helping to establish facts, and/or have been cited as a direct witness.

- In recognising the importance of candour all staff are required to cooperate to enable an investigation to be carried out effectively and promptly.

- Witnesses are not normally represented but can be accompanied by a trade union representative or colleague not involved in the matter. This is for support only. Witnesses must be reminded about the importance of confidentiality.

- The investigating officer/team should advise the witnesses that any information they provide during the investigation:
  - May be incorporated into the investigation report
  - May be shared with the respondent
  - May be shared (with appropriate redaction) as part of Subject Access Request or a legal discovery process.

- The investigating officer/team should also advise the witness that should the matter progress to a disciplinary hearing, you may be required to attend and participate as a witness. Any issues or concerns in respect of this should be explored and resolved with the support of HR on a case by case basis.

- The investigating officer/team will, in a timely manner and normally within two working weeks, send the witness a written note of their meeting, for confirmation that it is an accurate account of what is discussed.

- The complainant, the respondent and witnesses should all be advised that whilst the investigation process is confidential, records of evidence may be requested for example, by subject access request and may by law require to be furnished, subject to any appropriate redaction. In addition, records of evidence obtained during the investigation may be discoverable documents and may require to be disclosed where relevant to any subsequent legal proceedings.

Step Five: Reporting the facts

- The investigating officer/team will prepare a report outlining the facts, indicating their findings and whether a case of bullying or harassment is substantiated. They may also make recommendations.
- This will be considered by the relevant manager in collaboration with HR to determine the outcome and whether any further action should be taken. [5]
- Staff should be aware that there are a number of potential outcomes that an investigation may produce. Although this list is not exhaustive, examples include:
  - No further action required

[5] Medical and Dental staff should be aware that further action may be taken under MHPS.

- No further action required at this time, but the situation is to be monitored and kept under review.
- Mediation where both parties agree to take part
- Invocation of Capability Procedure where there is no evidence of intent to cause harm
- Redeployment of staff where there is an irretrievable breakdown in relationships (any decision to move a member of staff will be reasonable and proportionate, and taken in conjunction by senior management and HR, on a case by case basis, with regard to service need)
- Invocation of the Disciplinary Procedure

Step Six: Communicating the decision and right of appeal

- Once a final report of findings and recommendations has been produced and accepted by management, the complainant and respondent will be informed of the outcome of the investigation in writing, and a meeting will also be held to discuss. The potential outcomes of the investigation may include:
  - No evidence to support the concerns raised
  - An offer of mediation
  - Matter proceeds to be considered under disciplinary procedure for the respondent (without further investigation).
- On reviewing the report, management and HR also need to consider what, if any, learning can be taken and shared appropriately.
- Management must ensure that recommendation are implemented in a timely manner and are appropriate monitored or reviewed.
- The complainant has a right to request an appeal against the outcome of the formal investigation on the basis that there are factual inaccuracies and/or omissions within the investigation. The complainant may have an opinion or perception of a particular event, however it is important that the complainant can evidence if a point is factually incorrect, or there have been omissions made by the investigation team that may have a bearing on the overall findings, conclusion and outcome. It is not sufficient to dispute what the respondent, or other parties, may have said during the investigation process. This will not be regarded as a factual inaccuracy or omission. This appeal should include the specific grounds for appeal and should be made in writing to the Director of HR **within 10 working days of the outcome letter**. If the appeal letters does not state the specific grounds for appeal, management or HR will seek this detail in advance of the appeal hearing.
- The appeal process will consist of a formal hearing by a panel of two managers, at higher level than the manager who considered report, and who have had no

prior involvement in these matters. Those in attendance at the appeal hearing will include:

- Complainant
- Complainant's trusted work colleague or trade union representative
- Investigating officer/team

The appeal panel will receive a copy of the investigation report and the letter of appeal.

- The complainant will be required to submit any evidence that they intend to rely upon 5 working days in advance of the hearing.
- At the hearing the complainant will be invited to present their case first and the investigating officer/team will then be invited to present their response. The panel may question the parties for further information or clarification.
- The panel will issue their outcome in writing normally within 10 calendar days after the appeal hearing. Where this is not possible, the panel must ensure appropriate updates are communicated to the complainant.

The potential outcome of the appeal hearing may include:

- The panel find that there is no evidence to support the complainant's point of appeal (factual inaccuracies or omissions).
- The panel uphold some or all of the complainant's points of appeal and make recommendations as to what action is required to rectify matters (factual inaccuracies or omissions).
- In respect of the respondent, the right of appeal is only afforded through the disciplinary procedure at a formal hearing.

Review

The operation of this policy will be monitored and reviewed regularly (every 5 years) to ensure its relevance and effectiveness.

Appendix 1

Outcome of Screening **(to be completed jointly by Management and HR)** To be completed within 5 days of complaint/concern.	
SECTION A - Details of complainant (s)	
Name:	
Position/Role :	
Location:	
Who is the complaint against?	
SECTION B - Nature of complaint/concern: summary of complaint identifying if a) general conflict; b) bullying; c) harassment. Consider definitions of each from CBH policy. NB Important to consider if the concerns are related to one or more of the protected equality grounds (i.e. Harassment on the grounds of age for example) Where management and HR are satisfied that the issue(s) constitute interpersonal conflict there is no automatic right to a formal process. (Section 3.5 CBH Procedure)	
Summary of complaint/concern:	
SECTION C – Decision and rationale (having considered all relevant factors)	
Consideration of circumstances of case:	

	Yes/No	**Please detail:**
1. Do you consider this to be a case of general conflict, bullying or harassment? If harassment – under what protected characteristic(s)?		

2. Has the matter been raised in a timely manner in line with policy guidance?		
3. Have the concerns been explored in relation to Paragraph 3.5 of CBH Policy and Section 1 of CBH Procedure?		
4. What has been the impact of the behaviours?		
5. Would another person be likely to react in the same or similar manner?		
6. What actions (if any) to date have been taken to help resolve the concerns?		
Mitigation	**Yes/No**	**Please detail:**
Are personal circumstances and or health / disability of the complainant and/or respondent a relevant factor in whether this goes to formal investigation?		
Decision and rationale: Consider the information arising from the questions above in agreeing whether this should proceed to formal investigation. It will be useful to consider any previous informal attempts (i.e. facilitated conversations, mediation) to resolve matters, including whether the issues are similar, when the informal attempt(s) took place and the outcome(s).		

Is a formal investigation required? Please circle YES or NO. If no, complete Section D. If yes, complete Section E.	
SECTION D – Details of any other action to be taken (for example, learning for the team, change in process, training to be completed, facilitated conversation, mediation).	
SECTION E – Terms of Reference	
1. To investigate (insert matters of concern to be investigated) 2. To prepare a report outlining the facts. 3. To provide a set of recommendations for management to consider. 4. To keep the Terms of Reference under review as required. This investigation will be conducted under the Conflict, Bullying & Harassment Policy.	
SECTION F (If considering any of the following measures please refer to relevant guidance in Section 5 Conflict, Bullying & Harassment Procedure.)	
Transfer respondent and/or complainant to other duties?	Yes/No Details of and effective date:
Restrict practice of respondent and/or complainant?	Yes/No Details of and effective date
Place the respondent on precautionary suspension?	Yes/No Effective date:
Decision to place an employee on Precautionary Suspension/Restricted Practice or transfer to other duties must be reviewed by management every four weeks. (See section 5 of the Conflict, Bullying & Harassment Procedure)	
Name of Employee Support Contact:	
Name of Investigating Officer(s):	
Date complainant was advised verbally of the screening outcome and by whom:	
Date respondent was advised verbally of the screening outcome and by whom:	
SECTION G - Authorisation	

Case Manager	**Signed:** _____ **Date:** _____
HR Manager	**Signed:** _____ **Date:** _____
Professional Lead (if applicable)	**Signed:** _____ **Date:** _____
NEXT STEPS: EACH HSC ORGANISATION TO AMEND ACCORDINGLY	

Northern Ireland Ambulance Service
Health and Social Care Trust

MINUTES OF THE SAFETY, QUALITY, PATIENT EXPERIENCE AND PERFORMANCE COMMITTEE HELD AT 9.30AM ON THURSDAY 7 SEPTEMBER 2023 IN THE BOARDROOM, NIAS HQ

PRESENT:	Mr D Ashford	-	Committee Chair
	Mr W Abraham	-	Non-Executive Director
IN ATTENDANCE:	Mr M Bloomfield	-	Chief Executive
	Ms R Byrne	-	Director of Operations
	Ms L Charlton	-	Director of Quality, Safety & Improvement
	Mr P Nicholson	-	Director of Finance, Procurement, Fleet & Estates
	Dr N Ruddell	-	Medical Director
	Mr R Sowney	-	Senior Clinical Adviser (left the meeting at 12.20pm)
	Mrs C Mooney	-	Board Secretary
	Ms R Finn	-	Assistant Director QSI
	Ms H Sharpe	-	Assistant Director EPRR (for agenda items 5 & 6 only)
	Mr J McArthur	-	Assistant Director EPRR (for agenda items 5 & 6 only)
APOLOGIES:	Mr T Haslett	-	Non Executive Director
	Ms M Lemon	-	Director of HR & OD
	Ms M Paterson	-	Director of Planning, Performance & Corporate Services
	Ms K Keating	-	Risk Manager

1 Apologies & Opening Remarks

The apologies were noted.

The Chair welcomed members to today's meeting.

2 Procedure

2.1 Declaration of Potential Conflicts of Interest

There were no declaration of conflicts of interest.

2.2 Quorum

The Chair confirmed that the Committee was quorate.

2.3 Confidentiality of Information

The Chair emphasised the confidentiality of information.

3 Previous Minutes (SC07/09/23/01)

Ms Charlton referred to page 22 of the minutes of 8 June and the discussion around referrals in relation to domestic violence. She clarified that figures were not currently reported to the SPPG. However, Mr Flannagan was currently engaging with SPPG colleagues in this regard.

The minutes of the previous meetings on 8 June 2023 and 27 July 2023 were **APPROVED** on a proposal from Mr Abraham and seconded by Mr Ashford.

4 Matters Arising (SC07/09/23/02)

Members **NOTED** the action list.

Ms Byrne advised that she had recently met with the team in EAC to discuss skill mix. She acknowledged that the focus recently had been on skill mix in CSD. However, the team was now considering staffing across all grades. Ms Byrne said she intended to bring a paper to SMT in the near future and would provide a further update to the November meeting of the Safety Committee.

The Chair suggested that it might be more relevant for an update to be presented to the PFOD Committee.

Dr Ruddell noted that the final report of the Strategic Review of Clinical Education would be presented to the November meeting.

The Chair welcomed this and asked that sufficient time be set aside on the agenda for discussion.
The Chair alluded to the ongoing work around EPRR and welcomed Ms Sharpe and Mr McArthur to the meeting. He said it was likely that a further meeting would be needed but he said that the Committee could decide following the update.

Mr Bloomfield welcomed this and said it would be important for the Committee to be content with the level of progress. He added that having focussed discussion on this work was impacting on the mapping of agenda items to be considered by the Safety Committee. Mr Bloomfield advised that he and the Chair had discussed EPRR with the Permanent Secretary during the recent Accountability Review and had advised him of the approach adopted by the Committee.

5 **Standing Items:**

(i) **Identification of Risk**

No emerging areas of risk were identified.

(ii) **EPRR Assurance & Improvement Group Update**

Ms Sharpe advised that the EPRR Assurance and Improvement Group replaced the previous Emergency Planning & Business Continuity Group. She explained that the purpose of the Group was to provide an additional level of assurance, ensuring that EPRR improvements and developments were evidence based and in keeping with the Trust's strategic objectives.

Ms Sharpe noted that the revised Group met in mid-August and was in the process of reviewing the Terms of Reference. She added that, while it was likely meetings would take place more frequently in the initial months, it was envisaged that they would take place on a quarterly basis. Ms Sharpe indicated that updates would be provided to SMT with quarterly reports to the Safety Committee.

The Chair suggested that reports to the Committee might be required more frequently.

6 **Emergency Preparedness, Resilience and Response – Improvement Plan and Progress Update (SC07/09/23/03)**

The Chair welcomed Ms Sharpe and Mr McArthur to the meeting and asked them to provide a detailed update on the work to date.

The Chair thanked all concerned and said he looked forward to further updates.

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

7 **Involvement and Consultation Scheme Commitment (SC07/09/23/04)**

Ms Charlton noted that this item was For Noting and explained that NIAS had signed off on the original PPI Consultation Scheme in 2009. She advised that the Regional HSC PPI Forum had reviewed and restructured the original scheme to ensure a coherent and coordinated approach across HSC and said there were references to the DoH Policy Guidance Circular, Change or Withdrawal of Services (ECCPD) 05/2.

Ms Charlton advised that the Involvement & Consultation Scheme Commitment outlined how HSC Trusts would deliver on their statutory duty to involve and consult.

She explained that, in signing off on the Commitment, she and Mr Bloomfield were providing assurance that the Trust would progress a number of areas, namely:

- ensuring that Involvement and Consultations undertaken would meet recognised best practice standards.
- ensuring that there were Involvement opportunities within every Directorate.
- ensuring that service users and carers were appropriately reimbursed for any out-of-pocket expenses as set out in Regional Reimbursement Guidance.
- where appropriate, would consider remuneration of service users and carers for their contribution, where this was deemed to fall within the qualifying scope, scale and nature of the eligibility criteria, as defined in agreed Regional Remuneration Guidance, when this was finalised and adopted.

- ensuring the statutory Involvement and Consultation and PPI Policy obligations formed part of the Service's induction programme and embedded into all staff appraisals.

Ms Charlton acknowledged that further work was required around the remuneration of service users and said that there was a commitment in NI to ensure that service users were remunerated appropriately. She advised that NIAS had been the only Trust not to receive transformation monies to recruit Partnership Officer posts and added that she had requested a meeting with the PHA Director of Nursing to discuss further. She reminded the meeting that the Trust had a statutory duty to involve.

Mr Sowney enquired as to the resources available to provide training to service users and carers.

Responding, Ms Charlton explained that there was no dedicated post to provide training and advised that a number of staff had dual portfolios. She confirmed that that, in the monitoring template, the Trust had noted that significant progress had been made not only to engage but involve service users in work and projects. Ms Charlton advised that the Quality & Safety Strategy had references to a number of service user focus groups. She added that the Trust had also engaged with service users around a bereavement leaflet for patients as well as around the introduction of body-worn video.

Ms Charlton alluded to the 10,000 More Voices survey recently published around service users' experiences of using emergency services and said there had been approximately 141 stories gathered. She said that these would be presented to the Safety Committee in accordance with the agenda mapping.

Mr Sowney suggested that there would be a challenge in ensuring staff involvement in PPI and said that one of the actions alluded to was ensuring this was included as an item on team meeting agendas. He emphasised the importance of putting team meeting arrangements in place.

Ms Charlton said it was her observation that this was now increasingly taking place. She said she did not have the capacity to ensure that QSI staff would be present at all meetings but added that the SAI team and Mr Gillan had attended meetings in Divisions and Directorate meetings.

Mr Sowney said he recognised the efforts being made but suggested that the tier of staff below that was where the challenge lay and he asked how the Trust intended to improve this.

In response, Ms Charlton advised that, when speaking to staff re the Quality and Safety and PPI Strategies, Mr Gillan had met with staff at EDs. She alluded to the NICE Shared Decision Making Framework, in particular the guideline around decision making at the time of delivering care and said this was operational based and that members of the Trust clinical team represented NIAS on the PHA related regional working group.

Mr Sowney said the challenge for the Trust was in creating a culture whereby Station Officers, for example, engaged with staff on a regular basis.

Ms Finn added that PPI was now included on the agenda at induction training.

Mr Bloomfield agreed with Mr Sowney's point and said discussions also needed to take place in the context of other areas for discussion, for example absence management.

Following this discussion, the Involvement and Consultation Scheme Commitment was **NOTED** by the Committee.

8 **Policy for the Completion of Patient Records (SC07/09/23/05)**

Dr Ruddell explained that, with the transition to electronic records, it was timely to refresh and update the Policy for Completion of Patient Records since the previous version was released in June 2022. He advised that the revised policy had also been agreed by Trade Union representatives and said that the primary focus of the revision was the emphasis of the creation of electronic Patient Care Records (ePCR) as standard practice, transitioning away from the use of paper records and contributing to the overall HSC Digitisation Strategy.

Dr Ruddell said that he looked forward to the introduction of electronic records and said that having good contemporaneous records allowed for thorough investigations and an explanation of staff's thinking and decision-making. He acknowledged that the

Policy was the most recent iteration and took account of the implementation of REACH.

The Chair asked if REACH had been universally accepted by staff.

Responding, Dr Ruddell confirmed that all staff had been trained in the use of REACH and said that full implementation would be completed by the end of March 2024.

Mr Abraham alluded to the reference in paragraph 2.2 that the 'written PRF will be only used as a contingency on occasions that hardware/software is unavailable to produce the electronic patient care record and will be directed by Medical Directorate, Operations Directorate or IT notifications, directly to all operational staff via existing processes (for example MDT bulletins)' and asked whether this was the current status or a proposed lead in.

Dr Ruddell explained that this was a 'fail safe' in the event of a technical failure. He indicated that currently over 10,000 electronic records had been completed. He said that, while the system was operational, it was not being used universally. Dr Ruddell advised that the ED at the Ulster Hospital had been unable to receive electronic records and the Trust's IT team had been liaising with its SET counterparts in an effort to resolve this matter. He said that the Policy made reference to the fact that staff could not decide when to complete an electronic record but would be advised to complete a paper record by either the Medical or Operations Directorates or IT due to a systems failure.

Ms Charlton welcomed the fact that over 10,000 electronic records had been completed but acknowledged that, in the context of over 300,000 attendances per year, this number was small.

Mr Abraham said that he had found paragraph 2.2 to be confusing and asked how electronic records would be completed if it happened to fail at scene.

Responding, Dr Ruddell explained that staff had been issued with personal devices and said the Trust had received a further tranche of funding to procure approximately 80 Toughbooks. He confirmed that contingency plans had been put in place in the form of vehicle based devices as well as devices being made available at receiving hospitals.

Mr Abraham suggested that the document should be revised to reflect that the Policy would be fully adopted 'subject to the implementation plan'.

Mr Sowney asked why the implementation date had been set at March 2024 when the devices had been distributed and staff had received the necessary training.

Dr Ruddell explained that it was important to ensure that the links to hospitals were in place and said the challenges within the SET had been particularly challenging.

Mr Sowney asked, if this was the case, why had an implementation date been set when certain issues were outside of the Trust's control.

Responding, Mr Bloomfield explained that the introduction had been made on a Division by Division basis. He advised that there had been some discussion around mandating the introduction of REACH. However, the Trust had not wished to mandate a date which it could not meet. He indicated that the allocation of devices to vehicles appeared to have been welcomed by staff.

Mr Sowney asked how many staff would require further training when the Trust reached the implementation date.

Mr Bloomfield advised that providing support to staff in the use of the REACH device had been the primary focus of the implementation plan.

Ms Byrne noted that Ms Paterson was due to provide an update on REACH at the October Trust Board.

Mr Abraham suggested that the implementation plan should refer to 'subject to adoption in all EDs.

Ms Charlton said it was important to have a policy on record keeping in general as well as clearly setting out the policy expectation in terms of paper copies.

She pointed out that the policy was the extant policy in advance of REACH becoming operational. She acknowledged that it may be helpful to revisit the narrative to ensure it was explicit in this regard.

Subject to this change, the Policy was **APPROVED** on a proposal from Mr Abraham. This was seconded by the Chair.

9 **Service User Feedback Team Annual Report 2022-23 (SC07/09/23/06)**

Ms Charlton drew the Committee's attention to the Annual Report for 2022-23 and highlighted a number of salient points, namely:

- 208 complaints were received. This was a 22% decrease on the previous year and represented a complaint rate of 0.06% of all emergency and non-emergency ambulance attendances (334,806), and 0.09% of all emergency 999 calls received.
- 36% of complaints were responded to within 20 working days. This represented a 19% increase on previous year. Staff absences and operational pressures remained significant challenges for the timeliness of resolving complaints.
- 278 complaints were closed – a 5% increase on the previous year.
- The top three issues of complaint had changed from previous years with Quality of Treatment & Care being the most complained about followed by Staff Attitude/Behaviour and delays in emergency ambulance response.
- 406 compliments were received – a 8% increase on the previous year.

Alluding to the percentage of complaints responded to within the 20-working days standard, Ms Charlton said Ms McVeigh had contacted other HSC colleagues to ascertain if there were similar trends in other organisations. She emphasised the importance of each complainant receiving a bespoke response and said this was a position shared by the Chief Executive.

Mr Bloomfield agreed that the 20-day timeframe was nearly impossible to adhere to and said he would not support an approach whereby complainants received template letters. He said that, if the Trust was unable to respond within the 20-day timeframe, the Trust advised the complainant and kept them informed.

The Chair confirmed that the 20-day timeframe was a regional position.

Ms Charlton advised that it was and said that the regional policy was under review.

Mr Sowney commented that it appeared that other HSC organisations were experiencing similar difficulties in terms of responding within the 20-day timeframe. He asked if a joint approach to the DoH from the six Trusts might prove helpful in terms of seeking an extension to the timeframe and agreed with the Trust's decision to ensure complainants received a good quality response.

Ms Charlton alluded to the approach to patient satisfaction in England where the focus was more on patient and service user satisfaction and staff involvement in the process. She reminded the meeting of the Trust's attempts to change culture and said it was important for staff to be involved in a just culture process. Ms Charlton said that the Trust had responded to the NI Public Service Ombudsman (NIPSO) to express the view that it would prove difficult to ensure a just culture with the current timeframes and that the public had been given an expectation which could not be delivered upon. She said that Station Officers were encouraged to phone the complainant to discuss the complaint and added that, on many occasions, a direct apology was all that was needed by the complainant.

Ms Charlton noted that there had been an 8% increase in compliments and confirmed that every member of staff mentioned in a compliment received a copy. She indicated that compliments were published on a weekly basis in the Daily Bulletin distributed amongst all staff.

Mr Bloomfield questioned why there had been a reduction in the number of complaints received when delayed responses were increasing. He expressed concern that there was now a lower level of expectation amongst the public on all areas of public service and said this was worrying.

Mr Abraham queried whether the 20-day timeframe was applicable to an ambulance setting.

Ms Charlton confirmed that it was and said that it was becoming increasingly difficult to respond within this timescale given the mobile nature of the NIAS workforce. She advised that some Trusts in England had different ambulance indicators, KPIs and had extended timeframes for response. She added that this information had been shared with the NIPSO.

Mr Sowney commented that 57% of complaints related to A&E services and sought clarification on whether these related to care and treatment and staff attitude. He asked whether the EAC complaints related to delayed response.

In response, Ms Charlton clarified that they accounted for 27% and said that A&E complaints related to delayed response. She suggested that the EAC complaints might be related to call categorisation.

Mr Sowney asked how the Trust might focus on ensuring less complaints were received and he queried whether online complaints training was making a difference.

Ms Charlton explained that the online training provided was regional training with a focus on managing complaints early and acknowledged that there was less of a focus on preventing complaints. She said that a member of staff had asked for a leaflet which could be given to patients advising on how to make a complaint and added that the staff member was now working with Ms McVeigh to develop a leaflet around seeking feedback as opposed to focussing on complaints. Ms Charlton said she was unsure as to how the Trust might avoid complaints.

Mr Sowney suggested that the focus should be on managing complaints more effectively.

Ms Charlton alluded to the dashboards in place around complaints and said that this had assisted in clarifying the recommendations, associated actions and progress against these actions. However, she acknowledged that further work was needed to refine this further.

Mr Sowney emphasised the need for team meetings and Station Officers engaging with staff as that was where important discussions took place. He noted that 502 staff had completed the

online training and asked if it would be possible to drill down into this number to determine how many Operational/support staff had completed the training.

Ms Charlton advised that the new regional Learning Management System would allow further drilling into the overall numbers and allow more sophisticated information to be collated. She noted that there was a number of KPIs which related to delivering direct patient care. Ms Charlton noted that the report had given some detail with regard to complaints but not on compliments and she undertook to examine whether it would be possible to identify themes or trends in an anonymised manner to ensure the reader had a feel for the nature of the compliment.

Subject to a number of minor amendments, the Committee **APPROVED** the Annual Report 2022-23 on a proposal from Mr Abraham which was seconded by the Chair.

10 **PPI Monitoring Returns (SC07/09/23/07)**

Ms Charlton clarified that this agenda item was For Approval as opposed to For Noting.

She explained that the return to the PHA required the template to be signed by the Chair of the relevant Trust Committee and that, by signing it, the Trust was confirming adherence to a number of points.

Ms Charlton advised that the return covered the period 1 October 2022 to 31 March 2023 and provided an overview of the Trust's activity in this area.

She pointed out that the return alluded to monitoring activity and she reminded the meeting that the Trust had not received funding for this post. However, she said it would be important for the Trust to sign the return with this in mind and emphasised that it would not absolve the Trust from fulfilling its statutory responsibilities.

Ms Charlton said that the Trust would continue to engage with the PHA around funding as they had overall responsibility for the regional implementation of PPI across the HSC and added that the PHA was fulfilling its function in line with the regional framework.

Ms Charlton said she was content that the return was an accurate reflection of the Trust's activity.

Mr Nicholson commented that the return provided a further layer of assurance for the PHA in making its overall return to the DoH.

The Chair said that he was happy with the assurance provided by Ms Charlton and the Committee APPROVED the signing of the return to the PHA on a proposal from Mr Abraham and seconded by the Chair.

11 **AACE Safeguarding Peer Review (SC07/09/23/08)**

Ms Charlton advised that references had been made to the Peer Review of the Trust's safeguarding arrangements in a number of meetings and explained that this had been undertaken by the Heads of Safeguarding for London & Welsh Ambulance Services She acknowledged the significant risk presented by the current NIAS safeguarding staffing, referral infrastructure, education and training within the organisation and said this had been reflected in the RQIA Improvement Plan issued in December 2019 as well as the Trust Corporate Risk Register, Trust Safeguarding Position Reports and Assurance Statements.

She added that, in the context of no formal baseline safeguarding commissioning, this risk had been raised with DoH and SPPG colleagues.

Ms Charlton acknowledged that the report made for difficult reading and identified a number of areas for improvement and recommendations in areas such as referral process; training and governance and assurance. She advised that, in the absence of any commissioned funding, the Trust's Senior Management Team had approved two additional posts to support the Head of Safeguarding to continue to focus on making the necessary improvements to ensure the Trust worked towards delivery of its statutory responsibility in this regard.

Ms Charlton said that previously the Trust would not have been in a position to identify who had completed the various levels of training and added that there were different criteria for frontline and non-frontline staff as well as a difference in frequency of training. Ms Charlton indicated that the Committee had been left vulnerable in

the absence of this data. She advised that the Intercollegiate Documents for Safeguarding Roles and Competencies for Health Care Staff (2018) had stated that all paramedics should be trained to Safeguarding Level 3. Ms Charlton indicated that NIAS paramedics were currently trained to Level 2.

Continuing, she explained that she and Mr Flannagan were committed to delivering face-to-face training as it allowed attendees to discuss various scenarios. Ms Charlton said that Mr Flannagan had engaged with Dr Ruddell's team with a view to ensuring safeguarding training was included in the Education Review in terms of sessions with staff to improve the knowledge and understanding in the Trust.

Ms Charlton acknowledged the variation in referral rates throughout the Trust which, she said, may be a reflection of failure to recognise or failure to report.

Ms Charlton advised that there had been a change in welfare referrals in that staff would submit a DATIX but the Trust would navigate the welfare pathways thereafter. She said that NIAS had asked the other Trusts to provide a standard welfare pathway and added that the issue had been raised at the Trust's Ground Clearing meeting with DoH colleagues as well as at the Accountability Review meeting. She explained that, when REACH was fully implemented, staff would be able to refer onwards at the press of a button and the referral would be made contemporaneously. Ms Charlton pointed out that AACE colleagues had been content that a welfare referral would be made within 48 hours whereas the Trust had been striving to make immediate referrals.

Mr Abraham highlighted the importance of this work and the low baseline from where the Trust had started. He said that he had been the NED Champion for Safeguarding and added that this was now an areas of increasing focus. Mr Abraham extended his thanks to Mr Flannagan for his significant contribution to date.

Mr Sowney welcomed the progress which had been made since Mr Flannagan's appointment in June 2021. He acknowledged the significance of the recommendations within the report and commented that Mr Flannagan had been identified as the lead against all of them.

Ms Charlton referred to the peer review lead view that Mr Flannagan should not be providing safeguarding training and pointed out that it had been Mr Flannagan's commitment that had ensured training had been provided to NIAS staff. She recognised the risk but queried how best to address the bigger risk of staff knowledge within available resources. Ms Charlton pointed out that decisions had been taken based on the level of risk in terms of where resources should be prioritised.

Continuing, Ms Charlton acknowledged that the additional staff would make a significant difference. She assured members that the Safeguarding Team had continued to progress certain areas of work while awaiting publication of the Peer Report. Ms Charlton alluded to the professional standards element and said that Mr J Noble would be leading on this area of the work. She acknowledged that there were a number of areas in which the Trust had been under-resourced for a considerable period of time but said that the onus was on the Trust to ensure the best use of available resources. Ms Charlton acknowledged the significant improvements which had been made in the Trust but recognised further work was required.

Mr Sowney referred to disciplinary investigations and the importance of ensuring these had been completed by the time a staff member left the organisation.
Ms Charlton advised that the Trust had been asked re the processes in place for such circumstances and the clarity around referrals to DBS if concerns were identified.

Mr Bloomfield agreed with Ms Charlton's earlier point that the report made difficult reading. He said that he would like to take this opportunity to commend Ms Charlton's leadership of this area of work and said her commitment was clear. He said that Ms Charlton continued to press on two specific areas, namely the development of standard welfare pathways and the case for investment in safeguarding. Mr Bloomfield expressed some frustration around the commissioning process and the SPPG's consistent refusal to providing funding and stating that the Trust had to prioritise its funding. He said the Trust remained committed to doing everything possible within the resources available.

The Committee **NOTED** the AACE Safeguarding Peer Review.

12 **Handover Delays – Learning from the Data (SC07/09/23/09)**

Ms Charlton advised that, from 1 March 2023, the DoH regional standard had been that *'no ambulances to be waiting more than 2 hours at EDs for handover'*. She reminded the meeting that handover delays had also been included on the Corporate Risk Register.

Referring to ED handover delays greater than 2 hours (Mar-May23), Ms Charlton provided an overview of a number of clinical considerations and noted the variation regionally and internally within HSC Trusts.

Ms Charlton's presentation also included data relating to call categorisation, chief complaint of call and use of data to understand variation and opportunities for improvement. She advised that, while the data within the presentation provided a helpful overview, she would acknowledge that a further detailed clinical review of clinical records would be required to better understand the clinical condition and outcome for patients.

Mr Abraham welcomed the helpful breakdown of the data and expressed deep concern. He reminded colleagues that this issue had been discussed over many months and was of the view that it was a hospital failure to be unable to take responsibility for the patient upon conveyance to ED by NIAS. He believed that the statistics shared by Ms Charlton were stark and clearly demonstrated the harm coming to patients as a result of delayed hospital handovers. Mr Abraham said he would be keen to find out what actions were being taken by other Trusts to address this issue and ensure they were fully aware of the associated risks as well as ensuring they were brought to the respective Trust Boards' attention.

Ms Charlton assured the meeting that NIAS Directors raised this issue at every opportunity.

Mr Abraham suggested that Trusts should ensure nursing care was provided to those patients who remained in the back of an ambulance for longer than 30 minutes. He acknowledged that NIAS staff were not trained to provide nursing care to patients.

Ms Charlton advised that a number of other ambulance services had recognised these challenges and the context in which they worked. She said that, as a result, other ambulance Trusts had introduced policies around pressure care in the back of ambulances as well as introducing the use of pressure relieving mattresses. Ms Charlton stressed the need to consider this issue collectively and collaboratively as well as understanding what could be done to safeguard patients. She believed that, as registrants, NIAS staff were potentially vulnerable as the Trust was placing staff into situations whereby they had to remain outside hospital EDs for a number of hours. Ms Charlton alluded to HCPC standards re the safe management of patients and believed it would be important for the Trust to support staff in a sensitive way and with support from Trade Union colleagues.

Continuing, Ms Charlton suggested the introduction of cohorting patients in a hospital environment rather than have patients remain in the back of ambulances and acknowledged that, although not an ideal solution, cohorting patients in hospital would allow access to nursing care.

Mr Bloomfield agreed with the points made by Mr Abraham and said that, in reality, the data in Ms Charlton's paper were in fact 'work arounds' for a system which was not operating as it should. He indicated that the data presented by Ms Charlton had also been presented at a recent meeting with colleagues from the South Eastern Trust and said that the ED consultant attending the meeting had requested the data so he could share it with his teams in terms of the age profile of patients. Mr Bloomfield advised that a similar meeting with Southern Trust colleagues was planned for the coming weeks and said NIAS was attempting to highlight that, while different approaches were being used to address the issue, the most important focus was on the patients involved.

Ms Byrne suggested that it would be important to bring such information to the attention of the appropriate Committees in other Trusts.

Ms Charlton indicated that she had spoken with Trust Director of Nursing colleagues in the context of avoidable pressure damage statistics as she was aware from discussions that these were increasing. She said that her focus would be to escalate the safeguarding concern around the care of frail elderly patients. She

added that, while it was the responsibility of the receiving Trust on paper, in her view, it did not negate NIAS' professional responsibility.

Dr Ruddell said that Ms Charlton had raised a valid point in relation to professional responsibility and vulnerability. He referred to her recent meetings with the Chief Nursing Officer and asked if she had supported this view.

Ms Charlton explained that Trust Directors of Nursing would be meeting with the Chief Nursing Officer in the coming weeks and said she had no doubt that the Chief Nursing Officer would ensure this issue was afforded considerable time for discussion. Ms Charlton added that Allied Health Professions colleagues would also be present at the meeting.

The Chair alluded to other critical needs, such as toileting and hydration, of frail elderly patients who had to wait in the back of ambulances for prolonged periods of time.

Mr Bloomfield referred to Mr Abraham's suggestion that the Committee should confirm the position in other Trusts and suggested that the Chair of the Safety Committee should write to his counterparts in the respective Trusts to express his concern and seek clarification on how Trusts were addressing this issue. Ms Charlton undertook to draft correspondence for the Chair's consideration.

Continuing, Mr Bloomfield advised that, through Ms Byrne's influence, the SPPG was now circulating details of delays in each hospital site and seeking clarification on the actions being taken. He reminded the meeting that there was a Regional Escalation Protocol which set out measures to be taken at such times of pressures and commented that this Protocol was now being utilised on a daily basis. Mr Bloomfield referred to the Strategic Co-ordination Centre which would come into operation before Christmas and said he hoped the Centre, which would act independently of Trusts, would assist in reducing delayed handovers.

Ms Charlton pointed out that the Trust had not received any complaints relating to care in the back of ambulances and very few had been received by other Trusts. Likewise, she said, there were

few stories posted on Care Opinion regarding the care provided in the back of ambulances. However, Ms Charlton commented that, while it might not necessarily be the responsibility of NIAS, it was NIAS' responsibility to advocate on a safeguarding perspective on behalf of those patients who had to endure considerable delays in the back of ambulances.

The Chair thanked Ms Charlton for her presentation which was **NOTED** by the Committee.

13 **Date of next meeting**

The Chair advised that it had become necessary to reschedule the meeting scheduled for 9 November and said Mrs Mooney would confirm the rescheduled date over the coming days.

14 **Any Other Business**

There were no items of Any Other Business.

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

SIGNED: _____

DATE: 17 November 2023

Northern Ireland Ambulance Service
Health and Social Care Trust

'SAFETY' COMMITTEE REPORT TO TRUST BOARD 14/12/23

The Safety, Quality, Patient Experience and Performance Committee met on Friday 17 November 2023.

1	**Emergency Planning, Resilience & Response (EPRR) Update** The Committee noted the update on EPRR.
2	**Strategic Review of Clinical Education – final report** In February 2021, the Trust's Chief Executive endorsed a proposal to review clinical education within NIAS with the aim of modernising and enhancing the development of staff at all levels within the Trust. Dr Ruddell presented the final report to the Committee and highlighted the main findings and recommendations. It was agreed that the Report would be included on the agenda for the January meeting to allow the Committee monitor progress.
3	**Public & Personal Involvement (PPI) Update** The Committee noted the progress made in the period 1 April – 30 September 2023 and was advised that PPI awareness training had been delivered to six members of the Trust's Research Public Involvement Committee and one member of staff. To date, in total 47 members of the public and 53 members of staff have supported the development of the Strategy. An update was also provided in relation to actions against the PHA PPI Monitoring Plan.
4	**Safeguarding Update** The Committee received an update on the extant RQIA Improvement Plan and actions being progressed by the Trust in response to the Peer Review action plan. Members were updated on the number of safeguarding/ welfare incidents reported on the Trust's incident reporting system and the emerging themes/areas of care. NIAS continues to meet with other safeguarding agencies and the Committee noted that the Trust's Head of Safeguarding represented NIAS on the Safeguarding Board (NI). The Trust has also contributed to several Domestic Homicide Reviews in 2023 and participated in regional improvement work. The Committee also noted that, in respect of REACH, the software for safeguarding had now been agreed and was currently being tested.

Northern Ireland Ambulance Service
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5	**Quality & Service Improvement Update** The Committee received an update in relation to the first NIAS Quality Strategy which had been approved by the Board in June 2023 and noted that the official launch of the Strategy had coincided with World Quality week 6-10 November 2023. There are 17 projects identified within the Strategy and a full-day event was held in September at which Project Leads presented a 15-minute overview, followed by a 10-minute Q&A feedback session. A Project Leads Group has been established and meets on a monthly basis. The Oversight Group will ensure that each directorate, as well as Safety Committee and SMT, are aware of the impact the projects are having on the overall delivery of the Strategy and the early identification and escalation of barriers to strategic delivery.
6	**Infection Prevention & Control – Update Report and Environmental & Vehicle Cleanliness Report** The report summarised the performance in relation to agreed Key Performance Indicators (KPIs) in relation to Hand Hygiene; Personal Protective Equipment; IPC e-learning; IPC face-to-face training and Aseptic Non-Touch Technique. The Committee also received an update on changes to the frequency of vehicle deep-cleans, station and vehicle audit as well as the restructuring within the Environmental and Vehicle Cleanliness team.
7	**Annual Health, Safety & Fire Safety Report 2022-23** The Committee noted the report provided summary information relating to principal activities associated with the promotion and management of corporate health and safety and fire safety for the period 1 April 2022 to 31 March 2023. The report also highlighted the current key priorities for the Risk Management Team going forward. It was acknowledged that, while this function fell within the ARAC ToR, the Committee would also wish to have sight of the report.

Northern Ireland Ambulance Service
Health and Social Care Trust

MINUTES OF THE PEOPLE, FINANCE AND ORGANISATIONAL DEVELOPMENT COMMITTEE HELD AT 1.00PM ON MONDAY 16 OCTOBER 2023 IN THE BOARDROOM, NIAS HQ

PRESENT:	Mr J Dennison	Committee Chair
	Mr W Abraham	Non-Executive Director
IN ATTENDANCE:	Mr M Bloomfield	Chief Executive
	Ms R Byrne	Director of Operations
	Mr M Cochrane	Asst Director Operations
	Ms V Cochrane	Asst Director HR
	Ms L Gardner	Asst Director HR
	Ms M Lemon	Director of HR & OD
	Mr P Nicholson	Director of Finance, Procurement, Fleet & Estates
	Mrs C Mooney	Board Secretary
	Ms M Paterson	Director of Planning, Performance & Corporate Services (left the meeting at 2pm and rejoined at 2.15pm)

1 Apologies & Opening Remarks

The Committee Chair thanked Mr Abraham for facilitating the quorum.

Mr Bloomfield thanked everyone for accommodating the change in date.

2 Procedure

2.1 Declaration of Potential Conflicts of Interest

The Chair asked those present to declare any potential conflicts of interest now or as the meeting progressed.

No declarations of conflict of interest were made.

2.2 Quorum

The Chair confirmed the Committee as quorate.

2.3 Confidentiality of Information

The Chair emphasised the confidentiality of information.

3 NIAS Maximising Attendance

3.1 Metrics and Dashboard

Ms Lemon reminded the meeting that the Maximising Attendance project had been established as a project within the Delivering Value Programme. She advised that she co-chaired the project with Mr Cochrane, Assistant Director of Operations, and said that weekly project meetings were held with regular reporting through to SMT and this Committee. Ms Lemon said that, when the Committee came to discuss the Delivery Plan, she would describe the wider scope of the project and its focus, including details of the Information Group led by Ms Cochrane and Ms Avery.

Ms Cochrane acknowledged that, while there was a focus on identifying root causes around mental health, for example, or late finishes around the wellbeing of staff, the Trust Board and PFOD Committee needed assurance that attendance was being managed across the organisation. Ms Cochrane alluded to the dashboard and explained that this would help in demonstrating what a reduction of 7.5% would look like for every department within the Trust.

Ms Cochrane said she would be keen to hear members' view on whether a more aspirational target should be set for those areas which had high levels of absence. She acknowledged that the ability to achieve such a target was reduced in areas where there were lower levels of absence. She indicated that for the Trust to achieve corporately the target of 7.5% would in reality mean setting a corporate target of 10% and said that, if agreed, this target could be incorporated into the dashboard.

Continuing, Ms Cochrane pointed out that long-term absence was a significant contributory factor to absence overall and acknowledged that there were hotspots where short-term/recent short-term absence was challenging and which would require a different approach.

Ms Cochrane reminded the meeting that short-term absence was divided into episodes with four episodes becoming the trigger point and added that the dashboard had been configured in this way. She said that she would be concerned if the dashboard reflected members of staff with high numbers of episodes and added that the intention of the dashboard was to draw attention to those areas where there were high numbers of staff with high levels of absence.

Ms Cochrane indicated that long-term absence was defined as an absence of over 20 days and reflected the Level 1, 2 and 3 case management approach implemented by Ms Young. She explained that, in dividing cases into various Levels, attention would be focussed on those individuals with high long-term absence as the longer staff were absent from work, the less likely they would be to return. Ms Cochrane indicated that, in cases of long-term absence, consideration would be given to redeployment, ill-health determination or return to work.

Ms Cochrane drew the Committee's attention to a heatmap showing how this information was reflected. She suggested that it would be helpful to provide this information by Directorate as well as station and explained that the information informed her and Mr Cochrane's discussions around attendance management.

Mr Bloomfield was of the view that information by Directorate and station would be helpful as it would inform discussions with the Area Manager in term of being able to filter by station.

Referring to long-term employment processes, Ms Cochrane advised that the Trust did not hold all of the data centrally in a corporate system which allowed interrogation. She said consideration was being given to how the Trust could use HRPTS in terms of repurposing some functionality that had not been used to date to start recording such data. Ms Cochrane cited the example of a data field around long-term absence and

correlating activity such as the completion of reviews with staff having taken place. She indicated that another data field would relate to ill-health determination and the reasons for this.

Ms Cochrane said that HR would continue to work with BI colleagues to ensure more meaningful data collection with a view to identifying and collating other data that would be required.

Ms Lemon explained that this work aimed to provide managers with the necessary data to ensure an informed approach. She said it would start at Divisional level and identify those areas where further drilling down was needed.

Responding to a question from Mr Abraham, Ms Lemon confirmed that the target was to reduce absence to 11.2%.

The Chair acknowledged this and asked if this target was realistic.

Mr Bloomfield pointed out that, given the Trust's cumulative absence figure at the end of August was 14.5%, the target of 11.2% was not realistic. He pointed out that, to achieve the target of 11.2%, the Trust would have to achieve 7.5% for the remainder of the year which was not possible.

Ms Lemon clarified that the target of 11.25% had been set by the DoH.

Mr Abraham asked if there was any potential for the Trust to achieve 7.5% in December.

Responding, Mr Bloomfield said it would be necessary for the Trust to demonstrate that levels of absence had peaked and that, through its targeted approach and interventions, levels had started to reduce. He indicated that, should there be no sign of absence levels reducing, it would then be clear that the approaches and interventions adopted to date had not been effective.

Mr Abraham drew the meeting's attention to the slide which alluded to 'Absence Reason Summary' and suggested there were a number of categories which were very similar. Ms

Lemon explained that these categories were consistent across HSC.

Mr Abraham sought clarification on whether NIAS compared to other Trusts' absence levels and asked if the stress of late finishes had been shown to be a contributory factor to absence.

Mr Bloomfield acknowledged that absence due to mental health reasons was the most significant category and referred to the unique circumstances within the service which could potentially contribute to this position. He cited examples such as the trauma calls responded to and witnessed by staff; late finishes and inability to get annual leave as well as working conditions that exacerbated stress and manifested in mental health absence.

Mr Abraham agreed with the points made by Mr Bloomfield and said it would be interesting to determine the extent to which this was the case.

Ms Gardner explained that other Trusts had comparators across various professional groupings and environmental factors.

Ms Byrne highlighted the importance of the Maximising Attendance process and the need for the Trust's approach to be successful. She alluded to the interdependencies, for example, making significant progress to address late finishes, ensuring crews finished their shift on time and ensuring rest periods were taken. She hoped that progress on these issues would lead to a reduction in absence.

Ms Lemon agreed but indicated that, in addition to this, there were other specific employment issues, for example absence from work as a result of work-related stress and said that it would be important to address such absences through collaborative working.

Ms Cochrane acknowledged that NIAS experienced greater challenges in terms of redeployment as the Trust's ability to redeploy frontline staff, for example, to other roles was much more limited than in a larger Trust where there was more variation in roles.

Ms Lemon indicated that the Trust also continued to experience Covid-19 legacy in terms of staff who had been unable to undertake full duties during the pandemic and who had been redeployed but who had been unable to return to their substantive role.

Mr Bloomfield stressed the need for a consistent approach amongst managers and acknowledged that further work was required in this area. He said he would be meeting with Ms Byrne and Ms Lemon on a monthly basis and acknowledged that, while all Directors have a responsibility to manage absence, the significant proportion of it lay within the Operations Directorate. Mr Bloomfield said he would be using the dashboard to identify the information for discussion and determine the actions needed.

Ms Byrne assured the Committee that absence management was regularly discussed within the Operations Team and Assistant Directors would have this as an agenda item in their regular meetings with Area Managers with a view to focussing more on holding managers to account for performance against adherence to guidance on absence management within agreed timelines. She acknowledged the lack of consistency in approach and the need for dynamic management. Ms Byrne said that, from an operational perspective, she welcomed the structured approach in Divisions with HR advisors. However, she said she was also cognisant of the support needed for staff absent from work and their welfare and wellbeing.

The Chair alluded to the points around the need for consistency of application and asked if the supporting policies and procedures were sufficiently robust to allow intervention at the appropriate time.

Ms Byrne was of the view that they were sufficiently robust and pointed out that once a member of staff reached eight episodes of absence, there would be trigger points during this period requiring action and this should inform the necessary discussions.

Ms Lemon noted that the regional policies and procedures were currently under review.

Ms Gardner clarified that the regional policy had one process to manage both long and short-term absence in a consistent manner and noted that the fundamental question was whether there was an underlying health condition and whether the individual remained fit to undertake the role and continue in employment. She said the policy would also help ensure escalations and decisions took place in a timely manner and where necessary.

Ms Lemon explained that a decision had been taken to have the trigger at eight episodes to take account of the fact that the process to date had not been applied consistently and robustly.

Mr Cochrane referred to the monthly meetings between the Chief Executive, Ms Byrne and Ms Lemon and advised that there was also an operational manager dashboard which supported monthly meetings with operational managers.

Mr Bloomfield acknowledged that eight instances of absence was in exceptional circumstances and was of the view that discussions around absence should be taking place much earlier, for example, at 3-4 instances of absence. He said it would be important to ensure discussions took place as early as possible and the consequences of continued absence were clear and in line with the policies and procedures.

Ms Lemon acknowledged that the Trust was trying to forge cultural change. She highlighted the importance of HR support for managers and said this had been increased with HR Advisors working more closely within Divisions but also in functions based in HQ. She advised that there had been discussions with TU colleagues to ensure they were aware of the approach being adopted. Ms Lemon reminded the meeting that these processes had commenced in the absence of a formal redeployment process. She added that Ms Young had implemented the management of long-term absence which gave the overall project traction and said work was now ongoing to implement the short-term management of absence.

Mr Abraham referred to requests for assurance and cited the example of ensuring staff had undergone safeguarding training. He suggested that this could potentially be perceived by staff

as further expectations being placed on them. He alluded to appraisal and asked how this was taken into account.

Responding, Mr Cochrane acknowledged that this had now been included as part of the 1:1 regular reviews at each level and was a standing item on any management meeting. He added that the development of the dashboards would support such meetings in terms of performance management with each individual manager.

Mr Bloomfield acknowledged that Mr Abraham had identified a significant issue and said he recognised that the Trust did not have an effective annual appraisal system. He added that further work was to be taken forward in terms of providing management leadership training to staff.

Mr Abraham said that previously it had been clear that there was a correlation between sickness and refusal of annual leave requests.

Ms Byrne confirmed that the Trust had looked at seasonal absence and acknowledged the challenges associated with granting annual leave requests and the exigencies of the ensuring the service was delivered.

Ms Lemon stressed the need to learn and share learning from good practice. She added that following up on leadership discussions was also an important point.

Ms Gardner said that the Trust was keen to take forward a case management approach and ensuring managers had discussions with staff around how the Trust could assist in sustaining a member of staff's attendance at work or clarify what was preventing attendance at work. She also pointed out that it would be important to be clear on those aspects which were being performance managed with a view to ensuring that the process did not become a 'tick box' exercise. Ms Gardner said that work was ongoing to create a Maximising Attendance hub where managers could easily access all relevant policies and procedures.

Ms Lemon indicated that sessions had been provided to managers around having difficult conversations with staff and providing managers with the necessary skills.

The Chair alluded to the importance of effective communications and early intervention to support staff. He asked Ms Lemon to identify the top three priorities of the Project Board in taking forward the Maximising Attendance work.

In response, Ms Lemon stressed the importance of the action plan in terms of identifying those issues which needed to be progressed urgently; ensuring there was a robust redeployment process and ensuring HR support.

Mr Cochrane said that, from an operational perspective, ensuring HR support within each Division would be a key priority. He added that another priority would be to progress applications for medical redeployment and ill-health retirement. Mr Cochrane said that if these were progressed, there would be a correlated reduction in long-term absences.

Ms Cochrane noted that, while the Pension Branch had procured external support to work through the backlog of applications, it could be mid-2024 before any progress was made.

Ms Byrne asked whether it was possible to prioritise applications.

Responding, Ms Cochrane said that it was her understanding that the external support would focus on reducing the backlog in the first instance.

The Chair asked whether Ms Lemon had considered what information would be provided to the Committee and Trust Board.

Ms Lemon suggested that the Committee and Trust Board might find Divisional information helpful and believed that Trust Board would wish to be assured that there was access to data which would assist in identifying hotspots and in turn determine the actions to be taken.

Ms Paterson said it would be important to determine the levers to be used and measure their impact on outcomes, demonstrating their effectiveness. She pointed out that process compliance was only one aspect of the monitoring process.

Ms Gardner indicated that the average duration of long-term absence would be another important measure and would demonstrate how actions were being taken in an effective manner.

Agreeing with this point, Ms Cochrane said that this would be evident over time as numbers reduced. She suggested that it would be helpful to see progress against targets and how each individual area was performing against its target reduction.

Mr Bloomfield suggested that it also might be helpful to measure the Occupational Health Services (OHS) output. He said he agreed with Ms Cochrane's point re progress against targets but suggested that if there was no reduction in the numbers, this would provide an overall sense of progress as opposed to average percentage reduction.

Responding to a question from Mr Abraham as to how recent the data was, Ms Lemon acknowledged that the project had been operational for a number of months. She said that, as Chair of ARAC, Mr Abraham would be aware of a number of outstanding IA recommendations. Ms Lemon summarised the work which had been taken forward to address the IA recommendations but acknowledged that aspects of performance management which were now being progressed were relatively new.

Ms Byrne advised that she and Ms Lemon met on a weekly basis and had introduced a process whereby they discussed absence levels on a Divisional basis, choosing the Southern Division to start with as there were high levels of absence. She said that moving the Maximising Attendance project into the Delivering Value Programme had provided structure and the traction needed.

Mr Bloomfield suggested that it would be helpful to have information taking account of the number of staff.

Agreeing with this point, Ms Byrne explained that it was for this reason, the decision had been taken to review the position at station and Divisional levels.

Ms Cochrane suggested that Division by Division would be more comparable.

The Chair welcomed the provision of this data.

3.2 **Delivery Plan**

At the Chair's invitation, Ms Lemon took the Committee through the detail of the Delivery Plan and explained that the focus would be on staff health and wellbeing.

The Chair said he wished to make a number of observations which might be useful to consider. He referred to the significant work to be taken forward in terms of the HR&OD restructuring and he questioned the resources needed, both in terms of the HR&OD team and financial resources.

The Chair suggested that further work was required to identify the outcomes within the Delivery Plan. He referred to the fact that the Plan did not have any metrics which would demonstrate where objectives had been met or indeed where further work was required. The Chair acknowledged that consideration had been given to the leads and timescales for various elements of work but said he was unclear as to how progress would be tracked.

Mr Bloomfield explained that the Operations structure review would be a key enabler and added that the review was a significant programme in its own right.

The Chair suggested that it would be helpful to identify the top five priorities and believed that doing so would help identify timelines, KPIs and tracking of progress. He was of the view that it would not be necessary to measure every single aspect of the work and acknowledged that some aspects would be

'slow burn change'. The Chair recognised that not every action would have similar outcomes.

Mr Bloomfield said that the early part of discussion at the meeting identified the key priorities which needed to be progressed for staff health and wellbeing and the causal factors as to why staff were absent from work.

Ms Lemon said it would be important for assurance to be provided to the Trust Board that a robust approach was in place.

The Chair said he would be happy to assure the Board and would brief them on the detailed Delivery Plan presented at today's meeting. He acknowledged that there was some minor presentational amendments required to ensure the priorities were brought to the fore and prioritised as well as clarifying the metrics to be used.

Mr Abraham pointed out that the focus of the ARAC was to obtain assurance the necessary work was being progressed and reflected actions being taken.

Following this discussion, the Committee **APPROVED** the Delivery Plan subject to the minor amendments to be made.

4 **Date of next meeting**

The next meeting of the Committee is scheduled to take place on Thursday 19 October 2023 and will be finance-focussed.

5 **Any Other Business**

(i) AACE Review of HR

Ms Lemon alluded to the AACE review of HR which had been undertaken in 2021-22 and provided a brief overview of progress since then. This included undertaking a culture audit within the Trust and the development of a culture dashboard; the development of the Trust's 'Healthy People, Healthy Place - Our Health and Wellbeing Strategy 2022-2027'; the introduction of a business partnering approach and the appointment of senior business partner managers; the

rebranding of the HR Directorate to HR & OD Directorate and the appointment of a senior OD post.

Continuing, Ms Lemon advised that, during the pandemic, it had become necessary to stand down meetings which would have further progressed this work. However, she said that her priority remained to complete this transformation and present a People Plan to the Board in due course.

She mentioned that the AACE Review had alluded to the fact that the HR Directorate had staff who worked hard in difficult circumstances and said that, while this remained the case, there had been a renewed focus on the wellbeing of the HR team.

(ii) **Operations Restructure**

Ms Byrne advised that the importance of the restructuring of the Operations Directorate had been discussed on a number of occasions and said it was a key enabler to a number of important issues. She added that the delivery of this work had been subsumed into the Delivering Value Programme, with a considerable amount of work having already been completed. Ms Byrne advised that a further meeting was scheduled towards the end of the month to finalise the plan with a view to presenting it at SMT in the near future.

THIS BEING ALL THE BUSINESS, THE CHAIR DECLARED THE MEETING CLOSED AT 2.30PM.

SIGNED: _____

DATE: 6 December 2023

Northern Ireland Ambulance Service
Health and Social Care Trust

MINUTES OF THE PEOPLE, FINANCE AND ORGANISATIONAL DEVELOPMENT COMMITTEE HELD AT 9.30AM ON THURSDAY 19 OCTOBER 2023 IN THE BOARDROOM, NIAS HQ

PRESENT:	Mr T Haslett	Committee Chair
	Mr J Dennison	Non-Executive Director
IN ATTENDANCE:	Ms R Byrne	Director of Operations
	Mr P Nicholson	Director of Finance, Procurement, Fleet & Estates
	Ms V Cochrane	Asst Director HR
	Mrs C Mooney	Board Secretary
	Ms L O'Connor	Senior HR Manager (for agenda item 5 only)
APOLOGIES:	Mr M Bloomfield	Chief Executive
	Ms M Lemon	Director of HR & OD
	Ms L Gardner	Asst Director HR
	Ms M Paterson	Director of Planning, Performance & Corporate Services
	Dr N Ruddell	Medical Director
	Ms L Charlton	Director of Quality, Safety & Improvement

1 Apologies & Opening Remarks

The Committee Chair welcomed those present to the meeting and noted that this meeting would focus on finance as well as considering the NIAS Grievance Policy and Procedures.

2 Procedure

2.1 Declaration of Potential Conflicts of Interest

The Chair asked those present to declare any potential conflicts of interest now or as the meeting progressed.

No declarations of conflict of interest were made.

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 (PC19/10/23/01)**

The minutes of the previous meeting held on 4 July 2023 were approved on a proposal from Mr Dennison and seconded by Mr Haslett.

4 **Matters Arising (PC19/10/23/02)**

Members **NOTED** the actions points and the updates provided.

5 **NIAS Grievance Policy & Procedure (PC19/10/23/03)**

The Chair welcomed Ms O'Connor to the meeting.

By way of introduction, Ms Cochrane explained that the Grievance Policy and Procedure was a regional one which had been developed through the Assistant Director Network for Employee Relations. She added that NIAS had been fully involved in the development of the documentation which had been discussed and negotiated through the Regional Negotiating Framework. Ms Cochrane noted that there was little scope for any amendment.

Ms O'Connor highlighted the key changes within the revised Policy and Procedure. She explained that the Policy provided an approach to ensure concerns were dealt with quickly, fairly and constructively and aimed to encourage positive employee relations as well as secure constructive and lasting resolutions to workplace concerns.

Ms O'Connor also outlined the actions which had been taken to date to support the implementation of the revised Policy and Procedure. She advised that initial feedback following engagement

sessions with senior managers had been positive in relation to the Policy and Procedure and approach to managing grievances. Ms O'Connor also provided an overview of the future actions required. These included further management training for those who had been unable to attend the original training. She added that consideration would also be given to further skills training for effectiveness implementation of the new Policy and Procedure.

Ms O'Connor advised that the Trust had a disproportionate number of grievances in relation to total staff numbers compared to other Trusts.

Mr Dennison asked if any of the current grievances focussed on similar issues and whether there was an emergent pattern.

Ms O'Connor acknowledged that there was no clear pattern. However, she stressed the need to learn from grievances and apply this learning across Divisions. She advised that regular meetings were scheduled with managers and Assistant Directors to ensure a consistent approach was being adopted.

Ms O'Connor indicated that, if the Committee approved the revised Policy and Procedure, she would like to implement it from 1 November 2023.

Ms Cochrane commended the approach taken by Ms O'Connor in preparation for implementation of the Policy in terms of developing staff skills for handling difficult conversations, for example around managing attendance and disciplinaries. She said that this approach spoke to the change in leadership culture and a change to individuals' roles in people management and enabling and empowering managers to lead their staff.

The Chair sought clarification around the point at which it was determined that a final decision had been reached.

Responding, Ms O'Connor explained that the outcome of an appeal hearing was final.

The Chair alluded to the fact that it was hoped to implement the Policy with effect from 1 November 2023 and asked if any discussions with Trade Unions had taken place.

Ms O'Connor confirmed that discussions had taken place and advised that Trade Union colleagues were supportive of the Policy and its aim to resolve issues at informal resolution level.

Ms Byrne said that, from an operational perspective, Ms O'Connor had provided considerable support and focus in terms of training and support to managers to give them confidence to implement the Policy. She said that managers very much appreciated the training provided and the clarity within the Policy.

Ms Cochrane pointed out that the Policy and Procedure reflected best practice and she commended it to members.

Following this discussion, the Committee **APPROVED** the NIAS Grievance Policy and Procedure on a proposal from Mr Dennison. This proposal was seconded by the Chair.

The Chair thanked Ms O'Connor for her attendance and she withdrew from the meeting.

6 **Finance Update (PC19/10/23/04)**

Mr Nicholson drew members' attention to the report and noted that Month 6 figures had not been available when the report was drafted. He reminded colleagues that the Trust's Financial Plan had forecast an overspend of £2.2 million and said that this position remained the same. However, he noted that there had been some indication from the SPPG that some additional resources would be made available to the Trust.

Mr Nicholson indicated that additional resources had been made available to other Trusts, broadly reducing their deficits by 50%.

The Chair pointed out that the Trust was already more than six months into the 2023-24 financial year and to make the required savings of £1.975 million would prove challenging.

Responding, Mr Nicholson explained that, for absolute clarity, the Trust was required to save £1.975 million in addition to the £2.2 million deficit identified in the Financial Plan. He advised that, given the current projections, he was hopeful that there would be the opportunity to release more creditors through, for example, the granting of annual leave. Mr Nicholson explained that, during the

pandemic, staff had been unable to take annual leave which had resulted in an increased financial liability at the year end. As outstanding annual leave was taken, this liability reduced. This provided an in-year financial benefit to the Trust.

Mr Nicholson noted that the Trust had received a number of further allocations in relation to additional support for the Clinical Support Desk and the transfer of the Major Trauma Network to NIAS. He explained that the Clinical Support Desk, now known as the Integrated Clinical Hub, was part of the effort to reduce regional pressures on unscheduled care through the clinical advice provided to patients and avoidance of conveyance to hospital. Mr Nicholson said there were plans to implement this over the winter period with a view to exploring the feasibility of mainstreaming this in subsequent years.

Ms Byrne indicated that this additional funding had been provided on the back of lessons learned during periods of industrial action and its impact on the management of calls and the ability to upgrade or downgrade calls with a view to better managing demand. She welcomed the funding which had been provided by the SPPG following a request from the Trust.

Mr Nicholson pointed out that the Trust did not have a pool of staff from which to recruit and said that the recruitment would draw staff from the operational tier.

He reminded the Committee that there had been a previous savings proposal to reduce AAP training but that this had not been implemented.

Ms Byrne confirmed that approximately 65+% of annual leave entitlement had either been taken or rostered and said she was keen that this would continue to be the case.

Mr Haslett commented that it was unusual to consider annual leave as a creditor.

In response, Mr Nicholson advised that this practice had commenced a few years previously and Trusts had to account for outstanding annual leave at the year end. He added that for NIAS this was in excess of £3.5 million of a creditor and, with current

projections, this was estimated to reduce by the order of up to £1 million.

The Chair sought confirmation that such practice was permissible within accounting procedures.

Mr Nicholson confirmed that this was both permissible and required and advised that changes in the annual leave accrual had a similar impact on the financial position as changes in stock levels.

Mr Nicholson referred to the specific proposals for savings in 2023-24 and advised that many of these were non-recurrent proposals and therefore could not be delivered in future years.

Mr Nicholson alluded to the Trust's Delivering Value Programme which aimed to limit expenditure to the level of allocations received, particularly in relation to overtime and the use of VAS/PAS. He said that this remained a challenge for the Trust given its current operational pressures but pointed out that the trajectory was positive in comparison with previous years.

Ms Byrne advised that up to 20 IAS providers had been available and used and the Trust had worked to reduce that number to nine. She added that this reduction had been dependent on the Delivering Value programme and achieving efficiencies from PCS to meet the gap. Ms Byrne emphasised the need to maintain a focus on this and to keep the use of IAS to the trajectory of expenditure.

The Chair said that overtime was critical and said it would be important to ensure that the level of service was not unduly impacted by reducing overtime.

Ms Byrne confirmed that the reduction in IAS had not effected A&E provision.

Mr Dennison welcomed the reductions in overtime expenditure but noted that absenteeism was increasing and asked how these could be reconciled.

Mr Nicholson indicated that, with the outturn from the training school at the start of the year, the Trust had been very close to full establishment and these substantive appointments had reduced reliance on overtime. He acknowledged that the level of

absenteeism and the reduced level of overtime was counter intuitive, but advised that, when more staff were absent from work, there was a corresponding smaller number of staff available and willing to do overtime.

He also advised that the focus placed on this issue by Operational colleagues had been significant in understanding and managing the use of overtime.

Ms Byrne advised that, from an Operational perspective, overtime was risk managed on a daily basis and said there was now much more focus on highlighting those areas where overtime was needed.

Mr Dennison referred to late finishes and asked if overtime automatically came into operation when a member of staff was unable to finish his/her shift on time.

Ms Byrne confirmed that overtime was paid in such circumstances.

Agreeing with Ms Byrne, Mr Nicholson said that, as well as overtime, Time Off In Lieu (TOIL) was also available in that instance and he acknowledged that this element was more difficult to control. He reiterated that the continued focus within the Operations Directorate of targeting the use of overtime was to be welcomed. Mr Nicholson advised that the support of the Informatics Department had been invaluable in terms of developing management information around overtime which was more timely and provided the necessary detail and analysis to support Operational decisions. He pointed out that overtime costs continued in the region of approximately £500-£600,000 per month and said that sickness was one of the many factors impacting on the Operational need for overtime.

Mr Nicholson commented that overall overtime was on the right trajectory and said it was not unusual for July and August to incur additional overtime. He said that the report before the Committee contained further granular detail in terms of overtime by Directorate and added that it would not come as a surprise to the Committee that the majority of overtime was within the Operations Directorate.

Commenting on the availability of information, Mr Nicholson said that it was now possible to access the necessary information before

the end of the month and added that this had proved extremely useful.

Mr Dennison was of the view that there was a correlation between overtime and absence and referred to the high absence and overtimes levels within EAC. He enquired whether the DoH viewed overtime costs as core costs.

Responding, Mr Nicholson said he believed that the DoH viewed overtime as a necessary requirement. He acknowledged that the reasons for overtime had changed over the years and explained that, where previously core shifts would have been undertaken through overtime, posts had now been recruited to on a substantive basis. Mr Nicholson said he would have expected expenditure on overtime to reduce, however, further overtime costs had been incurred in order to cover staff absence.

Mr Nicholson alluded to CRM funding and said that any enhancement of the service would be used to fund overtime in the first instance for up to 12-18 months while staff were recruited and trained. He indicated that this level of investment was being supported by Covid-19 allocations from SPPG, recognising the pressures within the service and the level of absenteeism.

Referring to VAS/PAS costs, Mr Nicholson reminded the Committee that these had increased significantly over the Covid-19 period and said that the figures presented provided an analysis across the last three years. However, he said the figures for September had been included within the Trust Board report and demonstrated a welcome containment in costs. Mr Nicholson said that the efforts to reach this position should not be underestimated. However, he pointed out that the costs for the use of taxis had increased significantly as the Trust looked to support the patient transport service. He indicated that the VCS had reduced over the pandemic and work was now ongoing to return this to pre-Covid-19 capacity levels. Mr Nicholson also alluded to the core non-emergency PCS and productivity gains which the Trust was intending to introduce as part of the significant body of work being taken forward within PCS. He explained that the figures were a combination of invoices and estimates in an attempt to produce the most robust financial position within a reasonable timeframe.

The Chair sought clarification that the Trust had not taken any direct intervention to reduce the level of transport and commented that this had been identified, at one stage, as a potential area for savings.

In response, Ms Byrne explained that, at the height of the pandemic and due to limited cover because of absence, the Trust had prioritised PCS to convey patients to cancer/renal appointments using NIAS crews. She noted that VAS/PAS had also been used to to convey other patients, leaving PCS to convey higher acuity/priority patients. Ms Byrne said that the intention was to continue to deliver the cover but not always using NIAS vehicles and supplementing the service with VAS/PAS and taxis.

Mr Nicholson said that NIAS was resetting this element of its service post the pandemic.

The Chair sought clarification on how the Trust intended to achieve the remaining savings.

Responding, Mr Nicholson clarified that the intervention had focussed on containing expenditure in terms of reducing overtime and VAS/PAS. He acknowledged that there were variable elements which could be ceased but said it would be important to clearly understand the quality, performance and safety aspects of any decisions taken.

Mr Nicholson drew the Committee's attention to the financial information provided around staff substitution provided by AACE and the HSC Leadership Centre and reminded the meeting that this had been an Internal Audit recommendation. He said that he was pleased to report a reduction across both areas of expenditure. Mr Nicholson indicated that the Trust was currently finalising the support it would seek from AACE for the 2024-25 year.

Ms Byrne said it would be key that the Trust would continue to avail of AACE expertise around EPRR and noted that previous support from AACE had reduced as NIAS continued to build its own resilience.

Mr Nicholson stressed the importance of the Committee having sight of information around the Trust's engagement of Associates through the HSC Leadership Centre.

Ms Cochrane advised that the Trust had now trained a number of staff to undertake job evaluation on panels and said she would expect to see that nature of expenditure reducing once staff had developed the necessary skills and become competent in job evaluation.

Mr Nicholson explained that a Regional Co-ordination Centre was being established and said a briefing would be provided to the Trust Board meeting in due course. He advised that NIAS had agreed to act as host Trust in order to facilitate 'pay and rations' and said that the Leadership Centre Associates would be providing that function over the winter period. Therefore, he said, while expenditure would be reported in the NIAS' budget, it would be resource matched as costs were being shared regionally by all Trusts.

Moving to discuss the capital programme, Mr Nicholson advised that the total budget was currently £7.1 million and said that the Chair had often highlighted the fact that expenditure on capital schemes had traditionally been profiled towards the end of the financial year. This was 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.

Mr Nicholson acknowledged the significant increase, in some cases 30%, in vehicle costs which had materialised this year and said the Trust had received additional support in its baseline capital resources to support these increases. He said that the baseline now totalled £5.7 million and that this included an additional £1 million received to support estates. Mr Nicholson advised that the fleet replacement programme pre-Covid-19 had been in the region of £4 million. However, over Covid-19, there had been an inflationary impact and this cost had increased to just over £4 million. He said that the Trust continued to engage with DoH/SPPG colleagues as it had now become clear that approximately £5.5 million would be required to replace the A&E, PCS and support vehicles within the programme.

Continuing, Mr Nicholson said that members would be aware that construction costs had increased significantly. He noted that the 10-year capital plan in place prior to the pandemic had now been stood down and work was ongoing to review it in light of the increase in costs.

Mr Nicholson confirmed that additional funding had also been identified in-year for replacement defibrillators. He expressed concern that the business case had not yet been completed and approved at this stage of the financial year. He said that there was a risk around the expenditure moving into the next financial year when funding was not guaranteed.

Mr Nicholson also alluded to the additional support received in respect of REACH devices and confirmed that the business case for the second tranche of Toughbooks had been approved.

Mr Nicholson expressed some concern over the global availability of goods across the areas of fleet, estate and IT and the resultant impact on supply and associated costs. He said that, while the Trust continued to place orders early with suppliers, the global availability issue was continuing to impact on the capital programme.

The Chair alluded to the plethora of small projects within Estates and asked who project managed these.

In response, Mr Nicholson explained that the Trust had a small in-house Estates function, supported by DoH Health Estates colleagues, that would oversee projects. These were delivered through a combination of NIAS suppliers and also local Trust Health Estates functions and suppliers.

The Chair commented on the impact of estate issues on staff welfare.

Mr Nicholson said that the Trust had invested resources in staff welfare at EDs in order to support staff during protracted handovers. He said that, although he welcomed the fact that the Trust had invested in staff welfare hubs, such resources should be invested in stations and supporting staff at NIAS locations, not EDs.

Ms Byrne agreed with this point and reminded the meeting that the recent staff engagements had taken place at EDs rather than at local stations.

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

7 **Date of next meeting**

The next meeting of the Committee is scheduled to take place on Thursday 23 November 2023. However, Mr Dennison noted that he may be unable to attend on this date and undertook to keep Mrs Mooney informed.

8 **Any Other Business**

There were no items of Any Other Business.

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

SIGNED: _____

DATE: 6 December 2023