Northern Ireland Ambulance Service
Health and Social Care Trust

Minutes of NIAS Trust Board held on Thursday 14 December 2023 at 10am in the Boardroom, NIAS HQ, Knockbracken Healthcare Park, Saintfield Road, Belfast BT8 8SG

Present:	Mrs M Larmour	Chair
	Mr D Ashford	Non-Executive Director
	Mr P Quinn	Non-Executive Director
	Mr M Bloomfield	Chief Executive
	Ms R Byrne	Director of Operations
	Ms M Lemon	Director of Human Resources & Organisational Development (HR & OD)
	Mr P Nicholson	Director of Finance, Procurement, Fleet & Estates
	Dr N Ruddell	Medical Director
Apologies:	Mr J Dennison	Non-Executive Director
In Attendance:	Ms L Charlton	Director of Quality, Safety & Improvement (QSI)
	Ms M Paterson	Director of Planning, Performance & Corporate Services
	Mr N Sinclair	Chief Paramedic Officer
	Mrs C Mooney	Board Secretary
	Mr P Corrigan	Non-Executive Director (in an observer capacity as due to take up post on 1/1/24)
	Ms D Doherty	Paramedic (for agenda item 6 only)
	Ms L Stevenson	Emergency Medical Technician (EMT) (for agenda item 6 only)
	Ms R Finn	Assistant Director QSI (for agenda item 6 only)

1 **<u>Welcome, Introduction & Apologies</u>**

Welcoming those present to the meeting, the Chair noted the apologies. She said she was delighted to welcome Mr Phelim Quinn who had taken up post as Non-Executive Director on 11

December 2023 and Mr Paul Corrigan who would take up post as Non-Executive Director on 1 January 2024. She advised that she had asked Mr Corrigan to join today's meeting in an observer capacity.

Welcoming the appointments and skill mix, the Chair said she intended to meet with Non-Executive Directors in January to consider Committee membership and added that the skills brought by Mr Quinn and Mr Corrigan would complement those of Mr Ashford and Mr Dennison. She believed that the skill mix would be of value as the Trust moved forward into yet another challenging year.

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

Mr Corrigan advised that a family member was an employee of the NIAS Trust.

The meeting was declared as quorate.

2 **Previous Minutes (TB14/12/2023/01)**

The minutes of the previous meeting held on 24 October 2023 were **APPROVED** on a proposal from Mr Ashford. This proposal was seconded by Mr Bloomfield.

3 **Matters Arising (TB14/12/2023/02)**

Members **NOTED** the Matters Arising.

At the Chair's invitation, Ms Paterson provided an update in relation to the roll-out and implementation of REACH. She advised that all EDs were now receiving ePCR, including Craigavon and Ulster Hospitals which had experienced some difficulties. Ms Paterson advised that the policy around the 'Completion of Patient Records' had recently been launched and said that these two elements had resulted in ePCR being part of all patient digital medical records. She reminded the meeting that the REACH programme had been instigated by Dr Ruddell some years earlier and she thanked him for his significant contribution.

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Ms Paterson advised that there had been a significant uptake in the use of electronic records with an increase from 6% to 37% usage two weeks previously and noted that the Belfast Division had seen a 47% use of ePCR. She believed that this significant uptake spoke to the importance of the policy as well as Operational, Medical and Clinical teams encouraging staff to use REACH. Ms Paterson noted that increasing numbers of staff were accessing the training videos and said there had been no reports of any technological issues with those devices which had been rolled out. She advised that approximately 70 vehicles (46%) had been fitted with the new technology and a further 40 devices were due to be rolled out in the coming days.

Ms Paterson explained that the technology provided the opportunity to enhance clinical audit of the care provided by frontline staff and help the Trust to understand the impact and the outcome of the care provided.

The Chair said that the fact that the Trust was still operating paper records in 2023 had captured her attention when she took up post in April. She said the roll-out of REACH was an excellent example of digital transformation, efficiency and effectiveness which cut across all departments. The Chair said the use of electronic records would greatly improve how the Trust operated and, most importantly, its services to patients.

Mr Quinn suggested that, as a new Non-Executive Director, it would be helpful for him to have sight of the REACH training video and have a better understanding.

Ms Paterson agreed to make the necessary arrangements.

Mr Bloomfield noted that, at the most recent staff engagement sessions, staff were observed using the device upon arrival at EDs and said it had been very positively received.

The Chair conveyed her particular thanks to the South Eastern HSC Trust which had introduced REACH while also launching Encompass.

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4 **Chair's Update**

Commencing her update, the Chair explained that, at the October meeting, she was unaware of the status of Non-Executive Director appointments and therefore had been unable to thank Mr Abraham and Mr Haslett for the significant contributions they had made during their eight-year tenure as Board members. She said that she would like to organise an event in the New Year to recognise their contribution.

Mr Nicholson also alluded to the contribution both members had made at Committee level.

The Chair reported on her attendance at the HSC Chairs' meeting with the Permanent Secretary and updated members on the main areas of discussion.

She advised that she had attended the Public Sector Chairs' Forum as a Committee member; met with the Assistant Directors of Operations; met with the Chair and Chief Executive of the Regulation and Quality Improvement Authority (RQIA) as well as attending a briefing given by the Head of the Civil Service, Ms J Brady.

Continuing, the Chair reported that she had met with the SHSCT Chair and observed a meeting held to review hospital flow. She noted that her visit had coincided with the first day of the pilot of the Regional Co-ordination Centre (RCC) which had been stood up to support the Encompass launch.

The Chair acknowledged that the most challenging element of her visit to the SHSCT was her visit to ED where patients had been waiting for between 24-48 hours. She noted that the challenges with hospital flow then impacted on NIAS in terms of delayed handovers and the challenges in responding to calls in the community. The Chair said that the SHSCT was hugely complementary of the Hospital Ambulance Liaison Officers (HALOs) who helped in the prioritisation of patients. The Chair said that she and the SHSCT Chair had committed to continue working as collaboratively as possible with a specific focus on ensuring more effective and efficient patient flow.

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The Chair reported that she had attended the PFOD Committee on 6 December when the Committee received an update in relation to the Maximising Attendance Delivery Plan which would be discussed later in the meeting.

She advised that, along with Mr Ashford, she had also undertaken Public Accountability and Governance Training.

The Chair advised that she had also met with Mr Wilkinson and Mr Jakobsen, DoH, to discuss a number of issues, including the Trust's strategic planning, and staff changes within the DoH. She noted that Mr Wilkinson and Mr Jakobsen would retain NIAS within their portfolios.

Concluding her report, the Chair advised that the Trust had recently met with Ms Sheenagh Weir, the mother of Maggie Black, and several family members. She added that the NIFRS Chair and colleagues also attended the meeting.

For the benefit of the new Non-Executive Directors, Mr Bloomfield provided some brief background to Maggie's Call and the campaign being taken forward by Ms Weir which would see NIFRS personnel responding to nearby cardiac arrest calls and providing initial CPR until the emergency ambulance response arrived. He explained that unfortunately NIFRS Trade Unions had objected to the roll-out of the pilots and the issue was now subject to national negotiations. However, Mr Bloomfield advised that NIFRS staff in Carnlough, who had already been trained by NIAS, were continuing to attend cardiac arrest calls and said that NIAS had deployed them on several occasions. He said that NIAS was ready to continue to provide the necessary training and the plan was to roll the programme out to other NIFRS stations across the region.

Mr Bloomfield said that Ms Weir continued to promote the Maggie's Call campaign and added he hoped to see some movement in the near future.

The Chair's update was **NOTED** by members.

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5 **Chief Executive's Update**

Commencing his update, the Chief Executive welcomed the new Non-Executive Directors to NIAS and said he looked forward to working with them.

He said it was this time of year that the pressures on the service and across the HSC were at their greatest. Mr Bloomfield believed that the term 'winter pressure' was misleading and was of the view that pressures existed throughout the year but winter brought particular challenges with increases in respiratory illnesses and flu. He added that the Trust had seen the impact of that in recent weeks and had been at the highest sustained level of pressure, Resource Escalation Action Plan (REAP) Level 4 for the last week as well as regularly operating at the highest levels of its Clinical Safety Plan (CSP). He explained that this was largely due to the number of calls waiting on the stack at any time without available resources to allocate. Mr Bloomfield indicated that, during the last week, the Trust was regularly seeing in excess of 80 calls waiting and not reducing as evening approached. He added that these calls had peaked on Sunday 10 December at 120 calls which had been extremely unusual.

Mr Bloomfield explained that, while this was related to the Trust's capacity levels in terms of staffing, it was also related to wider pressures across the system. He said that delayed handovers had significantly deteriorated over the last month and delays of between 14-16 hours were now being experienced by both patients and NIAS staff outside EDs.

Mr Bloomfield said that he would like to thank and pay tribute to the professionalism of NIAS staff who continued to care for patients as best they could in such circumstances. He added that the care provided often fell short of that which staff would like to and expect to provide.

Continuing, Mr Bloomfield said that his thanks were also extended to staff within the Emergency Ambulance Control (EAC) who performed an exceptionally difficult role and acted as the first point of contact for patients. He explained that EAC staff were very mindful of the risk attached to those calls waiting on the stack and to which, on many occasions, it was not possible to dispatch a timely emergency response. Mr Bloomfield explained that the Trust had

increased the level of senior clinical presence in the room. He advised that members of Mr Sinclair's team reviewed those calls waiting, called patients back to review their condition and were able to downgrade calls as necessary. Mr Bloomfield acknowledged that this impacted heavily on the team's workplans which focused on the transformation and reform agenda. However, he emphasised that the priority within EAC was to keep it as safe as possible. He commented that he had visited EAC on Sunday evening and saw at first hand the positive impact the increased presence of experienced clinical staff was having. Mr Bloomfield said that this highlighted the need to develop the Clinical Hub which the Trust hoped to have in place by the end of January.

Mr Bloomfield said he had been particularly pleased when the Permanent Secretary and other senior SPPG colleagues, when visiting the RCC, had taken time also to visit the EAC to speak to staff and acknowledge the pressures on them.

Moving to refer to the establishment of the RCC, Mr Bloomfield explained that this was a joint initiative by all six HSC Trusts. He alluded to the recent report from the Getting It Right First Time which would be discussed later in the meeting and which identified the most significant risk to urgent and emergency care patients was that of delayed ambulance handovers. Mr Bloomfield said that he welcomed the establishment of the RCC which became operational at the start of December. He said that he had assumed responsibility as the lead Chief Executive on behalf of all Trust Chief Executives and added that the establishment of the Centre had taken up a great deal of his and NIAS colleagues' time. He acknowledged that it had not been without challenge. However, he said the RCC offered significant potential benefits for the whole system.

The Chair said she would like to take this opportunity to recognise Mr Bloomfield's efforts and that of the Senior Management Team in ensuring the RCC was operational within the intended timeframes.

Mr Bloomfield continued his report by referring to the join strategic planning days held with the Air Ambulance NI at the end of October to consider possible developments into the future, for example the extension of the operating hours of the Helicopter Emergency Medical Service (HEMS) and said NIAS officers were working with the charity in this regard.

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Mr Bloomfield reported that he had represented the Trust at the Festival of Remembrance on 4 November alongside representatives from other emergency services and said he was pleased that, for the first time, NIAS staff participated in the actual ceremony.

Continuing, Mr Bloomfield noted that the Trust had launched its Quality Strategy on 9 November during World Quality week. He said this was an excellent Strategy led by Ms Charlton and her team and reflected the increased capability within the Trust to implement quality improvement (QI) initiatives and to progress projects using QI methodologies.

Mr Bloomfield reported that, accompanied by other NIAS Directors, he had visited the new NIFRS Learning and Development Centre in Cookstown on 14 November. He said the facilities were excellent and included a range of buildings where practical scenarios could be staged to provide training. Mr Bloomfield said the NIFRS was keen that NIAS would explore the opportunities to use the facilities and added that Mr Sinclair and his team were currently scoping the potential to do so. However, he highlighted that, while there would be costs associated with its usage, it would provide opportunities to work collaboratively and produce real benefits.

Mr Bloomfield advised that he and Mr Sinclair had met with representatives from Community First Responder Schemes across Northern Ireland at the end of November. He explained that the Schemes comprised volunteers who were trained by NIAS to provide assistance, usually in the form of responding to cardiac arrests. Mr Bloomfield said that he and Mr Sinclair had been advised of some challenges the volunteers had experienced and acknowledged that the Trust had had some difficulties in maintaining training requirements with groups. He said the Trust was looking at how this could be addressed.

Continuing, Mr Bloomfield believed there was a need for the Trust to engage much more proactively with volunteers, for example volunteers in the Community First Responders Scheme and the Voluntary Car Scheme. He said the Trust relied on these volunteers who provided an excellent service and needed to demonstrate how much it valued their contributions.

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Mr Bloomfield advised that, at the start of December, he had met with the most recent cohort of Associate Ambulance Practitioners (AAPs) who were now halfway through their training. He said Board members would recall that, back in March, consideration had been given to delay the start of this AAP course as a means of addressing the Trust's need to identify savings. Mr Bloomfield said that, at that time, the decision was taken not to proceed as the impact on the service would be too great. He indicated that he believed this was the correct decision and said that this cohort of staff would become operational in March 2024.

Referring to the most recent series of staff engagement sessions, Mr Bloomfield indicated that he and Directors had had constructive discussions with NIAS staff at the Causeway and Daisy Hill EDs. He explained that issues similar to those raised at other sessions were discussed, for example late finishes, missed meal and rest periods, challenges in getting annual leave, frustration at handover delays. Mr Bloomfield said he welcomed these sessions with staff and added that there had been several interesting suggestions from staff as to how certain issues might be addressed.

Mr Bloomfield advised that Directors would visit every station across Northern Ireland on the approach to Christmas and he stressed the importance of continuing to engage with staff.

Mr Bloomfield reported that he had participated in routine DoH meetings such as the Performance and Transformation Executive Board (PTEB) at which discussion had focussed on the financial position; Hospital Reconfiguration Blueprint Oversight Group which was developing proposals for a future Minister on the wider configuration of hospitals. He pointed out that any proposals had the potential to impact on NIAS and said that, as it had been recognised that NIAS was a key enabler to many of these proposals, it was important that the Trust continued to participate in these discussions.

Concluding his update, Mr Bloomfield said he had attended the Joint Emergency Carol Service in St Columb's Cathedral on 11 December which had been organised as part of the Princess of Wales Foundation.

The Chair commented that the update provided by the Chief Executive clearly demonstrated the significant work and effort

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ongoing in many different strands. She expressed her sincere thanks to the Chief Executive and the senior team for their contribution.

Mr Ashford expressed concern at the fact that the Trust had returned to a sustained period of REAP Level 4 and had not entered into the winter period proper. He welcomed the fact that NIAS and NIFRS were exploring opportunities for more collaborative working and training and encouraged the Trust to make use of the new NIFRS facilities if at all possible.

Mr Bloomfield advised that Mr Aidan Jennings had recently been appointed as Chief Fire Officer and said he looked forward to working with Mr Jennings into the future.

The Chair made reference to the NIFRS facility at Boucher Road and asked if this was no longer an option for NIAS.

Responding, Mr Bloomfield explained that initial explorations of the site had indicated that there would be significant costs associated with its use and a business case would be required. He clarified that the Trust had considered this site as a training location. However, he noted that, with the NIFRS offer to use its Cookstown facilities, albeit at a cost, NIAS would have to consider whether this might free up some classroom facilities at HQ, thereby negating the need to consider the facility at Boucher Road. Mr Bloomfield noted that the Trust still needed to explore options for a Belfast hub and he cited the Broadway station which was no longer fit for purpose for use as an ambulance station.

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

6 NIAS Staff Quality Improvement Group – Late Finishes (TB14/12/2023/03)

By way of introduction, Ms Charlton acknowledged the impact of late finishes on operational crews and said that the issue had been the subject of discussions at nearly all of the Trust's Committees as well as being discussed with other Trusts. She alluded to the fact that late finishes had been raised continually by staff during the recent round of staff engagement sessions.

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The Chair welcomed Ms Dayna Doherty, Paramedic, and Ms Lynn Stevenson, Emergency Medical Technician, to the meeting, and invited them to recount their experiences of late finishes and the impact on their personal and professional lives. She also extended a welcome to Ms Finn.

Following their presentations, the Chair thanked Ms Doherty and Ms Stevenson for their honesty and candour. She said both had conveyed to the meeting the challenges as well as the real human impact on individuals.

The Chair said that, having worked in a blue light organisation, she very much understood the challenges. She said she had discussed the issue with the Chief Executive and did not feel that the current situation was either sustainable or acceptable. The Chair advised that she had also raised the issue of late finishes with the Permanent Secretary who had made it clear that he had expectations that the system would work collaboratively to resolve this issue. She acknowledged that there were elements which lay within NIAS' influence but there were aspects which lay within the control of other Trusts.

The Chair said it was unacceptable that NIAS staff would go to work and be unsure as to when they would get home and added that this should be the exception as opposed to the norm.

The Chair acknowledged that another challenge that faced her as Chair was that the Trust currently had over 14% of staff absent from work. She said that this made it more difficult for her to seek additional resources and staffing. The Chair said that the Trust was focussed on ensuring staff did not have to be absent from work by putting in relevant mechanisms and pathways to access support.

She said she would be keen to encourage a happy and healthy working environment and believed that this was what the Trust should be striving towards. The Chair said that, while members understood the issues, the experiences recounted by Ms Stevenson and Ms Doherty had made these issues real.

The Chief Executive shared the Chair's view and conveyed his thanks to Ms Stevenson and Ms Doherty for their attendance and for their openness and honesty around the impact late finishes was having on their personal and professional lives.

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Mr Bloomfield said he accepted that there were occasions when staff across the HSC had to work late. However, he said, what was different for NIAS staff was the frequency on which this occurred and they could not walk away and leave patients. He acknowledged that this was an issue which needed to be resolved.

He said the point made by Ms Stevenson and Ms Doherty re responding to calls and feeling guilty that patients in the community had been waiting extended periods of time was very powerful. He stressed that, while both should not feel guilty at the inability of the service to respond in a timely manner, it was encouraging to know that they cared greatly about the patients.

Mr Bloomfield said that the HSC system had a collective responsibility to improve the position. He briefly described the actions taken by the Trust over the last year to address late finishes, including sending crews coming on shift to relieve colleagues waiting at EDs, crew relief teams as well as derogations. He noted that Dr Ruddell had made significant effort to hold as many calls as possible within derogation guidelines. However, Mr Bloomfield said that the bigger risk, in his view, was not having staff to respond to any calls through staff absence. He said that the DoH had recently issued guidance around the reintroduction of cohorting patients either through NIAS cohorting patients or using IAS as receivers.

However, despite these actions, Mr Bloomfield said that the biggest issue impacting on late finishes remained delayed handovers.

Mr Bloomfield stressed that the Trust was committed to making every effort to resolve late finishes. He acknowledged that a 12-hour shift was long and was of the view that there was a need to look at rota patterns to explore whether staggering them would assist.

Ms Finn advised that the Trust had set up an Improvement Group to look at late finishes and to date, 25 staff had volunteered to participate in the group.

Mr Ashford said it had been difficult to get a clear picture of the real impact on staff and he thanked Ms Stevenson and Ms Doherty for their willingness to meet with the Board.

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Ms Lemon said that their stories had been powerful and insightful. She assured both that the Trust was determined to do everything within its power to address the issue of late finishes and continued to raise the issue at every opportunity.

Ms Charlton extended her thanks to Ms Stevenson and Ms Doherty for attending today's Board meeting. She explained that the quality improvement methodology and Improvement Group focussed on ensuring there was no hierarchy with a view to listening and trying suggested solutions. She acknowledged that, while some might not be successful, the group had influence over what was tested.

The Chair thanked both for their attendance and asked them to advise their colleagues that the Trust was very aware of the impact of late finishes and was committed to trying to resolve these issues.

Ms Stevenson and Ms Doherty withdrew from the meeting at this point.

7 <u>Regional Co-ordination Centre (RCC) Memorandum of Understanding (TB14/12/2023/04)</u>

Mr Bloomfield explained that the origins of the Regional Co-ordination Centre (RCC) came from the very difficult winter experienced in 2022-23 and the view of Trusts that more could be done to equitably spread pressures across the region. He said there was a view that the system could work more collaboratively to understand and address the pressures.

Mr Bloomfield advised that a number of Trust colleagues had visited a Strategic Co-ordination Centre in the north west of England led by Mr Seamus McGirr which had been effective in improving patient flow.

Mr Bloomfield said that Trust Chief Executives in Northern Ireland had worked with Mr McGirr to identify a similar solution and a decision was taken in September 2023 to establish the RCC in Northern Ireland which would be a joint initiative by and funded by all six Trusts.

He drew members' attention to the Memorandum of Understanding which had been included in the Board papers and which had been signed by all six Trust Chief Executives to give authority to the RCC

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to act on their behalf. Mr Bloomfield said that Chief Executives would not challenge any decisions made by the RCC on a day-to-day basis.

Mr Bloomfield pointed out that he had assumed the role of lead Chief Executive and NIAS would act as the host Trust for the operation of the RCC. He clarified that the MOU made it clear that neither he nor NIAS would have any responsibility for operational decisions taken by the RCC and that the NIAS' role as host Trust would be to enact any contractual arrangements, for example remuneration of RCC staff, IT and estate arrangements.

Mr Bloomfield indicated that the RCC became operational on 4 December. He added that RCC staff had met with Trust Chief Executives to discuss the learning from that time and had signed up collectively to some actions to be taken forward.

At this point in the meeting, members left the meeting to visit the RCC.

8 **<u>Getting It Right First Time (GIRFT) Report (TB14/12/2023/05)</u>**

At the Chair's invitation, Ms Byrne explained that the SPPG had commissioned the report to be undertaken by the Getting It Right First Time (GIRFT) team comprising experienced clinicians. She advised that three main issues had been identified, namely patient handover delays from ambulance staff to ED staff and consequent poor ambulance response times; ED exit block for patients requiring hospital admission and poor patient flow within hospital and hospital exit block for patients requiring social and community care. Ms Byrne said that the Trust had been encouraged by the fact that the team had highlighted patient handover delays as the biggest risk to patient safety. She believed the team had recognised the challenges faced by the Trust and were supportive.

Ms Byrne advised that the report put forward a number of recommendations, some specifically for NIAS, which were further divided into short and long-term targets. However, several recommendations were dependent on other Trusts and their ability to deliver. She cited the example of access to patient care pathways and said that NIAS was dependent on Trusts making these available.

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Continuing, Ms Byrne said that the SPPG had been tasked with developing an implementation plan and added that the Trust had had first sight of this at the end of last week. She believed that the work should provide a stimulus to restart and embed recovery of emergency care services in Northern Ireland. Referring to those recommendations specifically for NIAS, Ms Byrne advised that some of these related to non-conveyance to hospital by the use of Hear and Treat and See and Treat and how NIAS could increase utilisation of these initiatives. Another recommendation related to the work being taken forward by Mr Sinclair's team around establishing a clinical hub in the EAC.

Ms Byrne said she would have preferred to have been involved in the development of the action plan and noted that some of the actions would require business cases for financial development and the establishment of a Clinical Reference Group. She noted that the report also made reference to ambulance transfers and how they would be arranged.

Ms Byrne said that, given the GIRFT report identified delayed ambulance handovers as the biggest risk to patient safety in Northern Ireland, she had expected more the specific recommendations focussing on how handovers would be addressed. She advised that, at a recent meeting with DoH and SPPG colleagues, Mr Bloomfield had sought clarification as to how the plan would be escalated and actioned at pace.

The Chair advised members that, following receipt of the GIRFT report, she had invited SPPG colleagues to the Board to discuss the report in more detail given the level of risk highlighted within the report. She indicated that the SPPG's preference had been to discuss the report with Chief Executive who would in turn brief the Board.

Mr Bloomfield said he had clarified with SPPG colleagues that NIAS had welcomed the report and the Chair's invitation to attend the Board meeting had been based on the fact that the DoH had commissioned the report. He had advised the Board was keen to understand how the report would be taken forward, given the direct statements around risk.

Mr Bloomfield advised that, in a recent meeting with SPPG colleagues and following his correspondence to Ms Gallagher re

patient safety concerns, he had proposed a meeting to discuss the report further. He noted the absence of specific recommendations around what could be done urgently to improve handovers. Mr Bloomfield referred to the reintroduction of ambulance cohorting and reminded members that this had been the practice prior to the pandemic. He alluded to the guidance around cohorting issued by the DoH and pointed out that it was 'guidance' as opposed to a requirement.

Mr Bloomfield expressed concern that there would be no immediate changes as a result of the report and said he was of the view that, when such a report was published by a group of respected and experienced clinicians, the recommendations therein needed to be progressed as a matter of urgency. He alluded to the Board's visit to RCC and said he was hopeful that handover times would be improved through its operation.

Ms Byrne stressed the importance of ensuring the report's recommendations dovetailed with the work being taken forward by the RCC.

Mr Ashford expressed his disappointment at the SPPG approach and hoped the Trust was in a position to help shape the draft report. He sought clarification around the term 'urgent care co-ordination hubs'.

Ms Byrne acknowledged that it was unclear what was meant by this term and said she intended to seek clarification from the SPPG. However, she believed that the GIRFT team was of the view that the establishment of the RCC would address that particular recommendation.

Mr Quinn noted that ambulance handovers was included on the Corporate Risk Register and asked whether the report changed the perception of risk by the Trust in terms of whether the risk could be transferred to the SPPG given their responsibility and accountability for the provision and commissioning of health and social care.

Responding, Mr Bloomfield referred to the cover paper which accompanied the report and the references therein to various correspondence. He believed the report validated what the Trust had been saying for some time in terms of the risk to patients in the

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community who had not been seen by clinicians as opposed to those patients waiting in an overcrowded ED.

Ms Byrne highlighted the importance of ensuring the risk was accurately reflected in the Risk Register and the associated mitigating actions.

Responding to a question from the Chair as to the timeframe, Ms Byrne advised that there was no indication as to the expected timeframe. She clarified that, while NIAS had made it clear it intended to provide feedback on the action plan, there had been no accompanying e-mail or letter to the plan seeking comments.

Mr Bloomfield reiterated that none of the proposed actions directly addressed what had been identified as the biggest risk, ie ambulance handover delays.

There was some discussion as to how the Trust should respond to the action plan.

Mr Bloomfield suggested that he should respond to the SPPG to thank them for sharing the action plan, making reference to the discussion at today's Board meeting, but pointing out that the Board was of the view that the action plan needed to be strengthened to address the risk of delayed ambulance handovers. Mr Bloomfield emphasised that it was a collective responsibility to address this risk so all organisations should be exploring the various options to mitigate the risk.

Ms Byrne noted that the draft action plan had identified some indicative milestones and she cited the example of the implementation and financial plan for 1-5 and 5-10 years to be agreed in December 2023 as well as the establishment of the Clinical Reference Group for Emergency Medicine by January 2024.

Ms Paterson noted the intonation that there would be an opportunity to discuss the plan at the regional workshop being scheduled for early January.

Mr Quinn commented that, from a lay member perspective, the report appeared to leave the risk of ambulance delayed handovers as the responsibility of NIAS to address. He suggested it would be important to take the opportunity to co-produce a meaningful action

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plan and said it was clear from the visit to the RCC how elements of that work would clearly feed into such an action plan.

The Chair noted that the Board was not due to meet in January and said she would be keen for the Board to be updated at the earliest opportunity. She indicated that, in light of the response received by the Trust, she would consider whether the issue should be raised at the next meeting of Trust Chairs. The Chair noted that the Chair of the Belfast HSC Trust had extended an invitation to her and the Chief Executive to attend their February Board meeting to discuss several challenges being experienced and how they might be addressed collaboratively.

Mr Bloomfield was of the view that the issue would benefit from being raised with other Trust Chairs. He said that he had been surprised that the report had not been the subject of detailed discussion following its publication.

Ms Byrne agreed and suggested that other Chairs would be interested in the report from an acute hospital provider perspective.

The Chair agreed to circulate the report to other Trust Chairs with a view to requesting it would be discussed at the Chairs' meeting on 15 January.

The Chair thanked Ms Byrne for her update and the GIRFT report was **NOTED** by the Board.

9 Maximising Attendance Delivery Plan (TB14/12/2023/06)

Ms Lemon drew the Board's attention to the Delivery Plan to support the health and wellbeing of the workforce and reduce sickness absence within the organisation. She reminded members that the DoH target was 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 and advised that this represented a target for NIAS of 11.24%.

Ms Lemon acknowledged the challenges for the Trust in achieving such a target in the context of a legacy of high levels of absence. She advised that the Plan was based on an approach which focussed on a number of issues, namely:

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- 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 and
- Improved governance arrangements with appropriate accountability and reporting mechanisms.

Ms Lemon said it would be important for members to be aware and understand that the Trust was attempting to affect a huge cultural shift. She explained that, traditionally within the organisation, uniformed officer managers sat within the operational tiers and carried out a broad range of duties and responsibilities. She suggested that leadership of staff may not have been a primary focus and staff had not necessarily been equipped and supported to do so. She stressed the importance of ensuring line managers understood this key role and were supported to perform it.

Continuing, Ms Lemon said that there were a number of actions relating to the reporting process but also ensuring training and support was available for managers, with a particular focus on procedural elements and leadership development. She also outlined other work which had been ongoing, for example training in having difficult conversations; writing Occupational Health Service (OHS) referrals and setting up a management OHS helpline. Ms Lemon pointed out that some of the actions being taken forward correlated to several Internal Audit recommendations.

The Chair sought assurance from Ms Byrne around the implementation aspect as operational managers were within the Operations Directorate and had been tasked with implementation in collaboration with HR Advisers.

Ms Byrne alluded to the recent meeting the Chair had had with Assistant Directors (ADs) Operations and said it was her understanding that the ADs had assured the Chair re the reporting structures in place.

The Chair was of the view that greater accountability was required at Station Officer level and ensuring they were fully aware of the mechanisms in place. She added that she had expressed this view at the meeting with the ADs Operations.

Ms Byrne said that, in addition to verbal assurances, she and Ms Lemon had discussed the need for the development of KPIs to allow for monitoring of the application of the policies and procedures.
The Chair expressed concern at the timeframes associated with the Trust's redeployment process and said she had discussed this with the ADs. She was of the view that this process should be completed within days with a focus on returning staff to work.

Ms Byrne agreed that ADs would be keen to avoid any protracted timeframes. She said that the embedding and strengthening of HR Advisers at Divisional level had been welcomed by the team. She acknowledged that, while it was not the HR Advisers' responsibility to have discussions with staff, they had a role to play in linking in with managers and providing expertise when necessary.

Ms Lemon agreed with the need to reduce bureaucracy around that process and explained that this particular point would be an element for discussion around the OHS provided to NIAS. She said there was a cultural shift needed in terms of managers understanding that they should not be concerned at accepting a redeployed member of staff.

Ms Lemon explained that the Delivery Plan had been requested by the DoH. She referred to the context behind the Plan in terms of the workstreams progressing the various elements of work which would be major contributory factors to the success of the Plan, for example, getting staff home on time and ensuring staff received their annual leave.

Mr Ashford commented that the second biggest reason for absence related to musculo-skeletal issues and asked what steps the Trust was taking to address this. He noted that the issue had been escalated to the Education Steering Group.

Responding, Mr Sinclair said that, from an education perspective, his team were collating all education needs with a view to developing a training plan which prioritised training needs.
The Chair asked whether the data was easily accessible so managers could monitor the specific reasons for absence of individual staff members and identify whether a trend was emerging.

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Ms Lemon confirmed that this was possible and said that it had been possible to identify staff who had had repeated episodes of short-term absence for example. However, she acknowledged that there was further work to do in this regard.

The Chair welcomed the improving picture around data and cultural shifts.

Mr Corrigan expressed surprise at the level of absence within the Trust. However, he said that, having heard earlier from Ms Stevenson and Ms Doherty, he fully understood the context in which the Trust was operating. He welcomed additional focus on line manager involvement and believed this was key. Mr Corrigan acknowledged that managing absence was challenging and required an ongoing focus.

The Chair commented on the oversight arrangements in place and advised the Board that, as well as Ms Byrne and Ms Lemon meeting on a weekly basis, the Chief Executive met with them both on a monthly basis. She noted that she, Mr Dennison as PFOD Committee Chair, Ms Lemon and Mr Bloomfield had initially met in September to discuss the Trust's approach to absence management and how this would be progressed. The Chair expressed her concern that there appeared to have been little progress since September with absence figures continuing to deteriorate and said there was a need to see tangible progress and a reduction in absence figures. She said that she viewed this as a significant risk to the organisation and indicated that, if it became clear that no progress was being made, it would be important to pause and reconsider the Trust's approach.

Mr Bloomfield agreed with these comments and pointed out that absence management was every Director's responsibility.
Mr Quinn alluded to Ms Lemon's earlier reference to 'softer management skills' and noted that, on occasions, individuals entered management without having had the requisite management skills. He said it would be important to ensure that, over time, the necessary training and leadership was provided to allow the development of these skills.

The Chair acknowledged that there had been a void in terms of the development of individuals in the Trust.

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Ms Lemon concurred with the Chair's comment. She said that, in terms of the cultural shift, the fundamental roles had not been assigned as individuals in leadership roles. She noted that the restructuring of the Operations Directorate would be critical as well as ensuring individuals were recruited on the basis of having the necessary skills.

The Chair thanked Ms Lemon for presenting the Plan to the Board and said she looked forward to further updates. She thanked everyone for their comments and the Maximising Attendance Delivery Plan was **NOTED** by the Board.

10 Trust Corporate Scorecard and Performance Report (November 2023) (TB14/12/2023/07)

Ms Paterson advised the Board that the Trust was developing a suite of measures across safety, quality and performance and said that the metrics would expand the breadth and depth of the information available. She said she had reflected earlier in the meeting on the benefits that the full implementation of REACH would bring and acknowledged that such a wealth of information could become overwhelming in terms of consideration.

Ms Paterson indicated that the Trust Board had agreed in August 2021 to introduce a corporate scorecard to surface the key metrics for scrutiny. She highlighted that the items included in the scorecard were those KPIs currently reported on. However, she noted that these would change over time and could be influenced by the Trust's governance structure.

Ms Paterson highlighted the importance of presenting information in a meaningful way to the public and said that the metrics and wording used would evolve over time. She said that the Trust's PPI team would be instrumental in engaging with the public in terms of seeking their views on what information they would like to see.

Mr Sinclair explained that, with the implementation of REACH, a key issue for the Trust would be the development of clinical measures and he said that work was currently being progressed with the Trust's data team.

The Chair alluded to the need for information around finance.

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Agreeing, Ms Paterson clarified that finance was reported through the People, Finance and Organisational Development (PFOD) Committee. However, she acknowledged that, over time, there was a need to understand which elements from a scrutiny perspective could be reported to the PFOD Committee and which elements could be incorporated into the scorecard. She said that, due to the challenging financial climate, she would be reluctant to consolidate the presentation of financial information too much.

The Chair agreed but pointed out that because of the very fact that the financial climate was so challenging, it would be important to ensure its inclusion.

The Chair commented on the extensive nature of the performance report and, while acknowledging the challenges, noted the lack of improvement across several areas.

Mr Ashford noted the level and amount of good quality information now available. He said he would find it helpful for the report to highlight areas of concern.

Ms Byrne explained that Directors had attempted to do this through the narrative behind the performance. She referred to discussions with Trust and SPPG colleagues in which NIAS officers had highlighted the correlation between performance/response times against those areas where handover times had significantly deteriorated.

Ms Charlton highlighted the importance of patient outcomes and the increased incidence of harm. She alluded in particular to October where there were more incidences of delayed responses with a poor patient outcome. She said that ambulance handover times had shown a deteriorating position from quarter one to quarter two. She advised that this had continued in the first month of quarter three where a deterioration in NIAS response times was also noted. Ms Charlton pointed out that DoH winter preparedness monitoring in quarter three also showed the longest ambulance handover times in the SEHSCT and SHSCT areas correlated to the longest response times to patients in the community.

Continuing, Ms Charlton said it would be important for new Non-Executive Directors to be aware that all incidents relating to the deaths of patients might not necessarily meet the regional criteria to

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be notified as Serious Adverse Incidents (SAIs). She described the multi-professional and Directorate deliberations at the Rapid Review Group (RRG) meeting in this regard. Ms Charlton pointed out that, during a recent Trust Board meeting, the complex considerations of determining whether a delayed response directly contributed to a patient's outcome were discussed.

Mr Quinn commended the information with the Performance Report and said he looked forward to meeting with Directors to discuss further.

Mr Bloomfield briefed the meeting on a recent meeting he and a number of Directors had had with SPPG colleagues following correspondence he had forwarded to Ms Gallagher re safety concerns. He said that SPPG colleagues were very much aware of the linkages between delayed handovers and harm and shared the concerns.

Ms Charlton advised that one of the points made at the meeting was the ability of the acute hospital Trusts to report adjusted mortality rates. She added that NIAS, as an ambulance Trust, was not in the same position. Ms Charlton said it would be helpful to have further discussion both internally and externally about a methodology of reporting mortality in a meaningful way to ensure transparency. Ms Charlton also referred to the importance of understanding patient outcomes and alluded to the challenges for an ambulance service in terms of patient outcome data for patients with protracted responses. She referred to C2 calls which took over double the 90th centile standard (80 minutes) to respond to and said that currently, unless informed by a hospital Trust through DATIX, NIAS would not be routinely sighted on the outcome data for patients. Ms Charlton explained that, when a SAI review was undertaken in relation to a delayed response, there tended to be a number of learning points with the most significant impact often being that of handover delays. However, she reiterated that they were not always the main contributory factor.

Mr Quinn acknowledged that such information could be taken out of context and therefore appreciated the need for supporting explanation.

Ms Charlton emphasised the importance of ensuring there was a human dimension to any SAIs discussions.

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The Chair said the Performance Report indicated a 2% decrease in call demand and yet the Trust was under-performing against national targets. She alluded to the GIRFT report which singled out ED handover delays as the biggest risk to patients in Northern Ireland.

The Chair said worthy of note was the fact that the Trust was using overtime to source up to 20 x 6 hour shifts per day to relieve crews at EDs. She welcomed the ongoing discussions between the Trust and DoH/SPPG colleagues but suggested it would now be timely to deliver on actions to address the issues. She acknowledged that she was not aware of any co-ordinated action plan across Trusts as to how these issues would be addressed collaboratively.

The Chair emphasised the importance of maintaining a focus on this issue.

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

11 <u>Finance Report (November – Month 8) (TB14/12/2023/08)</u>

Commencing his report, Mr Nicholson explained that it would be important for the Trust to maintain the current position towards the end of the financial year. He advised that details regarding VAS/PAS expenditure as well as expenditure relating to taxis and overtime costs were contained within the report. He indicated that Finance officers had worked with the Trust's BI team to develop a dashboard showing overtime expenditure and said this would prove helpful in terms of being able to drill down into the granular detail and access more timely information.

Mr Nicholson said that members would be aware of the Trust's savings target of £1.975 million and he confirmed that the Trust was on track to deliver this magnitude of savings. He said the means by which these savings were delivered were on a non-recurrent basis and would not be repeatable in subsequent years.

Referring to the Capital Resource Limit (CRL), Mr Nicholson advised that there had been a reduction in the Trust allocation which related to slippage in ICT schemes. He expressed concern

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that, as at October (month 7), the Trust had only spent £0.36 million against its total allocation of £6.38 million.

He reported that the Trust performance in relation to prompt payment of invoices remained strong.

Mr Ashford noted Mr Nicholson's concern re expenditure against the Trust's capital allocation and suggested that it would be difficult to ensure expenditure of such magnitude in the last quarter of the financial year.

Mr Nicholson said that many of the delays related to supply issues and clarified that the majority of the issues related to the supply of vehicles.

Mr Bloomfield said it would be important for Board members to be aware that the Trust had forecasted a year-end deficit of £2.2 million. He added that this had been discussed in detail at the Accountability Review meeting the Chair and he had had with the Permanent Secretary. Mr Bloomfield explained that the Trust had been able to address the forecast deficit of £2.2 million through agreement with the DoH to use £1.4 million, which had initially been provided for training, flexibly to offset the Trust deficit. He explained that the remaining £800,000 had come about as a result of Mr Nicholson adjusting the amount of funding required to accrue for annual leave, taking account of an updated position on the amount of leave taken by staff in-year. He added that the Trust had also been able to use this funding to offset its deficit.

The Chair acknowledged the tremendous efforts to get the Trust to this point.

Ms Paterson commended all those involved in the Delivering Value Programme and commented that being able to maintain that position going forward would be challenging. She added that the sustainability of progress would be predicated on maximising attendance.

Ms Charlton commented that, while it was important to acknowledge the savings which had been made, it was also important to be mindful of patients' experiences and how the Trust delivered, for example, on the need to convey patients to out-patient

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appointments, repatriations, discharges where NIAS had to contribute to the effort to improve patient flow through hospitals.

Concluding his report, Mr Nicholson noted that financial planning for the 2024-25 year continued. He explained that this planning would be split over two phases – one relating to the recovery phase for 2023-24 and the other to the planning for the new financial year. He clarified that NIAS differed slightly from other Trusts in that it had not been asked to develop a recovery plan up to 31 March 2024. Mr Nicholson stressed that the Trust needed to continue to manage its financial position within its estimates up until that point, notwithstanding the comments made at today's meeting. He pointed out that the Trust was spending less on IAS in the current year and alluded to the Chair's references to uncommissioned services.

In response to a question from the Chair as to the timelines involved, Mr Nicholson explained that these were very much driven by the DoH and the DoF requirements. He pointed out that the deadline for submission of the Trust's financial plan was 5 January and said that the service would have to demonstrate how it was delivering productivity, efficiency and reform as part of its financial plan. He noted the continuing significant financial constraints in the 2024-25 year.

The Chair thanked Mr Nicholson for the Finance Report (November – month 8) which was **NOTED** by the Board.

12 **NIAS Policies:**
- Grievance Policy & Procedure;
- Completion of Patient Records;
- Conflict, Bullying and Harassment (TB14/12/2023/09)

The Board **NOTED** the above policies which had been approved by the relevant Committee.

13 **Committee Business:**
- **Safety Committee – minutes of meeting on 7 September & report of meeting on 17 November 2023;**
- **People, Finance & Organisational Development Committee – minutes of meetings on 16 & 19 October 2023; (TB14/12/2023/10)**

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

Ms Charlton noted that some time previously she had presented on handover delays and the impact on those patients waiting in the back of ambulance and the fact that the waits were impacting increasingly on an older age profile of patients.

She was of the view that the focus needed to be on the outcome for patients and the determination to write to other Assurance Committee Chairs was in the context of patient safety and the then Permanent Secretary's correspondence of November 2020 when he clearly articulated that '*For the avoidance of any doubt, it is Department's policy that from the moment an ambulance arrives at the Emergency Department, that patient's care is the responsibility of the hospital…'*

Ms Charlton highlighted the importance of shared risk and responsibility and referred to the fact that over 40% of patients waiting in the back of ambulances were over 80 years old and 12% were over 90 years old. She said it was for this reason that Mr Ashford, as Chair of the Trust's Safety Committee, had decided to write to his Trust counterparts to highlight the impact of delayed ambulance handovers on patient safety. Ms Charlton advised that responses had been received from the South Eastern, Northern and Western Trusts and added that she and Mr Ashford were scheduled to meet with Southern Trust colleagues in mid-January.

The Chair noted that the focus of the correspondence had been on ensuring the 'right thing' was done for patients. She sought clarification on the next steps and asked whether any trends had been identified in the responses which could be taken forward collectively. The Chair said she would be willing to have further discussion with other Trust Chairs or meet with Trust Governance Committees if that would be helpful. She suggested that it might be possible to consider a lead Chair or Committee Chair progressing some collaborative work.

The Chair noted that the Belfast Trust Chair, Mr Mulgrew, had extended an invitation to her and Mr Bloomfield to attend the BHSCT February Board meeting to discuss a number of issues and suggested that the meeting would provide an opportunity to raise the issue of delayed ambulance handovers.

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Ms Charlton suggested that it would be helpful to await the outcome of the meeting with the SHSCT colleagues in the first instance.

Mr Ashford thanked the Chair for her offer and said that it would be helpful to identify common trends.

Ms Charlton advised that NIAS officers continued to meet with other Trust colleagues to share that level of detail re patients waiting in the back of ambulances and enable a collaborative approach re improvements.

The Chair said that, while she was assured by the level of data shared with other Trusts, she was less assured by the actions being taken by Trusts to address the issues.

Mr Bloomfield said that the discussions with Trusts provided an opportunity and he referred to the earlier discussion around the GIRFT report which focussed on similar issues.

The Chair asked Ms Charlton and Mr Ashford to keep the Board updated on progress.

14 **Date of Next Meeting**

The next NIAS Trust Board will be held on Thursday 22 February 2024 at 10am in the Boardroom, NIAS HQ.

15 **Any Other Business**

THIS BEING ALL THE BUSINESS, THE CHAIR CLOSED THE PUBLIC MEETING AT 1.45PM.

SIGNED: ________________________

DATE: 22 February 2024