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 8 JUNE 2023 IN THE BOARDROOM, NIAS HQ

PRESENT:	Mr D Ashford	-	Committee Chair
	Mr W Abraham	-	Non Executive Director
	Mr T Haslett	-	Non Executive Director
IN ATTENDANCE:	Mr M Bloomfield	-	Chief Executive (left the meeting at 1.10pm)
	Ms R Byrne	-	Director of Operations
	Ms L Charlton	-	Director of Quality, Safety & Improvement
	Ms M Lemon	-	Director of HR & OD
	Mr P Nicholson	-	Director of Finance, Procurement, Fleet & Estates
	Ms M Paterson	-	Director of Planning, Performance & Corporate Services
	Dr N Ruddell	-	Medical Director
	Mr R Sowney	-	Senior Clinical Adviser
	Mrs C Mooney	-	Board Secretary
	Ms R Finn	-	Assistant Director QSI
	Ms M Larmour	-	Trust Chair (observer) (left the meeting at 11.30am)
	Mr N Gillan	-	PPI & Co-production Lead (for agenda item 8 only)
	Mr C McCracken	-	QSI Lead (for agenda item 9 only)
	Mr S Maguire	-	QSI Lead (for agenda item 9 only)
APOLOGIES:	Mr J Wilson	-	Boardroom Apprentice
	Ms K Keating	-	Risk Manager

1 **Apologies & Opening Remarks**

The apologies were noted.

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The Chair welcomed Ms Larmour to the meeting as Trust Chair and explained that she would be observing today's meeting as part of her induction to the Trust.

He advised the meeting that he intended to discuss agenda item 11 'Emergency Preparedness, Resilience and Response' after Matters Arising.

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 (SC08/06/23/01)

The minutes of the previous meeting on 28 February 2023 were **APPROVED** on a proposal from Mr Haslett and seconded by Mr Abraham.

4 Matters Arising (SC08/06/23/02)

Members **NOTED** the action list.

Ms Charlton advised that, in the interests of time, she and the Chair had agreed that she would provide a verbal update in relation to an update on the Falls Pilot and that more detailed information would be provided to the September meeting.

Ms Charlton explained that a pilot had been undertaken in January and February whereby Clinical Support Desk clinicians had undertaken some operational shifts and had responded to falls calls. She pointed out that over a period of 13 days throughout January and February, 28 calls had been responded to. She said that the data collated to date had suggested that there had been

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improvement between response times and in terms of utilisation of resources double crewed ambulances were not being allocated to calls suitable for CSD clinicians. Ms Charlton said it would be important to undertake some further analysis to understand the variables, in particular to consider factors which may have contributed to the improved response such as reduced demand and also to understand the utilisation of the CSD responders for this purpose.

Continuing, Ms Charlton said she was pleased to inform the Committee that the Trust would be working with St John's Ambulance on a charitable basis to operate a pilot to commence in August in keeping with the Falls Governance Framework produced by the Association of Ambulance Chief Executives (AACE) for falls by patients over 65 years of age. Ms Charlton advised that St John's Ambulance would respond to falls calls for those with no suspected injuries where a conveyance to hospital was not considered likely. She indicated that the Trust was developing a Memorandum of Understanding and Standard Operating Procedures in line with the AACE Falls Governance Framework and these would be in place with St John's Ambulance.

The Chair welcomed the pilot and reminded colleagues of the delayed responses to such calls.

Ms Byrne referred to Ms Hanna's presentation at the February meeting when she had expressed some concern in relation to compliance rates in relation to the Medicines Regulator correspondence which had been circulated to all paramedics outlining responsibilities on possession and use of CDs. Ms Byrne confirmed that there had been an improvement in compliance. She advised that the documentation would be issued to home addresses to ensure any outstanding compliance was addressed. Ms Byrne advised that it was intended that the exercise would be completed by the end of June.

Ms Finn confirmed that information re progress in addressing actions within Docworks would be reported within the reporting matrix from September onwards.

Mr Bloomfield noted that, in respect of the update around the Review of Clinical Education, it had been intended to move away

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from the themes and include more narrative. He said that he would ensure this was actioned for the September meeting.

5 Emergency Preparedness, Resilience and Response – action plan to address recommendations (S08/06/2023/08)

Dr Ruddell provided the background to this agenda item and reminded members that, following his request, the Association of Ambulance Chief Executives (AACE) undertook an external review of the Emergency Preparedness, Resilience and Recovery function within NIAS.

Ms Sharpe and Mr McArthur provided a detailed update on the work to date.

The Chair thanked all concerned and said he looked forward to further updates.

6 Standing Items:

(i) Identification of Risk

Dr Ruddell said that the Committee would be aware of the challenges in delivering refresher training within the Trust due to the difficulties in having staff released from operational duties. He confirmed that there were also financial challenges but said Mr Nicholson would confirm that this was not a limiting factor.

Continuing, Dr Ruddell acknowledged the need to ensure a balance between operational cover and quality of care. He further acknowledged that, very often, it was easier to postpone or suspend training but that this increased long-term risks in terms of whether staff were able to deliver appropriate care when treating patients.

The Chair sought clarification on what mitigation was being put in place.

Dr Ruddell alluded to the review of clinical education and explained that the review set out the way forward not just for the internal development of training but more crucially continuing clinical education to ensure staff maintained the

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quality of care to be delivered to patients. He explained that staff were permitted two days per year to undertake training but acknowledged that this could be subsumed in other training. Dr Ruddell said that the final review report would put forward a recommendation in terms of what was needed to deliver the necessary training and it would then be a decision for the Trust on whether it could enact the recommendation. He said that the recommendation would require protected time for staff to undertake training.

Ms Byrne said it would be important to prioritise training and explore whether operational rotas, for example, could include dedicated time for training. She acknowledged that operational staff were not 100% compliant in terms of mandatory training. Ms Byrne referred to the Cardiac Arrest Masterclasses which were undertaken in November 2022 and said that these had been welcomed by staff. She also suggested the practice of having Clinical Support Officers and Divisional Training Officers on ride-alongs with staff to see staff clinical practice at first-hand.

Ms Charlton acknowledged that understandably each Director considered their respective training areas as important and she cited the example of safeguarding training within her remit. She agreed with Ms Byrne that challenges existed in the delivery of statutory training and education. Ms Charlton suggested that there should be a risk-based approach in terms of the balance of risk in relation to operational cover to ensure staff received the necessary training.

Mr Nicholson said that the Trust's ability to release staff had been an issue throughout the pandemic and added that there had been an element of trying to catch-up on the training which had been set aside during the pandemic. He welcomed the new Directorate structure in respect of training.

Ms Paterson accepted the complexity of the issues and the balance of prioritisation. She pointed out that approximately 60 RIDDOR incidents had been reported on patient handling and acknowledged that the linkages between training and potential staff absence which in turn impacted on operational cover.

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Ms Larmour asked whether the Trust was maximising the opportunity for staff to undertake digital training while waiting at EDs for example.

Ms Charlton said that, while e-learning was to be welcomed, on occasions it did not provide the level of training required by staff and tended to be theoretical. She alluded to the need for scenario-based training in certain areas. Ms Charlton referred to the implementation of REACH and acknowledged that the hand-held device would provide additional opportunities for staff to avail of training.

Ms Larmour indicated that Dr Ruddell had highlighted a risk around mandatory training earlier in the meeting and believed that, when staff were delayed at EDs for significant periods of time, it would be worth exploring the potential to use this as an opportunity to access e-learning. She acknowledged that this might require discussions with Trade Union colleagues.

Mr Bloomfield pointed out that it would be important for the Trust to avoid giving the perception that it was accepting handovers as routine occurrence and acknowledged the importance of not compromising patient safety. He said the Trust would be keen to cohort patients so crews could be released to respond to calls in the community.

Mr Sowney agreed with the point made by Mr Bloomfield and pointed out that the majority of crews would be keen to respond to calls in the community rather than wait outside EDs. He suggested that it would be important for the Trust to consider alternative ways of delivering the necessary training, for example, cohorting patients and Clinical Support Officers providing scenario-based training. Mr Sowney said that it was clear, from speaking with crews, that they would welcome such an approach.

Ms Larmour suggested that opportunities should be taken when they arose to provide training which could then be supplemented by classroom training.

The Chair noted that this appeared as a risk on the Risk Register.

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Dr Ruddell acknowledged the ongoing challenges around operational pressures but stressed the importance of ensuring quality of clinical care. He reminded the meeting that the Trust, through the Rapid Review Group, continuously reviewed incidents and complaints, for example, to identify any potential themes which might indicate a need for refresher training and further clinical guidance.

Ms Paterson alluded to discussions at SMT on this matter where it had been agreed that all training risks on the Risk Register relating to capacity should be collated into one composite risk to allow the holistic impact to be easily understood.

The Chair thanked everyone for their comments.

7 **NIAS Involvement and Co-production Strategy (SC08/06/23/03)**

The Chair welcomed Mr Gillan to the meeting and asked Ms Charlton to introduce this agenda item.

Ms Charlton explained that the Strategy had been developed as a result of engaging with service users and staff and commended Mr Gillan on his leadership. She said his enthusiasm for and expertise in public involvement had been clearly reflected in the events held. Ms Charlton advised that, if approved by the Committee, the Strategy would be presented to the June Trust Board with a view to launching it on 6 July with other strategy.

Mr Gillan provided the Committee with a detailed overview of the development of the Strategy and highlighted the engagements conducted with service users, carers, communities and staff.

He indicated that other Trusts had received funding for Partnership Officer posts but NIAS had not received similar funding and he acknowledged the potential impact on the Trust's ability to deliver on the Strategy.

Mr Gillan emphasised the need for staff to support the Strategy and indicated that PPI training was included in the mandatory training programme.

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The Chair referred to the resources and capacity required to implement the Strategy and asked if the Trust would be able to deliver on it.

Responding, Mr Bloomfield stressed that it would be important for the Trust to make every effort to do so. He pointed out that Mr Gillan would provide the knowledge and expertise to assist in the delivery of the Strategy but stressed that it was everyone's responsibility to deliver on it and just solely Mr Gillan's. Mr Bloomfield acknowledged that the Trust had not receive any funding in respect of a Partnership Officer and had decided to proceed at risk with posts.

Ms Charlton agreed with the points made by Mr Bloomfield and confirmed that the Trust now had two dedicated posts in respect of PPI and Co-production. She acknowledged that, while a certain degree of uncertainty remained around the terminology used, PPI and co-production simply started with having conversations with service users, staff and carers. Ms Charlton emphasised the importance of giving staff as well as the public the confidence and opportunities to do so and said this was one element which the Trust could deliver on.

Ms Charlton said that the measurement framework would be key to monitoring and providing evidence of outcomes and where improvement was needed. She acknowledged that, while some elements of the Strategy were outside the Trust's gift, the Trust could achieve a certain level of attainment.

Ms Lemon welcomed the Strategy and said it was an excellent piece of work. She alluded to the correlation with elements of the equality work being taken forward and said she would be keen to continue partnership working. Ms Lemon agreed that this aspect of the Trust's work started with discussion but was of the view that PPI and co-production should ultimately be mainstreamed into all the Trust's work.

Mr Sowney commended Mr Gillan and Ms Charlton on the production of the Strategy. He agreed that staff were unsure as to what co-production actually meant and said that the majority of staff were already undertaking shared decision-making when treating patients. Mr Sowney suggested that demystifying this work would be key to its success.

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Mr Haslett referred to the intention to establish a Patient Voice Forum and asked what progress had been made. He also alluded to the work around 10,000 More Voices and asked whether the outworkings of this could be used in progressing the Trust's Strategy.

Responding, Mr Gillan advised that the Trust had been successful in identifying eight service users to work with Ms Wolfe around the research function and confirmed that the necessary tools and resources were in place. He pointed out that the Public Health Agency was currently recruiting for the Regional PPI Forum and, once that recruitment had been completed, the Trust would look to recruit service users for its Patient Voice Forum. Mr Gillan confirmed that work had been completed around Expressions of Interest to be issued in early autumn and said the Forum's draft Terms of Reference had been developed for consideration by the Forum. He said it was envisaged that the Forum would then consider the development of an action plan which would assist the Trust in implementing the Strategy as well as serving to quality assure the actions being delivered. Mr Gillan added that the Forum would also work to ensure co-production was being embedded within the Trust and said the Strategy would serve to pull together patient/client experience and PPI developments into one approach.

Ms Charlton indicated that a 10,000 More Voices survey had recently been undertaken for NIAS in the context of service users' experiences of using NIAS in an emergency context. She added that there had been over 140 responses and undertook to provide a more detailed report to the Committee in due course.

Following this discussion, Mr Haslett proposed the approval of the NIAS PPI and Co-production Strategy. This proposal was seconded by Mr Abraham and **APPROVED** by the Committee.

The Chair thanked Mr Gillan for his attendance and he withdrew from the meeting.

8 NIAS Quality Strategy (SC08/06/23/04)

The Chair welcomed Mr McCracken and Mr Maguire to the meeting and invited Ms Charlton to introduce this agenda item.

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Ms Charlton explained that the Trust's Strategy To Transform committed to the development of a new Quality Strategy which reaffirmed the Trust's commitment to quality improvement as well as collating the activities aimed at improving the quality and safety of the care delivered.

Mr McCracken highlighted the salient points of the draft Strategy and advised that he had benchmarked quality strategies in other UK ambulance services. Continuing, he referred to projects which had been identified against the framework for quality, ie safe, effective, compassionate, well-led and responsive, and the leads in each. Mr McCracken explained that each identified project would have an agreed suite of quality and outcome measures. He advised that a Quality Strategy BI dashboard was currently being developed to promote service level quality management and to assist in reporting.

Mr McCracken acknowledged that, while the measures may change as implementation of the Strategy was progressed, any amendments would support achieving the project aim. He said that a Quality Oversight Group would be established and assurance would be through SMT and through bi-annual reporting to Trust Board.

Mr Haslett commended the Strategy and sought clarification on how success might be measured.

In response, Mr McCracken indicated that a baseline had been identified for each of the projects. He cited the example of missed meal breaks and said it would be important to evidence a level of improvement and present this to staff.

Ms Charlton referred to the Quality Strategy dashboard and said this would clearly set out the outcomes to be achieved and would be both accessible and readable for patients and staff. She acknowledged that the biggest issues identified by staff were late finishes, cover and handovers.

Mr Haslett suggested that a reduction in SAIs and complaints for example might be one indication of improvement.

Mr Maguire said that, following engagement with staff, it was important to return to staff to update them in a meaningful way on the issues raised.

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Mr McCracken explained that meal breaks were number five on the list of issues raised by staff and suggested that this was due to the fact that, at the time of engagement with staff, handover delays had peaked and staff were not getting home on time and missing meal breaks.

Ms Paterson pointed out that project managers were already leading on projects with specific measurable outcomes. She said it would be important to dovetail quality with performance and create a synergy between the two.

The Chair sought clarification on how this would fit in with the Integrated Quality and Performance Report and said it would be important to avoid duplication.

Ms Charlton explained that the QI dashboard would incorporate data from other initiatives and would act as a single source for data requirements.

Ms Lemon welcomed the level of engagement and involvement carried out in developing the Strategy and reiterated the importance of mainstreaming and dovetailing this work with other areas of work such as sickness absence for example.

Mr Sowney agreed that the top five concerns identified by staff were the same as those raised by operational crews when he met them. He said that crews would allude to the fact that NIAS was working collaboratively with other Trusts to reduce handovers but would acknowledge that they were not seeing the results of this collaborative working at EDs.

Continuing, Mr Sowney said that crews very much welcomed the engagement sessions and encouraged the continuation of these. He said that staff continued to find it difficult to identify issues or raise concerns in relation to a colleague's practice for example. However, he believed that this was due to the current model of service delivery whereby crews worked together for long periods of time and said that this was an issue for ambulance services throughout the UK.

Mr Sowney alluded to the fundamental importance of record keeping and acknowledged that improvements were needed. He

referred to written information on PRFs and was of the view that this impacted on NEWS scores which were vital for patients waiting in the back of ambulances outside EDs for longer periods of time.

Ms Charlton acknowledged that the full implementation of REACH would be helpful in this regard. She alluded to work being taken forward by Mr Maguire around the escalation of deteriorating patients whilst waiting at EDs. She expressed her agreement with all of the points made by Mr Sowney.

Ms Charlton referred to the culture of identifying concerns and acknowledged the need to raise awareness re how to raise concerns about sexual safety for example. She noted that Ms Gardner was working specifically on the regional raising concerns framework in NI.

Mr Sowney referred to the fact that 32% of employees would recommend NIAS as an organisation in which to work. He asked how the Trust was addressing and developing compassionate leadership at the various tiers of management. Mr Sowney believed that senior management had a responsibility to drive forward culture and set the tone within the organisation and move away from the command and control culture.

Ms Charlton agreed and said that the Culture Charter was on paper but it was incumbent on senior management to make this meaningful to staff.

Mr Maguire said that Mr Sowney's points were all valid and acknowledged that the culture was changing. He referred to the students due to graduate through the Ulster University and believed they represented a new kind of staff. Mr Maguire said that staff had always been willing to speak to him and Mr McCracken when they had visited EDs. He reiterated his earlier view around the importance of ensuring staff were provided with feedback on any concerns raised. He emphasised the importance of communicating with staff at the right level, giving the right message and committing to any undertakings given.

Mr Haslett proposed the approval of the NIAS Quality Strategy. This proposal was seconded by Mr Abraham and **APPROVED** by the Committee.

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The Chair thanked Mr McCracken and Mr Maguire for their attendance and they withdrew from the meeting.

9 **Annual Safeguarding Position Report (SC08/06/23/05)**

Ms Charlton advised that the Annual Safeguarding Position Report was a regional template provided by the SPPG and was considered an important overview and governance tool by all organisations and groups supporting adults and children at risk or in need of protection. She confirmed that the Trust's Head of Safeguarding, Mr Des Flannagan, would attend the Trust Board to present the report as it contained significant information for an organisation's Senior Management Team and Trust Board. Ms Charlton added that there was an expectation that the Position Report should be made available for any external audit purposes.

Continuing, Ms Charlton advised that the Position Report was key in demonstrating organisational levels of compliance with the RQIA Safeguarding Quality Improvement Plan issued in December 2019, the Adult Safeguarding: Prevention and Protection in Partnership (July 2015) Policy, and Co-operating to Safeguard Children and Young People in Northern Ireland 2017.

She said that the Report reflected significant organisational progress but acknowledged that the Trust was not yet fully discharging its statutory responsibility and had further work to do to support staff to report safeguarding concerns. Ms Charlton indicated that the Report provided an overview of the actions in place to address this work. She acknowledged that there was a variation against national referral rates with NIAS rates lower than its UK counterparts and said the Report provided referral rates by Division and staff group.

Ms Charlton accepted that there had been challenges with delivery and release of operational staff for face-to-face Level 3 training and said that the Intercollegiate Documents for Safeguarding Roles and Competencies for Health Care Staff (2018) recommended that the Trust all paramedic staff should be trained to Level 3. She pointed out that this level of training would include at least a half-day face-to-face training.

Ms Charlton said it would be important to recognise that, as an organisation, the Trust had not receive any baseline funding

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allocation in respect of safeguarding and confirmed that this had been included as a risk on the Trust's Corporate Risk Register. However, she pointed out that the Trust had taken a decision as a Senior Management Team to proceed at risk and recruit two further posts in respect of safeguarding and would continue to engage with SPPG colleagues re funding.

In terms of work being progressed, Ms Charlton added that work was being taken forward with other Trusts around the development of welfare pathways which, she said, on occasions, staff found difficult to navigate. She indicated that work was also underway to develop a Standard Operating Procedure (SOP) in the event of safeguarding allegations and acknowledged that this was a difficult process both for the individual and the member of staff. Ms Charlton said that the development of a Chaperone Policy would be important and support staff in their practice to ensure everything appropriate was being done. She made referred to the Sexual Safety Charter and commented that work had recently commenced to explore this area of work further.

The Chair alluded to the inconsistent approach within Trusts in respect of referrals and asked what steps could be taken to resolve this.

Ms Charlton acknowledged the variances in national referral rates. She said she had sought clarification on the operational definitions used on a national basis and was of the view that, despite potential inconsistencies in measurements, NIAS remained an outlier. She reminded the meeting that the Trust only mandated safeguarding training approximately two years previously. Ms Charlton accepted that the Trust was currently not meeting its Key Performance Indicators (KPIs) and e-learning uptake was not at the required compliance level. She indicated that the two additional safeguarding posts would assist in this regard and said she appreciated SMT support. Ms Charlton said further work was needed around awareness and focussing on the actions required.

The Chair expressed his shock at the 25% increase in domestic violence referrals and asked whether the Trust highlighted these figures.

Responding, Ms Charlton confirmed that Mr Flannagan was reporting these figures to the SPPG and said that similar increases

had been noted by other UK ambulance services. She alluded to recent domestic violence campaigns and suggested that these may have contributed to the increase in referrals. She added that Mr Flannagan reviewed referrals on a weekly basis and said it would be important for the Trust to do everything possible to manage and support staff in such situations.

Ms Lemon advised that she and Mr Flannagan had met with DoH colleagues given the prevalence of domestic violence in society and the fact that staff would have to deal with domestic violence cases. Ms Lemon said that the Trust would be keen to develop domestic violence training in-house so staff could be appropriately signposted.

Ms Charlton advised that Northern Ireland had one of the highest levels of domestic violence across Europe.

Referring to the SMT decision to proceed at risk and appoint two additional members of staff to the safeguarding team to support Mr Flannagan, Mr Bloomfield said that this decision demonstrated the importance of this area of work and the increasing nature of it. He said that, in doing so, SMT recognised that this added to the Trust's financial pressures but said it was the right thing to do. Mr Bloomfield said that he and Ms Charlton both continued to press the DoH and SPPG re funding. He advised that, while the DoH and SPPG acknowledged the need and taking account of the current financial situation, they were of the view that if this area of work represented a priority for the Trust, then the Trust should prioritise its funding appropriately.

Ms Charlton explained that the Domestic Homicide Review process had recently been established in Northern Ireland and Mr Flannagan was currently working with EAC to provide specific training to EMDs. She added that Mr Flannagan had also provided one specific session for Clinical Support Desk officers. She said that this need had been highlighted in the peer review which the Trust was aware that it needed to take forward but having the infrastructure to support this had proved difficult.

Mr Abraham emphasised the importance of safeguarding and acknowledged the low starting position for the Trust. He said he was encouraged by the progress which had been made.

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The Committee NOTED the Annual Safeguarding Position Report as presented by Ms Charlton.

10 Governance of Safety & Quality Alerts (SQAs) (SC08/06/23/06)

In Ms Keating's absence, Dr Ruddell presented the new 'Procedure for the Management and Dissemination of Safety and Quality Alerts and Learning'. He highlighted the type of Safety and Quality Alerts (SQAs) received by the Trust and explained that these focussed on the dissemination of regional learning the HSC system within NI and were issued to support improvement in practice.

Dr Ruddell explained that previously individual Directors would have received SQAs for appropriate circulation and action and that this new procedure on Datix recorded the SQA on a central repository and a member of the Datix team would ensure that the SQA was being actioned and the actions recorded.

The Chair asked whether all Trust staff had access to Datix.

In response, Dr Ruddell clarified that all staff had access. He explained that the Datix system would generate automated e-mails after a certain timescale to ensure that the appropriate action had been taken and responses recorded accordingly.

Dr Ruddell cited the example of a SQA re a drug and said that the new process would ensure that the SQA was logged. He added that he would determine the appropriate action to be taken and the actions would be recorded on the system as evidence.

Mr Abraham noted that the Committee would receive an annual report.

The Committee APPROVED the new 'Procedure for the Management and Dissemination of Safety and Quality Alerts and Learning' on a proposal from Mr Abraham. This proposal was seconded by the Chair.

11 Integrated Quality & Performance Report (SC08/06/23/07)

Ms Paterson indicated that the Trust was currently transitioning to a Integrated Quality and Performance Report. She said the intention

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was to disaggregate the key level information and ensure it was presented at the appropriate Committee and ultimately Trust Board.

Ms Paterson drew the Committee's attention to the report and highlighted the data around patient-focused, productivity and efficiency Key Performance Indicators (KPIs). She advised that work was ongoing to develop a comprehensive set of productivity indicators and until these were finalised, the Trust would report on patients transported and patients per journey.

Ms Paterson indicated that the report included data on trajectories agreed with the SPPG for 2023-24 and the Trust's performance against these.

She said that the Trust continued to transition to the new form of reporting and ensure the appropriate information was presented to members to give them the opportunity to ask the most pertinent questions.

Mr Bloomfield expressed concern that, despite the Trust not having received any CRM funding, the SPPG trajectories had NIAS achieving response times by March 2024.

Ms Paterson confirmed that this point had been discussed with SPPG colleagues and they were aware of this point.

Ms Lemon highlighted the approach being taken through the Attendance Management Project. She said that work was being undertaken to look at the data and drill down into the reasons for absence. Ms Lemon said that 'heat mapping' would also be undertaken to determine incidences of absence. She acknowledged the high sickness levels within the EAC and said this was evidenced by the high turnover rate and the number of referrals to peer support. She referred to the stressful nature of the work undertaken in EAC and said it would be important to examine potential causation factors.

Continuing, Ms Lemon said she was pleased to report that the process and model for Attendance Management had been shortlisted as a finalist in the HPMA HR Professional Innovation System Awards. In terms of reporting, Ms Lemon indicated that the Chief Executive currently chaired the Programme Board and the PFOD Committee would monitor progress of the project.

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Ms Byrne acknowledged that staff had innovative suggestions to put forward and cited the example of the Trust planning to move forward with systematic changes to the rota. She said that, while the current Action Short of Strike had impacted on these plans, Trade Union colleagues had been made aware of the Trust's plans and its intention to move forward with this work. Ms Byrne welcomed the small pockets of change across Divisions and said that it was likely that a change in rota system would be piloted within the North Division.

The Chair thanked attendees for their comments and the Report was **NOTED** by the Committee.

12 Clinical Support Desk Update (SC08/06/23/09)

Dr Ruddell reminded members that an undertaking had been given to provide the Committee with an update on the activity of the Clinical Support Desk (CSD). He explained that CSD clinicians provided a secondary clinical triage of calls over and above the AMPDS protocols and were trained to carry out remote assessments by telephone and also by video calls as well as providing patients with an appropriate clinical response. CSD clinicians are also able to signpost patients to a patient care pathway or provide clinical advice.

Dr Ruddell advised that CSD clinicians played an important safety role in terms of being able to further interrogate calls which may be more significant than first thought, hence he said the data showing an upgrade rate of 41.45% between 4 April 2022 and 31 March 2023.

Dr Ruddell advised that, between 1 April 2022 and 31 March 2023, 13 CSD clinicians had managed 6,827 incidents without having to send an emergency response and said this averaged approximately 18.70 incidents on a daily basis.

Continuing, Dr Ruddell indicated that members were aware of the inherent risk to patients who waited significant periods of time for an emergency response and said there was evidence to show that harm was being caused to these patients. He acknowledged the pressure placed on CSD clinicians in terms of the number of welfare calls to those patients waiting on an emergency response.

Referring to CSD quality and audit, Dr Ruddell explained that, from an assurance perspective, audit was a requirement of the licencing agreement with the provider of the Manchester Triage System (MTS) and he reported that, for the year 2022-23, the Trust undertook 356 audits which enabled feedback to staff as well as ensuring the CSD clinicians were undertaking safe clinical practice.

Dr Ruddell acknowledged the challenges which had been experienced by the CSD service during the pandemic in terms of staffing the rota. He advised of the changes to the CSD job plan which allowed for a better combination of working in the Control Room as well as undertaking operational shifts and believed that this would make the role of CSD clinician more attractive. Dr Ruddell advised that, while CSD was funded for 21 FTE staff, staffing numbers were between 10-14 staff. He said that a further recruitment programme had recently closed with 16 applications received.

Mr Sowney alluded to the reference to CSD clinical support to EAC staff and queried whether it would be more beneficial to have a separate clinical role which supported staff and lead on CSD work.

Ms Byrne advised that the Trust had used baseline funding from vacancies to put in additional temporary posts until funds could be identified to undertake a recruitment exercise for two permanent Clinical Support Managers.

Mr Sowney referred to the operational exposure.

Responding, Dr Ruddell was of the view that there was a balance to be struck and believed that, making the role more attractive might encourage applications. He pointed out that the role of a CSD clinician was challenging and pressurised.

Ms Byrne welcomed the 16 applications and said that this had been the highest number of applicants for some time. She added that she would be keen to encourage skill mix in this role but it had been agreed that the recruitment exercise should focus on paramedic applications on this occasion. She pointed out that the Trust currently had a nurse in the role of CSD clinician with another due to take up post in the summer.

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In response to a question from Mr Sowney as to how a traditionally paramedic structure would incorporate nurses, Ms Byrne advised that there were ongoing discussions with Craigavon from an ED perspective and the Trust was currently working through the governance arrangements.

Mr Sowney suggested that it would be helpful for NIAS to engage with other ambulance Trusts who had multi-disciplinary professional teams in terms of their management arrangements.

Dr Ruddell indicated that other services were moving towards having skill mixes in the Control Room. He added that the Trust had been progressing this as a separate project to encourage applications from mental health practitioners to handle mental health calls specifically. He cited the example of the London Ambulance Service which had determined that it had a greater proportion of calls suitable for a midwife to handle and had employed a midwife in the Control Room.

Ms Byrne advised that work had been undertaken to engage with other services regarding job descriptions to ensure the work remit across a range of roles within the room accurately reflected the duties now undertaken/had responsibility for and she undertook to seek an update.

Ms Charlton emphasised the importance of professional governance and reporting. She advised that Mr Chris Clarke had dual registration and was supporting some of the nursing staff. Ms Charlton added that there were currently eight nurses within the Trust.

The Chair thanked Dr Ruddell for presenting the CSD Update which was **NOTED** by the Committee.

13 **<u>Strategic Review of Clinical Education Update (SC08/06/23/10)</u>**

Dr Ruddell drew the Committee's attention to the interim update, in particular the second slide which provided an update on progress as well as highlighting some of the planned activity. He pointed out that work was underway to address the driver training issue which had been identified to the Committee as a risk some months previously.

FINAL

Mr Nicholson commended the nature and volume of training undertaken over the last 4-5 years. He reminded the meeting that the last cohort of NIAS trained BSc students was due to graduate at the end of the month and said these students had been resourced through the £5 million received by the Trust for the last four years.

Dr Ruddell referred to the misperception that the Trust would have more capacity now that paramedic training had moved to the remit of the Ulster University. He emphasised the need to ensure that the Trust had a programme of ongoing development and refresher training for staff and said the training team would now focus on the provision of such training.

Mr Bloomfield said that he planned to escalate this issue to the attention of DoH colleagues. He said that he had recently met two student paramedics who were aware of rumours that the Trust would not be able to employ them following graduation. Mr Bloomfield said it was inconceivable that, having introduced the BSc programme, the DoH would not be in a position to provide resources to allow the Trust to recruit paramedic graduates.

Mr Sowney agreed with the points made by Mr Bloomfield and acknowledged that many students were considering employment elsewhere. He stressed the need for informal feedback and for students to be encouraged to feedback. Mr Sowney said he had been advised that some clinical placements had been of the view that they had been unable to provide any meaningful teaching to the students and were not sufficiently prepared to take on student placements.

Mr Bloomfield said it would be important to provide feedback to the Ulster University in a constructive manner.

Dr Ruddell confirmed that the Trust would be meeting with the University to discuss a number of areas.

Dr Ruddell noted that a number of EMTs had been successful in joining the second year of the BSc programme.

Mr Abraham commented on other organisations where contracts included a clause whereby trainees were required to work within the organisation for a certain period of time.

FINAL

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

14 Community Resuscitation Team Update (SC08/06/23/11)

Dr Ruddell commented that this was very much a positive story and welcomed the increase in schemes and the number of volunteers who had received CFR training. He advised that the CFR Scheme now had over 360 CFR volunteers across 22 schemes with four new areas having recently been established and trained during 2022. Dr Ruddell acknowledged that there was a demand for new and expansion of CFRs within existing schemes but these were limited by capacity and resource within the Community Resuscitation Team.

Dr Ruddell drew the Committee's attention to the work being carried out around ensuring Automated External Defibrillators (AED) were registered with NIAS on the Circuit national defibrillator database. He explained that the tagging process enabled NIAS to audit community AEDs in relation to their location and the accuracy of information provided when the AEDs were registered.

Dr Ruddell also alluded to the fact that the GoodSAM system had gone live on 7 February enabling over 4,000 members of the public who had a minimum of Basic Life Support training and had registered as a GoodSAM responder to respond to calls.

He advised that NIAS remained committed to working with the NIFRS in terms of a co-responder model.

Mr Bloomfield advised that he had attended the CFR conference at the end of April and said the level of interest in establishing further CFR schemes was clear. However, as already had been mentioned, there were challenges within the CRT due to capacity and resources. Mr Bloomfield suggested that it would be helpful to explore other types of work which could be undertaken by volunteers.

Ms Charlton advised that a further meeting with NIFRS colleagues would take place in July and she would update the Committee at its September meeting.

FINAL

The Chair commended all involved and welcomed the progress being made in relation to the increase in CFR schemes and volunteers.

The Community Resuscitation Team Update was **NOTED** by the Committee.

15 **Infection Prevention Control & Environmental and Vehicle Cleanliness Report (SC08/06/23/12)**

Ms Finn explained that the paper provided a summary of the Trust performance in relation to Hand Hygiene (HH), PPE and e-Learning KPIs as well as setting out how the IPC Team was supporting staff and Divisions in relation to continuous improvement. She advised that there was a plan to pause HH and PPE auditing and engage with staff at EDs in relation to dynamic risk assessment, standard and transmission based precautions.

Ms Finn advised that there had been a significant reduction in audit scores in HH and PPE and there was a need to understand the reasons for this and she outlined a number of actions being taken in relation to HH and PPE.

Ms Finn indicated that face-to-face engagement with staff tended to prove more effective and said that the position would be monitored to see if this engagement might result in an improvement in audit scores.

The IPC EVC Update was **NOTED** by the Committee.

16 **Adverse Incidents Governance & Learning (SC08/06/23/13)**

Ms Charlton explained that the way in which an organisation managed and learned from adverse incidents was one of the key markers of success in relation to risk management, corporate and clinical and social care governance standards. She indicated that effective risk management was effective by adopting learning and enhancing practices.

She drew members' attention to the report which provided an overview of adverse incidents and associated learning and explained that Ms Keating had highlighted salient points for ease of reference.

FINAL

The Chair welcomed the decrease of 6% in incidents of violence and aggression against from 2021-22 to 2022-23 and noted that this was the first reduction in six years.

Ms Paterson referred to the earlier discussion in relation to the identification of risk around manual and patient handling. She said that this risk had been flagged because the Trust recognised that a significant period of time had elapsed since training had been updated. Ms Paterson said that not prioritising this training created potential additional capacity issues when staff reported absent due to injury. She explained that, when drafting the report, the complexity of the challenges, for example the need to prioritise training against the need to maintain cover, were highlighted.

Ms Paterson acknowledged that, while the report was helpful in identifying issues which could be learned from, it also identified issues which warranted further consideration.

Mr Sowney welcomed the move by the Trust to procure a new defibrillator which would have 4G and enhanced connectivity.

Dr Ruddell acknowledged the most common theme at present was defibrillator malfunction and said that this was mostly due to failed transmissions in the WHSCT area due to a lack of signal. He said that, while procurement was still underway, whatever device procured would have better 4G connectivity. Dr Ruddell pointed out that another issue which presented a risk was the failure of staff to clear the memory of the defibrillator at the end of each use.

Members **NOTED** the Report on Adverse Incidents Governance & Learning.

17 **Date of next meeting**

The next meeting of the Safety Committee will take place on Thursday 7 September 2023 at 9.30am in the Boardroom, NIAS HQ.

18 **Any Other Business**

There were no items of Any Other Business.

FINAL

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

SIGNED: ____________________

DATE: 7 September 2023

FINAL