NORTHERN IRELAND AMBULANCE SERVICE TRUST

TRUST BOARD - THURSDAY 22 FEBRUARY 2024 AT 10AM

Boardroom, NIAS HQ, Site 30,

Knockbracken Healthcare Park,

Saintfield Road,

Belfast BT8 8SG

Agenda

1 Welcome, Apologies & Declarations of Conflict of Interest

For Information

2 Minutes of the previous meeting held on 14 December 2023

For Approval

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3 Matters Arising

For Noting

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4 Chair's Update

For Noting

5 Chief Executive's Update

For Noting

6 Integrated Clinical Hub Update & Initial Report

For Noting

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7 Appointments to Trust Committees

For Approval

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8 Corporate Risk Register

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9 Trust Performance Corporate Scorecard (January 2024)

For Noting

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11 NIAS Policy:

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- Operational Road Risk, Fleet Safety Policy v1.0

For Noting

11 - 02 - Occupational Road Risk Fleet Safety Policy (final draft of v1.0).pdf ***Page 96***

- Driving and Care of Vehicles on behalf of the Trust - Standard Operating Procedure (SOP) v1.0

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12 Committee Business:

For Information

- Safety Cttee - minutes of meeting on 17 November 2023 & report of meeting on 25 January 2025

For Noting

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12 - 02 - Briefing Note for TB re Safety Cttee report 250124.pdf ***Page 173***

- Audit & Risk Assurance Cttee - minutes of meeting on 5 October 2023 & report of meeting on 1 February 2024

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12 - 03 - ARAC mins 051023 final.pdf ***Page 176***

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13 Date & venue of next meeting: Thursday 28 March 2024 at 10am in the Boardroom, NIAS HQ

For Information

14 Any Other Business

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 Welcome, Introduction & Apologies

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.

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.

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.

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.

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.

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.

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

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.

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.

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.

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 **Regional Co-ordination Centre (RCC) Memorandum of Understanding (TB14/12/2023/04)**

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

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 **Getting It Right First Time (GIRFT) Report (TB14/12/2023/05)**

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.

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

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

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:

- 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.

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.

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.

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

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.

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 **Finance Report (November – Month 8) (TB14/12/2023/08)**

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

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

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.

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: _____

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD – 14 DECEMBER 2023

		INDIVIDUAL ACTIONING	UPDATE
	PUBLIC		
1	REACH – share training video with NEDs	MP	Training videos shared with NEDs on 7/2/24.
2	Keep Board updated on discussions with Trusts re patient safety	LC	Meeting held with SHSCT on 11/1/24.
3	GIRFT report: - draft response and provide feedback on draft action plan on back of discussion at Board meeting; - provide further update to Board	MB MB	The GIRFT report and associated action plan was discussed at the December meeting. The Director of Operations subsequently engaged directly with SPPG to provide feedback and seek clarification on next steps. In the interim, NIAS has taken the opportunity to raise the report in a number of fora, including the NIAS Accountability Review with the Permanent Secretary, as well as with Trust Chairs. The SPPG has convened a meeting on 12 March 2024 for NIAS to discuss the recommendations for our Trust, and the opportunity to discuss inter-dependencies with other Trusts to achieve required outcomes. This meeting will be attended by the GIRFT Unscheduled Emergency Team and SPPG Unscheduled Care Management Unit.

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

PRESENTATION OF PAPER

Date of Trust Board:	22 February 2024
Title of paper:	NIAS Integrated Clinical Hub (ICH) Update and initial report
Brief summary:	Late last year, NIAS moved to introduce a new ICH model to replace the existing Clinical Support Desk (CSD) model that had ran for approximately seven years. This would move to a much more clinically led remote assessment model which was anticipated, following pilot data, would lead to more patients getting the right care first time, but also increase patient safety for those waiting for an ambulance response.
Recommendation:	**For Approval** ☐ **For Noting** ☒
Previous forum:	SMT – 13/2/24
Prepared and presented by: **Date:**	Karl Bloomer, Consultant Paramedic – Urgent Care Neil Sinclair, Chief Paramedic Officer 15 February 2024

NIAS Integrated Clinical Hub

Northern Ireland Ambulance Service
Health and Social Care Trust

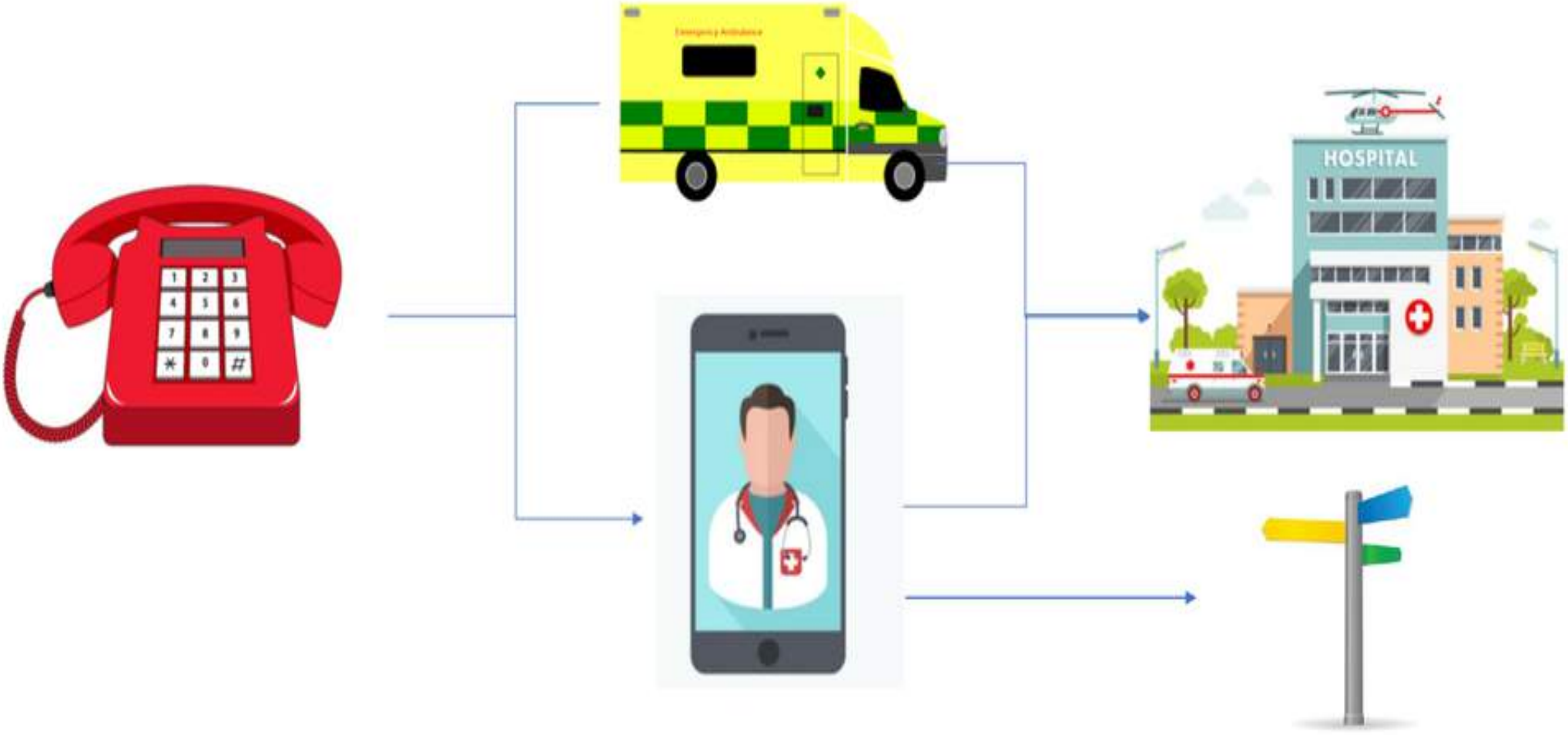
NIAS
Integrated Clinical Hub

February 2024 update

NIAS Integrated Clinical Hub

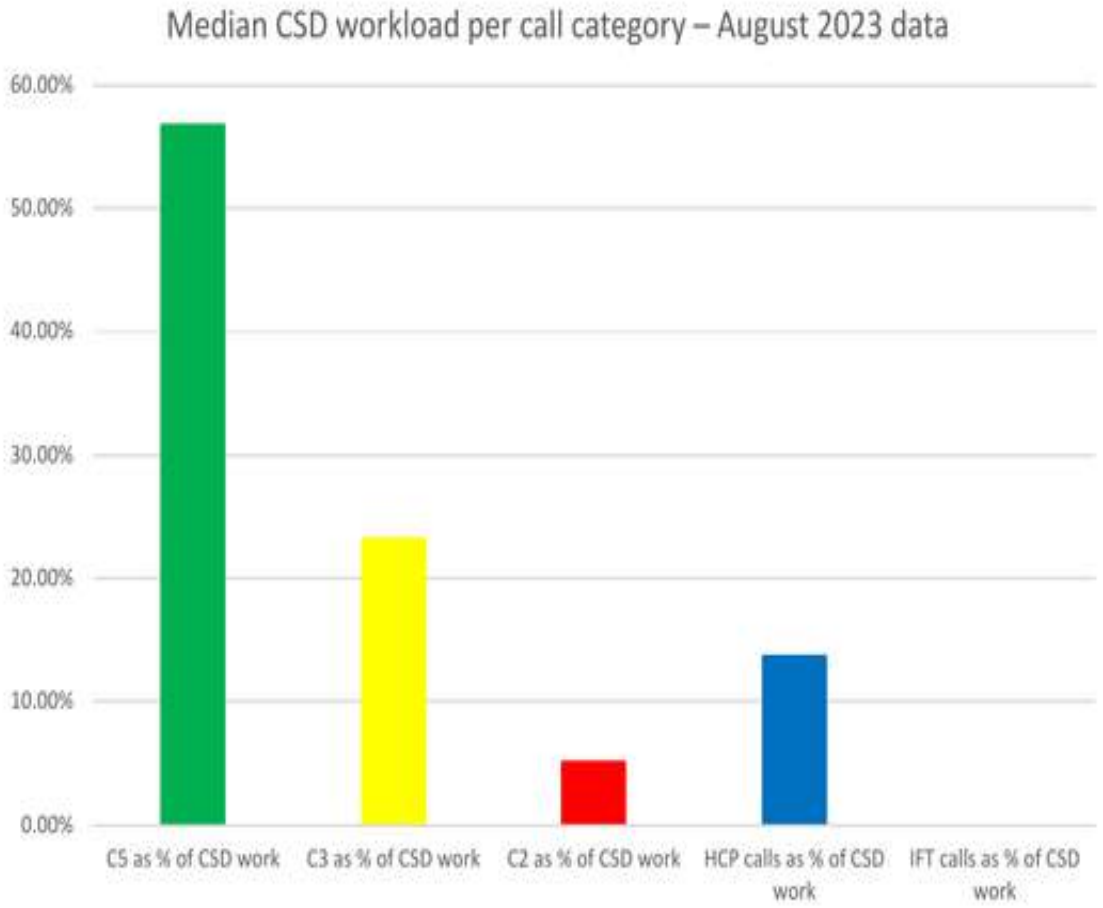
Northern Ireland Ambulance Service
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Right Care – Right Time



Background Data

- Overwhelming majority of CSD workload traditionally Category 5
- Previously perceived as the best target for CSD
- However, Category 5 had high percentage of face to face response

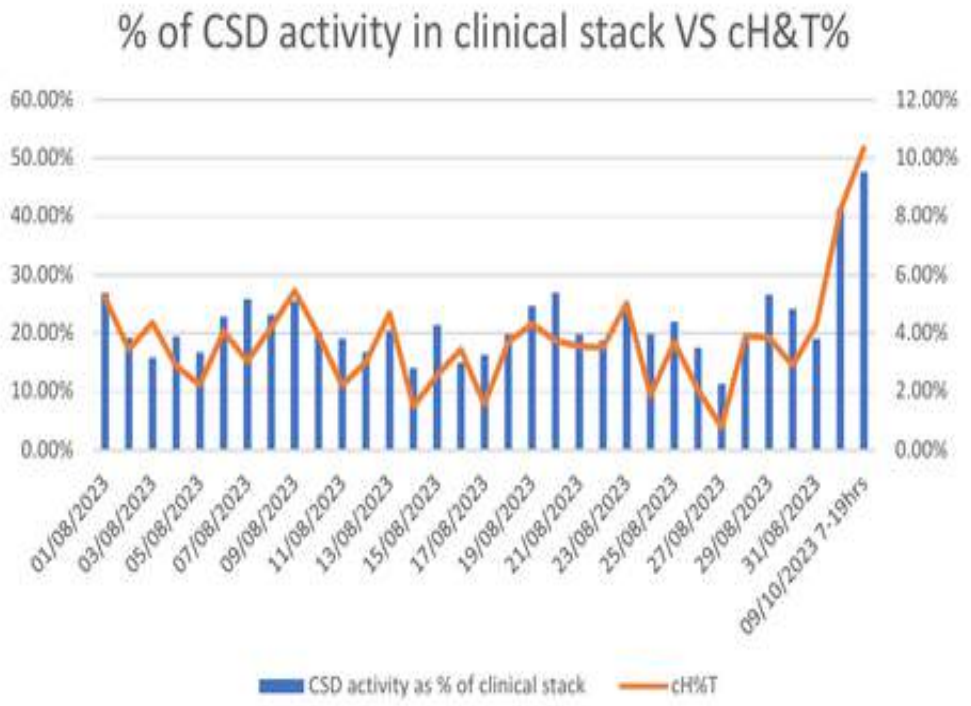


NIAS Integrated Clinical Hub

Northern Ireland Ambulance Service Health and Social Care Trust

Pilot Day 9th October

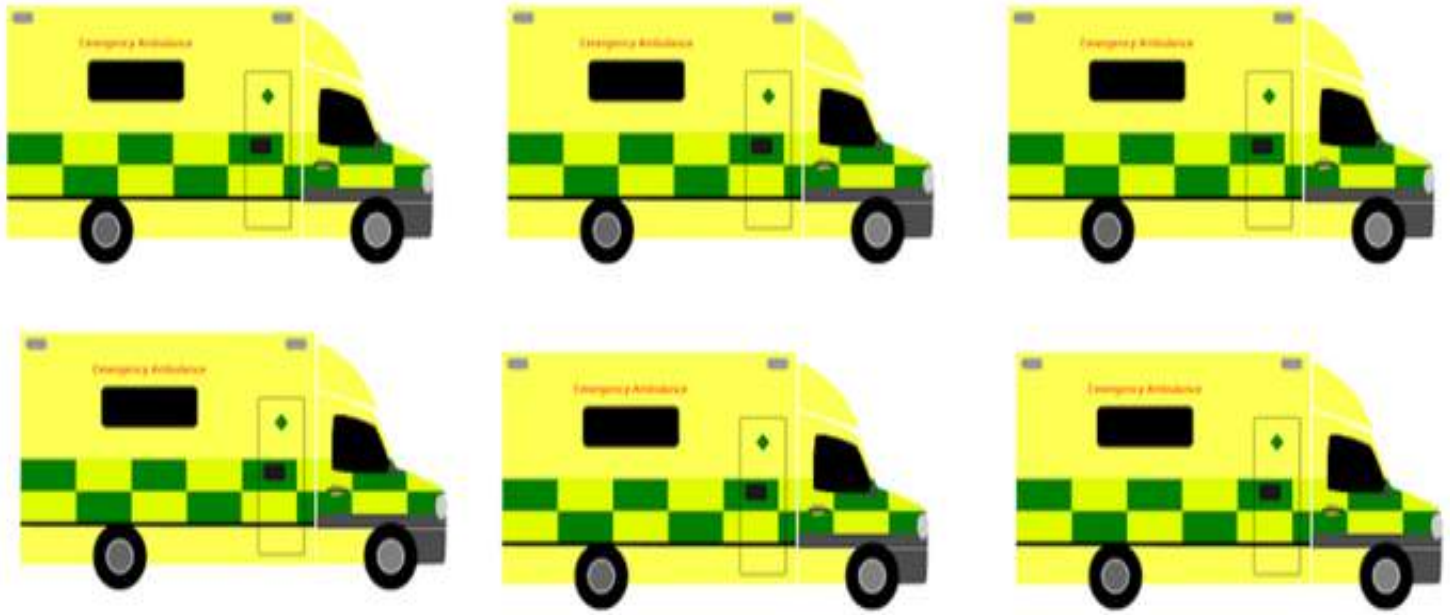
- Increase in amount of overall 999 calls receiving clinical assessment
- Considerable increase in volume of calls not normally assessed including:
  - Category 2 calls
  - Category 3 calls
  - HCP calls
  - IFT calls
- Ratio of return up from 0.17 to 0.22 under clinically led model



	Total %	Conveyed %	Clinical See & Treat %	Clinical Hear & Treat %
2023 Aug Baseline (New data analysis methodology)	100%	82.13%	14.47%	3.41%
Pilot Day 9th October	100%	79.32%	10.49%	10.19%

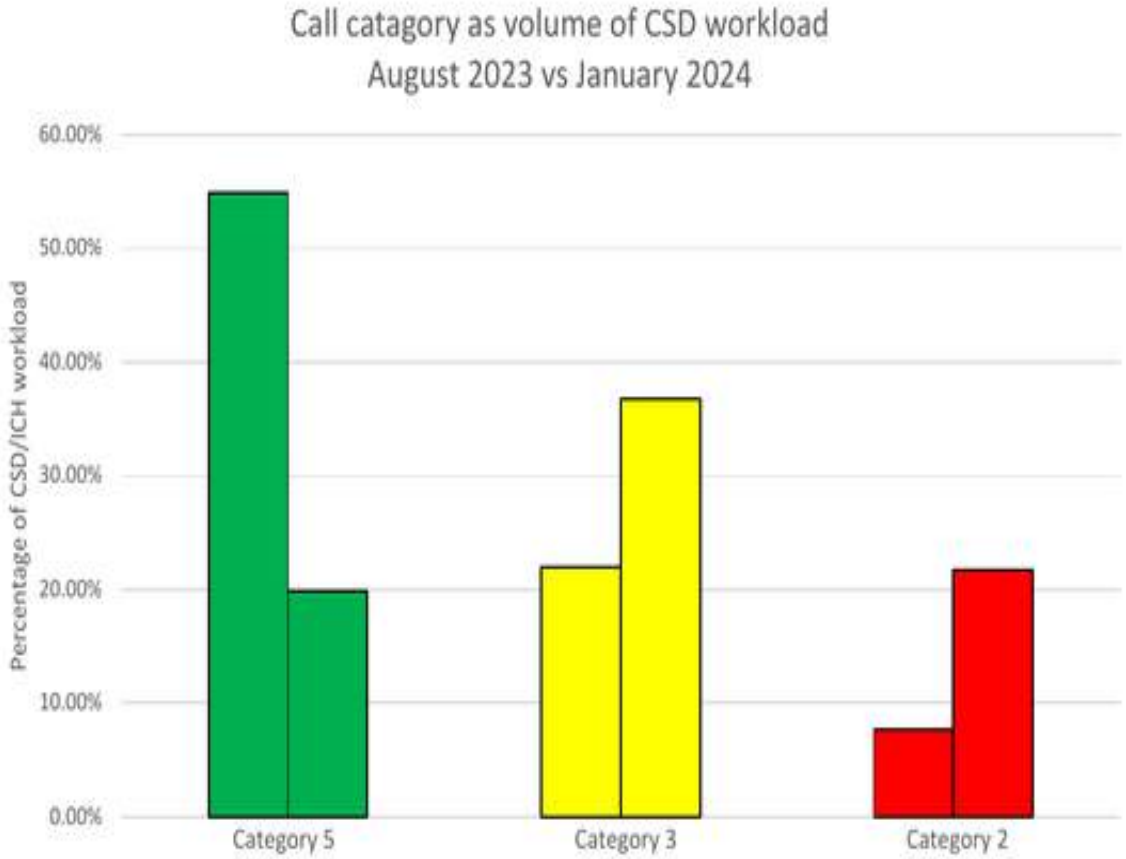
Right Response – Right Time

- Hear and Treat 1% increase saves in 24hrs approximately six ambulance responses to scene



Initial strategy following pilot day

- Increase of clinical leadership
- Shift in method of working – clinically led workload
- Staffing model to meet the demand



NIAS Integrated Clinical Hub

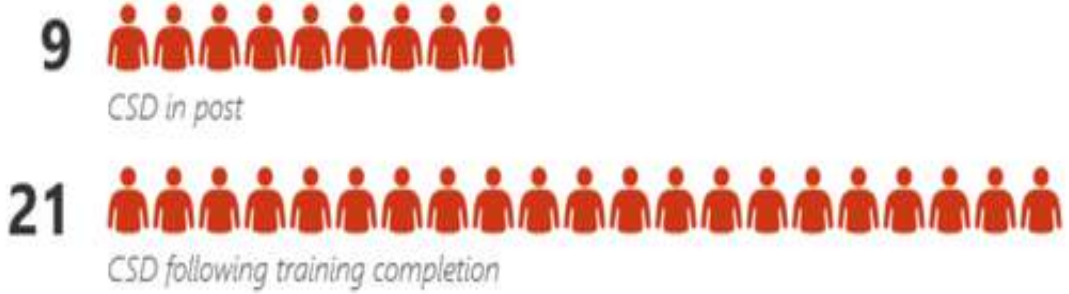
Northern Ireland Ambulance Service
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Workforce

- EOIs for Clinical Support Manager (CSMs)
  - Planned increase from x2 to x8
  - X5 now in post and x1 in training



- EOI for CSD Clinicians
  - X9 existing in post – legacy recruitment difficulties
  - X12 in training over next three months
    - X5 started training January
    - X5 starting training in February
    - X2 starting training in March



Remote Hubs

- Open for testing Dec 2024

- Used under an escalation period
  - Local clinician able to attend and use during safety escalation
  - Able to save 16 emergency ambulance deployments over 8 hour period via cH&T and downgrades

- IT challenges preventing expanding into other regional strategic sites at present



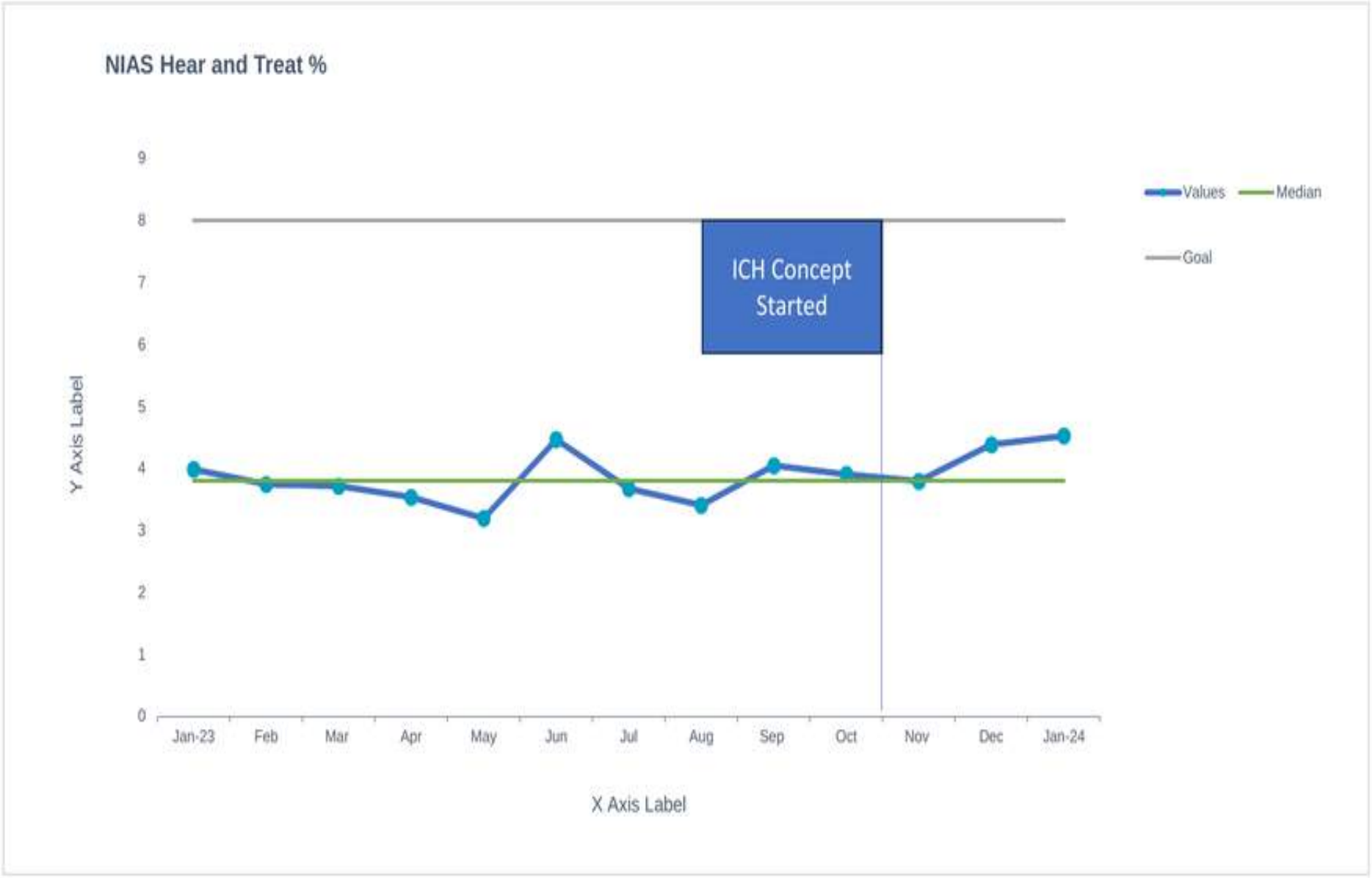
Clinical Governance

- Audit a key requirement for continued use of remote triage software
- Three months behind previously
- Backlog caught up and in stronger position for new intakes (new clinicians require height auditing volume)

NIAS Integrated Clinical Hub

Northern Ireland Ambulance Service
Health and Social Care Trust

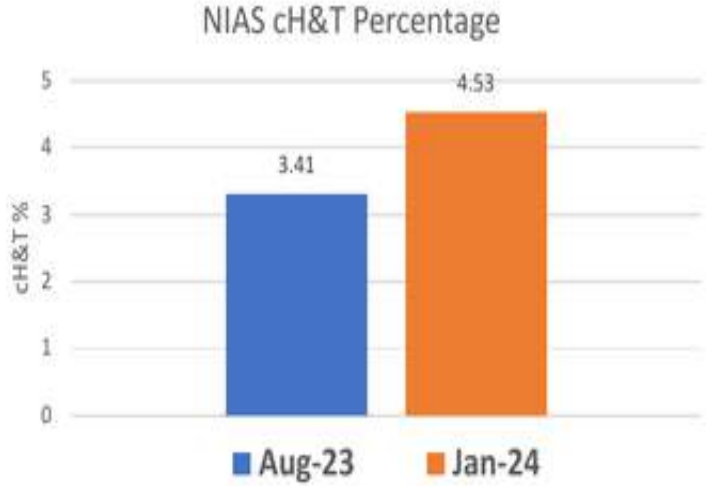
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NIAS Integrated Clinical Hub

Northern Ireland Ambulance Service
Health and Social Care Trust

Current Trajectory & Next Steps





2,452

Additional patients per year with a Hear and Treat outcome

- Next Steps
  - Continue recruitment to fill last gaps
  - Establish further governance framework for new model and team
  - Demonstrate clear benefit to patient and trust

NIAS Integrated Clinical Hub

Northern Ireland Ambulance Service
Health and Social Care Trust

Thank you and Questions

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

PRESENTATION OF PAPER

Date of Trust Board:	22 February 2024
Title of paper:	Appointments to Trust Committees
Brief summary:	With the recent appointment of three new Non-Executive Directors, the Chair has been able to confirm Committee membership. However, as per the Trust's Standing Orders (para 4.6 'Approval of Appointments to Committees'), '*The Board shall approve the appointments to each of the Committees which it has formally constituted.* Board approval is sought to the Committee membership as set out overleaf.
Recommendation:	**For Approval** ☒ **For Noting** ☒
Previous forum:	If applicable
Prepared and presented by: **Date:**	Carol Mooney, Board Secretary Michele Larmour, Trust Chair 15 February 2024

NIAS COMMITTEE MEMBERSHIP

AUDIT & RISK ASSURANCE

Philip Graham – Chair
Dale Ashford
Paul Corrigan

SAFETY, QUALITY, PATIENT EXPERIENCE & PERFORMANCE

Dale Ashford – Chair
Phelim Quinn
Philip Graham

PEOPLE, FINANCE & ORGANISATIONAL DEVELOPMENT

Jim Dennison – Co-Chair (HR)
Phelim Quinn – Co-Chair (HR)
Paul Corrigan – Co-Chair (Finance)

REMUNERATION COMMITTEE

Michele Larmour – Chair
Phelim Quinn
Jim Dennison

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

PRESENTATION OF PAPER

Date of Trust Board:	12 February 2024
Title of paper:	Corporate Risk Register (CRR)
Brief summary:	There are currently 19 open Corporate Risks. Two have been deescalated (708 & 419) since the June 2023 summary. One new risk has been added (815) and one risk has been escalated from Directorate to Corporate (4). The Trust's Risk Management Strategy requires the Corporate Risk Register to be presented to the Board on an annual basis for review.
Recommendation:	**For Approval** ☐ **For Noting** ☒
Previous forum:	SMT – 23/1/24 ARAC – 1/2/24
Prepared and presented by: **Date:**	Séamus Mullen, Head of Planning Maxine Paterson, Director PP&CS 15 February 2024

Northern Ireland Ambulance Service
Health and Social Care Trust

CORPORATE RISK REGISTER (SUMMARY)	Date:	11 January 2024

NEW risks for consideration:	Financial Stability - Achieving Financial Balance 2023-24 (815)
Changes to risks / escalations etc.	Strategic Business Continuity Policy & Planning (4)
Risks to be de-escalated to Directorate risk registers / closed:	

ID	Title (beginning with highest rated)	Date Opened	Date Reviewed	Director Responsible	Risk Level	Risk Rating
1	Ambulance Turn Around Times at Emergency Departments (357)	03/05/2018	15/12/2023	Rosie Byrne	Extreme	25
2	Capacity of the Emergency Preparedness, Resilience and Response (EPRR) Department (760)	24/01/2023	11/01/2024	Rosie Byrne	Extreme	25
3	Strategic Business Continuity Policy & Planning (4)	30/12/2010	15/12/2023	Rosie Byrne	Extreme	20
4	Cyber Security (311)	09/08/2017	07/12/2023	Maxine Patterson	Extreme	20
5	Trust Safeguarding Arrangements (455)	25/02/2020	29/12/2023	Lynne Charlton	High	16
6	Financial Stability - Achieving Financial Balance 2023-24 (815)	30/07/2023	15/12/2023	Paul Nicholson	High	16
7	Sickness Absence (403)	13/08/2019	10/01/2024	Michelle Lemon	High	16
8	Increase Commissioned Hours / Clinical Response Model (CRM) (591)	01/06/2021	09/01/2024	Maxine Patterson	High	16
9	Medicines Asset Management & Governance (712)	20/06/2022	10/01/2024	Dr Nigel Ruddell	High	16
10	Staff Competency / Training (790)	09/06/2023	10/01/2024	Dr Nigel Ruddell	High	16
11	Clinical Audit / Clinical Supervision (417)	18/07/2019	10/01/2024	Dr Nigel Ruddell	High	16
12	Operational Management Structure (372)	03/10/2018	15/12/2023	Rosie Byrne	High	15
13	Violence & Aggression In The Workplace (395)	17/12/2018	18/12/2023	Maxine Patterson	High	15
14	Organisational Culture Improvement (559)	06/11/2023	15/12/2023	Michelle Lemon	High	15
15	Estate Condition (262)	31/12/2014	19/12/2023	Paul Nicholson	High	12
16	Support For Staff Health & Wellbeing (301)	03/10/2018	15/12/2023	Michelle Lemon	High	12
17	Management of Independent Sector Resources (531)	28/07/2020	11/01/2024	Rosie Byrne	High	12
18	Corporatewide Contract Management (276)	01/04/2015	19/12/2023	Paul Nicholson	Medium	12
19	Attracting & Retaining Suitably Qualified Staff (575)	16/03/2021	15/12/2023	Michelle Lemon	Medium	9

Corporate Risk Register - Feb 2024

ID	Title	Risk Type	Description	Risk level (initial)	Risk level (current)	Risk level (Target)	Opened	Review Date	Initial Action Taken to Control/Mitigate Risk	Action Plan to Address /Mitigate Risk
Risk level (current): Extreme										
816	Ambulance Turn Around Times at Emergency Departments	Corporate Risk	The HSC standard for hospital turnaround is 15 mins. HSC Delivery Plan monitoring shows a continued deterioration in ambulance handover delays, with 19% of ambulance handovers regionally in Q3 23/24 greater than 2 hours. This results in significant loss of NIAS operational capacity (Q3 23/24 23%) to respond to emergency calls in the community and subsequently an increased risk of harm to patients awaiting a response an waiting for handover in the back of an ambulance. Q1 23/24-8.8% of all ambulance arrivals greater than 2 hours Q2 23/24-12.2% of all ambulance arrivals greater than 2 hours Q3 23/24-19.2% of all ambulance arrivals greater than 2 hours Q3 Lost operational hours: 27,115 (Shift equivalency: 2,259)	Medium	Extreme	Low	26/01/2024	26/01/2024	Raising of intertrust incidents and lost production hours with Trust Governance Teams. August 2021 and ongoing. DATIX Administrator. Appointment of additional HALOS (October 2021). AD OPs. Installation of decommissioned A&E vehicles at three Health Trusts for the treatment of patients and / staff welfare (December 2021). AD Ops C&C. Regional Unscheduled Care Escalation guidance revised and issued by the HSCB (December 2021). DOps. Three QI projects 1. Reduction in the morning late finishes by identifying a designated handover crew. 2. Evening handover shifts, by adding in additional crews and 3. Re-introduction of ED receivers at the end of the day shift. December 2021 and ongoing. DOps. Request to PHA to meet with relevant NIAS colleagues regarding the potential for a regional learning letter relating to learning identified within a number of our SAI reviews regarding delayed response within NIAS (April 2022). DQSI. AACE 'Delayed Hospital Handovers Impact Assessment of Patient Harm' report published November 2021 and NHS England & NHS Improvement 'Ambulance Service Pressures – sharing risk across the system' letter shared with Public Health Agency (April 2022). DQSI. Correspondence from CEX to Deputy Secretary Strategic Planning and Performance Group, DoH outlining the impact of delayed handovers, lost production hours, patient safety implications, RCEM research regarding clear links between delayed admission and mortality along with significant Senior Management and Trust Board concerns. April 2022. CEX. Letter RE nominations for Quality Improvement in relation to the early detection of the deteriorating patient waiting outside EDs sent. May 2022. DQSI. Establishment of Patient Safety/Quality Falls response group. June 2022. DQSI. NIAS CEx and Director of Quality Safety and Improvement meeting with RQIA Director of Hospital Services, Independent Health Care and Reviews and Audit to discuss Delayed Hospital handovers June 22 Establishment of Performance Optimisation Steering Group focusing on operational work streams. August 2022. AD PP & CS / AD Ops. Unscheduled Care Summit, SPPG letter requesting corridor cohorting, SPPG correspondence, PTEB meeting at which lack of progress on cohorting was discussed and Permanent Secretary email highlighting the risk from delayed ambulance handovers and asking CExs to agree actions to reduce delays. November 2022. CEx, DPP & CS & Ops Director. Update to Permanent Secretary outlining a number of planned and	Presentation to CNO Business meeting re handover delays and frailty considerations Sept 23 Letter from Chair NIAS Safety, Quality, Experience & Performance Committee to Chairs of respective committees within HSC Trusts re 'Ambulance Handover Delays – Patient Safety Issues' expressing concerns re safety risks resulting from handover delays and seeking assurances re actions taken to address October 2023 Letter from NIAs CEx to Deputy Secretary SPPG regarding Safety Concerns associated with Ambulance Handover delays and seeking a meeting to discuss. Nov 23 Presentation to Deputy Secretary SPPG relating to ambulance handover delays and patient safety incidents. Nov 23 Series of ongoing NIAS Executive Team meetings with HSC Trusts regarding safety concerns regarding hospital handover delays – commencing in SET Aug 23 and SHSCT Nov 23. RCC regional meeting - agreement to establish a Task & Finish Group to consider -Consistency in approach to patient safety prior to being seen by a treating clinician in EDs. Jan 23

									proposed actions by CExs, including the introduction of a maximum handover backstop of 3 hours from 19 December 2022. Meeting chaired by NIAS CEx to further discuss proposed actions involving Permanent Secretary, CMO, CNO, CSSO, SPPG, Trust CExs and professional Directors Timeline. Joint statement issued by Trust CExs announcing the immediate actions to be introduced, including 3 hour handover backstop. NIAS CEO media interviews in relation to joint CEx statement. December 2022. CEx, DPP & CS & Ops Director. Meeting chaired by NIAS CEx with same group as 16 December meeting, to review progress on implementation of previously announced actions, email from Permanent Secretary's office listing actions from earlier meeting, email from Permanent Secretary outlining arrangements for further meeting, meeting chaired by Permanent Secretary to review progress on implementation of previously announced actions, handover performance discussed at PTEB meeting, Peter May's letter to Trusts welcoming the improvement in handovers and the need to maintain ongoing oversight arrangements. January 2023 CEx, DPP & CS & Ops Director. 3 hour back stop introduced Dec 22 with a move to a 2 hour backstop by March 23 (CEX initiative endorsed by Perm Sec). DOps. SSPG have worked with Trusts to develop a new dashboard that will reflect a suite of metrics and link handover times to performance when patients are declared medically optimised to leave the hospital but still remain an inpatient after 48 hours. This is also correlated with the impact on Cat 2 & 3 response times. SPPG and Trusts have access to the detail on delayed handover times on a daily basis. SPPG February 2023. Further SPPG engagement at workshop in May 2023 with a view to establishing an unscheduled care regional control centre. DOps. Two hour backstop introduced, however attempt to reduce to 2 hours ineffective 22 crews waiting more than three hours, longest being 6 hrs 42. April 2023. AD OPs Receivers removed and CRT scaled back. April 2023. AD Ops. Regular oversight meetings ongoing. Outputs from meetings will continue to be shared with Permanent Secretary & Departmental colleagues. April 2023. CEx, DPP & CS & Ops Director. Review of Crew relief team and hospital receivers complete. AD Ops, May 2023. SPPG review of targets for improving response times complete. May 2023. SPPG. Previous action plan from Initial Risk: Further SPPG engagement at workshop in May 2023. SPPG proposal to establish Regional Control Centre. Expected completion 2025. SPPG. SPPG have engaged Getting It Right First Time (GIRFT), scoping exercise of current unscheduled care meeting. Site visits to be completed for all Trusts. Expected completion December 2023. SPPG / DOps. 15.12.2023. A Regional Coordination Centre (RCC) established to monitor and manage daily pressures across HSC including hospital	

									handover times. Production hours lost as a result of excessive handover times continues to rise and now equates to almost30% of lost production hours	
760	Capacity of the Emergency Preparedness, Resilience and Response (EPRR) Department	Corporate Risk	The current structure and capacity of the Emergency Preparedness, Resilience and Response (EPRR) Department is not sufficient to achieve the full breadth of statutory and organisational responsibilities, this may result in a failure to access funding, adhere to legislative and nationally recognised standards resulting in the inability to respond to major incidents, provide a specialist response, support large events, manage risk to public safety at mass gatherings etc.	High	Extreme	Low	24/01/2023	11/01/2024	Recruitment exercise conducted to return Department to core levels, January 2023. AD EPRR. NIAS EPRR draft Transformation and Improvement Plan presented to SMT February 2023. AD EPRR. AACE review of EPRR Department completed (published Feb 2023). Chief Executive. Consultation with partner agencies regarding the implementation of the Manchester Arena Inquiry. April 2023. AD EPRR. Appointment of two temporary Assistant Directors of EPRR. Medical Director. May 2023. AACE review of NIAS specialist response capabilities. Received July 2023. AACE. Interim funding identified for 2 x B8a and 1 x B7, end of financial year only (July 2023). JD for B8a EPRR Manager developed and job matched (1st September 2023) AD EPRR. 2x band 8 interviewed 15 Dec 2023. Proposed start date end of Jan. AD EPRR	Development of a business case to support t development of an EPRR structure. PP&CS support required in drafting of the same due to complexities. Expected completion December 2023. AD EPRR. Implementation of EPRR Improvement and Transformation Plan including AACE recommendations and Manchester Arena Inquiry recommendations. Expected completion March 2025. AD EPRR. Review of NILO capability and associated SOPs (including external communication arrangements during a major incident). Expected completion December 2023. AD EPRR. Band 7 training officer JD to be developed and EOI put out to fill this position and subsequently the band 6 position if left vacant. AD EPRR
311	Cyber Security	Corporate Risk	Information security across the HSC is of critical importance to delivery of care, protection of information assets and many related business processes. If a Cyber incident should occur, without effective security and controls, HSC information, systems and infrastructure may become unreliable, not accessible when required (temporarily or permanently), or compromised by unauthorised 3rd parties including criminals. This could result in unparalleled HSC-wide disruption of services due to the lack of/unavailability of systems that facilitate HSC services (e.g. the ability to dispatch and monitor emergency ambulances, appointments, admissions to hospital, ED attendances) or data contained within. This may result in the need for HSC to cancel appointments and treatments, or divert emergency/essential clinical or other services. The significant business disruption could also lead to increased waiting lists, delayed urgent clinical interventions and ambulance response, suboptimal	Extreme	Extreme	Low	09/08/2017	01/02/2024	• Technical Infrastructure Security, Security Policy and procedures in place, Disaster Recovery Plans (reviewed 2016). AD ICT. • Emergency Planning & Service/Business Continuity Plans (2019). AD EP. • Corporate Risk Management Policy & Strategy (2019). Risk Manager. • "Faux" cyber security exercise (Q3 2017). AD ICT. • Internal Audit assessment – 10 Steps to Cyber Security (Q1 17/18). AD ICT. • ICT Security Monitoring standing agenda item on IGSG. Cyber updates to Trust Board included in ICT Report (Q1 17/18). AD ICT. • ISO 27001 compliance review undertaken by security consultant from DXC (Q1 2018). AD ICT. • Band 5 funding Cyber Security Officer identified 2017/18. AD ICT. • Regional Cyber Security Programme Board established (Q2 18/19). AD ICT. • Business Impact assessments in relation to Business Continuity (2018/19). AD EP. • Regional Cyber Incident Management Response tested Q1 2019/20. AD ICT. • Trusts self-assessed against a range of security requirements to determine where focus should be placed. Q1 2019/20. AD ICT. • HSC Cyber Incident Response Action Plan approved by Cyber Security Programme Board and officially launched (6th December 2019). AD ICT. • Draft ISO 27001 gap analysis action plan developed to address the findings from DXC cyber audit. AD ICT. Q3 2019/20. • Band 5 and Band 7 Cyber Security posts have been filled by internal IT Staff temporarily acting up. (Q1 19/20). AD ICT. • Forescout and Tenable have been implemented (Q3 2019/20). AD ICT. • Citrix Remote Access solution has been expanded, Netscalars have been updated and additional Keyfobs, Xenapp licenses + servers put in place (Covid). AD ICT. Q1 20/21. • Audit reports, DXE and Regional Ansec report combined into a	• Regional business case to fund improved cyber security for HSC is ongoing. In development Q1 18/19. Delayed. Expected completion Q4 20/21. Delayed again. Further Delays. Expected Completion now Q4 23/24. AD ICT. • Review of AD Privileged Access Accounts commenced Q2 22/23. NIAS and 3rd party Supplier Accounts to be locked down to "Least-Privilege" admin model where possible. Work has started and is progressing. Estimated Completion Q4 23/24. Cyber Lead. • Use of Oracle Java on NIAS Citrix Farm to be replaced with a more secure Java variant (Amazon Corretto). This is planned to take place during upcoming farm rebuild + OS refresh - ETA Q3 23/24. Cyber Lead.

			clinical outcomes and potentially bring liabilities for the Service. It could also lead to unauthorized access to any of our systems or information (including clinical/medical systems), theft of information or finances, breach of statutory obligations, substantial fines and significant reputational damage.				single Action Plan. Q1 20/21. AD ICT. • CyberSecurity training has been undertaken by Cyber Security Manager - CompTIA and Forescout. Q2 20/21. AD ICT. • Network manager appointed. Q2 20/21. AD ICT. • SMT and Board Update October 2020 and request for mandatory training Q3 20/21 AD ICT. • Internal Audit recommendations actioned where possible (Forescout and Tenable; encrypted text, reduced domain admin accounts; safeword portal restricted; IT Accounts divided; patch levels updated) addressed and ongoing Q3 20/21 AD ICT. • Remote Station Network IP changes have been completed (Q3 20/21) which allows for Forescout rollout to stations to be planned/scoped. • Third Party Penetration testing has been performed by ITGuarded (Q3 20/21). AD ICT. • Forescout Training completed by Band 5 post holder Q4 2021/22. ICT Manager. • Implementation of port security on network switches completed Q4 20/21. AD ICT. • Regional Standardization of Forescout policies + reports completed Q1 21/22. AD ICT. • Meeting held between IT Direcorate and Emergency Planning etc to discuss Cyber Security Incident Business Continuity Processes, June 21. AD ICT. • Regional Standardised ICT Policy Development Project complete - accepted by HSC regionally regionally and approved at NIAS audit committee in June 21. AD ICT. • Confirmation of non-recurrent funding for B6 for cyber security monitoring. January 2022. DPP&CS. • Appropriate levels of Cyber Security Training have been determined and courses procured and scheduled for all NIAS IT staff. Training completed Q1 22/23. AD ICT. • Ransomware protection solution (Bullwall) has been procured and implemented. Completed Q1 22/23. AD ICT • BitDefender AV has been rolled out to Control Room devices (Q1 22/23). Cyber Lead. • Cloud Sophos is in the process of being rolled out + implemented across estate. REACH tablets, new servers, etc (Q1 22/23). Cyber Lead. • Client Firewall is now implemented on Control Room Devices (Q2 22/23). Cyber Lead. • Forescout extension to NIAS remote station switches - completed Q2 22/23. Cyber Lead. Forescout Training undertaken by Network Manager and Assistant w/c 17/4/23. Forescout extension to NIAS remote station switches completed March 2023. • Station BT Routers have beed added to forescout - Q4 22/23. Cyber Lead. • NIAS and 3rd party Supplier Accounts being locked down to "Least-Privilege" admin model where possible. Progress being tracked on spreadsheet. Estimated Completion Q4 23/24. Cyber Lead. NIAS IT have complied with regional SOC/SIEM engagement session facilitated by NCC - Q2 23. HSCNI trusts Gap Analysis meeting held Q2 23.	

									• Use of Oracle Java on NIAS Workstations has been replaced with a more secure Java variant (Amazon Corretto) - Q3 23. Cyber Lead.	
4	Strategic Business Continuity Policy & Planning	Corporate Risk	If the organisation does not assess, review, update and test its internal business continuity risk and plans, this may result in the failure to deliver an appropriate service which could result in service users coming to harm.	Medium	Extreme	Medium	30/12/2010	11/01/2024	Emergency Preparedness and Business Continuity Planning Group established June 2012. AD Emergency Planning. EP/BCP planning training added to induction for all new staff (May 2015). AD Emergency Planning. Training for Directorate functional leads in BPC completed in November 2015. Business Impact Analysis Training carried out (February 2016). Emergency Planning Officer. Emergency Planning Lead seconded on a full time basis (2017). AD Emergency Planning. BCP Strategy and Policy ratified by Trust Board in (August 17). AD Emergency Planning. Business Continuity schedule has been developed as well as a calendar to capture all activations of the Business Continuity Plan (17/18 and ongoing/annually). AD Emergency Planning. Business Continuity Strategic Plan agreed at EP & BC Group (February 2018) and Trust Board (June 2018). AD Emergency Planning. 70% of BIAs completed (August 18). Emergency Planning Officer. 100% of Station Contingency Plans completed (April 19). Emergency Planning Officer. Schedule of exercises has commenced (2019). Emergency Planning Officer. Business Continuity Plans for Fuel Shortage and Medical Drug Packs updated 2019. AD Emergency Planning. Multiple exercises completed in relation to COVID-19 including evacuation of EAC (April 2020) and desktop of Silver Command Room (May 2020). Emergency Planning Officer. Departmental Surge plans for COVID developed and Flu plan revised February 2020. Emergency Planning Officer & IPC Lead. Recovery Co-Ordination Group established (June 2020). Director of Planning, Performance & CS. Rebuild Management Board (August 2020). Director of Planning, Performance & CS. Future Surge Group / Winter Resilience Group established (September 2021). Director of Planning, Performance & CS. New Temporary Emergency Planning Officer (BC) appointed (February 2022). AD Emergency Planning. Temporary Emergency Planning Officer provided with additional business continuity related training. July 2022. AD Emergency Planning. Temporary appointments made due to staff absence. October 2022. Medical Director. AACE Review of emergency preparedness, resilience and recovery undertaken by AACE November 2022. AACE. BC Manager returned following a period of absence. Ops were supported in planning for significant events. Tasks have been assigned and work commenced to update BC Plans, Policy and Strategy. May 2023. AD EPRR. All directorates asked to identify BC Leads. July 2023. AD EPRR. Further request for BC leads made at AD forum Jan 2024. EPRR group to meet Q1 2024 AD EPRR	All Directorate functional leads to review BIA and BCPs; supported by the Emergency Planning Unit Q2 17/18. This has slipped due competing priorities, expected completion Q1 24/25. AD EPRR. BCP Policy, Strategy and Strategic Management Plan to be reviewed. Expected completion Q4 23. EPRR approval required (SMT then SQEP). Operations Director.
Risk level (current): High										

417	Clinical Audit / Clinical Supervision	Corporate Risk	There is a reduction in clinical audit and clinical supervision of staff due to the increasing remit and current demand on Clinical Support Officers (CSOs). This may result in increased risks to patients.	High	High	Medium	18/07/2019	10/01/2024	Assistant Clinical Director appointed (August 2020). Medical Director. CSO Recruitment complete (May 2020 and August 2021). Clinical Training Manager. Full Induction Programmes in place for new cohort of CSOs (July 2020 and most recently September 2021). Clinical Training Manager. Twenty-nine Clinical Support Officers (CSOs) in post (establishment is thirty FTE – a number not in post as a result of secondments and sickness) as at October 2021. AD Education Learning & Development (ELD). Prioritisation of supervision of AAPs / Student EMTs (2021). Clinical Training Manager. Five additional CSOs in place (December 2021). AD Education Learning & Development (ELD). Provision of resource from Information Team has allowed development of a specific dashboards to address key areas of audit e.g. cardiac arrest with presentation of findings at Safety Committee. September 2022. Medical Director. DoH has agreed additional funding for a small number of posts to assist with Lead Practice Educator role. February 2023. Medical Director. Medical Director has held formal meetings with Director of Planning, Performance & Corporate Services, along with Information Team to seek to resolve information gap issues. April 2023. Medical Director. Following conclusion of the strategic review of clinical education, recommendations have been made regarding the role of CSOs and a return to regular supervision and clinical audit. December 2023. Medical Director. Further recruitment of CSOs undertaken. December 2023. Medical Director.	Wider scale audit of clinical care will rely heavily on the full implementation of REACH allowing real time data to be collated and easing the burden of manual audit on CSOs. REACH Project, expected completion March 2024. Head of Transformation.
262	Estate Condition	Corporate Risk	If the Trust does not make suitable arrangements to adequately maintain and improve the overall condition of its estate, this may result in breaches of statutory duty and put staff at risk.	High	High	Low	31/12/2014	19/12/2023	Fire Risk Assessments, Legionella and Asbestos surveys complete (March 2019 & 2022). Head of Estates. Estates TSSC Maintenance Contract for PPM, Remedials, Reactive repair works & certain statutory compliance went live on 3rd August 2020, replacing old FM Contract. Led by Head of Estates. Estates Department now has three permanent staff – Office Manager, Project Manager and Helpdesk Operator roles. Five other positions, (HoE, FM, QS & EO's x2) are occupied by agency staff which presents obvious continuity risks. December 2021. CRM Director. Six (6) facet building condition and functional suitability surveys completed in 2021/2022. Head of Estates. Other standalone maintenance statutory compliance contracts through BSO PaLS CAG's are also live e.g. FWT, PAT, Emergency Lighting & Lifts etc., 2021/22. Head of Estates. DoH have allocated £250K for backlog maintenance, 2021/22. Led by Head of Estates. New Modular building adjacent to HQ providing additional office accommodation for over 40 staff due for completion in 2020/21 was delayed due to Covid and Brexit. Completion was achieved early in 2021/22. Head of Estates. Capital Expenditure projects progressed through Emergency Services Consultancy Framework using IBI through CPD from 05.07.2020 until 31.03.2022. Head of Estates.	A program of minor works and backlog maintenance has realised some improvements across the NIAS Estate. This will continue into 2023/24. Head of Estates. MoU's with associated SLAs/JMAs between NIAS and landlords of HSC Trusts is underway. MoU's have been agreed and signed with NIFRS and NHSCT. Those with the other 4 HSC Trusts are works in progress, but cannot be completed by NIAS in isolation. Expected completion Dec 23. Head of Estates. Sluice program substantially complete with only problematic locations remaining outstanding. Solutions progressing for these. Expected completion June 2023. Head of Estates/Estates PM. SOC for Belfast (Broadway, Knockbracken, Purdysburn, NIFRS LDC Boucher) with DoH. No feedback yet. Head of Estates. 5 to 10 year Estates Strategy remains under development but is predicated on the implementation of CRM. This will include rationalisation of existing estate. Led by DoF Director.

									Estates TSSC Maintenance Contract for PPM, Remedials, Reactive repair works & certain statutory compliance contract replaced 1st April 2022 by a new FM Contract through a NHS SBS Framework, assisted by BSO PaLS (Legionella and Asbestos management included). Led by Head of Estates. April 2022. New Contract through CPD live Oct 22. Head of Estates. Estates Position update presented to SMT. January 2023. CRM Director. Estates TSSC Maintenance Contract for PPM, Remedials, Reactive repair works & certain statutory compliance contract replaced on 1st April 2023 by a new FM Contract through a NHS SBS Framework, assisted by BSO PaLS. This will include Legionella and Asbestos management. Led by Head of Estates/FM/QS.	This risk was raised before the current Management structure was put in place. Great strides have been made in the overall improvement of the condition of the Estate which has been reflected in the last 4 PAMP Reports issued by DOH. NIAS Estates have now in place a robust schedule of PPM's and response maintenance contracts to ensure compliance with all relevant statutory regulations. (FM)
815	Financial Stability - Achieving Financial Balance 2023-24	Corporate Risk	The Trust may breach its statutory duty to break even if it overspends against core budget, experiences unfunded cost pressures and/or service changes or does not deliver levels of required cash releasing efficiency savings.	High	High		30/07/2023	15/12/2023	Controls are in place to mitigate each of these factors as follows: A. Applying internal budgetary control processes led by Director of Finance reporting monthly to Chief Executive as Accounting Officer. This will continue to be underpinned by detailed budget reports produced by finance to support budget holders. Directors are held accountable to Chief Executive. Financial position is a standing item on SMT agenda for DoF to provide update and test assumptions. Director of Finance, ongoing 2023-24. B. Submission and engagement with DoH/SPPG re any emerging financial implications for HSC in the context of Northern Ireland public sector budgets to be reflected in NIAS Trust Delivery Plan. Ongoing monitoring, review and engagement with stakeholders. Director of Finance, ongoing 2023-24). C. Ongoing monitoring, review and engagement with stakeholders will continue throughout the year to highlight emerging cost pressures and service changes. Director of Finance, ongoing 2023-24. D. Ongoing monitoring, review and engagement with stakeholders will continue throughout the year recognising that there remain uncertainties in respect of some terms and conditions issues (both in terms of timing and magnitude). Director of Finance, ongoing 2023-24. E. Development and implementation of a Trust Financial Plan, including savings proposals, by NIAS for 2023-24 in conjunction with Trust Board. Engagement with staff and patient representatives and fulfilment of any statutory consultation requirements. Director of Finance, ongoing 2023-24).	
591	Increase Commissioned Hours / Clinical Response Model (CRM)	Corporate Risk	If adequate arrangements are not in place to increase commissioned hours in line with future increases in demand, this will further reduce response times, which may result in service users coming to harm.	Extreme	High	Low	01/06/2021	09/01/2024	NIAS financial planning prioritises provision of front-line resources. Director of Finance (DoF). Financial resource and activity/performance are issues discussed at Trust Board and with HSCB. Director of Finance (DoF). Proposed Clinical Response Model (CRM) developed and approved by Trust Board (September 2016). CRM Director. Recruitment programme on-going. Ops Director. Demand / Capacity review carried out (report July 2017). CRM Director. Programme for Foundation degree in science in Paramedic practice (FdSc) developed and approved by UU and HCPC (September 2018). Medical Director. CRM Public Consultation Closed (January 2019) and refresh of Capacity Review complete (September 2019). CRM Director. Implementation of NIAS Training Strategy to include Paramedic Education Programme, EMT and ACA programmes (on-going). Head	Ongoing discussion with DoH in regards to the reconfiguration of OBC to meet requirements of the Department of Finance. AD Planning, Performance & Corporate Services. Expected completion early February 2023 - timeframe TBC with DoH.

									of Training. CRM Outline Business Case (OBC) completed and submitted to the DOH on the 15 December 2021 (case for an additional 4.5K hrs of front line cover per week, to meet new response targets along with additional clinical and non clinical support staff, Fleet and Estates) CRM Director. December 2021. Review of the case by Department of Health Economists. Feedback to NIAS provided regarding reconfiguration. September 2022. CRM Director. CRM OBC submitted to DoH in February 2023 and awaiting feedback. Scenario planning taking place to adjust activity levels to different funding levels in preparation for change in commissioned hours. DPPCS. Raised with Deputy Secretaries (May 20213) and Permanent Secretary (June 2023. Chief Executive.	
531	Management of Independent Sector Resources	Corporate Risk	If NIAS continues to steadily increase its reliance on Independent Sector resources, without introducing a more robust performance management framework, there are potential financial, contractual, safeguarding, performance, compliance and patient safety (including issues relating to bariatric capacity) risks to the Trust.	High	High	Low	28/07/2020	11/01/2024	Independent Ambulance Services Framework in place detailing contract expectations (commenced November 2019). Agency IAS Manager supported by North Area Manager. Independent Ambulance Services quarterly meetings in (commenced November 2019 and continue on a quarterly basis). Agency IAS Manager supported by North Area Manager. Discharge Planning Desk in NEAC oversees the booking of all NEAC Independent Sector (IS) resources and maintains records of crews that operate each day (commenced November 2019). Agency IAS Manager supported by NEAC Manager. Finance Directorate checking invoices (commenced November 2019). Queries to be resolved/agreed dealt with by IAS Manager. NIAS Information Department monitors high-level non-emergency journey statistics (commenced November 2019). Corporate Manager. Presentation on risk management including incident reporting and safeguarding arrangements. NIAS Safeguarding Pathway shared with Independent Sector (November 2019). Risk Manager. Non-Emergency Ambulance Transport Framework Monitoring Meeting to review current arrangements (June 2020). Led by DSQI. Non-Emergency Ambulance Transport Framework Monitoring arrangements discussed at SMT. Areas of assurance include training, safeguarding, infection control, driving/vehicle safety, complaints and learning (June 2020). Led by DQSI. DQSI achieved approval for additional support in NEAC to oversee IPC and quality / governance issues with IS (July 2020). Agency IAS Manager appointed November 2020. IAS deployed to non-emergency work only, only to be utilised on any form of emergency work when the call has been assessed by a clinician as suitable for non-emergency transport. AD Ops, PCS Review. Internal Audit undertaken 2021. BSO. Quarterly Framework Scope and Service Specification Assurance Framework Assurance / Audit Tools approved at SMT 26th October 2021. Twice yearly unannounced inspection regime agreed. Utilisation of Doc Works to create reports / action plans for the purposes of continual improvement. IAS Manager supported by North Area Manager developed formalised inspection process. All inspection teams comprise IPC, H&S and IAS Management. Led by DQSI. NIAS requested two amendments to the IAS contract, one to	Ongoing PCS Improvement Programme (commenced February 2022) led by Transformation Team: • Relevant workstreams include call types suitable for IAS colleagues to be dispatched to, processes for utilising IAS on behalf of Trusts. • Procurement commenced for new Framework for IAS (summer 2022). Taxi Framework and procurement process planned for Q4 2023/24. NIAS representatives on CAGs to input to framework design and subsequent contracts. • DQSI leading regular audits and quarterly meetings with IAS contractors to monitor performance and quality. • Datix incident reporting and complaints systems utilised to monitor performance and to provide feedback • Development of framework for higher acuity call types deferred pending work of demarcation task and finish group identifying suitable call types for IAS and PCS crews. Expected completion March 2023, delayed expected completion March 2024. AD Ops.

									strengthen the IAS recruitment process (seeking of employer references) and a second amendment in the event of a safety related incident / concern, NIAS will have the discretion to take action proportionate to the level of risk until such time as a review of the incident has been undertaken. The requested variations will be addressed as part of the current Framework development process (CAG &BSO) - commenced summer 2022. DQSI. Meetings were held on the 15th December 2021 with Independent Ambulance Service colleagues, using the assurance template for the first time, action plans / timeframes agreed. DQSI. First set of Independent Ambulance Services unannounced inspections to took place (utilising new DocWorks audit tool). Q1 2022/23. Led by DQSI. New non-emergency ambulance transport framework procurement exercise commenced. August 2022. AD Ops (PCS). Demarcation group have issued IAS / PCS deployment guidelines. October 2022. AD Ops (C&C). Procurement documentation has been published by BSO. May 2023. AD Ops. Safeguarding guidance provided. May 2023. Safeguarding Lead Social distancing guidance issued. May 2023. AD Ops. Removal of 9 IAS as per Delivering Value Project. September 2023. AD Ops. A&E Support Crews returned to baseline / pre-covid position. September 2023. AD Ops. CAG started. 17 providers. November 2023.QSI IAS Lead.	
712	Medicines Asset Management & Governance	Corporate Risk	If arrangements for medicines asset management and governance are not improved, there is a risk of loss of packs and packs expiring and remaining in the system - risking expired medicines being administered to patients. The location of medicine packs in the system is unknown except at a very local level, due to use of a paper based system. This may lead to regulatory action / involvement of the Medicines Regulatory Group (statutory powers under the Medicines Act and subordinate legislation).	Extreme	High	Low	20/06/2022	10/01/2024	Audit conducted to determine pain pack locations - Spreadsheet created and maintained location by stores through Med04 data. April 2022. Lead Pharmacist. Planning & Performance Directorate have agreed to assist in development of associated business case September 2022. AD PP & CS. Scoping suppliers available on national frameworks (electronic / RFID options). Medical Devices Lead & Lead Pharmacist. August 2022. Scoping of suppliers and specifications; meeting took place 25/11/22 with potential suppliers, Medical Directorate & Estates. Lead Pharmacist.	Work completed on specific NIAS requirements, awaiting supplier to provide costing so business case can be developed. Development of business case required. Expected completion June 2024. Medical Director / Assistant Clinical Director / Lead Pharmacist / Project Development & Implementation Manger. 14/08/2023: work on hold due to lack of funding available. Lead Pharmacist.
372	Operational Management Structure	Corporate Risk	The current operational management arrangements (nine to five) present a risk to effective service delivery and in the necessary support to staff.	High	High	Medium	03/10/2018	15/12/2023	On Call Officer system in place for incident management (October 2018). AD Emergency Planning. Overtime arrangements in place (October 2018). AD Ops Frontline operations supported by Emergency Ambulance Control (October 2018). AD OPs C&C. AACE Consultant appointed December 2019. DOps. Extended hours for Station Officers. AD Ops (February 2020). A Case For Change paper was shared with SMT 21 May 2021 for noting. DOps. Enhanced operational cover across the Division with an increase in Station Officers. Area Managers working and covering weekends. Station Officers extended cover in all areas (Except North) over 9-5 cover. Extension of Supervisor model until Dec 2023. Operating within the current funding streams extended cover including	Service delivery model review and subsequent supporting structural review commenced November 2022, expected completion March 2024. Ops Director. For inclusion within Delivering Value Project, options to be presented to SMT by October 2023. DOps supported by Director of Planning, Performance & Corporate Services. Submission delayed and now expected to be completed by end of Q4 2023/24

									daily/weekend huddles. January 2023. AD Ops. Review commenced. Engagement sessions with CEX; ASAMs; Station Officers; Station Supervisors Clinical Directorate completed. Engagement sessions with ADs and HALOs postponed due to IA. Benchmarking with blue light partner agencies completed. April 2023. DOps.	
559	Organisational Culture Improvement	Corporate Risk	If matters relating to organisational culture, as indicated in the results of the HSC Staff survey (references to bullying culture, staff engagement, health and wellbeing and leadership) are not sufficiently addressed, this may impact on organisational reputation, staff morale, health and wellbeing and potentially performance including service delivery and patient care.	High	High	Low	06/11/2020	15/12/2023	Organisational Strategy – Strategy To Transform, 2020 – 2026 includes a key priority around Culture programme. DHR. Issued individual letters to all staff (October 2020). DHR. Issued a Chief Executive communication around culture and commitment to addressing (October 2020). CEX. Commissioned 2 days a week from HSC Leadership Centre to provide support to deliver this (November 2020). Led by DHR. Launched HSC Cultural Assessment Tool (November 2020). DHR. Draft Culture Programme of work with identity that gives profile to the culture work and related progress completed (June 2021). DHR Staff engagement sessions undertaken June 2021. DHR. Draft leadership development programme developed June 2021. DHR. Culture Improvement Strategy and Plan oversight by the People, Finance and Organisational Development (PFOD) Committee (presented June 2021 and December 2021). Led by DHR. Culture programme approved by PFOD December 2021. Interim Staff Recognition Awards - Friday 1st April 22. DHR. Leadership development programme underway (November 22). DHR. Programme with related plans presented to Trust Board December 2022. DHR. Staff Engagement sessions completed. February 2023. DHR. Leadership Development first cohort undertaken with related evaluation and recommendations presented to SMT in May 2023. DHR.	Pulse surveys planned for Q4 2023-24, a number of leadership development programmes underway. Leadership Conference and Staff Recognition events planned for March 2024. DHR. Training with managers related to approach in key people management processes underway including Absence management, Grievance Procedure, Having Difficult Conversations and Working with Trade Unions. NewConflict, Bullying and Harassment Policy approved by PFOD December 2023
403	Sickness Absence	Corporate Risk	If the management of sickness absence is not improved this may impact on service delivery and improvement as well as resulting in an inability to achieve financial balance. This could further exacerbate the potential for detrimental impact upon service.	High	High	Low	13/08/2019	15/12/2023	Capability to support management of attendance considered and addressed with appointment of five temporary HR Attendance Management Advisors (2019). Director of HR. HSC Leadership Centre Associate appointed to support redeployment programme for those on long term absence or unable to fulfil normal duties (October 2020). Director of HR. Health and well-being arrangements in place including the prioritisation of musculoskeletal and mental health issues (known key priority areas) – for further information refer to corporate risk number 301, health and wellbeing (2021), Director of HR. Direct access to a physio for musculoskeletal related absence, partnership working with Occupational Health (2021), Director of HR. Review of Occupational Health to ensure that it is fit for purpose to support attendance management. Improvement plan in place (2021). Director of HR, 2021. Significant work undertaken to support increased absence and abstractions associated with Covid including Occupational Health arrangements, related risk assessments, and the appropriate management of Clinically Extremely Vulnerable (CEV) staff (2021), Director of HR. Twice weekly meetings with Trade Union colleagues established (2021). Led by Director of HR. Ongoing reporting to People, Finance and Organisational	Project Board in Place, Delivery Plan developed approved by PFOD in October 2024, submitted to DoH in line with target and presented to Trust Board for noting December 2024. Funding approved for 6 new Band 6 Senior HR Officers to support managers in the management of absence and wider people agenda. Information-led approach in place and weekly meetings with Director Ops and Director HROD. Monthly meetings with Director HROD and Ops with Chief Executive to ensure maximum accountability. Enhanced reporting to PFOD and Trust Board. Process mapping undertaken and managers training delivered.

									Development Committee (2021). Led by Director of HR. Health and Wellbeing Strategy approved at Trust Board August 2022. Led by Director of HR. New Maximising Attendance Plan with new KPIs approved by PFOD September 2022 (the focus is on prioritised interventions with robust action plans to include actions such as medical redeployment, final review meetings as appropriate. Trade Union engagement and management training are key elements of the plan). Led by Director of HR.	
790	Staff Competency / Training	Corporate Risk	Due to the lack of capacity within the Clinical Education Department and the inability of Operational Services to release staff, the Trust has not been able to keep pace with the required levels of statutory and mandatory training. This presents patient safety risk with regards to clinical training (cardiac update) and staff safety risks with regards to health and safety related training (patient handling, violence prevention etc.).	High	High	Low	09/06/2023	10/01/2024	Benchmarking of other Trusts carried out and draft Mandatory Training policy developed (list compiled of Mandatory Training from Stakeholders/subject experts / Matrix of Mandatory Training developed for all staff (role specific & frequency) (June 17). HRD. Subject experts provided required eLearning content / platforms set up with HSC Leadership centre / eLearning is live from Q4 17/18 / solution secured to enable operational staff to access e-learning remotely via a suitable platform whilst attending PP. iPads procured and commissioned to enable staff to log on to HSC Leadership Centre to access eLearning. Wi-Fi solution (MiFi hubs) secured for remote access (e.g., in Divisions) Q4 17/18. HRD. Oversight of training needs by Education Learning & Development Stakeholder Group. Medical Director. 2023. A strategic review of clinical education concluded in September 2023 and will be presented to the SQEP Committee. A draft plan has been produced detailing an increase in continuing clinical education (CCE) but this will require cross directorate support regarding release of staff. October 2023. Medical Director. Additional recruitment to CSO undertaken December 2023. Medical Director.	Clinical Education Department Records/Local Records Transition to HRPTS (ongoing). Expected completion December 2023. Assistant Clinical Director. Review of courses to determine suitability for eLearning. Assistant Clinical Director / Risk Manager / HR Director / DQSI. Expected completion December 2023.
301	Support For Staff Health & Wellbeing	Corporate Risk	There is a risk to staff and potentially service delivery if the Trust does not improve and sustain arrangements to support staff health and wellbeing.	High	High	Low	03/10/2018	15/12/2023	Regional contract to provide counselling services reviewed to enhance scope of psychological support and interventions. Establishment of Peer Support Pilot Project (2017). HWB Manager. Staff Satisfaction and Wellbeing Partnership Survey Project with Trade Unions conducted (Q4 17/18). AD HR. Stress management and addiction workshops (Q2/Q3 2018/19). AD HR. Attachment of INSPIRE counsellor to EAC (commenced in 2017). EAC Manager. Flexible working/reasonable adjustments in place (2017). HR Director. Staff Resilience Module Paramedic Degree (commenced Q1 2018/19). Clinical Training Manager. Regular Trust-wide health checks programme established (Q1 18/19). AD HR. People, Finance and Organisational Development (PFOD) committee established providing scrutiny and challenge at board level for HR and workforce issues (2021). HR Director. Consultant Clinical Psychologist appointed on a part time basis and one year action plan agreed and underway (2021), HR Director. Core Peer Support team completed Critical Incident Stress Management (CISM) training first in-house programme delivered 22-23. Review of corporate health and wellbeing complete, November 2021. HR Director. Health and Wellbeing Strategy approved by Trust Board August 2022.	Ongoing implementation of Health and Wellbeing Strategy and Maximizing Attendance Plan. Proposal for new HWB function structure approved by SMT and scrutiny and recruitment processes underway.

									NIAS signed up to Mental Health at Work commitment and actions underway. February 2022. HR Director. Health and Wellbeing project specific to EAC underway. Health Connectors programme launched and mental health information hubs set up at two locations. Cohort one completed Couch to5k. Menopause programme underway. Fatigue working group re-established supported by Clinical Psychologist. March 2022. HR Director. Final Health and Wellbeing Strategy approved TB August 2022. Related plans monitored by PFOD. Maximising Attendance plan approved by TB September 2022. DHR.	
455	Trust Safeguarding Arrangements	Corporate Risk	If adequate corporate safeguarding arrangements are not in place, there is a risk that supports and effective protective interventions are not provided to service users.	High	High	Low	25/02/2020	26/01/2024	Risk Manager and Clinical Service Improvement Lead supporting with referral review and RQIA liaison (from November 2016). Medical Director. Safeguarding Pathway in place for staff to make direct referrals (January 2019, V.9). Medical Director & DQSI. Associate (with safeguarding expertise) from HSC Leadership Centre in place one day per week (February 2020). DQSI. Weekly Rapid Review Safeguarding Meeting (commenced May 2020). DQSI. Regular position report to SQEP Committee to provide safeguarding assurance (commenced October 2020). DQSI. Safeguarding Improvement Plan, driver diagram etc. presented to SMT (October 2020). DQSI. Safeguarding Lead JD developed, banded, recruitment exercise complete and officer in post (July 2021). DQSI. New Safeguarding Policy/Procedure and new Safeguarding Training & Education Plan approved (10th August 2021). DQSI. Lead NED for safeguarding identified. August 2021. DQSI. Regular meetings with HSCB Safeguarding Lead. Meeting in August 2021 to review pathway for welfare referrals with Trust Leads. Data provided to the HSCB in September 2021 detailing welfare referrals by Trust over a 6 month period. Further meeting with newly established SPPG August 2022 to agree to progress communication to all 5 HSCT and Chief Social Worker for NI on the issue of NIAS safeguarding processes. August 2022. HoS. Review of NIAS commissioned private ambulance providers to include safeguarding processes and staff training to ensure staff have the skills to identify and respond appropriated to safeguarding concerns (April 22). Quarterly Framework Scope and Service Specification Assurance Framework Assurance / Audit Tools approved at SMT 26th October 2021. Twice yearly unannounced inspection regime agreed. October 2021. DQSI. eLearning staff safeguarding training commenced, almost 600 staff completed by December 2021. Safeguarding training dates agreed for voluntary first responders and EMD staff in March/April 2022. HoS. Revised Safeguarding Training delivered to ACA and AAP (November and December 2021, May and June 2022). HoS. Work undertaken with REACH team to develop Safeguarding template which can assist with referral process and act as a safeguarding guide for staff (November and December 2021). Work completed on templates. REACH Team & HoS. Annual Report completed with recommended structure to SMT and Trust Board. March 2022. DQSI.	Further develop system to monitor, audit, investigate and report on adherence to the safeguarding referral process (data reviewed indicates possible underreporting of referral from ACA staff). Expected completion December 2023. HoS. Professional Allegations policy/procedures and Chaperone Policy/procedure currently in draft and under review. Expected completion June 2023. HoS and Head of Professional Practice. Child frequent caller policy/procedure to be explored with partner agencies with the support of the HSCB. Meeting dates to be agreed to discuss. Expected completion June 2023. HoS. Further work with REACH team to continue to develop safeguarding template. Delay due to a software upgrade in February 2022 which removed the safeguarding templates from REACH. It is understood that the software will replace these May 2022. Further work required to embed. Expected completion June 2023. HoS. Further engagement with IAS at quarterly framework meeting to raise awareness RE Safeguarding procedures in place in NIAS. Expected completion December 2023. HoS. Further engagement with SPPG around process for Welfare referrals, short life task and finish group commissioned to produce regional process for this, expected completion November 2022. Delayed expected completion November 2023. HoS. Safeguarding practitioner post in for job evaluation outcome awaited. Expected completion June 2023. HoS. Safeguarding training agreed to be delivered to volunteer car drivers in spring 2022. Expected completion June 2023. HoS. Safeguarding practitioner post job evaluated as Band 5, position number being raised via HRPTS and recruitment to be progressed, likely to default to redeployment list within NIAS. Status is in progress, action- continue to completion/

												Safeguarding Staff engagement at EDs took place July 22. HoS. Welfare Pathway Work commenced with SPPG and other 5 HSC Trusts, pilot of same being undertaken in Belfast Division. January 2023. AD QSI. Pilot Live March 2023.	recruitment. Expected completion September 2023. AD QSI. Pilot of welfare referral pathway commenced with BHSCT, currently ongoing. Status is in progress, action- continue for pilot and then assess impact prior to potential scale and spread regionally. Expected completion September 2023. AD QSI. NIAS internal group stood up to consider allegations with a safeguarding element and management of same, stand alone process being drawn up for this but recognised to have overlap with professional standards and potentially disciplinary/ capability processes also. Status is in progress, action- develop process, implement and evaluate same. Expected completion September 2023. AD QSI. As a result of the Safeguarding Peer Review, a review of the Safeguarding Education and Training Strategy is to be undertaken in line with NASAG Guidance. Expected completion December 2023. HoS. Reviewed HOS 27.06.23 See Training and allegation policy updates (Sept 23) Referral Pathway changed to reflect no telephone call for welfare referrals (Sept 23) Pathway for REACH referral - currently in process for testing (Devices to be updated for testing Aug 23) Reviewed AD QSI 29.12.23 Job description developed and evaluated at B7 for NIAS Safeguarding Manager. Post passed through NIAS scrutiny and SMT and approved 'at risk'. Post advertised at present, closing date 03.01.24. Timeline for interview before end of Jan. Timeline to appointment will be dependent on notice period of successful candidate 4-12 weeks. Staff member on light duties due to Maternity needs secured from 01.01.24 to support with administrative functions for service, will be time-bound by expected date of confinement. Update to reduce Current risk rating from Extreme to High Increase in Safeguarding awareness education ED engagement sessions with staff in relation to

										welfare pathways Appointment of a Safeguarding B5 post Commencement of a recruitment process fo Band 7 Safeguarding Practitioner Increased referral rate seen in December em from LC in 'Documents' requesting this Risk to remain on the register with rationale included.
395	Violence & Aggression In The Workplace	Corporate Risk	There is a risk that should the trust not develop, implement and resource an holistic, detailed and fit-for-purpose response to acts of aggression towards NIAS employees, there is potential for such aggression to continue to rise. This will adversely affect the health and well-being of staff.	High	High	Medium	17/12/2018	18/12/2023	Violence Prevention & Reduction Group established and meets quarterly (2015). Chaired by AD Ops. NIAS contributes to regional and national work streams (2017). AD Ops & Risk Manager. Introduction of daily 'huddles' to ensure appropriate follow-up action is taken with regards to assaults (July 2019). Ops Director. Violence Prevention & Reduction Group Workshop November 2019. Agreement reached on priority workstreams and projects. Risk Manager & AD Ops. Body Worn Video Project Screening forwarded to IG. February 2020. Risk Manager. Body Armour Pilot Business Case complete. February 2020. Risk Manager. Sample Body Armour received (July 2020). Risk Manager. Social media video complete (September 2020). Risk Manager, AD OPS & Media & Communications. Violence Prevention & Reduction Group Workshop and logo design agreed (October 2020). Violence Prevention & Reduction Group. Body Armour Pilot commenced March 2021. Risk Manager. Violence Prevention & Reduction Strategy developed and presented to SMT (February 2020) and Trust Board (May 2021). Risk Manager / AD OPS. Public Awareness Campaign (June 2021) Risk Manager / AD OPS / Media & Communications Manager. Appointment of agency Violence Reduction Officer / Case Manager. Risk Manager. December 2021. Body Worn Video Consultation Phases One & Two complete and pilot commenced. August 2022, Risk Manager. Meeting with RACTC RE Violence Prevention & Reduction Training. November 2022. Risk Manager. Engagement with DLS on Service Impact Statements. November 2022. Risk Manager. Engagement with Community Restorative Justice. November 2022. Violence Reduction Lead. Engagement with DoJ & QUB with regards to research potential. November 2022. Violence Reduction Lead. Escalation of training compliance concerns (Statutory / Mandatory Training Policy) to DHR&OD (Chair of H&S Committee) for the attention of SMT. January 2023. Risk Manager. Ongoing discussion and monitoring of data at Violence Prevention/Reduction Committee. Q1 and Q2 2023/24 data requested by Head of Planning to monitor trend in violence towards staff. 08/11//23 Head of Planning	Ongoing implementation of strategy. Expected completion March 2025. Led by AD Ops, Risk Manager and Working Group. Five Year Training Plan under development by CED to ensure Conflict Resolution Training requirements met (not currently adhering to Statutory / Mandatory Training arrangements). Expected completion December 2023. Assistant Clinical Director.
Risk level (current): Medium										
575	Attracting & Retaining	Corporate Risk	As an employer NIAS adheres to national terms and conditions. This may impact upon the Trust's	Medium	Medium	Low	16/03/2021	15/12/2023	Matter raised with the Chief Executive at Remuneration Committee - July 2020, December 2020 and February 2021. Chair. Implementation of regional and local strategy, policies and	DoH have commissioned a review of SEP which has begun and NIAS have been engaged in this

	Suitably Qualified Staff		ability to attract and retain staff with the required skills and experience to effectively deliver its Strategy to Transform and achieve the associated benefits.						procedures which include a new Recruitment Strategy, the Review of Clinical Education, training and development arrangements, succession planning (February 2021) SMT. Workforce Plan developed. December 2021. Programme Director, Workforce Planning. Pay circulars have been issued for the periods 20-21 and 21-22. HR Director.	regard. HR Director. Expected completion December 2023.
276	Corporate Wide Contract Management	Corporate Risk	There is a risk that ineffective monitoring and control of contracts could result in expenditure being inappropriately or inaccurately incurred. Internal Audit provided Limited assurance in 2019-20 in an audit of Procurement and Contract Management which focused on Estates. A previous audit recommendation was that a central record of contracts should be created and maintained. External Audit in 2019-20 also made recommendations regarding DACs and the record of contracts.	Medium	Medium	Low	01/04/2015	11/01/2024	A record of all NIAS contracts has been created which requires further development. Suppliers and payments have been mapped against the contract record. The format of the contract record and reporting are under review. The Stores & Procurement Manager updates the contract record on a periodic basis (April 2015). AD Finance. A Direct Award Contract Register has been created and is a standing agenda item at the Audit & Risk Assurance Committee (May 2021). Director of Finance. Short Position Paper to SMT. September 2022. Risk Manager. Comprehensive contract management overview completed. December 2022. DPP & CS. Format of the DAC Register has been reviewed and updated and is a Standing Agenda Item for Audit & Risk Assurance Committee. February 2023. Director of Finance.	Contract Management needs to be further developed within NIAS and additional resources are required to ensure the monitoring and control of contracts is effective, accurate and timely. Some progress has been made, but there have been a number of delays due to directorate pressures, staff absence and COVID-19. Expected completion December 2023. Director of Finance. Procurement guidance needs to be reviewed, updated and disseminated to managers including the use of DACs. Expected completion December 2023. Director of Finance. Current roles and Job Descriptions within Financial Services (Financial Accounts and Stores) will be reviewed in order to better align resources. Expected completion December 2023. Director of Finance. Assurance mapping of larger contracts and changes ongoing. Expected completion. September 2023. Head of Planning. Plan to implement recommendations from contract management overview. Expected completion. September 2023. Director of Finance Digital Strategy which should include oversight and management of contracts. Head of Planning. September 2023. Contract Management procedures drafted and circulated to AF Forum - December 2023. Proposals for contract management in NIAS to be discussed and agreed Jan 2024 by ADs.

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

PRESENTATION OF PAPER

Date of Trust Board:	22 February 2024
Title of paper:	Trust Performance Corporate Scorecard (January 2024)
Brief summary:	This paper is presented to Trust Board to note the key performance indicators across the Trust for data up to and including December 2023. The Trust Performance report provides Trust Board with further details on some of these key performance indicators, including trends over time and comparisons across financial years.
Recommendation:	**For Approval** ☐ **For Noting** ☒
Previous forum:	SMT – 30/1/24 SMT – 13/2/24
Prepared and presented by: **Date:**	Neil Walker, Head of Performance Maxine Paterson, Director PP&CS 15 February 2024

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST CORPORATE SCORECARD

NORTHERN IRELAND AMBULANCE SERVICE

January 2024

for December 2023 Data and Performance

Northern Ireland Ambulance Service
Health and Social Care Trust

Executive Summary

The Trust Performance report continues to evolve, and you will notice changes over the coming months to the report to help everyone in the organisation understand where performance is good and where we need to drive improvements.

December 2023 was a particularly challenging month during the month the Trust operated at REAP 4 Extreme Pressure. Although it must be noted that pressures continue across the system which is reflected in some of our performance measures in this paper. Action short of strike continues within the trust and is also impacting on some of our key performance metrics.

Demand:

- Demand for our services remains at a steady state,
  - Call answer demand in EAC has decreased by 2% when comparing Calendar Year 2022 & 2023.
  - Call responses has decreased by 1% when comparing Calendar Year 2022 & 2023.
  - Patients conveyed to Hospital has also decreased by 1% comparing Calendar Year 2022 and 2023.

Response Times:

- Response time In December were a challenge across all categories.
- However, Category 2 response times are of significant concern deteriorating by 23mins from Quarter1 to Quarter 3 during 2023. This is linked to increases in delayed Handovers and has an impact on patients waiting in the community for a response.
- NIAS continues to manage Action Short of Strike (ASOS). Category 1 calls are the only calls being responded to in the last hour of shift. The end of shift protocol continues to be implemented across the trust:
  - Sending oncoming crews to ED to relieve late finished crews
  - Holding calls at the end of shift until the relieving crews is released from ED

Clinical Hear & Treat and See & Treat

- The Clinical H&T rate for December 23 was 4.3%, which was an increase from November 23. Clinical See & Treat was static in October 23 at 13.8%.

Handover:

- December 23 saw the trust lose >12k hrs with handover delays >15mins this is an increase of 3% compared with December 2022, were the trust lost >11K.
- The patients waiting longer than 2hrs to handover at Emergency departments are deteriorating quarter on quarter though 2023.

	Percentage of Patients waiting >2hrs		
Area	Quarter 1	Quarter 2	Quarter 3
Regional	8.80%	12.20%	19.20%

Patient Care Service:

- Patient facing KPIs continue to require attention to improve the experience of our patients being taken to and from appointments. We are only achieving 40% of patients making appointments on time.
- Productivity and efficiency in December 2023 shows a decrease from November with average number of patients per shift transported decreasing to 4.15 through December 2023. However, it must be noted that clinic numbers were reduced in December due to public holidays.

Serious Adverse Incidents, Complaints, Compliments and Care Opinion:

- There have been 11 potential SAIs reviewed, with the Trust notifying 8 during December 2023. The trust has currently got 21 SAIs open, and they are all at level 1 review.
- During December the Trust received 20 complaints and 16 compliments, along with 6 stories submitted via care opinion during December 23

Absence Management:

- The Year-to-date Sickness absence rate is 14.68% for the trust.
- 68% of the Trusts sickness absence is contained within the following categories (Mental Health, Injury | Fracture, Miscellaneous, Influenza and Untoward accident). Concerted effort has begun to address the top 50 longest term absentees to bring these to conclusion.
- The largest category for sickness absence within the trust is for mental health reasons, with stress being the biggest reason.

December 2023

Northern Ireland Ambulance Service Health and Social Care Trust

Indicator	Measure	Detail	Latest Reported Period												2023/24 Target	Reporting Frequency
Our Patients will be professionally cared for: Always with compassion and respect			Outturn 22/23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24		
1.01	Category 1 Mean Response Time	The Average Time taken to respond to a Category 1 Call	10	9	10	10	11	11	11	11	11	12				10 mins	Monthly
1.02	Category 1 90th Centile Response Time	The time taken to respond to 90% of Category 1 Calls	21	19	20	20	21	23	22	22	22	23				21 mins	Monthly
1.03	Category 1T Mean Response Time	The Average Time taken to respond to a Category 1 Call with Transport	13	13	14	14	14	15	15	16	15	16				19 mins	Monthly
1.04	Category 1T 90th Centile Response Time	The time taken to respond to 90% of Category 1 Calls with Transport	27	26	27	29	27	32	28	31	27	32				30 mins	Monthly
1.05	Category 2 Mean Response Time	The Average Time taken to respond to a Category 2 Call	36	31	31	37	38	44	47	51	47	73				36 mins	Monthly
1.06	Category 2 90th Centile Response Time	The time taken to respond to 90% of Category 2 Calls	80	68	69	81	84	100	105	111	102	167				80 mins	Monthly
1.07	Category 3 90th Centile Response Time	The time taken to respond to 90% of Category 3 Calls	233	183	196	262	280	360	328	483	365	532				233 mins	Monthly
1.08	Call Answering Performance	% of calls answered within 5 Secs	89.5%	86.9%	85.3%	82.4%	80.7%	80.2%	82.2%	85%	86%	86%				90%	Monthly
1.09	No. of Calls Answered within Emergency Ambulance Control	Number of Calls Answered within EAC each month (Emergency 999 calls)	20,789	16,595	18,106	18,440	18,939	19,664	19,187	20,136	19,046	22,548				N/A	Monthly
Our Staff will feel positive and proud to work for NIAS																	
2.01	Cumulative % Hours lost from Sickness	Total Hours lost due to sickness absence/Total hours available (%). Year to Date 2023/24	12.15%	14.25%	14.20%	14.25%	14.27%	14.64%	14.60%	14.65%	14.82%	14.90%				11.2%	Monthly
2.02	Cumulative % Hours lost from Short Term Sickness	Total Hours lost due to Short Term sickness absence/Total hours available (%). Year to Date 2023/24	2.72%	2.57%	2.20%	2.33%	2.35%	2.55%	2.61%	2.63%	2.67%	2.74%				N/A	Monthly
2.03	Cumulative % Hours lost from Long Term Sickness	Total Hours lost due to Long Term sickness absence/Total hours available (%). Year to Date 2023/24	9.43%	11.68%	12.00%	11.92%	11.92%	12.09%	11.99%	12.02%	12.15%	12.16%				N/A	Monthly
2.04	Organisational Vacancy rate	Percentage of Vacancies within the Trust															Monthly
2.05	Cumulative Staff Turnover rate	Percentage of turnover of staff within the Trust over the past 12 months		5.15%	5.06%	5.77%	5.95%	6.20%	6.00%	5.80%							Monthly
2.06	Staff Engagement Survey	Number of Staff Engagement Surveys Complete															
2.07	Statatory and Mandatory Training	Percentage of Staff that have completed Statatory and Mandatory training	20.0%														TBC
Our Stakeholders and partners will have confidence in us as a reliable provider at the centre of USC																	
3.01	Average Handover Time at Type 1 ED	The average time it takes to hand a patient over to a Type 1 Hospital ED	64	64	53	57	60	64	66	85	78	89				15 mins	Monthly
3.02	Lost Hours from Handover delays >15mins	The Hours lost from handovers exceeding the 15min target at Type 1 EDs	8,967	9,780	9,861	7,686	8,425	8,978	8,748	12,035	10,649	12,145				N/A	Monthly
3.03	Number of Patients >2hrs for Handover	Number of Patients that wait >2hrs to be handed over at Type 1 EDs	16,286	991	880	1,028	1,205	1,369	1,332	2,087	1,814	1,983				0	Monthly
3.04	Hear & Treat Rate	The percentage of patients being clincally treated via the Clinical Hub within Emergency Ambulance Control	4.2%	3.5%	3.2%	4.5%	4.0%	3.4%	4.0%	3.9%	3.8%	4.4%				5.2%	Monthly
3.05	See and Treat Rate	The Percentage of patients being clincally treated at Scene by the Ambulance Crews	14.2%	14.0%	14.4%	14.8%	14.8%	14.5%	14.3%	14.6%	14.1%	13.8%				15.2%	Monthly
3.06	Conveyance Rate	The Percentage of patents being conveyed to Hospital	81.6%	82.50%	82.40%	80.70%	81.20%	82.10%	81.70%	81.48%	81.72%	81.29%				N/A	Monthly
3.07	Number of Scheduled journeys made	The number of journeys to and from a Healthcare facility by NIAS Patient Care Service resources	157,507	12,167	13,345	13,845	12,840	13,256	12,426	12,641	13,070	12,147					Monthly
3.08	Average Number of Patient Journeys per shift	The Average number of patients transported by PCS resources within each shift	3.65	3.58	3.70	3.80	3.89	3.90	3.84	4.29	4.32	4.15				N/A	Monthly
3.09	Average Number of Patient transported per Run	The Average number of patients transported to a healthcare facility per Run	1.19	1.19	1.19	1.23	1.26	1.23	1.23	1.36	1.37	1.37				N/A	Monthly
3.10	The Percentage of patient Journeys that arrive on time	The percentage of PCS journeys that arrive within 60mins of the patients appointment time	30%	39%	36%	36%	39%	37%	37%	34%	37%	40%				95%	Monthly
3.11	The Percentage of patient Journeys that start on time	The Percentage of journeys that start within 60mins of the patient being booked ready by the healthcare facility	56%	70%	71%	70%	70%	68%	67%	68%	67%	66%				95%	Monthly
Our Communities will continue to value and trust us																	
4.01	Number of potential SAIs reviewed	The number of potential SAIs that have been reviewed by the Trust	135	13	9	11	18	13	13	21	14	11				N/A	Monthly
4.02	Number of SAIs notified	The number of SAIs that have been notified to SPPG	42	3	3	2	0	5	4	6	8	8				N/A	Monthly
4.03	Number of Complaints	The number of complaints that have been received within the month by the trust for investigation	148	17	15	11	16	15	22	23	29	20				N/A	Monthly
4.04	Number of Compliments	The number of Compliments that have been received within the month by the Trust	272	58	41	36	32	29	36	31	34	16				N/A	Monthly
4.05	Nmber of patient stories received	The number of patient stories submitted within the month to the Trust	128	23	20	14	16	20	12	14	11	6				N/A	Monthly
4.06	Forecast Revenue Expenditure	Forecast Deficit / Surplus for YE against total revenue resource limit (£000s)	£	[redacted]	£ 500	£ 550	£ 731	£ 817	£ 1,100	£	£	£				£	Monthly

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Northern Ireland Ambulance Service
Health and Social Care Trust

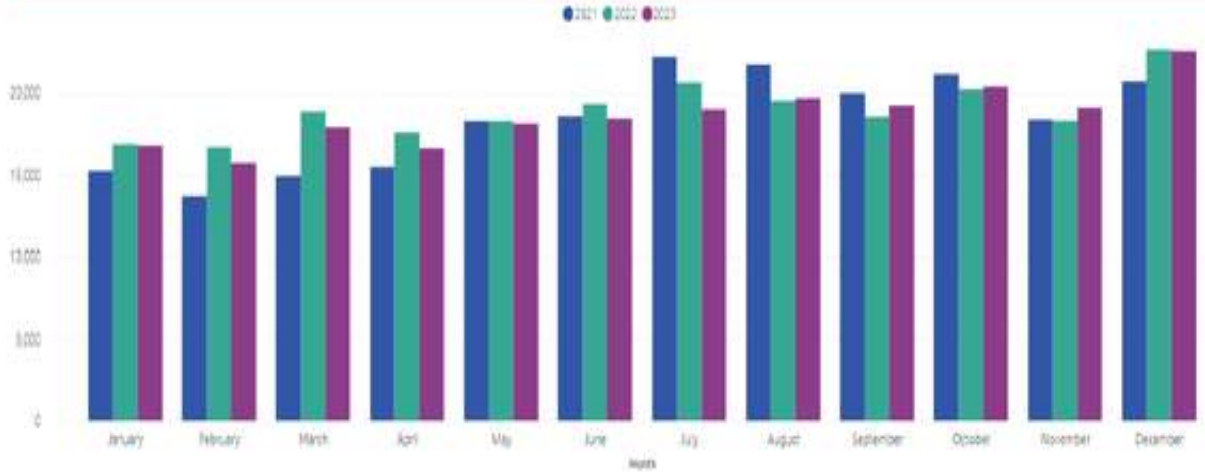
Our Patients | Emergency Demand Performance | Operational Demand

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

The analysis below describes: Calls Answered and Call Answering Performance

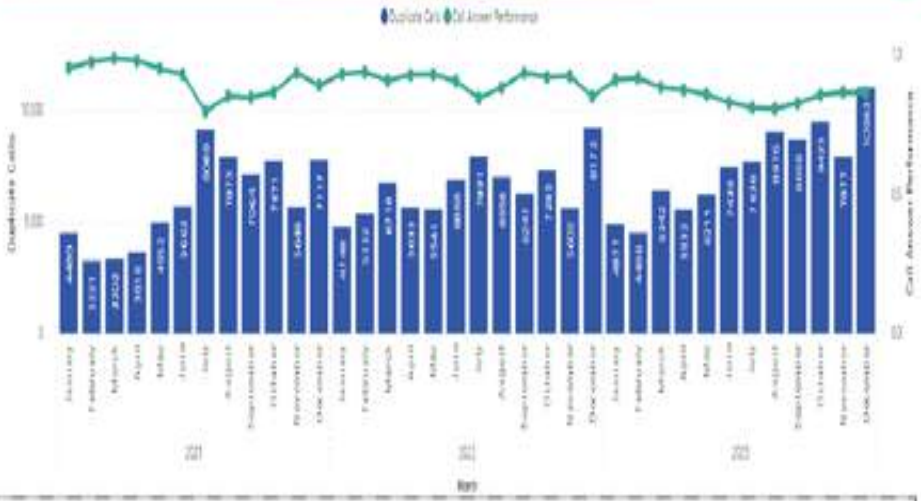
999 Calls Answered

Monthly Demand



Call Answering Performance and Duplicate Calls

Duplicate Calls (N) compared with Call Answer Performance (%)



- **December 23** has seen a slight drop year-on-year in demand levels but a significant increase at 18% month-on-month from November 23. The full calendar year demand for 2023 has been 2% less than the full calendar year 2022. In the same period, **Incidents** the trust has had to respond to have remained static Year to date 2023-24 to 2022-23.
- **December 23** saw an increase in the call demand from November 23, this was around 92 calls per day into EAC and this increase was mirrored across ambulance services in England.
- **Call Answering performance** continued to be a challenge through December 23 as staffing challenges within the control room persisted at weekends. However, **December 23 call answering performance** was **86%** for the month.
- **Duplicate Calls** significantly increased in December from the previous month, reaching over 10,000 for the first time ever.

Northern Ireland Ambulance Service
Health and Social Care Trust

Our Patients | 999 Response Time Performance | Response Times Scorecard

Latest Month	Dec-23

	Target	Current Performance: Latest Month	Current Performance: YTD (from April)	Current Performance: Rolling 12 Month	Benchmarking (Latest Month): National Data	Benchmarking (Latest Month): Best in Class	Benchmarking (Latest Month): Ranking (out of 12)
Category 1 response - Mean	8 Minutes	00:12:37	00:11:15	00:11:01	00:08:44	00:07:18	12
Category 1 response - 90th Centile	15 Minutes	00:23:46	00:21:51	00:21:30	00:15:26	00:12:46	12
Category 1T response - Mean	19 Minutes	00:16:16	00:14:42	00:14:16	00:10:51	00:08:18	12
Category 1T response - 90th Centile	30 Minutes	00:32:13	00:29:16	00:28:22	00:19:36	00:14:21	12
Category 2 response - Mean	18 Minutes	01:13:39	00:44:26	00:41:30	00:45:57	00:29:45	12
Category 2 response - 90th Centile	40 Minutes	02:47:05	01:37:37	01:31:00	01:40:58	01:00:12	12
Category 3 response - Mean	Not a target	03:23:32	02:06:45	01:55:20	02:37:05	01:21:00	11
Category 3 response - 90th Centile	2 Hours	08:52:09	05:22:31	04:48:48	06:24:23	02:58:43	11
Category 4 response - Mean	Not a target	03:46:56	03:42:28	02:51:45	02:55:44	01:57:14	10
Category 4 response - 90th Centile	3 Hours	09:31:42	10:53:39	07:56:01	07:00:34	04:28:52	9

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

Northern Ireland Ambulance Service
Health and Social Care Trust

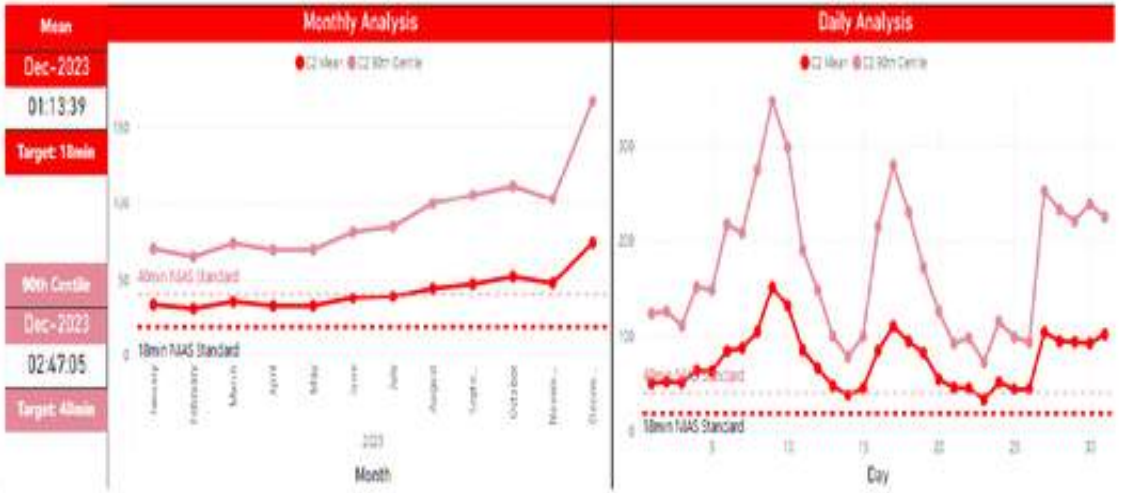
Our Patients | 999 Response Time Performance | Response Times

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

CATEGORY 1 Performance



CATEGORY 2 Performance



Category 1

- December 23 Category 1 mean response time was 12 minutes 37 seconds; while the Category 1 90th centile was 23 minutes 46 seconds.
- December 23 saw the Category 1 mean response deteriorate from previous months. This is replicated on the Category 1 90th centile performance.

Category 2

- December 23 Category 2 mean response time was 1 hour 13 minutes 39 seconds; while the Category 2 90th centile was 2 hours 47 minutes and 5 seconds.
- Both the Category 2 mean and 90th centile response times significantly deteriorated in December 23. These measures have been particularly impacted by:
  - A significant deterioration handover delays as seen in the quarterly deterioration in >2hr delays outlined in slides further in this paper.
  - Action short of Strike (ASOS) is being seen most clearly within our category 2 response times.
- The delay in this category 2 response time is having a significant impact on patient safety

Northern Ireland Ambulance Service
Health and Social Care Trust

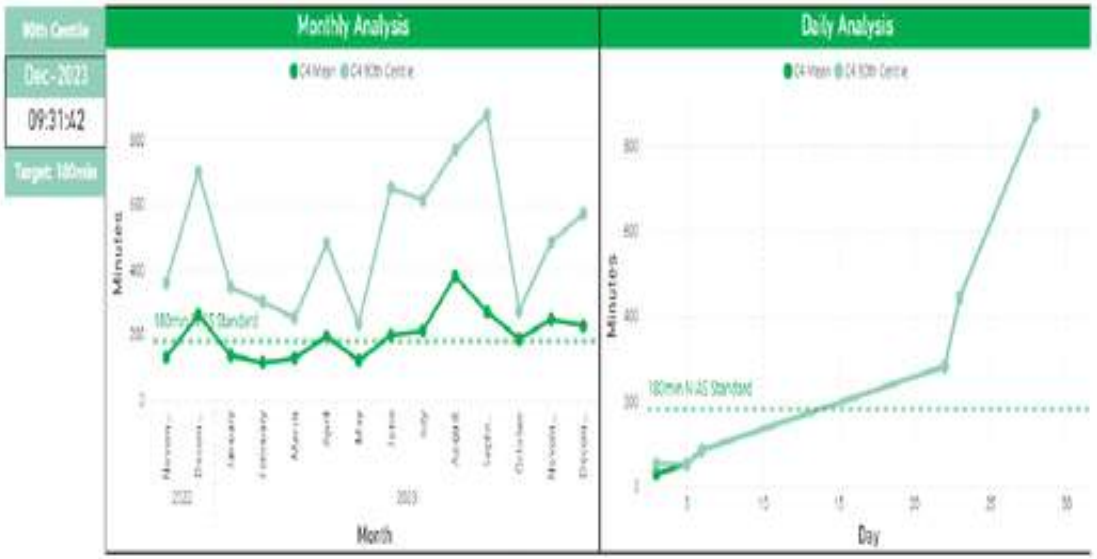
Our Patients | 999 Response Time Performance | Response Times

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

CATEGORY 3 Performance



CATEGORY 4 Performance



Category 3

- December 23 Category 3 mean response time was 3 hours 23 minutes 32 seconds; while the Category 3 90th centile was 8 hours 52 minutes and 9 seconds, over 6 hours above target.
- December 23 saw a significant deterioration in category 3 mean response time when compared to November 23, which had seen an improvement from the previous month. The 90th centile response time deteriorated significantly too.
- As outlined in the previous slide, category 3 response times are impacted by the same root causes.

Category 4

- December 23 Category 4 mean response time was 3 hour 46 minutes 56 seconds; while the Category 4 90th centile was 9 hours 31 minutes and 42 seconds. While this is an improvement from the summer months, it must be noted that the volume of Category 4 calls received by NIAS is very low and response times can be impacted significantly on a daily basis.

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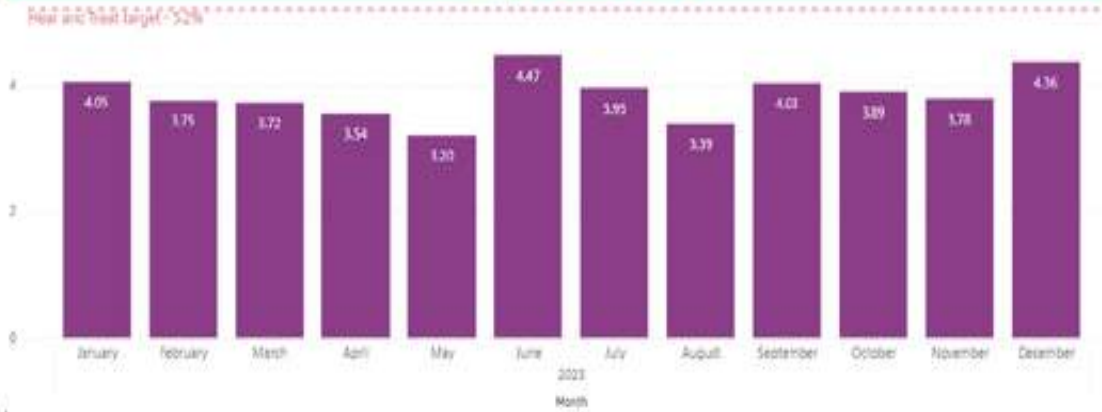
Our Patients | Emergency Demand Performance | Clinical Response

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

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

Clinical Hear & Treat

Monthly Hear and Treat %



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

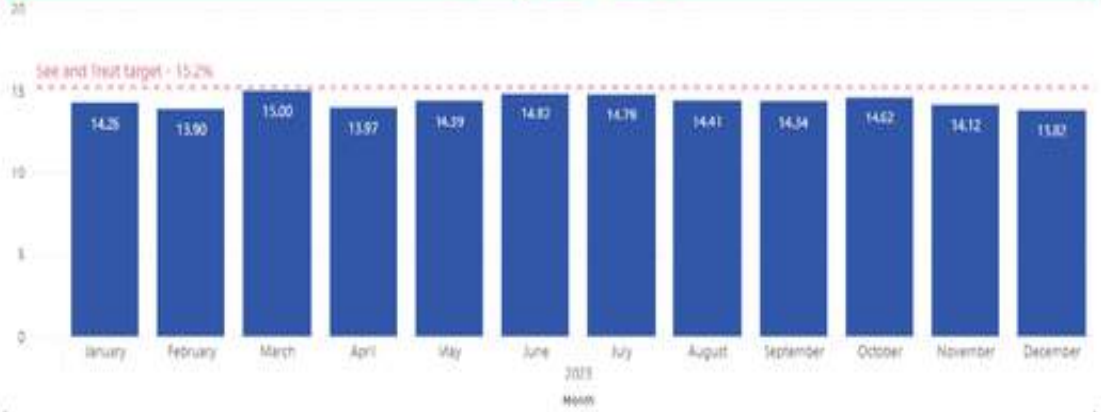
To support this, we have developed a revised dashboard which will support a quality and improvement approach to Hear & Treat outcomes.

In December 2023 the ICH appointed 5 additional Clinical Safety Managers to the 2 in post. There is now 5 operational within the department, with the 6th awaiting release from their current role.
In January, 12 new ICH Clinicians were appointed and the teams are currently working through the release of these staff and the process of onboarding in cohorts of 6, to complete training.

The aimed improvement trajectory is to increase Hear & Treat by a further 1.5% by 31st March 2024.

Clinical See & Treat

Monthly See & Treat %



As with Hear & Treat, a revised See & Treat dashboard has been finalised, which will allow for analysis of practice down to station level.

NIAS has developed a suite of care pathways and alternative destinations to provide a range of alternatives to the Emergency Department referral pathway.

Increasing See & Treat use will require education and support of clinicians to ensure safe and effective changes in practice. A supportive education package is being developed.

The aimed improvement trajectory is to increase See & Treat by a further 1.5% by 31st March 2024.

Our Patients | Emergency Performance | Hospital Handover Performance

Our operational efficiency is critical to our success. One of our key dependencies is the ability to handover a patient in a timely manner when conveyed to hospital. As such, we must strive to be as efficient as possible whilst always delivering the very best care for our patients.

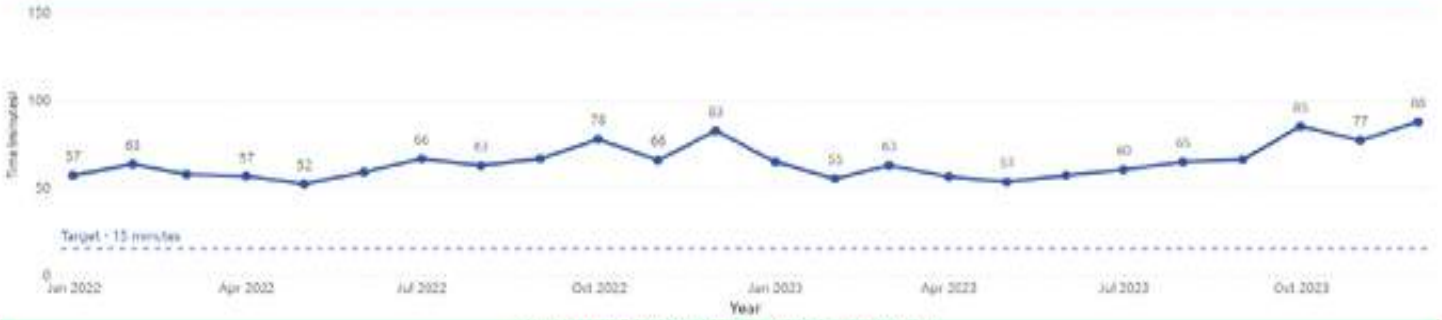
Arrival at Hospital to Patient Handover last month

Hospital Attended	Total Attendances	Total Handovers	Total Handovers Over 15mins	% Over 15mins	Total Handovers over 60mins	% Over 60mins	Total Time Lost (Hours)	Average Handover Time (Minutes)
ULSTER	1530	1520	1246	94.39%	736	55.76%	3,330.93	168.15
CRAIGAVON AREA	1199	1199	1123	93.66%	518	43.20%	1,713.84	100.46
ANTRIM AREA	1554	1554	1462	92.97%	616	39.04%	2,001.39	99.00
ROYAL GROUP	2054	2054	1877	92.26%	860	42.26%	2,340.83	80.75
CAUSEWAY	619	619	583	94.18%	262	42.33%	631.33	75.91
ALTNAGELVIN	1223	1223	1139	92.56%	408	33.20%	1,134.61	70.23
DAISYHILL	562	562	521	92.70%	155	28.09%	444.95	62.16
MATER	923	923	838	87.76%	119	21.99%	322.18	51.47
SOUTH WEST	697	697	616	88.38%	131	18.79%	315.73	41.71
LAGAN VALLEY	71	71	46	65.01%	5	6.85%	51.46	59.02
RBSC	95	95	65	68.42%	7	7.37%	21.00	26.67
BELFAST CITY	59	59	40	67.80%	1	1.69%	9.27	22.70
DOWNE	80	80	21	73.09%	0	0.00%	4.37	21.88
Total	**10030**	**10030**	**9218**	**91.90%**	**3887**	**38.75%**	**12,201.81**	**87.62**

Total Time Lost (Hours) - Last 12 months

108,462.00

Monthly Handover Times



Monthly Handover Times for Type 1 EDs, by Trust



In December 2023, NIAS experienced a total of 12,202 lost hours. This is the equivalent of 33 shifts per day where crews are waiting with patients outside EDs; 29% of our planned capacity. These lost hours were experienced from 9,218 instances where our crews waited longer than 15mins to handover their patient at ED. 3,887 handovers took longer than an hour in December 2023

In December 23, >76% of the 12,202 lost hours occurred at the four ED sites listed below in order of hours lost:

- *Ulster Hospital (3.3k hours; 94% > 15min; 56% > 1hr)*
- *Royal Victoria (2.2k hours; 92% > 15min; 42% > 1hr)*
- *Antrim Area (2.0k hours; 93% > 15min; 39% > 1hr)*
- *Craigavon Hospital (1.7k hours; 94% > 15min; 43% > 1hr)*

In the full year 2023, >92% of the handovers exceeded the 15min target at our acute EDs, resulting in circa 108k hours lost. The lost hours experienced in December 23 is an increase of 1,502 hrs or 14% from November 23, whilst the number of instance of delayed handovers increased by 2% in the same period.

The 12,202 operational hours being lost are equivalent to 1,017 12-hours shifts per month, or 33 12-hour shifts per day.

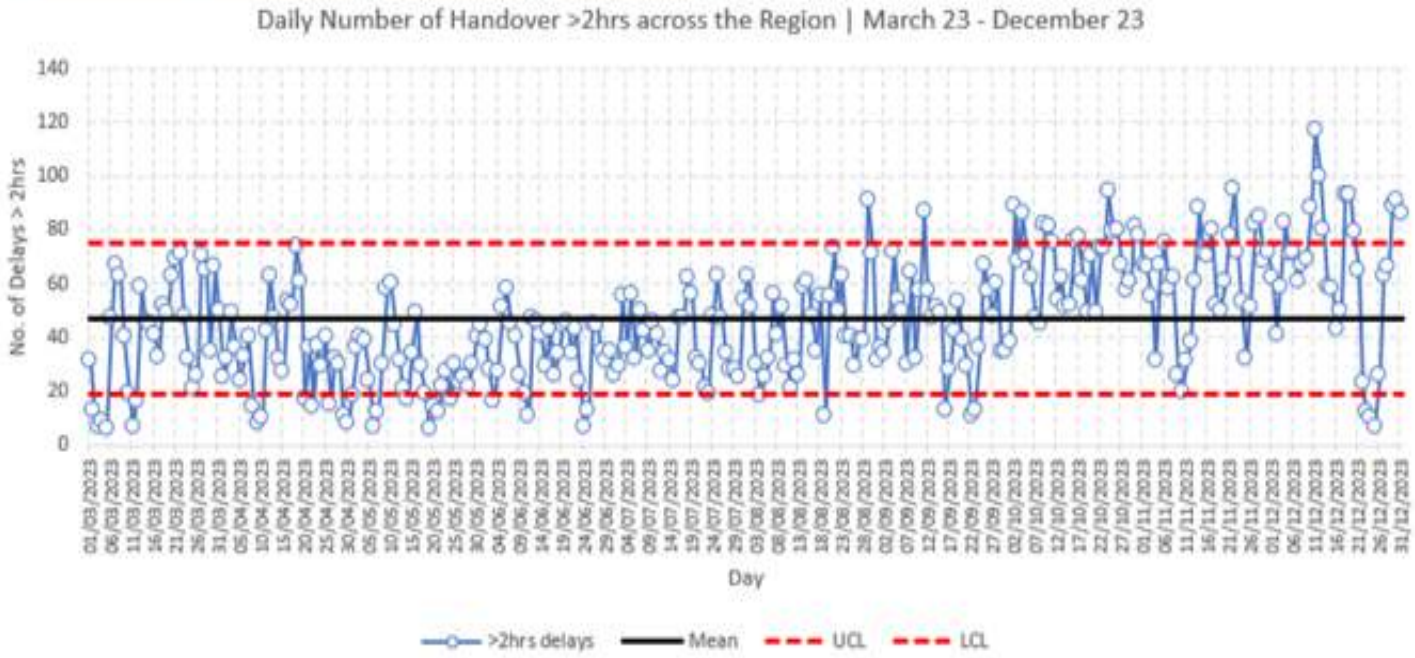
Northern Ireland Ambulance Service
Health and Social Care Trust

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

Our operational efficiency is critical to our success. One of our key dependencies is the ability to handover a patient in a timely manner when conveyed to hospital. As such, we must strive to be as efficient as possible whilst always delivering the very best care for our patients.

Area	Quarter 1	Quarter 2	Quarter 3
South Eastern	21.1%	23.5%	32.8%
Southern	9.5%	18.8%	20..2%
Belfast	6.6%	9.8%	18.9%
Northern	5.4%	7.2%	17.2%
Western	2.8%	5.3%	8.1%
Region	8.8%	12.2%	19.2%

The table shows the deterioration in >2hr delays by trust from March 2023.
There has been a quarter-on-quarter decline since the introduction of the 2hr backstop across the region. In some areas a third of patients will experience a >2hr delay to get into an Emergency department. Whilst just under a fifth will experience >2hr delay across the region.



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

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

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

Northern Ireland Ambulance Service
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Our Patients | Non-Emergency Performance | Productivity Performance

Patient-focused KPIs

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

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

In both of these measures month to month comparison between 2022/23 & 2023/24 began to show similar performance since Oct there is likely a few factors at play here.

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

The KPI 1 divergence in Dec is likely down to seasonal factors





Productivity & Efficiency KPIs (NIAS crews only)

KPI - Average Number of Patients Transported per Shift

The notable improvement in this indicator of activity from Oct both has largely been maintained with a slight drop in Dec (due to the no of Public Holidays when there would be limited Clinics).

This can largely be attributed to the commencement of Destination Focused Planning in Oct.



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

As above there has been a significant improvement in this measurement since Oct for the same reason.

To underline these figures NIAS crews carried out approx. 1000 more patient journeys in each of Oct, Nov & Dec '23 compared to the same months in '22



Points to Note

- Compliance against KPIs 1 & 2 relates to Ambulance Journeys where timestamps have been completed. Current timestamp compliance rates = NIAS 88%
- We don't currently have a comprehensive set of productivity indicators and while these are being worked on in the PCS Improvement Project, we will continue to report on Patients transported and Patients per journey.
- It remains the aim to be able in the near future to report on more specific utilisation and productivity indicators such as productive time v unproductive time.

Northern Ireland Ambulance Service
Health and Social Care Trust

Our Patients | Emergency Performance | Actions to Improve Performance

- Through the delivering value programme, service improvements are being identified and implemented through the operational efficiencies project. Further information can be found within the Delivering value programme update.
- Additional mitigation has been employed at the end and start of shifts to reduce the impact of late finishes on staff. The Trust is currently using its own staff to relieve crews at ED. This essentially means that these crews coming on shift are tasked to make their way to Emergency Departments to allow those crews finishing to get away as close to their finish time as possible.
- Newly appointed Integrated clinical hub clinicians are going through training over the coming weeks, which will allow a revised rota will be implemented from March 2024, that is based on call demand for the service. Performance management and clinical audit mechanisms have been strategically implemented to quantify and understand the hub's impact, aiming to optimise its full potential.
- Interviews are set for the coming days to recruit an additional five HALO at Emergency Departments to support crews during handover of patients at EDs.
- Initial recruitment campaign complete for Newly Qualified Paramedics, Qualified Paramedics and qualified Emergency Medical Technicians. The posts are being offered with a commencement date of 3rd April 2024. There will be 5 QPs, 5 NQPs and 5 Qualified EMTs offered roles within the trust
- Work is being prioritised to develop principles and approaches to introducing enhanced rotas to support staff health and wellbeing, along with delivering operational cover during times patients require the Trusts services.
- New logistics post commenced in January within EAC to reduce some of the administrative burden for EAC DCM staff to protect capacity for focus on performance and staff welfare.
- Improved utilisation of alternative care pathway and destinations to support our data to provide enhanced planning tools across operations and to remove admin processes that take away operational hours for our station officers;
- Continued discussion between SPPG/NIAS colleagues to progress with alternatives to ED conveyance (including direct access to Urgent Care Centres/Phone First etc). Discussions with acute trusts regarding the potential to improve the functionality of their handover areas , as well as potential for their provision of "cohort" areas continue and we anticipate direction from SPPG to all trusts regarding cohorting in November 2023
- A continued focus on Patient Care Pathways to maximise opportunities, signpost patients appropriately, and contribute to reducing conveyance rates. Work is ongoing with the Northern Trust to align the Hospital @ Home models for all Trusts.

Northern Ireland Ambulance Service
Health and Social Care Trust

Our Patients | Emergency Performance | Actions to Improve Performance

- NIAS has been heavily involved as a key stakeholder in the development of the Regional Control Centre which went live on 4 December 2023. Stocktake of the function will be taking place over the coming weeks to inform the position for the new financial year.
- Challenges with Duplicate Call activity in EAC have been highlighted earlier in the performance report. EAC have reviewed the process and how we can address this and have plans to mitigate
- A new CAD SMS module (Advanced Contact Caller Module) has been developed and is live within EAC. The system will enable EAC to send an SMS to mobile phone numbers providing more information regarding the 999 call and not to contact 999 again unless the there is a change in the patient's condition. This will be automated via C3 CAD and supporting information/awareness will be made available for staff.
- NIAS have been invited to join the GIRFT team and SPPG to discuss the recommendations of the GIRFT report.

Northern Ireland Ambulance Service
Health and Social Care Trust

Our Patients

SAIs & Complaints

Serious Adverse Incidents

During December 2023, the Trust reviewed 11 potential SAI's resulting in 8 notifications to SPPG. All incidents were notified as Level 1 reviews. Currently there are 21 open SAIs all of which are Level 1 reviews.



Themes

During the financial year 23/24, the 3 key National Ambulance Risk and Safety Forum themes have shifted slightly and are now as follows:

- Delays in call answering and dispatch
- Call Handling & Dispatch Incidents
- Clinical Assessment and or treatment on scene

The top NIAS themes are as follows:

- Delayed response out with standard associated with a patient outcome of death
- Deteriorating Patient – community
- ECG Recognition
- Elderly patients who have fallen

Recommendations & Learning

Work is continuing on completion of historical and recent SAI recommendations with 289 evidenced and closed, and 158 in progress. This represents a completion rate of 65%.
11 SAI's were closed in December with the following learning identified:

- ECG recognition in relation to Advanced Life Support
- Adherence to Advanced Life Support protocols
- Learning in relation to identification of ineffective breathing during the call taking process
- Importance of correct call categorisation
- Importance of following the procedure for the processing of duplicate calls
- Delay or absence in provision of welfare calls to patients experiencing delayed response due to challenges within CSD/CSM staffing, capacity & workload.

Complaints, Compliments & Care Opinion

During December 2023, **16 compliments** & **20 complaints** were received.





Timeliness of Process

23 complaints were closed during December 2023.



At the end of December 2023, 39 complaints remained opened with the average number of days opened being 35 working days.

Learning: Of the 23 complaints closed, 57% were upheld/ partially upheld with some of the following learning outcomes identified: dropped shifts management; call handling; MDT info being read by staff; and PRF completion.

Service Improvement Plans

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

Care Opinion

During December 2023, 6 **stories** were submitted via Care Opinion. By 1st of December these stories were viewed 346 times. The main areas of feedback were:
What's good – Ambulance crew / Care / Communication
Improvements – Irish sign language support
Feelings – Grateful / Believed / Cared for

Northern Ireland Ambulance Service
Health and Social Care Trust

Our People | Absence | Sickness

The Maximising Attendance Project Board continues to meet on a weekly basis to progress delivery of project workstreams against the Delivery Plan.

Managerial action has concentrated on progressing the top 50 longest-term absences to conclusion, supported by HR. Of these 50, at the time of reporting, 9 have retired on the grounds of ill-health, 7 have had a return to work facilitated, 7 have exited employment and 9 require redeployment to an alternative role. This has supported a reduction in long-term absence, which is reflected in the January 2024 figures, with the monthly figure demonstrating the lowest in-month level of absence for 2023/34. A robust case management approach to the remaining 18 of these long-term absences continues, with focused Occupational Health case management meetings scheduled.

Post-Covid, a significantly higher number of staff have sought redeployment on medical grounds to other roles than would normally have been expected. It has proved challenging to identify suitable alternative employment for these individuals, particularly in the context of increased scrutiny in relation to the filling of vacancies. To date, of those currently seeking redeployment, 46% have been, or are in the process of being, redeployed to permanent or temporary posts, 10% are no longer pursuing redeployment, while the remaining 44% have yet to have a suitable post identified.

Top 5 Sickness Categories 2023/24*	
Mental Health	30.00%
Injury, Fracture	12.12%
Miscellaneous	10.64%
Influenza	8.05%
Accident/Untoward Incident	7.74%

* Accounts for 68.55% of absence

Miscellaneous includes General Debility (5.15%); Hospital Investigations (2.49%); Post Surgical Debility (1.53%); Post Viral Fatigue (1.17%); Chronic Fatigue (0.26%)

Mental Health Reasons	
Stress	15.01%
Stress-Work Related	7.38%
Anxiety	2.70%
Grief/Bereavement	2.66%
Other Mental Health	1.06%
Depression	0.68%
Panic attacks	0.35%
Insomnia	0.05%

Sickness absence due to mental health reasons represents 30.00% of sickness absence in 2023/24, with stress and work-related stress accounting for 15.01% and 7.38% (22.39% in total) respectively. The Trust's Health & Well-Being Team continue to implement the Trust's Mental Health Action Plan as part of the Healthy People, Health Place Strategy, including raising awareness and offering manager training in the use of the Trust's policy and procedure on managing work-related stress.

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

	Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
1.	Absence Target (2023/24)	11.24%[1]											
2.	Current Status against Target	14.76% ↓											
3.	Cumulative % hours lost (22/23)	10.62%	10.64%	10.88%	10.94%	10.89%	10.93%	11.12%	11.19%	11.58%	11.91%	12.07%	12.30%
4.	Cumulative % hours lost (23/24) (Total)	14.25%	14.19%	14.25%	14.27%	14.64%	14.60%	14.65%	14.82%	14.90%	14.76%		
4.1	Cumulative % hours lost (23/24) (Non-Covid)	13.15%	13.27%	13.40%	13.46%	13.71%	13.33%	13.44%	13.88%	13.94%	13.78%		
4.2	Cumulative % hours lost (23/24) (Covid)	1.1%	0.95%	0.85%	0.81%	0.93%	1.02%	1.04%	0.94%	0.96%	0.98%		
4.3	Cumulative % hours lost (23/24) Short-Term	2.57%	2.20%	2.33%	2.35%	2.55%	2.61%	2.63%	2.67%	2.74%	2.82%		
4.4	Cumulative % hours lost (23/24) Long-Term	11.68%	12.00%	11.92%	11.92%	12.09%	11.99%	12.02%	12.15%	12.16%	11.94%		
5.	Monthly % hours lost (23/24) Total	14.25%	14.13%	14.36%	14.34%	16.04%	14.41%	14.91%	16.01%	15.56%	13.60%		
6.	Average standard working days lost/employee/month	2.78	2.98	3.01	2.93	3.60	2.94	3.19	3.43	3.19	3.05		
7.	Average estimated cost per month (£'000)	860	859	859	822	£911	£820	£840	£890	£858	£739		

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

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

Northern Ireland Ambulance Service
Health and Social Care Trust

Our Patients | SPPG Service Delivery Plan | Trajectories and Performance

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

Call Answer Performance:

	April 23	May 23	June 23	July 23	August 23	September 23	October 23	November 23	December 23	January 24	February 24	March 24
Call Answer Outturn	86.9%	85.3%	82.4%	80.7%	80.2%	82.2%	85.1%	86.1%	85.9%			
Trajectory	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%

Hear and Treat and See & Treat

	April 23	May 23	June 23	July 23	August 23	September 23	October 23	November 23	December 23	January 24	February 24	March 24
Hear & Treat Outturn	3.5%	3.2%	4.5%	4.0%	3.4%	4.0%	3.9%	3.8%	4.4%			
Hear & Treat Trajectory	4.2%	4.2%	4.2%	4.4%	4.4%	4.6%	4.6%	4.6%	4.8%	4.8%	5.0%	5.2%
See & Treat Outturn	14.0%	14.4%	14.8%	14.8%	14.5%	14.4%	14.7%	14.2%	13.9%			
See & Treat Trajectory	14.2%	14.2%	14.2%	14.4%	14.4%	14.6%	14.6%	14.8%	14.8%	15%	15%	15.2%

Northern Ireland Ambulance Service
Health and Social Care Trust

Our Patients | SPPG Service Delivery Plan | Trajectories and Performance

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

Response Times

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

Northern Ireland Ambulance Service
Health and Social Care Trust

Our Patients | SPPG Service Delivery Plan | Trajectories and Performance

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

Response Times

	April 23	May 23	June 23	July 23	August 23	September 23	October 23	November 23	December 23	January 24	February 24	March 24
Category 2 Mean	31mins	31mins	37mins	38mins	44mins	47mins	52mins	47mins	74 mins			
Cat 2 Mean Trajectory	36mins	36mins	36mins	36mins	36mins	36mins	36mins	36mins	36mins	36mins	36mins	36mins
Category 2 90th Centile	68mins	69mins	81mins	84mins	100mins	105mins	111mins	102mins	167 mins			
Cat 2 90th Centile Trajectory	80mins	80mins	80mins	80mins	80mins	80mins	80mins	80mins	80mins	80mins	80mins	80mins
Category 3 90th Centile	183mins	196mins	262mins	280mins	360mins	328mins	483mins	363mins	531 mins			
Cat 3 90th Centile Trajectory	233mins	233mins	233mins	233mins	233mins	233mins	233mins	233mins	233mins	233mins	233mins	233mins

Northern Ireland Ambulance Service
Health and Social Care Trust

Our Patients | SPPG Service Delivery Plan | Trajectories and Performance

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

Handover Performance

	April 23	May 23	June 23	July 23	August 23	September 23	October 23	November 23	December 23	January 24	February 24	March 24
<=15mins	8.8%	8.8%	8.7%	9.0%	8.3%	7.8%	7.3%	7.6%	8.1%			
<=15mins Trajectory	2%	4%	8%	8%	12%	15%	17%	19%	22%	25%	25%	25%
<=30mins	38.4%	36.5%	38.2%	36.1%	33.5%	33.2%	28.6%	29.3%	28.6%			
<=30min Trajectory	14%	14%	20%	25%	30%	35%	35%	40%	40%	45%	55%	60%
<=60mins	74.8%	76.1%	75.6%	73.1%	69.6%	69.7%	60.9%	63.5%	61.2%			
<=60mins Trajectory	59%	65%	65%	70%	70%	70%	75%	75%	80%	85%	90&	95%
>2hrs	9.2%	7.67%	9.6%	10.9%	12.7%	13.1%	20.1%	17.7%	19.8%			
>2hrs Trajectory	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
No of Patients >2hrs	997	881	1,040	1,206	1,371	1,334	2,090	1,821	1,992			
No of Patients >2hrs Trajectory	0	0	0	0	0	0	0	0	0	0	0	0

Trust Board Finance Report

December 2023 (Month 9)

Northern Ireland Ambulance Service
Health and Social Care Trust

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* Executive Summary
* Manage Within Allocated Revenue Resource Limit (RRL)
* Voluntary & Private Ambulance Services
* Overtime Expenditure
* Manage Within Allocated Capital Resource Limit (CRL)
* Prompt Payment of Invoices

Executive Summary

Statutory financial performance targets	RAG status
Manage within allocated Revenue Resource Limit (RRL) / Achieve financial break-even	
The Trust is reporting a breakeven position at 31 December 2023 (Month 9) and forecasting a breakeven position for the year ending 31 March 2024.	
Manage within allocated Capital Resource Limit (CRL)	
The Trust has received a Capital Resource Limit (CRL) allocation of £6.381m. This includes allocations for Fleet & Estate (£5.7m), ICT (£0.555m), Leases (£0.1m) and Backlog Maintenance (£0.026m). Resources identified for replacement defibrillators are subject to business case approval and supplier capacity.	
Prompt payment target-95% of suppliers within 30 days	
Cumulative performance is 96.9% for the nine months ending 31 December 2023 (Month 9).	

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

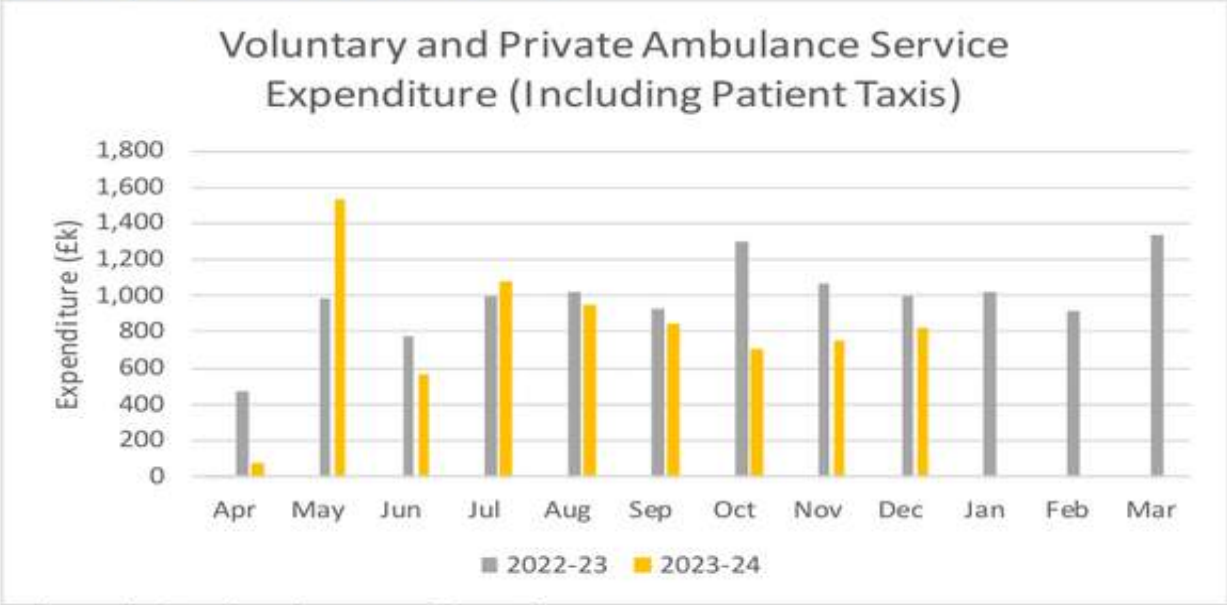
The Trust is reporting a breakeven position at 31 December 2023 (Month 9) and forecasting a breakeven position for the year ending 31 March 2024. This is a change to the previously reported position and the summary financial plan submitted to DoH/SPPG on 30 June 2023. This is due to a review of the initial allocations and assumptions identified in the financial plan and also further allocations notified by DoH/SPPG.

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

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

Voluntary & Private Ambulance Services (VAS/PAS)

- The Trust has benefited from significant additional funds as part of the response to Covid-19. This funding was applied to additional support from VAS/PAS to maintain and enhance ambulance provision during this difficult period. The Trust welcomes the support that VAS/PAS has given NIAS and HSC during this time.
- Expenditure on VAS/PAS in 2019-20 was £5.2m. Expenditure in 2020-21 was £10.1m, 2021-22 was £9.7m and 2022-23 was £9.2m. This level of expenditure was affordable given operational vacancies within the Trust and also with the additional resources provided in response to the pandemic. As the output of the training school fills vacancies, levels of expenditure should reduce.
- The sustained impact of pressures across HSC has resulted in the continued reliance on VAS/PAS to maintain services. The Trust has largely been operating at the highest levels of escalation and VAS/PAS spend remains significant. In 2022-23, further costs of the order of £2.6m were also incurred for the provision of patient taxis. Monthly expenditure in 2022-23 and the year to date are shown below.

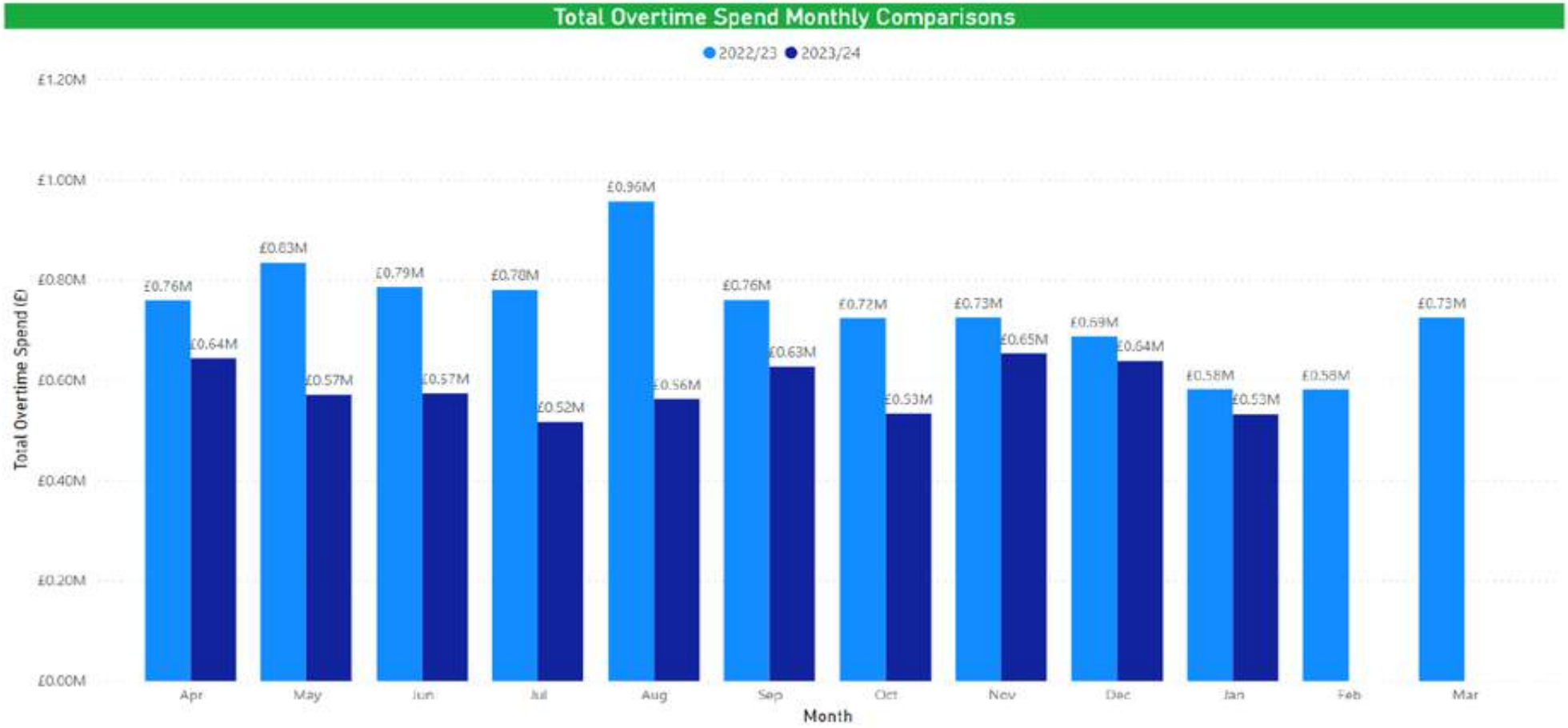


Overtime Expenditure

* The Trust relies on the use of overtime for the provision of services, predominantly for the provision of Ambulance cover. This reliance is for a number of reasons including vacancies, planned and unplanned absences and additional cover or programmes of work.
* Overtime is payable to staff in pay bands 1-7 under Agenda for Change (AfC) terms and conditions at a rate of time plus one half, with the exception of public holidays which are paid at double time.
* Overtime is paid monthly in arrears and claims should routinely be submitted within three months of the work being carried out. Staff also have the option of taking time off in lieu as an alternative to an overtime payment.
* Given the varying requirements for overtime, expenditure can vary significantly at different times in the year. This, combined with other changes between years, can mean that expenditure between years, and particularly between months between different years, may not be directly comparable.
* However, even with this variability, overall overtime has been remarkably consistent in prior years averaging circa £6m per annum. Costs in 2022-23 increased to £7.9m which was affordable with additional Covid allocations. Expenditure showed a slight downward trend for the last three months of 2022-23 (figures for March 2023 include pay award arrears estimated to be in the order of £300k). This downward trend has broadly continued for the first eight months of the 2023-24 financial year, with the exception of a slight upturn in September and November 2023. This control of expenditure will need to be maintained and sustained for the rest of the financial year to manage within currently available resources.
* The Trust has largely completed a programme of work to recruit substantively to positions that have historically been filled with overtime. There was a significant lead time for the recruitment and training of these staff. As the output of the training school fills vacancies, levels of expenditure on overtime should reduce. Levels of sickness absence are also a major driver of overtime spend.

Overtime Expenditure

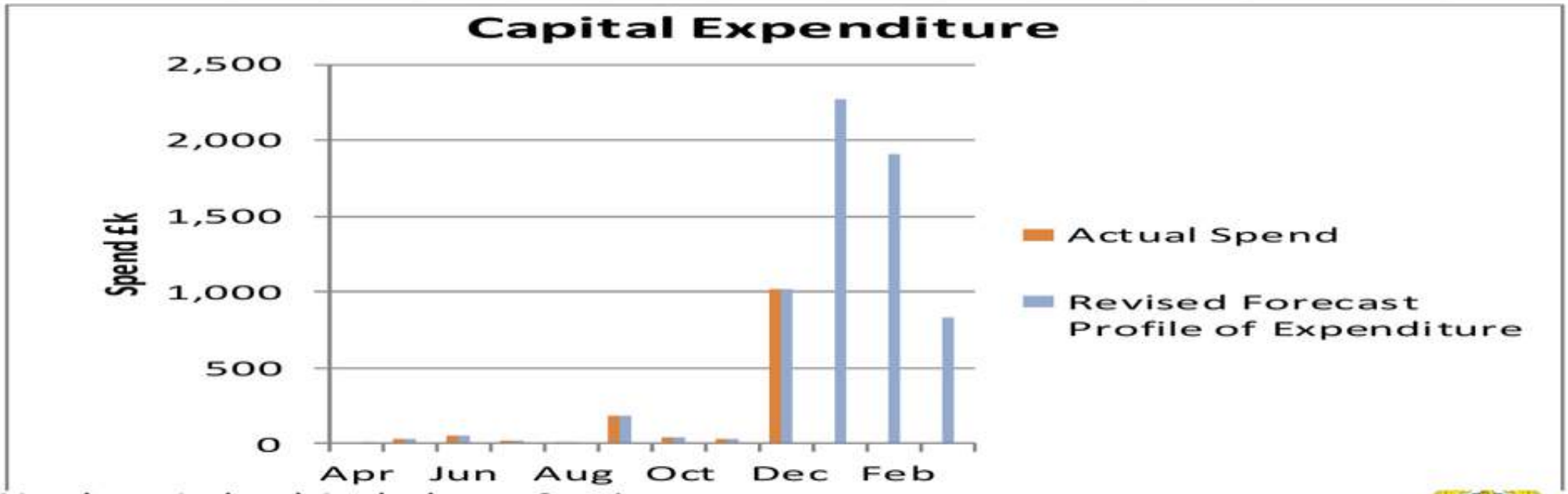
Total Overtime Spend Monthly Comparisons (£)



Manage within allocated Capital Resource Limit (CRL)

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

- Expenditure has traditionally been profiled towards the end of the financial year due to a number of factors, including business case approval, the availability of funds, procurement timescales, supplier capacity, internal capacity, project risks and lead times. Significantly, expenditure on fleet is profiled to the end of the financial year to maintain a smooth fleet age profile.
- These risks have been compounded recently due to a number of factors including EU exit, the global movement of goods, the global availability of raw materials and also associated costs of materials, production and delivery. The Trust continually reviews capital schemes to understand and mitigate against these risks.
- Provisional figures for expenditure at December 2023 (Month 9) is £1.380m against the allocation of £6.381m.



Prompt Payment of Invoices

The Trust is required to pay non HSC trade creditors in accordance with the Better Payments Practice Code and Government Accounting Rules. The target is to pay 95% of invoices within 30 calendar days of receipt of a valid invoice, or the goods and services, whichever is the latter. A further regional target to pay 70% of invoices within 10 working days (14 calendar days) has also been set.

* Performance by number of invoices paid for each of these measures is shown below. A range of measures are in place to improve and maintain performance in this area. As aged invoices are cleared and paid, performance between months can vary.

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

Number	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD Cum	Target
Total bills paid	1,940	2,425	2,348	1,974	2,252	2,283	2,608	2,302	1,643				19,775	
Total bills paid within 30 calendar days of receipt of undisputed invoice	1,900	2,316	2,280	1,876	2,193	2,226	2,569	2,219	1,589				19,168	
% bills paid on time 30 days	97.9%	95.5%	97.1%	95.0%	97.4%	97.5%	98.5%	96.4%	96.7%				96.9%	>95%
Total bills paid within 10 working days (14 calendar days)	1,745	1,629	1,854	1,621	1,919	1,858	2,087	1,790	1,395				15,898	
% bills paid on time 10 days	89.9%	67.2%	79.0%	82.1%	85.2%	81.4%	80.0%	77.8%	84.9%				80.4%	>70%
Targets			30 days	>95%	>90%	<90%		10 days	>70%	>65%	<65%			

End of Report

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

PRESENTATION OF PAPER

Date of Trust Board:	22 February 2024
Title of paper:	Operational Road Risk, Fleet Safety Policy v1.0 Driving and Care of Vehicles on behalf of the Trust – Standard Operating Procedure (SOP) v1.0
Brief summary:	The Policy and the SOP are designed to work in tandem to outline the basis for safe and effective driving practices within the Trust. Both are based on legal responsibilities in current and future anticipated law and associated best practice national guidance. The policy outlines core responsibilities for the organisation, various organisational managers, and each individual driver who drives Trust Vehicles or drives on behalf of the Trust. The SOP provides further detail on what best practice looks like for colleagues and people who drive on behalf of the Trust. This includes visual daily inspection process, emergency driving, non-emergency driving, and how standards of driver competency will be assessed and monitored. The Safety Committee acknowledged the challenges in implementing the Policy and approved the Policy and SOP with the caveat that the position would be reviewed in six months' time. It also asked for an implementation plan to be developed for

	consideration at its next meeting.
Recommendation:	**For Approval** ☐ **For Noting** ☒
Previous forum:	SMT - 14/3/23 SMT - 21/11/23 Safety Committee – 25/1/24
Prepared and presented by: **Date:**	Paul Corns, Consultant Paramedic Sean Kelly, Clinical Education Manager Trust Driving Instructors Neil Sinclair, Chief Paramedic Officer 15 February 2024

EXPLANATORY COVER SHEET FOR SUBMISSION OF:

Occupational Road Risk & Fleet Safety Policy v1.0

Driving Vehicles on behalf of the Trust Standard Operating Procedure v1.0

- The ORRFS Policy outlines the key responsibilities for the organisation, specific senior managers and individual drivers who drive for or on behalf of the Trust.

- This is the first policy to be introduced regarding driving in NIAS history.

- Driving under emergency conditions is an extremely high-risk activity. This policy and the accompanying SOP aim to give assurance to the organisation, set out the standards expected for NIAS drivers, and importantly ensure all NIAS drivers are aware of their legal obligations and exemptions afforded to them whilst emergency driving.

- The policy and SOP are anticipatory of legal changes to The Road Traffic (Northern Ireland) Order 1995. The Road Safety Act (2006) has already been amended in England to contain changes to 'Section 19'.

    - Section 19 changes include the regulation of high-speed driving education, outlines the need for regular re-assessment, and advocates the use of a high-speed register to log staff authorised to drive under emergency conditions for the Trust.
    - Similar changes expected to be introduced into NI legislation in due course. Timescale unknown.

Policy is implemented at risk:

- This policy outlines mandate of regular 3-5 yearly assessment of all drivers.
- At present we are unable to deliver the approx. 250 assessments per year required.

  - Our qualified driving instructors have full time jobs as Training Officers, their time is already committed to core education delivery etc.
- Therefore, this policy is implemented at risk.

Anticipated trajectory for delivery of assessments relating to policy:

- 2024/5 – 140 assessments
  - To fulfil driver policy requires approx. 240 assessments per year.
  - Therefore, anticipated deficit of 100 assessments per year.
  - This cannot be addressed with current team size and existing and planned education delivery.

- A separate business case in final draft stage to request dedicated driver team – this would immediately address yearly deficit once team is in place.

Northern Ireland Ambulance Service
Health and Social Care Trust

Title:	**Occupational Road Risk & Fleet Safety Policy**		
Author(s):	Katrina Keating, Risk Manager Terry O'Neill, Clinical Training Officer Frank Armstrong, Clinical Training Manager Sheridan Easter, Fire & Security Advisor Michael Heasley, Fleet Manager Clinical Education Department		
Ownership:	Maxine Paterson, Director of Planning, Performance & Corporate Services		
SMT:	14th March 2023	**ARAC:**	30th March 2023
Operational Date:	30th March 2023	**Review Date:**	March 2026
Version No:	1.0	**Supercedes:**	N/A
Key Words:	Driving standards, environment, breakdown, fuel efficiency, driver training, fatigue, risk management, driver assessment, driving licences, grey fleet, risk assessment, speed, vehicle condition, familiarisation, vehicle checks, seat belts, incident reporting, reversing.		
Links to Other Policies / Procedures:	Driving Standard Operating Procedures – Driving and Care of Vehicles When Driving On Behalf of the Trust. Health and Safety Policy and Procedures, Incident Reporting Procedure, Fire Safety Policy & Procedures.		

Version Control:			
Date:	**Version:**	**Author:**	**Comments:**
25/1/24	1.0	Clinical Education Department	Presentation to Safety Committee for review and approval, prior to publication.
21/11/23	0.6	Clinical Education Department	Presentation to SMT for review, comment and approval
November 2023	0.5	Clinical Education Department	Comments / revisions

October 2022	0.4	Trade Unions, line management & SMT	Comments / revisions
September 2022	0.3	Risk Manager	Further revisions / RA added
February 2022	0.2	Fire & Security Advisor	Complete review RE Occupational Road Risk
January 2016	0.1	RACTC & Fleet	Draft Driving Policy

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1.0 - INTRODUCTION

Safe driver, safe vehicle, safe journey.

1.1 - BACKGROUND

The Northern Ireland Ambulance Service (NIAS) is committed to improvement in workplace health and safety. As part of this commitment, the Trust recognises that the management of occupational road risk and fleet safety is integral to the reduction of injures, ill health and improved morale.

More than a quarter of all road traffic incidents may involve somebody who is driving as part of their work at the time (Department of Transport) and for most Trust staff, their vehicle is their workplace!

Under health and safety legislation, the management of risk associated with driving at work (occupational driving) is the responsibility of the Trust as an employer. The Trust must ensure that maximum support and protection is offered to its staff, patients, clients, service users, other road users and the general public through the application and maintenance of effective driving standards, processes and practices. NIAS will manage work-related road safety effectively by considering the following three areas of safety:

- Safe driver;
- Safe vehicle;
- Safe journey.

There are risks inherent in driving, however NIAS accepts this risk in the realisation that the benefits to patients can outweigh the risks.

It would not be practicable to detail every single procedure and process concerning driving duties within this document. Therefore, there are additional arrangements in place such as in depth training packages, Drivers Handbooks (DTAG & Police Foundation) and a Safe Driving of Trust Vehicles Standard Operating Procedure (SOP) to accompany this document. ***The SOP must be read in conjunction with this document to ensure those driving for and on behalf of the Trust have a full understanding of their legal duties and responsibilities when driving***.

1.2 - PURPOSE

The purpose of this Policy is to set the required high standards of driving within NIAS and establish a framework to promote a pro-active approach to maintaining and enhancing safe driving standards and procedures throughout the Trust. This Policy will ensure that the Trust remains compliant with all current applicable legislation and meets all of the legal requirements contained within. It aims to minimise risks to staff, patients, clients, service users, other road users and members of the general public through the application and maintenance of effective driving standards, processes, training and practices.

1.3 - OBJECTIVES

- Provide a clearly understandable policy, procedures etc.
- Define 'at work driving' and 'occupational road risk'.
- To outline the legal duties of the Trust and/or staff working on behalf of the Trust.
- Clearly identify accountability/responsibility for the management of occupational road risk.
- To ensure a standardised approach in driving standards/development within the Trust, and to enhance driving standards in line with best practice, training and legislation.
- To ensure that all vehicles owned and operated by and on behalf of the Trust are in a fit for purpose state and maintained to safe standards.
- Improve health and safety, reduce driving incidents and road traffic collisions (RTCs).
- To ensure the appropriate use of Telematics to monitor and reduce the Trust's carbon footprint on the environment and to monitor and support driving standards.
- Improve productivity (due to fewer incidents taking vehicles off the road).
- Commence a drive to reduce costs to the organisation (reduction of fleet premiums and cost of repairs and replacements).

2.0 - SCOPE:

This Policy applies to all staff driving on behalf of the Trust, this includes:

- Drivers of all Trust vehicles (including bank staff).
- Casual and essential car drivers / motorcyclists (grey fleet*).
- Contracted / external agencies (including taxis).
- Volunteer car drivers (SOP pending at time of publication)
- British Association for Immediate Care (BASICS) Doctors.
- Community First Responders (SOP pending at time of publication).
- Independent Ambulance Sector (IAS), including Voluntary and Private Ambulance Services (VAS / PAS) via agreed assurance arrangements.

*In terms of casual and essential drivers who drive their own private vehicle for the requirements of their role, for example staff who drive to attend meetings, conferences etc., in order to carry out their job role (work-related journeys). These vehicle are known as the 'grey fleet' as they are privately owned vehicles being use for Trust purposes. There are clear responsibilities on both the driver and the Trust in this area (detailed later in this document).

Health and safety law does not apply to people commuting (i.e. travelling between their home and their usual place of work), unless they are travelling from their home to somewhere which is not their usual place of work.

3.0 - ROLES AND RESPONSIBILITIES:

3.1 The Chief Executive is responsible for:

- Ensuring that there are suitable and sufficient arrangements in place for the full implementation of this Policy / SOP, including the necessary finance / resources, monitoring processes, and oversight coupled with the necessary Trust Board accountability arrangements.

- Ensuring there are suitable arrangements in place for the review and audit of this policy document to ensure that the Policy / SOP remains fit for purpose and that full Policy / SOP compliance is achieved.

3.2 Directors are responsible for:

- Ensuring compliance with this Policy.
- Ensuring that only those staff within their Directorate who have successfully completed an approved emergency driving course are permitted to drive under emergency conditions.

3.3 The Medical Director is responsible for:

- Providing and ensuring oversight and accountability of all driver training within the Trust (including behavioural based driver safety training / assessment).
- Providing the Chief Executive and Trust Board with information and assurance pertaining to the management of driver training within the Trust.
- Ensuring the necessary competence and expertise of individuals' assigned specific driving related roles and responsibilities.
- With regards to other groups of staff / volunteers driving on behalf of the Trust (i.e. Community First Responders [CFRs], BASICS etc.), ensuring that arrangements are in place to monitor driving standards and that these groups of staff are clear on the requirement to adhere to Highway Code, national speed limits etc.
- The timely review of this Policy / SOP.

3.4 Operational Services Director, Operational Services Assistant Directors (Performance) & Operational Services Assistant Director (Control and Communications) are responsible for:

- Implementing this Policy, and the *Safe Driving of Trust Vehicles Standard Operating Procedure (SOP)* along with any associated guidance based on risk assessments within their areas of responsibility.
- With regards to Operational Services, ensuring arrangements are in place for monitoring and compliance with this Policy / SOP.
- With regards to Operational Services, ensuring that there are suitable resources available for the implementation of this Policy / SOP.
- Ensuring the communication of the information within this Policy / SOP is cascaded to appropriate managers.
- Ensuring that crews have adequate time, i.e. 15 minutes to carry out Vehicle Daily Inspections (VDIs), with the exception of a confirmed CAT1.
- Ensuring that only those staff within the Directorate who have successfully completed an approved emergency driving course are permitted to drive under emergency conditions.
- Ensuring that adequate arrangements are in place to monitor and assess driving with regards to volunteer drivers, in particular ensuring that volunteer drivers are clear on the requirement to adhere to Highway Code, national speed limits etc. SOP under development at time of publication.
- Liaising with the Recruitment Team (Human Resources) to ensure that driving license information is passed to the Resource Management Centre and added to the Global Rostering System (system review underway at the time of publication) (Operational Services Assistant Directors (Performance).

- Ensuring adequate contractual arrangements are in place for the use of commissioned services (Independent Ambulance Sector, taxis etc.). This would include ensuring that contracted organisations provide assurance that their drivers are competent and hold the appropriate licence category for the vehicle that they are driving, the vehicles are road worthy and appropriately insured. The Trust will carry out inspections / spot checks as deemed necessary.

3.5 The Fleet Manager is responsible for:

- As far as reasonably practicable ensuring that all vehicles owned and operated by the Trust are roadworthy and fit for purpose.
- Ensuring that there are appropriate mechanisms and procedures in place to identify vehicle faults / defects and action as necessary to comply with this Policy / SOP.
- Ensuring all available safety enhancements are fitted, as far as reasonably practicable.
- Ensure that all vehicles procured meet the criteria for reducing the overall carbon footprint of the Trust as per Fleet Strategy.
- Regular issue of 'Motor Insurance – Duty To Disclose Material Facts', collating responses and advising insurance brokers.
- Issue of reminders to line managers to check driving licences bi-annually (financial appraisal of current arrangements ongoing at time of publication).
- Ensure vehicle specifications have suitable arrangements in place for the safe storage of medical gases (means to secure, signage etc.).
- Ensuring new vehicles are risk assessed on purchase and prior to commissioning.
- Ensuring vehicles are fitted with suitable fire extinguishers prior to deployment.
- Ensuring vehicles are not issued / loaned without assurances regarding adequate training.
- Ensuring that Fleet related data is captured, collated and presented relevant to any driving activity within, or on behalf of the Trust.
- To ensure the appropriate use of Telematics to monitor and reduce the Trust's carbon footprint on the environment and to monitor and support driving standards.

3.6 The Director of Finance, Fleet & Estates is responsible for:

- Ensuring that adequate resources and funding is available for insurance, procurement, commissioning and on-going maintenance of Trust vehicles.
- Ensuring that adequate funding is available for provision of initial driver training course as well as regular programmed refresher training course.

3.7 The Risk Management Team is responsible for:

- In partnership with the Clinical Education Department (CED) and Fleet Manager, the development of suitable policies, procedures and arrangements to ensure that risks to staff health and safety from driving related activities are reduced so far as is reasonably practicable.
- Providing support and advice to managers on completion of risk assessments to identify any potential health risks from driving are apparent and to implement the correct control measures as required.
- Ensure adequate health & safety training is provided for staff and line management in order to facilitate them being able to carry out appropriate risk assessments.

- Ensuring that all relevant risk data is captured, collated and presented relevant to any driving activity within, or on behalf of the Trust.
- Liaising with other specialists, i.e. driving instructors, HSENI and other agencies to ensure the information contained within this Policy / SOP is correct and follows applicable legislation.
- Reporting to the Health and Safety Executive for Northern Ireland (HSENI) under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (NI) 1997.
- Providing a point of contact between NIAS and external parties such as HSENI.
- Ensuring this Policy / SOP is reviewed every three years, and updated if required to reflect changes in practices, procedures, training and legislation.

3.8 Line Managers are responsible for:

- Ensuring staff / volunteers etc. within their area of responsibility are supported, made aware of and comply with this Policy / SOP (through local induction / team briefs and where changes occur). In particular ensuring only suitably trained staff drive under emergency conditions.
- Where reasonably practicable, ensuring the Policy / SOP and related driving procedures are adhered to and fully implemented as part of the Trust's integrated governance requirements.
- Being aware of all hazards associated with driving duties within the Trust.
- Regularly reviewing and monitoring risks and improvements achieved or planned.
- Intervening, reporting and escalating incidents where standards appear to be falling below those set out in this Policy.
- Actively promoting improving practices within their service on the safe use of vehicles.
- Ensuring compliance with Trust Incident Reporting Procedures.
- Ensuring driving licence checks are conducted on a six monthly basis, e.g. 31st March and 30th September each year and record (corporate arrangements under review at time of publication).
- Ensuring risk assessments including Driver Risk Assessments are in place and adhered to (support is available from the Risk Management Team and CED).
- If made aware, reporting any concerns regarding vehicle roadworthiness, defects etc. to the Fleet Manager.
- Taking action should it become apparent that a Trust vehicle is not roadworthy / fit for purpose, reporting all defects found.
- Reminding staff to ensure all driving related incidents are appropriately reported, investigated and/or reviewed as required (via DATIX etc.). Requirement for additional training under review at time of publication.
- Ensuring all notifications from staff about changes to their health or personal circumstances, that may affect their ability to drive, are actioned promptly and appropriately.
- Ensuring all Notification of Intended Prosecutions (NIPs) are reviewed and actioned accordingly.
- As necessary referring to, and working in partnership Clinical Education Department and Fleet Manager.
- Ensuring that CoSHH assessments are adhered to with particular focus on the storage of medical gases.

- Where applicable, ensuring that all vehicles in their control are presented for service, inspection, and repairs when requested.
- Where applicable, ensuring the presentation of relevant log books / records to the appropriate Line Manager / Supervisor for checking, sign off and filing.
- In conjunction with the Clinical Education Manager, arranging the completion of a Drivers Risk Assessment along with the production of a portfolio for staff employed prior to 1981.
- Monitoring staff / persons who are employed and / or contracted by the Trust and drive their own private vehicle for the requirements of their role. **As a minimum line managers should request to see a current driving licence along with evidence that the driver is insured for the vehicle they are using (business insurance) on an annual basis. Failure to adhere will result in the non-payment of claims for business mileage etc.**

3.9 The Clinical Education Manager is responsible for ensuring that:

- Ensuring that NIAS has a robust system and structure in place for the organisation and delivery of initial accredited ambulance driver training, assessment and review of driving duties within the Trust (including behavioural based driver safety training / assessment).
- Ensuring, during the pre-employment recruitment process, all new recruits joining the Trust undertake a relevant Driver Competency Assessment prior to joining the Trust.
- Through working with relevant Operations Department, ensuring the implementation of 5-yearly Driver Competency Reviews for those staff who are required to drive ambulance vehicles, in accordance with awarding body requirements, national standards, best practice, legislation, policy and related procedures.
- All ambulance driver education and assessment is conducted in compliance with awarding body requirements, national standards, best practice, legislation, policy and procedures.
- When appropriate, provide assistance in the conducting of investigations into driving related incidents carried out in accordance with the Trust's Incident Reporting Procedure and Risk Assessment Procedure.

3.10 Driving Instructor / Tutors are responsible for:

- The delivery of training and the ongoing development and review of driving standards in accordance with awarding body requirements, national standards, best practice, legislation and Trust Policy and related procedure (including behavioural based driver safety training / assessment).
- Ensuring that, during ambulance driver training and assessment, relevant staff are made aware of this Policy, the SOP and related legislation.
- Assisting in conducting investigations and adjudication into incidents / collisions involving a Trust vehicle.
- During driving training, reminding staff of the importance of adhering to rest periods as per rest period related SOPs and taking on adequate nutrients and fluids to ensure suitable concentration levels.
- Conducting risk assessments pertaining to driver training and related circumstances.
- Keeping abreast of current requirement and best practice.
- Providing expert advice to the Trust in relation to current legislation and driver training.
- Ensuring assessments of new drivers at six monthly intervals for the first year of driving or sooner if required.

- Mobile devices should only be used in accordance with applicable legislation which includes supervising driving students.

3.11 All staff, contractors and volunteers where appropriate are responsible for:

- Complying with this Policy / SOP, Trust Health & Safety Procedures and associated documentation relating to the safe and proper use of vehicles.
- Seeking advice from line managers for clarification on any information where required.
- Attending the relevant training and / or assessment commensurate with their job role (including behavioural based driver safety training / assessment).
- Reporting any injury sustained, which may affect their ability to drive, immediately to their line manager.
- Reporting any disability e.g. defective hearing, visual impairment, diabetes, seizures, any heart complaint or any other illness which is notifiable to the Licensing Authorities to line management (an individual risk assessment may be required).
- Taking individual responsibility to ensure fitness to drive, including not being overly tired, and should take such into account when planning outside activities if they may impact on their ability to drive at work.
- Ensuring that any vehicles they are required to drive on behalf of the Trust are roadworthy and legal to drive by undertaking the vehicle inspection procedures (VDI) prior to driving.
- Ensuring every effort is made to keep vehicles more than half full of fuel at all times. On completion of shift, vehicles should be shorelined (see Vehicle Shoreline SOP).
- Using mobile devices in accordance with applicable legislation.
- Reporting any defects detected, completing the required paperwork and take necessary action. Failing to report damage either caused or found, may result in investigation under the Trusts Disciplinary Procedures.
- Not using any vehicle under NIAS control for any reason other than that of its intended purpose.
- Taking time to familiarise themselves with vehicle controls and finding a comfortable and safe seating position. Not drive any Trust vehicle that they have not been familiarised with.
- Ensuring the security of the vehicle and its contents as far as possible when unattended. At the end of the shift, keys must be returned to key boxes. EAC / line management must be informed immediately in the event of a lost or misplaced key.
- Ensuring driver fatigue is considered and reduced by alternating driving duties where practicable. Professional clinical responsibility, however, should take precedence should a paramedic be required to monitor the person being transported in an ambulance. It is recognised lone workers are the exception to alternating driving duties.

- Booking on MDT from shift commencement time and then proceeding to commence the VDI. Operational staff should be aware that they will be tasked to a confirmed Category 1 call at any time from shift commencement (even before MDT book on is completed) via the Station Tannoy or phone. Staff must ensure basic roadworthiness of the Trust vehicle prior to driving it. These checks include, as a minimum, checking wheels, tyres, brakes, windows/wipers/washers, vehicle lights and, if driving under emergency conditions, emergency audible/visual warnings. Staff should ensure they carry out a full VDI at the earliest time after completion of Category 1 call.

- Reporting to line management, Human Resources and the Fleet Manager, prior to the commencement of the next shift, any convictions, licence suspensions, Notice of Intended Prosecution (NIPs), penalty points, licence expiry etc. Failure to do so may result in suspension of driving duties.
- Being aware of, and complying with, the rules of the road, current Highway Code and current Trust Polices, Procedures, SOPs and legislation.
- **Wearing seat belts at all times EXCEPT when providing medical treatment to a patient which due to its nature or the medical condition of the patient cannot be delayed (see relevant legislation / Trust Safety Alert 19-02 / SOP).**
- **Ensuring that all seats are either forward or rear facing for seatbelts to function correctly.**
- Being fit to drive and informing line managers immediately of any change to health that results in no-longer being fit to drive (this includes the temporary use of medication). If a driver becomes ill whilst driving, they should stop the vehicle as soon as it is safe to do so and report to their Supervisor/Line Manager/EAC.
- Ensuring that they never, under any circumstances, drive while under the influence of alcohol, drugs, solvents or prescription drugs that could alter their ability to drive.
- At each six-monthly check, on joining, or on request having and producing correct driving licence/s to the Trust. An example of a request could be as a result of an intended notice of prosecution which the employee is required to bring to the attention of their appropriate Line Manager / Supervisor. Failure to produce the required documentation with two weeks may result in suspension of driving duties.
- Holding a valid driving licence and relevant qualification, appropriate for both the vehicle and the circumstances under which it is being driven.
- Ensuring the correct following position from the vehicle in front, i.e. not tailgating a crew or attempting to provide an escort for another crew.
- Cooperating with the Fleet Manager in relation to fleet issues.
- Meeting current driving eyesight requirements set out by DVA.
- Complying with all driving and parking regulations, except when claiming an exemption which the driver must justify.
- Ensuring compliance with current arrangements for working time and compensatory rest.
- Being responsible and accountable for the care, condition and treatment of Trust provided vehicles, and for privately provided vehicles that may on occasion be used on Company business.
- Ensuring any and all vehicle incidents are reported in accordance with the Trust's Incident Reporting Procedure (DATIX), and completion of relevant documentation, e.g. insurance claim form.
- Only conveying passengers in connection with Trust business (other passengers may not be insured in the event of an accident).
- Not accepting an un-roadworthy vehicle or one that they cannot drive safely i.e. have not been trained to drive.
- Adhering to driver training and any manufacturer's instructions with regards to vehicle safety / maintenance.
- Ensuring that medical gases are correctly stored and suitably secured on vehicles.
- Adhering to the Trusts' Smoke Free Policy, i.e. smoking is not permitted in a Trust vehicle as set out in the Smoke Free Policy.

- Not eating and drinking whilst in control of a moving vehicle. This an offence under the Road Traffic Order.

In the case of members of staff / persons who are employed and / or contracted by the Trust and drive their own private vehicle for the requirements of their role (grey fleet), it is the responsibility of the driver to ensure that their vehicle is fit for purpose, roadworthy, taxed, has a valid certificate of MOT and the that the driver is insured for the vehicle they are using, i.e. business insurance will be required for any journey undertaken on behalf of the Trust. Individual's insurance providers should be contacted for further information. . Upon request on an annual basis, provide line management with evidence that the driver is insured for the vehicle they are using (business insurance). Failure to adhere may result in the suspension of driving on Trust business, and the non-payment of claims for business mileage etc.

3.12 The Health & Safety Committee is responsible for:

- Receiving reports from the Fleet Accident Reduction Group (FARG) and the escalation of any concerns as necessary.

3.13 Fleet Accident Reduction Group (FARG):

The Fleet Accident Reduction Group (FARG) is responsible for reducing the number of avoidable vehicle accidents within the Trust along with reducing injuries to patients, staff and others along with associated expenditure on vehicle repairs and insurance premiums (separate Terms of Reference available).

- Oversight of incidents and issues pertaining to driving duties within the Trust.
- Use of vehicle CCTV for the purposes of learning and improvement.
- The formulation of any remedial measures that may be required and to assist with the aim of seeking continual improvement of driving related tasks.
- Assessing any training requirements associated with driving roles and responsibilities.
- Ensuring lessons learned from the outcome of incidents are communicated to all drivers and the recommendations are implemented throughout the Trust.
- Escalating matters to Health and Safety Committee, Education, Learning and Development Group, Audit and Risk Assurance Group (ARAC) and Trust Board as necessary.
- To ensure the appropriate use of Telematics to monitor and reduce the Trust's carbon footprint on the environment and to monitor and support driving standards.

3.14 Trade Union Safety Representative are responsible for:

- Consulting with their members on 'at work driving' including conducting workplace surveys and undertaking joint workplace inspections.
- Working in partnership with line managers to address risks from 'at work driving' as outlined in this policy.
- Encouraging their members to address risk and access the range of support services available.

4.0 - KEY PRINCIPLES:

4.1 Definitions of Driving Within The Trust:

Driving tasks can be broken into two categories: normal road driving conditions and emergency response driving conditions as detailed in section 4.2 and 4.3.

4.2 Definitions of Various Terms In Reference To Driving:

- **Emergency response driving –** is the action taken when an emergency is considered an event that requires immediate preventative action to avoid the risk to life or health. These vehicles are fitted with blue lights and audible alerts. Only emergency response trained personnel are authorised to drive these vehicles under emergency response driving conditions.
- **Normal road driving conditions –** is the process of driving a vehicle to current legislation, Orders and Highway Codes.
- **High Speed Register** – is an electronic register held by the Trust, managed by the Clinical Education Department that contains the details of employees & Approved Volunteers permitted to undertake Emergency Response Driving (This will be necessary to fulfil anticipated legislative changes, and is under development at time of publication).
- **Grey Fleet Vehicles –** are privately owned vehicles used by a member of staff for Trust purposes. The employee is reimbursed for using their own vehicles on Trust related journeys.
- **Dynamic risk assessment –** is the constant and ongoing assessment of the changing risks. An example of this could be when applying the brakes as traffic lights change and/or seeing a pedestrian about to cross the road and keeping a visual on them.
- **Patient Carrying Vehicles** – are vehicles that are directly controlled by the Trust, or have been contracted in by a third party, that are designed to transport patients under normal road driving conditions.
- **Suitable/valid driving licence –** is a current driving licence indicating the holder has the appropriate category to drive the vehicle being driven.
- **Careless driving –** is an offence under part 2 of the "The Road Traffic (NI) Order 1995". It is classed as: "*if a person drives a mechanically propelled vehicle on a road or other public place without due care and attention, or without reasonable consideration for other persons using the road or place, they are guilty of an offence*".
  A person is to be regarded as driving without due care and attention if the way he drives falls below what would be expected of a competent and careful driver.
- **Dangerous driving –** is an offence under part 2 of The Road Traffic (NI) Order 1995. It is classed as: "*a person who drives a mechanically propelled vehicle dangerously on a road or public place is guilty of an offence"* A person is to be regarded as driving dangerously if (and only if) the way they drive falls far below what would be expected of a competent and careful driver, and it would be obvious to a competent and careful driver that driving in that way would be dangerous.
- **Satisfactory driving assessment** – is an assessment against the new Department for Transport 'High Speed' competencies supported by the Driver Training Advisory Group, where each competency is scored 3 or more.

4.3 Driving Standards & Requirements: Normal Road Driving Conditions:

The Trust seeks to minimise risks to staff, patients, clients, other road users and members of the public through the application and maintenance of effective driving standards. The following requirements have been identified in accordance with national standards, best practice and legislation:

- Members of staff employed and/or contracted by the Trust that are required to drive a Trust vehicle must hold a valid driving licence appropriate for the vehicle that is driven.
- All personnel driving on behalf of the Trust MUST drive in adherence with the current legislation, road safety laws and Highway Code.
- It is the driver's responsibility to ensure that all the necessary seatbelts / patient restraint systems are installed and used correctly prior to any journey.
- It is the driver's responsibility to ensure that all ancillary equipment such as wheelchairs, stretchers, medical equipment etc. are stored and secured correctly as per Policy / SOP, prior to any journey commencing. See relevant legislation / SOP.
- Mobile devices should only be used in accordance with applicable legislation.
- Volunteers who drive their own vehicle, or a vehicle owned by a voluntary organisation, and are tasked to drive on behalf of the Trust must hold a valid driving licence appropriate for the vehicle being driven. If driving a privately owned vehicle, it MUST have a valid MOT certificate, (if required) vehicle Tax, and the driver MUST be appropriately insured for that vehicle.
- Managers of operational staff will conduct driving licence checks on a six-monthly basis, i.e. on 31st March and 30th September each year.
- New recruits whose job role requires them to drive an ambulance vehicle as a condition of their job role must successfully complete an accredited ambulance driver education and assessment programme before driving unsupervised.
- Members of staff who are required to drive an ambulance vehicle as a condition of their job role are required to successfully complete a Driver Competency Review on a 3 to 5-year rolling basis.
- As a minimum, line managers of non-operational staff driving for business purposes (i.e. grey fleet), should request to see a current driving licence along with evidence that the driver is insured for the vehicle they are using (business insurance) on an annual basis. Failure to adhere will result in the non-payment of claims for business mileage etc.

4.4 Driving Standards & Requirements: Emergency Response Blue Light Driving:

The Trust will provide an approved accredited emergency response driver training programme for any person who is required to drive under these conditions. No other person/s are authorised to drive any of the Trust's vehicles under these conditions if not trained to do so. There are no exceptions to this condition.

- **All of the terms within section 4.3 "Driving standards and requirements, Normal road driving conditions" are applicable for this section also.**
- All vehicles that are required to potentially be driven under emergency response conditions must be fitted with the appropriate visual and audible emergency systems. These must be fully functioning prior to any emergency response journey as per VDI.
- All drivers, driving under emergency response conditions MUST adhere to what was taught during the accredited training course programme, as well as adhering to supporting documentation such as Roadcraft, Drivers Handbook and current SOP.

- When responding to an emergency call, every effort should be made to progress appropriately, taking cognisance of the current weather and road conditions.
- Any vehicle being used as an ambulance for emergency response may exceed the statutory speed limit, if observance of the speed limit would hinder the use of the vehicle for its official purpose. This exemption from the statutory speed limit will be based upon the constant dynamic risk assessment of the driver, alongside the clinical assessment of the patient's condition and medical requirements. The driver **MUST** be able to justify claiming any exemption. The category of the emergency will also determine the dynamic risk assessment of the driver.
- **The following table is not a cap / limit / target and is not intended to replace the skills & attitude given through the standards of driver training in selecting the appropriate speed in the given circumstances. However, it is considered helpful and can be used as a general reference point in accordance with road and weather conditions.**

Statutory Speed Limit	NIAS Guidance Limit
20mph	30mph
30mph	45mph
40mph	60mph
50mph	75mph
60mph	90mph
70mph	105mph

- Whilst exemption from statutory speed limits exist when engaged on emergency response driving and authorised driver training courses, there still remains an overriding statutory requirement for the driver, and in the case of driving courses, the Instructor, to maintain safety margins. The exemption afforded to the Ambulance Service does not allow staff to drive at a speed, or in a manner which would amount to driving dangerously or without due care and attention.
- **The Police Service of Northern Ireland (PSNI) may view excessive use of speed as dangerous driving and instigate the appropriate proceedings against the driver.**
- Emergency vehicles that are tasked to respond to non-life threatening calls will drive under normal road driving conditions.

4.5 Use of Audible and Visual Warning Systems (AVWS):

- Responding ambulance crews will respond to emergency calls using either a HOT or COLD response, i.e. with or without the use of full Audible and Visual Warning Systems (AVWS).
- A 'HOT' response is defined as using full Audible and Visual Warning Systems (AVWS).
- A 'COLD' response is defined as a response **WITHOUT** the use of Audible and Visual Warning Systems (AVWS).

4.6 Fitness To Drive / Medical Standards:

- If anyone driving on behalf of the Trust develops any medical condition(s) that will affect their ability to drive, they must inform their line manager for assessment, and approval from senior management of their ability to continue driving. They are obliged by Law (depending on their medical condition) to contact the DVA and inform them of same.

The driver, at the discretion of management, may be referred to occupational health for further investigation and approval to continue driving duties. A risk assessment may also be carried out to determine the level of risk from driving duties and implement sufficient and suitable controls as is reasonably practicable.

- All operational staff, who drive either in the emergency and non-emergency tiers of the service are required to satisfy Group 2 Medical Standards. The requirement to satisfy Group 2 Medical Standards is based upon driving licence requirements and/or occupational requirements of the job role.
- The Trust is committed to complying with its responsibilities under the Disability Discrimination legislation, including making reasonable adjustments. Consideration of such matters in relation to individual members of staff in the context of driving will ensure reference to DVA guidance, Occupational Health advice and engagement with the affected employee and their Trade Union representative.
- Staff can also Contact Occupational Health, DVA, CED or the Risk Management Team for advice: How to tell DVA about a medical condition | nidirect

4.7 Education & Training:

- All staff required to drive under emergency response conditions are required to complete and pass an approved and accredited emergency driver training programme and assessment prior to being authorised to drive a Trust vehicle under such conditions.
- All staff who are required to drive a patient carrying vehicle under normal road driving conditions are required to complete and pass a Trust driving course and assessment prior to undertaking driving duties on behalf of the Trust.
- Any other staff required to drive other Trust vehicles must undertake assessment and suitable training prior to commencing duties (agency, vehicle cleanliness, stores etc.).
- Anyone working on behalf of the Trust claiming mileage (grey fleet) may require a driving assessment. Requests will be made based on individual 'grey-fleet' driver's Driver Risk Assessment score (Appendix 1), to be periodically reviewed by relevant line manager in consultation with CED.
- Anyone transporting patients on behalf of the Trust, i.e. volunteer drivers, will have their driving standard assessed as deemed necessary by the Trust following driver risk assessment. These assessments would normally be conducted in the vehicle the volunteer driver uses for Trust purposes.
- All staff are required to complete the behavioural based driver safety training and assessment (Appendix 2) either during training programmes, or as a self-assessment exercise annually and / or as required as part of a Driver Risk Assessment (see Appendix 1).
- All third-party independent ambulance contractors, acting on behalf of the Trust, will be required to ensure their staff complete regular driving and health assessments, at least every five years, to ensure their competency. These requirements will be documented in all service level agreements with these organisations. Evidential proof must be retained by the contractors (and may be requested by NIAS during established quarterly audits) of compliance with these standards. It is expected that the driving assessments completed by third-party ambulance contractors is of similar standard to NIAS' own driver assessments, NIAS Clinical Education Department may request verification of driver assessment standards from third-party organisations to judge standard of assessment.

- Regular and periodic driving assessments will be carried out for all staff driving Trust vehicles to ensure standards are being maintained. These assessments will be carried out by an approved accredited driving instructor. These assessments will be no more than 5 years from initial assessment, or from last review (N.B. at time of publication we acknowledge there will be lead time to develop position and resource to deliver this).
- Where possible, staff should notify their line manager if they have not received notification to attend training, or assessment in accordance with this Policy / SOP.
- The assessment of any driver can be brought forward from 5 years at the discretion of the Trust or, after an incident or a report of the driver's actions and behaviours.
- In certain circumstances it may be necessary to provide re-training and/or assessment to staff; this may be following an RTC, or a number of minor incidents, or may be associated to extensive periods away (6 months or more) from driving for NIAS related work purposes. The provision of such training or assessment will be determined on an individual basis.
- Any drivers who, after assessment do not meet the required standard will be suspended from driving duties and a remedial action plan created with training delivered. Reinstatement of driving duties will be subject to satisfactory re-assessment an approved and accredited driving instructor.
- Any appeals as to the decision of a driver assessment will be dealt with on an individual basis by the Clinical Education Manager.

4.8 Mobile Devices:

- Mobile devices must not be used whilst driving as it is illegal. This includes messaging, and whilst stopped in traffic, unless the phone is being used to call 999 (or 112) in a genuine emergency where it is unsafe or impractical to stop.
- The Trust will ensure that when employees and volunteers are required to drive on behalf of the Trust and use a mobile device, this is done within the law and under the safest conditions possible.
- Drivers must be aware though that using a mobile device under any circumstances (including hands free) whilst driving may still distract attention from the road and must not be used without justification to avoid any unnecessary distraction. It remains the driver's responsibility to ensure that the standard of driving is not detrimentally affected by such activity. Failure to do so could leave the driver open to prosecution for dangerous or careless driving.

4.9 Fatigue:

- Driving when tired can greatly increase the risk of collision. Irregular work and shift patterns increase the risk of fatigue, and alertness is reduced if you drive at times when you would normally be asleep. Driving for long periods in monotonous conditions can promote tiredness. Drivers must ensure they are fit to drive before undertaking any type of driving, particularly emergency response driving.
- The Trust recognises the importance of guarding against fatigue and stress to protect the health and safety of those driving on behalf of the Trust, patients, other road users and third parties.
- The Trust will endeavour to ensure that staff receive sufficient time off throughout the working week to avoid excess fatigue and stress. There may be exceptions to this when the Trust is under extreme pressure, however all reasonable measures will be adopted

by the Trust to avoid this. Staff should alternate driving duties during shifts where possible (see Section 3.11 regarding HCPC requirements).
- Driving for this purpose is defined as: being in control of a moving vehicle and does not include sitting in a stationary vehicle whilst on standby.

4.10 Driver Assessments & Driver Risk Assessments:

For all staff driving Trust vehicles, the Trust will carry out a Driver Assessment under the following circumstances:

- A return to operational driving following a period of absence or alternative duties (6 months or more).
- A self-referral made by a member of staff.
- A transfer from another Trust/organisation.
- Any period of absence which has been due to a licence being revoked and subsequently reinstated by the DVLNI for medical fitness to drive reasons.

A Driver Risk Assessment (Appendix 1) will be carried out at the following triggers:

- A serious incident causing substantial damage or harm.
- Two vehicle related incidences resulting in any exterior vehicle damage within a six month period.
- Six or more penalty points on the driver's licence.
- A near miss that had the potential for serious harm.
- A driving related complaint has been received by the Trust.
- A self-referral following the identification of a personal training need.

The Trust will determine the appropriate intervention from the details of the incident and the drivers complete driving history in conjunction with the Driver Risk Assessment and Behavioural Based Safety Self-Assessment. Driving history includes all driving, i.e. personal and at work driving.

The Trust recognises that personal circumstances can impact upon their quality of driving and where this is the case, the Trust will provide the appropriate health and wellbeing support.

In the first instance the line manager at a local level will carry out an information gathering exercise and commence the Driver Risk Assessment. The line manager may seek advice from the Driver Training Team / Risk Management Team or escalate to the Clinical Education Manager as necessary. Where further similar incidents continue to occur, advice should be sought from the driver training team on the appropriate intervention.

Assessments and reassessments will be recorded on the employee's file.

4.11 Risk Management & Risk Assessment:

- The Trust will ensure that suitable and sufficient assessment of risk to the health and safety of its staff, including all risks to which they are exposed to while driving for work purposes are carried out. These risk assessments will be regularly monitored and reviewed for any required changes.

- A dynamic risk assessment must be carried out by the driver for each occasion where an emergency or non-emergency drive is to be conducted. Consideration should be given to:

    - The suitability and characteristics of the vehicle to be driven.
    - The ability of the driver and experience.
    - The nature of the journey.
    - Environmental conditions.
    - Road conditions.
    - Traffic conditions
    - Patient needs.
    - Staff/medical staff tending to patients in the rear of the vehicle.

All driving-related accidents or incidents must be reported in order that the Trust can meet its responsibilities for investigation purposes to determine the cause, and what preventive or supportive further actions can be taken to reduce the risk.

4.12 Driving Licence Checks & Declaration of Endorsements:

- Driving licence checks will be carried out on a 6 monthly basis (or annually for grey fleet drivers). This is applicable to all staff members who drive directly for, or on behalf of the Trust. This also applies to all voluntary and third-party contractors who drive on behalf of the Trust (as set out in contract documentation).
- Drivers must produce both parts of their licence upon request, within two weeks of being asked. Photocopies are not acceptable.
- If the drivers' licence has not been surrendered for inspection after the two-week time frame a second request will be made. Failure to surrender the driver's licence for a second time will result in the driver being suspended from driving duties. The only exception to this is if the licence has been lost or sent away for renewal/replacement. A reasonable timeframe will be permitted for surrendering the licence, dependent on current wait times/delays of the DVA.
- Drivers MUST declare any new endorsements or fixed penalty charges they receive. Failure to do so may result in disciplinary proceedings being initiated.
- Drivers must declare any bans or disqualifications, or changes to their driving category entitlements. Failure to do so may result in investigation under the Trusts Disciplinary Procedure.

4.13 Notices of Intended Prosecution (NIP):

- Staff must report any Notices of Intended Prosecution (NIP) to their line manager, Human Resources and the Fleet Manager, prior to the commencement of the next shift.
- Notices of Intended Prosecution (NIPs) will be reviewed by the line manager.
- Where NIPs are received and no appropriate rationale can be claimed or supporting exemption evidence is available, the incident will be investigated, and appropriate action taken.
- All NIPs received will be reviewed and audited against the Trusts Driving Policy standards. Where the policy standards are not met, an investigation will take place and appropriate action taken.

4.14 Fuel Efficiency:

- Fuel efficient driving can reduce consumption by 15%. Driving fuel efficiently means; less stress for drivers, safer driving, better standards, reduced wear and tear on vehicles and reduced operating costs. Reliable and economical fuel efficiency is a mark of professional driving.

4.15 Public Eye:

- Drivers must act in a courteous and considerate manner to other road users, portraying a positive and pro-active approach to members of the public and colleagues. Policy and Procedures in place for the management of complaints to be adhered to. Confrontation is to be avoided.

4.16 Professionalism:

- All drivers are to drive with the utmost due care and attention within the law and use defensive driving skills to avoid any RTC. Many RTCs are caused by driving too fast, reversing and rushing. If you feel you require additional training or advice on driving techniques or health and safety, please advise a Line Manager.

4.17 Environment:

- Drivers are to consider the effect on the environment and take every care to protect and minimise any damage against it. This includes pollution from fuel engines, noise, spillage, litter, damage to grass verges and trees.

5.0 - IMPLEMENTATION OF POLICY

5.1 Dissemination:

With regards to dissemination this Policy will be:

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

5.2 Resources:

- Information contained within this Policy / SOP will be made available to new employees at the commencement of employment, at employee induction programmes, and via information leaflets.

- For existing employees, information and training will be available through clinical updates, Health & Safety Training sessions, Risk Assessment Training sessions and ESR annual mandatory training in accordance with Trust Policies.

- The development of a specific cohort of staff to conduct Road Traffic Incident Investigation is under consideration at the time of publication.

- Line managers will be responsible for ensuring compliance with the Trust / organisation training matrix.

5.3 Exemptions:

There are no exemptions from the operation of this Policy / SOP.

6.0 - MONITORING:

- Regular monitoring and auditing of the Trust Driving policy will be undertaken.
- Managers of the Clinical Education Department will follow IQA (internal quality assurance) and EQA (external quality assurance) policy in relation to auditing driver training programmes for educational compliance against driving standards regulations.
- The 'High Speed' register will be monitored regularly by Clinical Education Department who will then escalate any issues/concerns to the appropriate Director or SMT for action.
- Audits and inspections of driving standards will be performed by approved driving assessors and/or driving instructors. The findings and recommendations will be reported to all relevant managers, who will then be reporting to relevant Directors for communication via SMT to Trust Board.
- Driving incidences and vehicle damage will be investigated / reviewed. Findings will be recorded and actioned accordingly, in accordance with this policy and other approved Trust policies.
- Responsibilities will be checked through performance review.

7.0 - EVIDENCE BASE/REFERENCES:

The primary legislation governing road safety is the Road Traffic (NI) Order (1995), which is supported by the Highway Code. Health and Safety legislation also places a legal duty on the Trust as an employer to provide employees with a safe working environment, and to assess any work-related risks. **This applies to employees driving on the road in the course of their employment.**

Legislation relevant to this policy:

- The Health and Safety at Work (NI) Order 1978.
- The Management of Health and Safety at Work Regulations (NI) 2000.
- The Workplace (Health, Safety and Welfare) Regulations (NI) 1993.
- Provision and Use of Work Equipment Regulations (NI) 1999
- Working Time Regulations 1998.
- Motor Vehicle Driving License Regulations (NI) 1996.
- Motor Vehicle Wearing of Seatbelts Regulations (NI) 1993.
- Motor Vehicle (Speed limits) Regulations (NI) 1989.

- Motor Vehicles (Speed Limit Restrictions) (Exemption) Regulations (NI) 1998.
- Road Vehicles (Traffic) Regulations 1933.
- Roads (NI) Order 1993.
- Road Vehicle (Display of Registration Marks) Regulations 2001.
- Road Vehicles (Registration and Licensing) Regulations 2002.
- Road Traffic Offenders (NI) Order 1996.
- Criminal Justice (NI) Order 1994.
- Road Traffic Order (NI) 1995.
- A Guide to Workplace Transport HS(G)136.
- The Highway Code (www.highwaycode.gov.uk).

8.0 - CONSULTATION PROCESS:

This Policy has been developed by the Clinical Education Department, the Risk Management Team and the Fleet Manager. Consultation took place with Trade Unions, Senior Managers, Assistant Directors and Directors within the organisation. The final content of the document was agreed at Health and Safety Committee (27/10/22), SMT (21/11/23) and Safety Committee (25/1/24).

9.0 - EQUALITY STATEMENT

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

9.2 The outcome of the equality screening for this Policy undertaken on 19th October 2022 is:

Major impact ☐
Minor impact ☐
No impact. ✓

10.0 - SIGNATORIES



Katrina Keating **Date: 30th March 2023**
Lead Author



Maxine Paterson **Date: 30th March 2023**
Lead Director

APPENDIX 1 – DRIVER RISK ASSESSMENT TEMPLATE:

Name:		**Line Manager Name:**	
Role:		**Driving Tutor Name:**	
Vehicle Type / Registration:		**Date Completed:**	
Further Action:	**No**	**Yes (See Action Plan):**	

DRIVER							
	Check:	**Low (1)**	**Med (2)**	**High (3)**	**Extreme (4)**	**Score**	**Considerations**
1	Age	31-64	Over 65	22-30	17-21		
2	Time with NIAS / Other NHS Ambulance Service	24+ months	12-24 months	4-11 months	0-3 months		
3	Number of years licence held (C1 and / or B)	10+	6-9 yrs	2-5 yrs.	<2 yrs.		
4	Penalty points/endorsements/convictions (last 5yrs.)	0	1-5 points	6-8 points	9+ points		
5	Number of driving disqualifications (drink / drug offences involved (last 5 years)	0	-	-	Yes		
6	Number of vehicle related incidents (non-fault / third party) in last 5 years	0-2	3	4	5+		
7	Number of vehicle related incidents / damage (at fault) last 5 years	0	1	2	3+		
8	Eye sight test within last 2 years / able to read a number plate at 20m	Yes	No	-	-		
9	Undertaken NIAS approved driver training / assessment	<5yrs	5-6yrs	6-7yrs	7yrs+		
10	Behavioural Based Driver Safety Self-Assessment Rating	0-6	7-15	16-24	25-42		
	Total Score						

VEHICLE							
	Check:	Low (1)	Med (2)	High (3)	Extreme (4)	Score	Considerations
11	Vehicle type	Car / van (non response)	PCS	Response Car	A&E / NISTAR		
12	Reversing assistance / equipment	Rear sensors, reversing cam	Reversing camera	Rear sensors	None		
13	Active safety systems	Brake assist / lane assist	Brake assist only	Lane assist only	None		
	Total Score						

ROUTE							
	Check:	Low (1)	Med (2)	High (3)	Extreme (4)	Score	Considerations
14	Miles per annum (both personal and business)	<10K	10–15K	15-30K	More		
15	Predominant driving environment	Entirely rural	Mostly rural	Mostly urban	Entirely urban		
16	Typical journey duration (excluding breaks)	<1hr	1 – 2 hrs	2 – 4 hrs	4+ hrs		
17	Typical total driving time per day	<2hrs	2 – 3 hrs	3 – 5 hrs	5+ hrs		
18	Typical time spent driving between 20.00 & 06.00 (%) per month	0	<25%	25% - 50%	>50%		The average emergency crew will drive 25-50% between 20:00 & 06:00
19	Typical length of working day	<8 hrs	8 – 10 hrs	11 – 12 hrs	12+ hours		
20	Shift working	No	-	Yes	-		
21	Emergency driving	No	-	Yes	-		
	Total Score						

FINAL QUESTIONS			
Check:	Yes (✓)	No (✓)	Please Comment:
Medically fit to drive (DVLA Medical Requirements)			Occ Health referral in the event of any medical issues
GP advice sought for any conditions such as diabetes, epilepsy, cardiac, substance misuse, psychiatric illness?			Occ Health referral in the event of any medical issues
Have any other relevant health concerns been reported?			Occ Health referral in the event of any medical issues
Is there anything affecting your ability to drive?			
Is there anything else you would like to add?			

Element	Score		Risk	Score
Driver			Low (1)	21 – 36
Vehicle			Medium (2)	37 – 52
Route			High (3)	53 – 68
Total Score			Extreme (4)	69 – 84

ACTION PLAN								
Item / Issue	Risk Rating				Action Required	Person Responsible	Date Completed	Comments
	Low	Med	High	Extreme				

RISK LEVEL	POTENTIAL ACTIONS
Extreme	• Immediate suspension from driving duties. • Clinical Training Manager to assess driver's current standard. • Formal corporate and local monitoring (involving periodic re-assessment).
High	• Driving Instructor / Tutor assessment of driver's current standard. • Formal tuition / retraining as required. • Local monitoring – may involve periodic re-assessment.
Medium	• Driving Instructor / Tutor assessment of driver's current standard. • Local monitoring by Line Manager.
Low	• No action required at this stage.

APPENDIX 2 – BEHAVIOURAL BASED DRIVER SAFETY SELF-ASSESSMENT:

Name:		**Line Manager Name:**	
Role:		**Date Completed:**	
Further Action:	**No**	**Yes (See Action Plan):**	

	LAPSES				
	Do you sometimes:	**Answer**		**Score**	**Total**
1	Pull away in third gear?	Yes (1)	No (0)		
2	Choose the wrong lane for your exit at a roundabout?	Yes (1)	No (0)		
3	Forget where you left your car at a car park?	Yes (1)	No (0)		
4	Have no recollection of the road you have just travelled on?	Yes (1)	No (0)		
5	Select the wrong gear for the road speed?	Yes (1)	No (0)		
6	Switch something on when you meant to switch something else on?	Yes (1)	No (0)		
	ERRORS				
	Do you sometimes:	**Answer**		**Score**	**Total**
7	Fail to see a stop and give way sign?	Yes (2)	No (0)		
8	Fail to see a cyclist?	Yes (2)	No (0)		
9	Fail to notice a pedestrian?	Yes (2)	No (0)		
10	Fail to look in the mirror before manoeuvre?	Yes (2)	No (0)		
11	Incorrectly estimate the speed of oncoming vehicles when overtaking?	Yes (2)	No (0)		
12	Brake too harshly?	Yes (2)	No (0)		
	VIOLATIONS				
	Do you sometimes:	**Answer**		**Score**	**Total**
13	Disregard the speed limit late at night or early morning?	Yes (4)	No (0)		
14	Proceed through traffic signals when on amber?	Yes (4)	No (0)		
15	Drive close to the vehicle in front to speed them up when in a rush?	Yes (4)	No (0)		
16	Drive even though you realise that you may be over the legal blood alcohol limit?	Yes (4)	No (0)		
17	Indicate to other motorists, by gesture, that you are unhappy with an action they have performed?	Yes (4)	No (0)		
18	Travel in excess of the posted speed limit?	Yes (4)	No (0)		
	OVERALL TOTAL SCORE				

CRASH INVOLVEMENT RISK		**ACTIONS**
Low	0 – 6	No action required at this stage.
Medium	7 – 15	Driver Risk Assessment to be conducted
High	16 – 24	Driver Risk Assessment to be conducted
Extreme	25 – 42	Immediately contact the Clinical Training Manager for advice and Driver Risk Assessment to be conducted

Acknowledgements:
Professor Lisa Dorn – Reader Driver Behaviours Cranfield University
Professor Stephen Straddling – Psychologist in Drivers Behaviours, Manchester University.
Paul Jones-Roberts – MSc. NPA – Driving Standards Consultant

Standard Operating Procedure

Northern Ireland Ambulance Service
Health and Social Care Trust

SOP: **Driving and Care of Vehicles When Driving on Behalf of the Trust**
Reference: **v1.0**

Reference:	**January 2024 – v1.0**
Produced By:	**Clinical Education Department / Frank Armstrong / Terry O'Neill**
Reviewed By:	**TBC**
Authorised By:	**TBC**
SOP Type:	**Driving Vehicles on behalf of the Trust**
SOP Issue Date:	**January 2024**
SOP Review Date:	**January 2027**
Version log:	

Date	Version	Description	Actioned by
Sep 23	**0.1**	Draft version of initial document	**CED / Frank Armstrong / Terry O'Neill**
Oct 23	**0.1**	Draft shared with TU colleagues (NIPSA, GMB, Unite, Unison) for comment. Comments received and amendments made.	**CED / Paul Corns / Sean Kelly**
21/11 23	**0.2**	Draft version shared with and presented to SMT for review and comment.	**CED /Paul Corns / Sean Kelly**
Jan 24	**0.2**	Final edits, addition of appendix 6.	**CED / Paul Corns / Sean Kelly**
16/1/24	**1.0**	Version 1.0 presented to Safety Committee for final approval prior to dissemination	

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Standard Operating Procedure

Northern Ireland Ambulance Service
Health and Social Care Trust

SOP: **Driving and Care of Vehicles When Driving on Behalf of the Trust**
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RELEVANCE OF SECTIONS TO GROUPS:

Section 1 – All staff who drive on behalf of the Trust.

Section 2 - Emergency Response Driving (ERD) procedures are for those who drive under emergency conditions;

- Accident & Emergency
- PCS (NISTAR)

Section 3 – Non Emergency driving procedures for the following staff/personnel;

- Accident & Emergency
- PCS
- Fleet
- Stores
- IAS
- BASICS
- Volunteer car drivers

SOP: **Driving and Care of Vehicles When Driving on Behalf of the Trust**
Reference: **v1.0**

Driving on behalf of the Trust	
1.1	The Trust **MUST** satisfy itself that all drivers meet the required standards in driving commensurate with their job role.
1.2 – VDI	
1.2	The driver is responsible for ensuring that the vehicle is in a roadworthy condition. Trust drivers are required to check their vehicles to ensure they comply with the law and service standards & procedures before undertaking any driving duties. (Appendix 1, VDI Check).
1.2.1	If a full VDI is not practicable, basic roadworthiness checks must be completed prior to driving a trust vehicle (see appendix 6). This is a legal responsibility of the driver. These include, at a minimum, a visual inspection check of wheels, tyres, brakes, windows/wipers/washers, all vehicle lights and emergency audible/visual warnings. A full VDI should be completed at the earliest opportunity thereafter.
1.3	The driver is responsible for completing the vehicle defect form and submitting it to their line manager following completion of the VDI, or at any other stage if required.
1.4	The driver where possible should seek to rectify the problem by contacting line manager, EAC, maintenance department, or outside contractors.
1.5 BREAKDOWN – In the event of a breakdown, the following actions should be taken	
1.5.1	Where possible stop the vehicle where it presents minimum hazard to other road users.
1.5.2	Contact EAC/NEAC and give details of your location if necessary.
1.5.3	If on a motorway the driver and any passengers should alight where possible, and reasonably practicable (i.e. people requiring stretcher-based care should remain secured in vehicle), from the vehicle via the left hand doors. (Highway Code (HWC) 275).
1.5.4	Every warning should be given to other road users of the hazard by displaying the vehicles hazard warning lights and the wearing of Hi-Visibility clothing.
1.5.5	If the vehicle has created a hazard which may effect the safety of other road users, pedestrians etc, the police should be informed when safe to do so, or via request a to EAC.
1.5.6	Remain at the scene until assistance has arrived, if the fault has been rectified before the requested assistance arrives, EAC must be

	informed immediately.
1.5.7	On a motorway do not even attempt simple repairs, wait for breakdown service to arrive.
1.5.8	If you are not on a motorway, place the hazard warning triangle where available (applies to 'grey fleet' users) at least 50 metres behind the vehicle and in a position where oncoming traffic will see it. If your vehicle has stopped around a bend or over the crest of a hill ensure that the hazard warning triangle is placed where oncoming drivers will see it before the bend or hill. Ensure your own safety at all times.
1.6 – INCIDENT REPORTING AND INVESTIGATION	
1.6.1	Anyone driving on behalf of the Trust are responsible for complying with the law when reporting any road traffic collision. The following procedures **MUST** be followed in the event of an accident.
1.6.2	If involved in an accident/incident the driver MUST stop and provide on request of any persons having reasonable ground for doing so: • His/her name and address • Registration, make, and call sign of vehicle • Insurance details for injury incident *(if insurance details are not readily available, persons requesting should be directed to Fleet Management with contact number provided)*
1.6.3	The responsibility for compliance with the legal requirements is the drivers and may not be delegated to any other person, such as the attendant.
1.6.4	There is no legal exemption from leaving the scene of a road traffic collision (RTC), even when engaged on an emergency call. Ambulance Control should be informed immediately following involvement in an RTC in order to allocate another vehicle to the original call if appropriate.
1.6.5	Whilst drivers can become stressed or agitated following an RTC, no matter what the circumstances or provocation, NIAS staff **MUST NOT** admit to liability at scene.
1.6.6	**Reporting to police** -There is a legal responsibility on the driver to report the incident to a police constable or at a police station as soon as possible and, in any case, within 24 hours as this is the absolute maximum time permitted. 'As soon as possible' means without avoidable delay. To report at the end of your shift might not be 'as soon as possible'.

1.6.7	If Police arrive at the scene the driver is to comply with any request e.g. a Breathalyzer, drug test and completion of statements. No statement is to be made to any other person (s). The vehicle or components resulting from the accident should not be moved until permission is given by the Police. If in doubt seek advice from line management /EAC.
1.6.8	If there is any doubt as to the roadworthiness of the vehicle or the driver's ability to drive after an RTC then this should be conveyed to the supervisor, line manager or EAC/On Call Officer immediately.
1.6.9	Should the owner of a vehicle or property not be available; the driver **MUST** wait a reasonable time (depending on the condition of the patient) to enable any interested party to arrive at the scene. The law does not state what 'a reasonable time' is, but the driver must be able to justify their actions later if required to do so.
1.7.0	It is the responsibility of the driver (or if injured) the attendant of the vehicle involved in the incident (or the first manager on the scene if the driver and attendant are incapacitated) to ensure that Control are informed immediately. If a patient is being transported in the vehicle whilst involved in incident, the crew must ensure continuity of care, and request via EAC a further vehicle to continue patient transport and/or care. It is the driver's responsibility to comply with the legal reporting procedures as stated in the Highway Code rules 286 and 287, Road Traffic (NI) Order Article 175 & 176.
1.7.1	Whenever a serious incident occurs, or extensive previously unreported damage to a Trust vehicle is found, the incident will be investigated by the relevant Manager, in conjunction with the Risk Manager and Clinical Education Manager.
1.7.2	For every incident in which a service vehicle is involved the Trusts Incident and Reporting procedures (Datix, personal injury, vehicle accident form, insurance incident report forms) **MUST** be complied with and all documentation completed as soon as possible, or at the latest, at the end of the shift, except in exceptional circumstances.
1.7.3	Statements should be clear and concise but with as much relevant detail as possible. If there is insufficient room on the incident report for all the details, use an additional sheet(s) of paper. If this is done, the relevant section should be marked "see attached sheet". Verbal admissions by other parties to the incident should be shown in the statement in block letters and in inverted commas, e.g. "I'M SORRY, IT'S ALL MY FAULT".
1.7.4	**All incidents, no matter how trivial, should be reported (see appendix 4)**

1.7.5	The Senior On-call Officer will be informed in cases of serious incidents that result in fatality or serious injury to any person involved in the incident. This will also apply to any other incidents if the on-call officer or Control considers it appropriate.
1.7.6	The driver of the vehicle may be immediately suspended from driving duties pending an investigation into the incident. This would be based on the seriousness of the incident and may be made by the senior on-call officer, in discussion, where possible, with a Trust Driving Instructor and/or Clinical Education Manager (see also 1.8.4)
1.7.7	Ambulance Control will arrange for the attendance of an On-call Officer where necessary.
1.7.8	In the event of a serious incident occurring which Involves a Trust vehicle an investigation will be conducted to ascertain facts relating to the incident. The Clinical Education Manager may, when appropriate, appoint a Driving Instructor or suitably qualified person to conduct an investigation of the incident and produce an incident report. This will also include data from the vehicles telemetry and CCTV system. The incident report will include an assessment of whether the incident should be adjudicated as "attributed" or "not attributed" against the member of staff involved. PSNI may also chose to investigate a driving incident through a separate process. Staff are expected to engage with all relevant PSNI investigations into driving incidents.
1.7.9	In such incidents the information obtained from the investigation and any recommendations will be provided to the individual's line manager, which would then inform the suitable actions required to prevent a reoccurrence, as far as practically possible. This may be in the form of reviews of safety processes, additional training requirements or disciplinary action when deemed appropriate.
1.8.0.	An incident will be assessed 'attributed' where the larger proportion of accident cause accrues due to the member of staff. Where no, or minimal cause is attributed to the member of staff, the incident will be recorded as 'not attributed'.
1.8.1	If the driver on adjudication is 'attributed', a recommendation will be included on the degree of responsibility which should be attached to the member of staff. This will be recorded on the staff members driving record (*See, Driving History Records, below).* Any decision to relieve a member of staff from driving duties will be made in the normal way using the guidelines set out below.
1.8.2	When an incident occurs outside the NIAS boundaries the incident must be reported to the local police / Garda. In addition, the driver will inform their own ambulance service through Control for assistance.

1.8.3	If it is the opinion of a Driving Instructor that an employee should be removed from driving duties, a detailed account of how and why the decision has been reached **MUST** be produced without delay. Instigating this action will have serious implications surrounding operational cover and the terms of the employment of the employee, so will not be taken lightly.
1.8.4	Where the Driving Instructor relieves the driver from driving duties they **MUST** inform the Line Manager, Resource Management Centre (RMC) and Control. This should only be instigated if the officer believes that to allow the employee to continue driving would represent an unnecessary and unacceptable risk to the Trust. The Driving Instructor will, where practicable, discuss this decision with the Clinical Education Manager and/or Operations Manager prior to implementation to ensure shared oversight of the decision.
1.8.4.1	If the driver involved is a member of PCS he/she may be transferred to an operational environment where the driving/non driving requirements are more suited to their skill level. This is dependent upon a suitable position being available, which may be assessed on a case-by-case basis where appropriate. Operations management should consider the risk of driving fatigue for staff supporting non-driving staff member when resourcing vehicles.
1.8.4.2	If it is a Paramedic that has to refrain from driving duties, they may act in the role of attendant on non-driving duties on a double crewed ambulance. This is dependent upon a suitable position being available, which may be assessed on a case-by-case basis where appropriate. Operations management should consider the risk of driving fatigue for staff supporting non-driving staff member when resourcing vehicles.
1.8.4.3	If it is an EMT/AAP, they may be deployed to non driving duties on PCS tier (with any gaps in training provided.) This is dependent upon a suitable position being available, which may be assessed on a case-by-case basis where appropriate. Operations management should consider the risk of driving fatigue for staff supporting non-driving staff members when resourcing vehicles.
1.8.5	The suspension from driving duties will apply until: • A full investigation is conducted as per Trust policy. • All recommendations have been successfully completed following the Accident Investigation report /Driving assessment report (any suspension from driving duties will have no detriment to remuneration or

	conditions of pay pending the outcome of investigations)
1.8.6	A driver who has been relieved from driving duties may be directed to take an assessment before reinstatement. In addition to the driving assessment, they may also be required to undertake health assessment and/or or a written test and/or other assessment process as deemed necessary to address the cause(s) of the original incident(s).
1.9	Less serious incidents will not require an investigation. The incident report form will usually suffice in the allocation of liability. Should the report contain insufficient information the operational manager and/or Risk Manager through the Clinical Education Manager may request a Driving Instructor to obtain additional information from the driver to determine accountability.
1.9.1	Drivers accumulating a history of driving incidents will have their driving assessed by a Driving Instructor (Occupational Road Risk and Fleet Safety Policy section 4.10 outlines risk stratification of incidents and suitable driving history triggers). The Clinical Education Manager, in conjunction with a Trust Driving Instructor will agree an action plan highlighting any appropriate action to be taken to prevent re-occurrence. This will be forwarded to the relevant line manager.
1.9.2	Any previous incident(s) a driver has been involved in, should be detailed on the insurance incident report form if requested to do so. This includes the driver's personal motor insurance policy should they have one. This process works in reverse as well i.e. 'At work' road traffic incidents are reportable to your private motor policy provider.
1.9.3	You **MUST** inform your manager immediately of any legal action following an incident whilst on or off duty. This should include the receipt of any documents relating to a prosecution, or intended prosecution, and the resultant decision of the Court.
1.9.4	It is anticipated that ambulance staff summoned in respect of traffic offences whilst on duty will seek to be represented by the Solicitor of their trade union. If representation in this way is not possible and the circumstances are such that the Trust may offer legal representation, the relevant manager should be asked to enquire whether assistance could be obtained.
1.9.5	Should a criminal charge be raised against an employee for a driving offence (i.e. Dangerous or Careless Driving), the Trust may maintain a full driving suspension until such time as the Police / Public Prosecution Service had reached a decision, and if deemed appropriate the case had gone through the Court system. Only under exceptional circumstances would this suspension be lifted prior to the above.

1.9.6	Where incidents of poor driving standards are reported from any source, even when no collision or damage has occurred (near misses), the incident will be investigated by a Trust Driving Instructor, including a review of telemetry/CCTV from the vehicle, where possible. This may also include a non-operational Driving Competency Review (DCR) and following this may require remedial action to be taken.
1.9.7	An "incident record summary" (IRS) against individual drivers will be kept as all vehicle incidents are reported through the Risk Manager/Incident reporting procedure. The IRS will contain a summary of the incidents. The driver's full history could be taken into account when any remedial training plans are created.
1.9.8	The Risk Manager will provide an overview of the incidence and causation of ambulance incidents. Analysis of the detailed information included on the revised statistics form will enable: • The identification of training needs for consideration by the CEM. • The analysis of trends in driver behaviour and driving standards for the identification of any need for additional or modified driver training.
1.9.9	A member of staff finding damage to a Trust vehicle during the pre-drive VDI, that has not been previously reported (in vehicle defect book or to a line manager) **MUST** immediately inform their line manager or Ambulance Control and comply with the NIAS incident reporting procedure. The line manager should then initiate an investigation into the damage and link with the risk manager.
1.9.10	When there is a reason to believe that damage found is the result of a crime, the reporting member of staff will ensure that the incident reporting procedure is followed, and the crime is reported to their Line Manager immediately.
1.10	Where the vehicle is suspected to have a defect rendering it "unroadworthy", that vehicle must be recovered and removed from service and it will be the responsibility of the Fleet Manager to ensure that an appropriate mechanic, appointed by the Trust, inspects the vehicle as soon as practically possible and reports on their findings before the vehicle can be returned to service.
1.11	Any person injured whilst travelling in, operating, or being loaded / unloaded from any Service vehicle -The Trusts Incident and Reporting procedures (Datix, vehicle accident form) MUST be complied as soon as is reasonably practicable.

SOP: **Driving and Care of Vehicles When Driving on Behalf of the Trust**
Reference: **v1.0**

1.12 – DRIVING RECORDS	
1.12.1	All relevant NIAS staff who have been authorised by the Trust to drive Trust Vehicles and or on behalf of the Trust, will have a NIAS driving record stored on the training records database alongside a High-Speed Register (see ORRFS policy 4.2), where applicable. (High-Speed Register under development at time of publication)
1.12.2	The driving record will include: details of driver training and/or assessment dates, substantiated complaints regarding driving issues, and any previous actions or interventions in relation to the individual's driving history.
1.13 - GENERAL GUIDANCE	
1.13.1	In the event if there is a fire in a Trust vehicle, staff should adhere to NIAS SOP Ambulance Fire Evacuation
1.13.2	Mobile devices **MUST** not be used by the driver whilst the vehicle is in motion unless it is placed in a correctly working hands-free mobile device. This includes whilst stopped in traffic and texting. The use of a mobile device **MUST** not distract the driver of the vehicle from being able to comply with their duty of care whilst driving.
1.13.3	The MDT screen **MUST NOT** be operated by the driver whilst the vehicle is in motion, as this may distract the driver's vision and attention from the road. In the case of solo responders, control should only transmit information to the vehicle via the MDT screen if it is stationary. If the vehicle is mobile, then all information should be passed through the Radio Telephone (RT).
1.13.4	Drivers who wear spectacles to correct their vision should carry, where available, a spare pair at all times. Drivers who wear contact lenses to correct their vision should carry, where available, a spare set of lenses or pair of spectacles at all times. It is the individual's responsibility to have regular eyesight tests.
1.13.5	Tinted spectacles may only be worn during bright sunlight or when vision has been reduced by adverse glare or reflection. The wearing of such (non-prescription) spectacles could be dangerous in other conditions because loss of vision might result in a developing or existing hazard not being readily seen.
1.14	**Reversing - Double-crewed vehicles** - Prior to reversing, the driver and attendant **MUST** agree a safe path for the vehicle to take. The attendant is to act as "Banksman" and the vehicle is not to be reversed until he/she has checked that the area into which the vehicle is to travel is clear. Always wind your window down before reversing and listen to

	the banksman, as well as watching. The banksman **MUST** first put on a service high visibility tabard (fastened) and then stand in a position from which they can best be seen and heard by the driver in their rear view mirrors. Verbal instructions alone are inadequate as they may be drowned by the vehicle engine or other noise. The banksman should ensure that their view of the driver does not become restricted. Eye contact **MUST** be maintained between the driver and banksman at all times. If the driver loses eye contact of the banksman they **MUST** stop the vehicle. Where the attendant is working with the patient and cannot assist the driver, the driver should ensure the route is clear from danger before continuing, single manned.
1.14.1	**Single crewed vehicles** - The driver should take the opportunity to fully assess the space to be reversed into when approaching / passing it. The vehicle is not to be reversed until the driver is satisfied that the way is clear and sufficient space exists for the manoeuvre to be completed safely. Even then, particular care is to be taken in case a person approaches unseen behind the vehicle. On ambulance stations and hospital premises, other members of the Ambulance Trust are often present. It is reasonable to request suitably knowledgeable colleagues to assist with reversing manoeuvres for single-crewed vehicles. . The driver has full responsibility for the safety of the manoeuvre in these circumstances.
1.14.2	**It should be remembered that all reversing manoeuvres must be carried out at very low speeds and, where fitted, the reversing alarm and reversing cameras should be used. The Highway code states you MUST NOT reverse your vehicle further than necessary.**
1.15	**Refueling of vehicle** -It is the responsibility of the driver to ensure that the vehicle has adequate amounts of fuel. The driver **MUST** consider refuelling at the earliest convenient time when the fuel gauge falls below halfway. Staff should ensure refuelling of the vehicle is completed prior to the end of their shift unless operational pressures do not allow, and this has been agreed with an Ambulance Control Officer.
1.15.1	Prior to refuelling it is the driver's responsibility to ensure the fuel station accepts NIAS fuel cards. Vehicle mileage **MUST** be given to the fuel station on every transaction and staff have a duty to ensure the most cost-effective fuel is purchased where possible. **Disposable gloves MUST be worn** in line with the Trusts Health and Safety Policy.
1.15.2	Staff should check fuel type prior to refuelling. Should an error of this nature occur, staff should not start the engine. They **MUST** then contact their respective control centre to arrange recovery.

1.15.3	Disciplinary action may be taken against individuals for each occurrence of an incorrect refuelling incident under the NIAS disciplinary procedure.
1.16	**Wearing of seat belt** -Drivers and all passengers in ALL vehicles are required by law to wear seat belts. In Ambulances, rear seat belts may be removed if ***"a person riding in a motor ambulance while that person is providing medical treatment which due to its nature or the medical condition of the patient cannot be delayed***." The motor vehicles (wearing of seat belts) (Amendment) Regulations (Northern Ireland) 2020. Staff should not remove seatbelts for other purposes, such as donning or doffing PPE. **Rear seats in Ambulance vehicles MUST always be forward/rearward facing to ensure the seatbelts are effective, and seatbelts worn at all times.**
1.16.1	Occasions where a seat belt does not legally require to be worn (outside of providing medical treatment outlined in 1.16) are very rare and would only be from the following list: • If you are carrying out a manoeuvre which includes reversing • If you have a valid medical exemption certificate verified by the Trust • If your seat belt has become defective on your journey and you are en-route to have it repaired. • If you are pregnant
1.16.2	The responsibility for wearing a seat belt rests with each individual if over the age of 14. It is the driver's legal responsibility to ensure that any child between the age of 12 and 13 or over 1.35 meters tall wears a seat belt, and any child under that age or height wears the appropriate child restraint. Failure to do so could result in a prosecution of the driver. (H/C, NI 99 & 100, MV(WSB)R 1993) If a patient or escort refuses to wear a seat belt ambulance control **MUST** be informed immediately. Care should be taken when alighting from a vehicle that the seat belt has returned and it is not causing obstruction, or tripping hazard.
1.16.3	**When engaged on all ambulance transportations all patient securing devices fitted or supplied by the Trust i.e. "Six Point Trolley Harness / Pedi-Mate / KangooFix / Child Seats, etc MUST be used. Wheelchairs MUST be secured with the appropriate and approved system, and all staff MUST be trained prior to securing a wheelchair.**
1.17	**Rough ground [off paved roadway/hard standing] -**When property is entered all reasonable instructions of the owner / inhabitant should be accepted and steps taken to avoid damage to premises or property consistent with the assistance to, or recovery of, the patient. **YOU** the

	driver are solely responsible for the safe entry and exit of the vehicle and as a result **MUST** be entirely sure that this can be achieved. If you are unsure of the security of any surface, perform a risk assessment on foot prior to driving on any uncertain terrain.
1.18	All NIAS vehicles should be left at the end of use in an immediately usable condition. The exception being, if the vehicles driver has received permission from a control officer not to do so due to operational pressures. It is the responsibility of the controller to record this instruction on the daily occurrences report.
1.19	When intending to leave the vehicle, the driver should bring it to rest in the safest and most convenient position, close to the kerb if on a road. An automatic gearbox should be left in `P' position and with a manual it may be desirable to select either first or reverse gear when parking on a gradient. The vehicle should be properly secured if it is to be left unattended. All reasonable precautions **MUST** be taken to ensure the safety of the vehicle and its equipment and to prevent it being driven away by unauthorised persons. When parking on a hill, staff should follow the advice on Highway code rule 252.
1.19.1	Run-lock' is fitted to most front line vehicles. Once at scene, press the 'run- lock' button (arrived at scene), this allows the engine to remain running and the ignition key/fob to be removed, the engine will automatically cut out should the doors be opened, or the handbrake is released. This option should be used whenever possible as it allows emergency lighting to remain illuminated and use of the vehicle tail lift / hoist without discharging the batteries.
1.19.2	On all occasions when a vehicle without 'run-lock' fitted is left unattended away from its station, the engine **MUST** be switched off and the ignition key/fob removed. Keys/fob should not be removed from the ignition when at a major incident.
1.20	Vehicles left unattended or parked at designated ambulance stations should, where available, be connected to a charging "shore" line. Keys should be removed and placed in the designated key safe. It is the driver's responsibility to ensure the "shore line" is ejected prior to driving the vehicle. If the "shore line" does not eject the driver should isolate the shoreline then manually remove it prior to driving off and report the defective shoreline to their line manager.
1.21	In no circumstances may an ambulance vehicle be moved with any doors open. Equipment **MUST** be properly secured to avoid injuries to passengers. It is the responsibility of the driver to ensure that all steps are in the (stowed) up position and that all doors are closed before moving off.

1.22	Animals are not to be transported on Trust vehicles except if they are registered disability assistance animals (guide dogs, hearing dogs etc). Where an animal is to be transported by a Trust vehicle an appropriate harness **MUST** be used (supplied by the owner of the animal).
1.23	Outside of emergency response driving anyone driving a vehicle should attempt to reduce vehicle emissions by avoiding hard acceleration or hard/ excessive braking. This will be monitored on Trust vehicles fitted with data recording technology.
1.24	Weather conditions may present as a major hazard, it is imperative that speed is reduced to cope with adverse conditions. Types of conditions that require extra vigilance include fog and mist, snow and sleet, heavy rain and high winds etc. Staff should follow guidance from the Highway Code, and determine the risk presented by adverse weather conditions.
1.25	To drive well you need to remain alert, ready to anticipate, identify and respond to Hazards. Staff should guard against the effects of fatigue by taking breaks and by being aware of the signs of fatigue. In the event of a member of staff becoming fatigued to the point of being unable to drive they should contact ambulance control so that the appropriate measures can be implemented. Ambulance control should contact the relevant line manager or duty officer.
SECTION 2 – EMERGENCY DRIVING	
EXEMPTIONS	
2.1	**Speed Limits** -A vehicle being used for [emergency] ambulance purposes may exceed any statutory speed limit (those governing roads and vehicles) if observance of the limit would hinder the use of the vehicle for its official purpose on that occasion. The exemption could be claimed when travelling to an emergency call, but on the journey to hospital it would not normally be relevant unless the patient's condition justifies the exemption. If this should be the case, the Emergency Ambulance Control (EAC) must be informed.
2.2	The ambulance should always be driven at a speed compatible with the patient's condition. The vehicle **MUST** be driven at a speed whereby the driver can accurately assess, plan and deal with all existing and developing hazards safely. Distractions within the vehicle should be reduced, by, for example, switching off the commercial radio.
2.3	When driving an Automatic vehicle whilst responding to an emergency call the Paddles (TIPTRONIC CONTROLS) (where fitted) MUST be used to provide greater vehicle stability and control. This is also advised in foul weather and when negotiating corners and bends.

2.4 The choice to utilise the exemption from the statutory speed limit must be based upon the constant dynamic risk assessment of the driver, alongside the clinical assessment of the patient's condition and medical requirements. It is not an acceptable excuse to exceed the statutory speed limits only for the fact of responding to an emergency. The category of the emergency may also influence the dynamic risk assessment of the driver.

The following table is not a cap / limit / target and is not intended to replace the skills & attitude given through the standards of driver training in selecting the appropriate speed in the given circumstances. However, it is considered helpful to provide a guide to a reasonable limit which can be used as a general reference point in accordance with prevailing weather and road conditions.

Statutory Speed Limit	NIAS Guidance Limit
20mph	30mph
30mph	45mph
40mph	60mph
50mph	75mph
60mph	90mph
70mph	105mph

2.5 **The DRIVER must be able to justify the speed and manner in which they chose to drive the vehicle at all times, possibly in a court of law. The exemption afforded to the ambulance service does not allow staff to drive at a speed, or in a manner which would amount to driving dangerously or without due care and attention.**

2.6 **Traffic Control Signals** -When approaching a red traffic signal it **MUST** be treated as a 'STOP' or 'GIVE WAY' sign and no attempt should be made to proceed unless the driver is sure the way is clear. Audible and visual warning devices are to alert other road users of your presence, and **MUST** be used, but do not give any *'right of way'* to your vehicle. Only when you, the driver, are absolutely certain that you have been observed by all the other road users and they have reacted in the appropriate / required manner can you proceed onto the junction. Progress through the junction with extreme caution and at a speed appropriate to the prevailing road, traffic and weather conditions.

2.6.1 In order to comply with the above guidance (2.6), your approach speed to any red traffic signal **MUST** be reduced accordingly and you **MUST** not go through a red light at a speed that could cause danger to other road users. In all cases, it is incumbent on the driver to ensure that they are able to stop the vehicle safely within the distance they can see to be clear.

2.6.2 If no advancement can be made due to the volume of traffic, the driver

	should cancel audible warnings, and hold back from the stationary traffic in order to prevent other road users committing a traffic offence by forcing them through a red light.
2.6.3	**Temporary Traffic Signals** –The driver **MUST BE** absolutely certain that he/she is able to negotiate the hazard without causing danger to any other road user. Whilst operatives at roadwork's may be signalling you through, it is you the driver who **MUST** be satisfied it is safe to proceed. Drivers **MUST** ensure the exit from the hazard is clear before proceeding. If the exit is not clear or indeed if the exit cannot be sighted, e.g. on a bend, the driver **MUST NOT** proceed. In this instance the driver **MUST** wait until the signals return to green. Only visual warning lights should be utilized in the instance. Control **MUST** be informed of any prolonged delays.
2.6.4	**Pedestrian Crossings** -Extreme caution **MUST** be exercised at all times on the approach and negotiation of these crossings. You **MUST NOT** proceed until you are completely satisfied that any pedestrians have observed your approach and you have elicited the appropriate response, enabling you to negotiate the hazard safely.
2.6.5	**Island-Passing on the offside (keep left/right signs)** -There are occasions when because of traffic or an obstruction, it becomes necessary for a Trust vehicle to pass on the offside of an island to avoid delay when engaged **on an emergency call**. In these circumstances, the greatest care **MUST BE** exercised.
2.7	**Use of Bus Lanes** -Road Traffic Law (NI) permits Ambulance Service vehicles to use a bus lane for either emergency or non-emergency purposes. Drivers exercising this exemption **MUST** comply with the direction of bus flow lane at all times. **Drivers should be aware of other road users when using the bus lanes especially whilst responding as an emergency as they may not expect to see an emergency vehicle within these lanes.**
2.8	At the commencement of each shift, or any vehicle change throughout the shift, the audible and visual warning devices **MUST** be checked in conjunction with the vehicle daily inspection (VDI) (see Appendix 1). It is the driver who holds full responsibility for the use of all emergency warning devices.
2.8.1	Emergency visual warnings systems fitted to the vehicle should be used at all times during an emergency response drive whether this is during the hours of day or night.
2.8.2	Audible warnings should also be used throughout the emergency drive as they help to protect the driver, other road users and pedestrians by giving advanced warning of emergency vehicles approach. However,

	circumstances may dictate otherwise, (e.g. passing animals/horse boxes or during the hours of darkness, where no road users exist, and no benefits can be gained by the use of these devices).
2.8.3	Flashing headlights (HI/LO) are provided to assist the vehicle in achieving maximum progress and **MUST** be used at all times when responding to all emergency calls. (except as per 2.16).
2.8.4	Flashing headlights (HI/LO) are not to be used in the periods where headlights are required, as their use is likely to be confusing to the general public and could very well be seen as an invitation to pull out in front of the vehicle.
2.8.5	The manual flashing of the headlights **MUST NOT** be used during emergency driving, day or night.
2.8.6	Where vehicles are fitted with more than one type of audible warning device optimum use can be made by changing the tone. The wail tone should be used between major hazards, changing to the yelp/piercer/hi-low tone for approaching and negotiating them. The driver **MUST NOT** assume they can be heard, it is essential to control speed whilst using audible warning devices.
2.8.7	The factory fitted vehicle horn**, MUST NOT** be used in an aggressive or intimidating manner. The other siren tones should be used on the approach and negotiation of hazards, coupled with appropriate speed, positioning and sound driving plans for the situation.
2.9	The blue lights may be left on at scene (arrived scene mode) if required to protect scene and alert other road users of the potential hazard if considered to be necessary. The exception being at the scene of a Major Incident, the blue lights **MUST** be switched off. This is to enable the control vehicle to be easily identified.
2.10	When dealing with a motorway incident, where the incident is adequately protected by Police, Fire and Rescue or Highways Agency vehicles, Ambulances will usually be positioned in front of the incident. All the visual warnings should be switched off, if safe to do so as too many flashing lights can be disorientating for all at scene.
2.11	The use of arrive scene mode [alternate flashing rear facing red lights] provides minimum conspicuity for safety purposes. They are only to be used whilst stationary and must be extinguished whilst mobile.
2.12	When EAC has advised to "**stand down**" from an emergency call and the crew have **confirmed** the "**stand down**", then all emergency warning devices **MUST** be switched off immediately and no further exemptions can be claimed.

2.12.1	In the situation where a 'stand down' has been advised by EAC, but to do so would be potentially dangerous, then, the emergency warning devices should be continued to be used, and the vehicle should continue to negotiate the hazard safely. Once the hazard has been safely negotiated and / or, the vehicle has been returned to the correct side of the road, then EAC should be advised that the vehicle is now standing down from the emergency. At that point all emergency warning devices should be switched off and no further emergency exemptions claimed.
2.13	Any misuse of these devices may lead to formal disciplinary action being taken. The driver may also be liable to prosecution, as the use of any exemptions may have to be justified in a court of law.
2.14	**PARKING – Clearways** -Trust vehicles are permitted to stop and park on clearways subject to it being necessary to carry out essential duties that could not be done if the vehicle were to be parked elsewhere.
2.15	No driver is exempt from leaving the vehicle in a dangerous position, and it is the responsibility of the driver to ensure that the vehicle is not left in such a manner, position or circumstances as would be likely to present a danger to other road users.
2.16	All precautionary means (e.g. blue lights, rear red flashing lights, flashing beacons or hazard warning lights) should be considered when stopping in potentially hazardous situations. Where possible, rear doors should be closed and facing oncoming traffic due to the benefits of their reflective hazard warning systems.
2.17	**White / Yellow lines** -Parking at or near to solid white or yellow lines is permitted subject to 2.15.
2.18	**Parking on Pedestrian crossings (Zebra, Pelican, Puffin and Toucan)** -Ambulance vehicles are permitted to park within the controlled area and on the crossing; subject to the vehicle not remaining longer than is necessary and/or it could not be parked effectively elsewhere. Justification **MUST** be absolute, as dangerous parking will be a strong consideration in these places.
2.19	**Floodlights** -White lights, other than reversing lights, can be used to the rear and/or side (down lights) of an ambulance, whilst stationary, to illuminate an incident. These lights **MUST** be extinguished when mobile.
2.20	**Stopping the engine whilst parked** -Stopping the engine whilst stationary is not necessary if there are good grounds for not doing so. Stopping the engine should only take place where the crew is working in close proximity to the vehicle. Where fitted, a "Run Lock" system

	should be utilized when the vehicle is to be left unattended.
2.21	**Miscellaneous Claimable Exemptions** • Parking on the offside of the road at night • Parking on footway/verge/central reservation • Using audible warnings at night • Entering a pedestrian precinct • Motorway regulations
2.3	**Non Exemptions,** There are no exemptions for the driver of an Emergency vehicle, even when responding to an emergency call, from the following: • Careless Driving • Crossing or straddling a solid white line nearest to you in the centre of the road (other than those occasions listed in the Highway Code rule 129) • Dangerous Driving • Dangerous Parking • Driving without wearing a seat belt (see also 'wearing of seat belts' section 1.16) • Failing to obey traffic lights controlling a railway crossing or fire station • Failing to obey a 'STOP' or 'GIVE WAY' sign ** • Failing to obey a 'NO ENTRY' sign** • Failing to obey a 'ONE WAY TRAFFIC' sign • Failing to stop if involved in a road traffic incident ***Note*** ** unless instructed to by a police officer in uniform.
2.4	**Convoy** -Currently NIAS advise that convoy driving under emergency driving conditions should be limited. However, it is accepted that in modern day ambulance function that this is not always possible and sometimes unavoidable, especially at times of a serious or major incident with the presence of rapid response vehicles and specialist resilience vehicles, eg HART.
2.4.1	It is good practice to activate a different siren sound to the vehicle being followed, and, in addition to this, the vehicles behind the lead vehicle need to be extra vigilant with regard to the unexpected behaviour of other traffic and the public, who may not be expecting more than one emergency vehicle.
2.4.2	If driving in a convoy, the driver must be aware of the increased risk, in particular the ability of following vehicles drivers' ability to identify

	and react to hazards.
2.4.3	**Police Escorts from Scene** – The Police may provide a Police escort during emergency driving if deemed necessary. Any request for such escorts **MUST** be made via ambulance control and after considering the condition of the patient and the prevailing traffic conditions.
2.4.4	EAC will liaise with Police Control and advise of the availability of a police escort and confirm rendezvous arrangements.
2.4.5	Police and ambulance should meet at the rendezvous point, agree their route, procedures in the event of separation or alternative actions being required. Communication methods should be agreed in relation to speeding up or slowing down of the convoy.
2.4.6	If the Police escort a Trust vehicle to hospital, then the driver of the Trust vehicle **MUST** not get drawn into trying to 'keep up' with the police drivers. They are there to assist the safe progress of the vehicle and not the other way around.
2.4.7	PSNI escort is there primarily to ease the ambulance progress through serious road or traffic disruption. Under no circumstances should treatment or transport of the patient be delayed waiting for escort arrangements to be put in place.
2.4.8	***There is no exemption or entitlement for an ambulance solo responder (or any other trust vehicle) to provide an escort for another emergency ambulance vehicle with emergency warning equipment activated under any circumstances. This is a specialised function and must not be undertaken by persons untrained or unauthorised.***
2.5	**HIGH SPEED DRIVER ASSESSMENTS** -The High Speed Driver Training Regulations RTRA 1984 S87 and clause 19 of the Road Safety Act 2006 (and anticipated future NI legislation) means that all members of the statutory emergency services, who are expected to claim the exemption of adhering to posted speed limits as part of their occupational function/role whilst engaged on emergency response driving duties will undertake a Driving Competency Review (DCR) once every 3-5 years in order to be registered as a high speed driver and therefore be in compliance with the law.
2.5.1	Compliance requirements made by the Secretary of State include: • 3-5 yearly driving assessment of competency for all personnel claiming the exemption for speed. • 3-5 yearly assessment of instructor competencies [Separate register]

	• 3-5 yearly assessment of accredited centres
2.5.2	NIAS will maintain their own database of competency review outcomes. Individual's will be assessed for competency for their specific role i.e. claiming exemptions for 'ambulance purposes' in vehicles specific to the individual's role i.e. C1 category (A/E ambulance, Fleet) or B category (PCS ambulance, car) type vehicles.
2.5.3	Suitably qualified, trust approved, driving instructors will conduct driving competency reviews. Staff will be profiled for their assessment in order of commencement of employment [longer serving members first].
2.5.4	All staff will receive an initial DCR (Appendix 3) and thereafter on a 5 yearly rolling basis.
2.6	Existing staff who have not attended a nationally accredited course in high speed, driving due to the non-availability of such a course at the time of their commencement of employment, will be registered under grand parenting rights. They will be required to produce a portfolio as Accreditation of Prior Experiential Learning [APEL] and satisfactorily complete an assessment of competency. This group of staff may not be required to attend a full driving course.
2.7	The DCRs will be planned by the Clinical Education Department and staff will be advised in advance of the assessment/educational day.
2.7.1	Reviews will take place in the category of vehicle that the member of staff is exposed to the most as part of their duties.
2.7.2	The review **MUST** include direct observation of driving under emergency / non-emergency response conditions.
2.7.3	The driving instructor will accompany the crew/solo drivers as supernumerary crew members.
2.7.4	A full procedural briefing and post review debriefing will be provided, whereby it will be explained that the review is designed to improve upon existing driving skills, identify any driving faults and, where appropriate, provide the necessary remedial training prior to re-evaluation of competencies.
2.7.5	All staff will be required to produce a valid driving licence for the appropriate category of vehicle at the time of the assessment.
2.7.6	Triggers for Driving Assessment, other than the Trust 5 yearly assessment, will be implemented in line with the Occupational Road Risk Fleet Safety Policy.

2.7.7	Should an interim driving assessment be required for any reasons associated with a history of road traffic collision involvement or a deficit in the maintenance of driving skills including ERD, then the interim assessment will be to identify and correct potential faults, this assessment will not impact on the high speed driving register.
2.8	**ASSESSMENT OUTCOMES** - A summary of the successful and unsuccessful outcome of an assessment is identified in the DCR algorithm (Appendix 2).
2.8.1	Should the driver demonstrate competencies that fall below the expected standard, the driving instructor will discuss these areas with the driver and agree on an action plan highlighting areas needing developed. A subsequent DCR will be arranged to ensure these areas have been corrected.
2.8.2	Where a driver has demonstrated a danger to others, the instructor will inform the driver, the driver's line manager and the Divisional Training Officer (DTO) of the outcome, highlighting the main areas of concern. The driver will refrain from emergency driving duties, or all driving duties, dependent on the individual's performance. The driver may be transferred to an operational environment where the driving requirements are more suited to their skill level. This is dependent upon a suitable position being available.
2.8.3	The recommendations within an action plan, depending on the individual's performance during the assessment, can range from one or more days remedial training followed by re-assessment, or, up to a full ambulance driving course.
2.8.4	Staff who are recommended to undertake remedial training within the agreed action plan will be afforded two re-assessment opportunities.
2.8.5	In the event a member of staff does not achieve the required standard following re assessment opportunities this will be managed by the line manager under the capability policy and procedure.
2.9 - APPEALS	
2.9	All drivers have the right of appeal against the outcome of the DCR/assessment process if it is felt that the way in which the review was conducted did not follow procedure. Drivers do not have the right to appeal against the resulting fault analysis or the points allocated by the assessor during the actual review which may have resulted in the removal from operational driving duties.
2.9.1	An appeal **MUST** be lodged and submitted to the Clinical Education Manager, within 14 calendar days of the review detailing the reasons

	for the appeal.
2.9.2	Appeals will be heard as soon as possible, normally this will be within four weeks of receiving the appeal. The employee will be given at least 14 calendar days' notice of the hearing.
2.9.3	In the first instance the appeal will be investigated by a Driving Instructor not involved in the case, the findings of which will be provided to the employee who lodged the appeal.
2.9.4	In the event of non-agreement with the driving instructor's initial investigative findings into the appeal, a formal hearing will take place attended by the CEM, Driver Instructor, and line manager, as appropriate.
2.9.5	The employee will be invited in writing to the appeal meeting to discuss the matter which will detail the purpose and content of the meeting. Employees should normally be notified of the decision within seven days in writing.
2.9.6	The employee has the right to be accompanied by a work colleague, trade union representative or friend not acting in a legal capacity.
2.9.7	If it is found that a capability issue exists, then this will be managed by the line manager under the capability policy and procedure.
2.9.8	The outcome of the initial driving competency review/assessment will stand until the hearing has been held.
SECTION 3 – NON – EMERGENCY DRIVING	
3.1	The tables below show the maximum speed limit for each of the categories of Trust vehicles where national speed limits are in force (H/C, NI 2008). They apply to all roads unless signs show otherwise and the lower speed limit will always apply.

(Category "B") Cars & Vans up to 3.5 Tonnes m.l.w. E.g. Officer cars, RRV, PCS Minibus etc.			
Built up areas	**Single carriageways**	**Dual carriageways**	**Motorways**
30 MPH	60 MPH	70 MPH	70 MPH

3.1.1	**(Category "C1") Goods vehicles up to 7.5 Tonnes m.l.w. E.g. A/E Mercedes, Equipment Vehicles etc.**

SOP: **Driving and Care of Vehicles When Driving on Behalf of the Trust**
Reference: **v1.0**

		Built up areas	Single carriageways	Dual carriageways	Motorways
		30 MPH	50 MPH	60 MPH	70 MPH
3.2	Trust vehicles **MUST**, at all times, be driven at a speed compatible with the patient's condition, with safety and with reasonable consideration for all other road users. Trust non-emergency drivers (including PCS, VCO, voluntary drivers) are governed by the same regulations as all other drivers using the road. Non-emergency drivers are not permitted to drive NIAS vehicles under emergency conditions, unless employed directly in a role which includes emergency driving within the role's scope of practice (i.e. NISTAR).				
3.3	**Patient Care Service (PCS) - Exemptions** – only 'stopping' or 'parking' or 'entering a bus lane during its hours of operation' exemptions listed in the Emergency Response Driver's Handbook can be claimed. If these are claimed the driver must do so safely and there must be no legal stopping / parking alternative available to the same effect. The Highway Code and Road Traffic Regulations for normal road use **MUST BE** complied with at all other times, even if non-emergency personnel have been diverted by ambulance control to render first aid.				
VOLUNTARY CAR SERVICE AND BASICS					
3.4	Drivers **MUST** hold a current unrestricted and unendorsed driving licence.				
3.5	All vehicles **MUST** be kept clean and roadworthy at all times.				
3.6	All vehicles **MUST** be taxed and insured with comprehensive cover or at least 3rd party Class A, which includes "business use" and "social, domestic and pleasure" cover. It is the driver's responsibility to ensure that they are fully covered by insurance in respect of claims arising as a result of accident or injury. The driver **MUST** ensure that only the vehicle that has been registered with the Trust **MUST BE** used.				
3.7	All drivers **MUST** ensure that NIAS is fully indemnified by their motor insurance in respect of all claims arising whilst in the course of this voluntary service. Drivers **MUST** inform their insurance company of this requirement and satisfy themselves and the Trust by providing written evidence that they are fully covered. They must provide to the relevant manager: 1. Sight of their Certificate of Insurance 2. Details of the Insurance Company 3. Policy Number 4. Renewal date in respect of the vehicle used				

3.8	Drivers are expected to maintain a high standard of mechanical efficiency in all cars used when tasked/registered by NIAS.
3.9	Drivers at registration/commencement stage will be required to undertake a driving assessment by a Trust Driving Instructor as detailed in (see Appendix 5)
3.10	Drivers already on the Trust register or driving a NIAS vehicle will be required to undertake a DCR by a Trust approved Driving Instructor. To ensure maintenance of driving standards as required by the Trust, re assessment should take place every 5 years or if an "assessment trigger" is activated.
3.11	Failure to meet the Trust's driving standard will result in the individual not being tasked to drive on behalf of the Trust / or drive a Trust vehicle pending the outcome of an action plan.
3.12	**BASICS -** A BASICS doctor **MUST** contact control to determine if their attendance is required at an incident. If attending, control will log their call sign against the call records. Unless employed directly by the Trust, doctors will travel in their own private vehicle to the scene and are permitted to use green visual warning devices as per current road traffic legislation. Emergency warning equipment MUST only be used if the driver has passed an NIAS Trust approved emergency driving course.
3.13	A summary of the successful and unsuccessful outcome of an assessment is identified in the algorithm (Appendix 2).
3.14	Following a successful outcome the driver will be issued with a copy of the report that provides the authority to drive and will be recorded for a maximum of 5 years.
3.15	Should the driver demonstrate competencies that fall below the expected standard, the driving instructor will discuss these areas with the driver and agree on an action plan highlighting areas needing developed. A subsequent repeat of the initial DCR will be arranged to ensure these areas have been corrected.
3.16	Where a driver has demonstrated a danger to others, the assessor will inform the driver, the driver's line manager and the Divisional Training Officer (DTO) of the outcome, highlighting the main areas of concern. The driver may have to refrain from driving on behalf of the Trust dependent on the individual's performance.. Until formulation and completion of any action plan;

	• The member of Patient Care services (PCS) will be crewed as attendant non driving duties only. • Fleet or Stores staff will refrain from driving Trust vehicles. • The Voluntary car driver will refrain from driving on behalf of the Trust. • The BASICS doctor will not be tasked to drive on behalf of the Trust.
3.17	Staff who are recommended to undertake remedial training within the agreed action plan will be afforded two re-assessment opportunities.
3.18	In the event that a member of PCS, Stores or Fleet staff does not achieve the required standard following retraining, and after 2 re-assessments, this staff member will be referred to Human Resources where the capability procedure may be invoked.
3.19	In the event a member of the voluntary car driver service does not achieve the required standard that individual will be removed from the Trust voluntary car service register.
3.20	In the event a BASICS doctor does not achieve the required standard that individual will not be tasked to respond on behalf of the Trust.
3.21	**APPEALS –** Employees / individuals have the right of appeal refer to Section 2.9.

Standard Operating Procedure

Northern Ireland Ambulance Service
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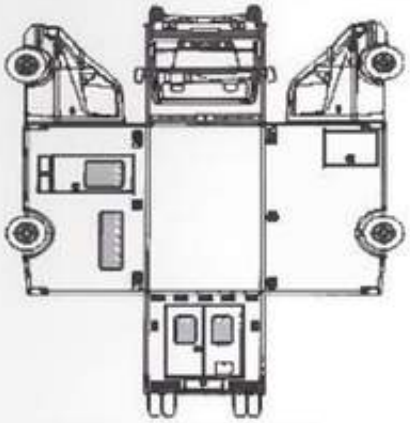
Appendix 1 – Visual Daily Inspection Form

VDI

INSPECTION

Northern Ireland Ambulance Service
Health and Social Care Trust

Date:		Shift Start Time	
Vehicle Call Sign		Vehicle Mileage	
Driver Name		Attendant Name	



Visual Damage to be identified by an X

INDICATE VEHICLE DEFECTS	VISUAL DAMAGE COMMENTS

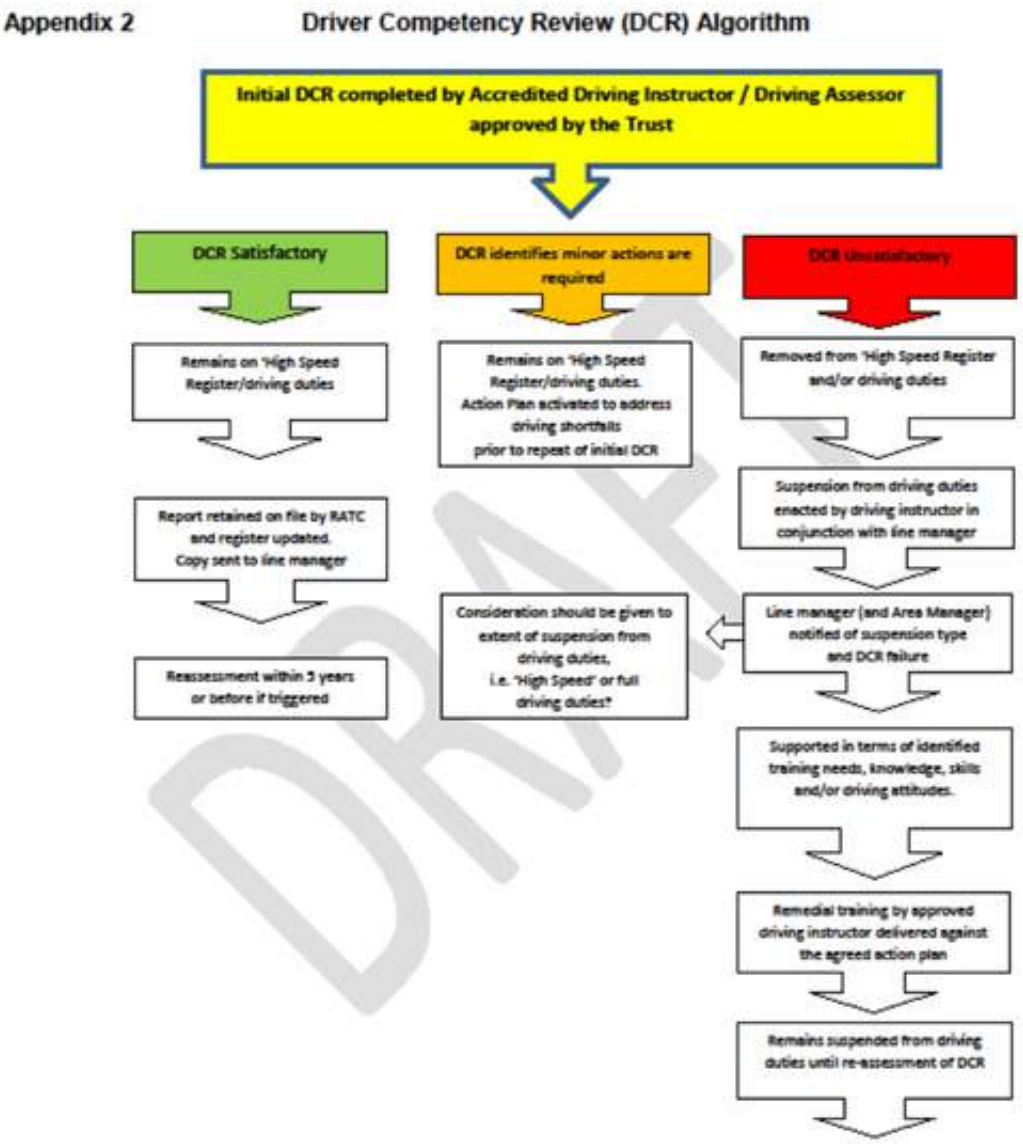
PRIMARY / SECONDARY VDI (Completed as per checklist)

PRIMARY VDI ☐ SECONDARY VDI ☐

COMMENTS/ACTIONS

Reported to:	Driver Signature:
Time:	Attendant Signature:

Appendix 2 Driver Competency Review (DCR) Algorithm

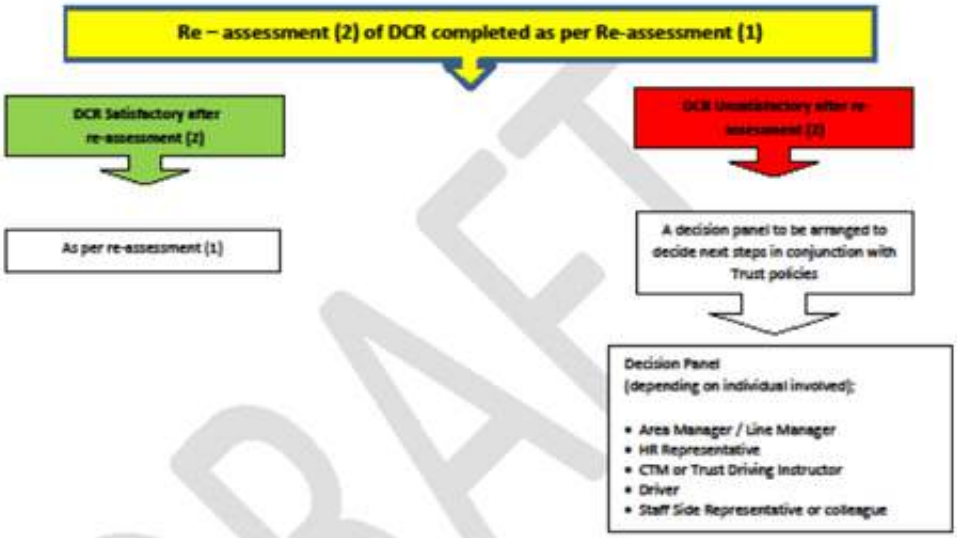


DRAFT

1

Standard Operating Procedure

SOP: **Driving and Care of Vehicles When Driving on Behalf of the Trust**
Reference: **v1.0**



DRAFT

1

SOP: **Driving and Care of Vehicles When Driving on Behalf of the Trust**
Reference: **v1.0**

Appendix 3 Driver Competency Review Forms (DCR3 / DCR Deferral Support Plan)

Northern Ireland Ambulance Service
Health and Social Care Trust

Driving Competency Review (DCR3) Action Plan

Candidate Name: **Assessor Name:** **Date:**

Assessor Comments	**DCR3 Ref Number**

Candidate Comments

Miscellaneous Events / Untoward Incidents during review

Assessor Signature: **Student Signature:**
Internal Verifier: **Date:**

SOP: **Driving and Care of Vehicles When Driving on Behalf of the Trust**
Reference: **v1.0**

Northern Ireland Ambulance Service
Health and Social Care Trust

DRIVING COMPETENCY REVIEW (DCR3)

Candidate Name:					Vehicle Category	B.	C1.	C.	D1.	D.
Assessor Name:					Licence Expiry Date. 4b					
Candidate Division:	N	S	E	W	B	Licence Number				

Date:	A/E	PCS	RRV	O	Vehicle type: B C1 C D1 D	Make:
Other *(Please Specify)*						
Start. :	Finish. :		Minimum 1hr		Registration:	Call Sign:
Environment	Urban		Rural		Weather Conditions:	

1 Serious Error – Refer. > 4 Minor Errors in any 1 Box – Refer. >14 Minor Errors overall – Refer. Total Errors. ☐

	Minor	Serious	HSD Ref.
Eyesight 20.5 m	☐	☐	1 (a)
(High Speed Driving Units to be referenced where applicable)			
Unit 1: Demonstrate Basic Skills.			
• Safety Checks	☐	☐	1 (b)
• Defects / Reporting	☐	☐	
• Pre Driving Checks	☐	☐	
• Parking, Manoeuvring	☐	☐	1 (c)
• Obtaining assistance whilst reversing	☐	☐	1 (d)
• Attitude to public safety and professionalism	☐	☐	1 (e)
• Use of mirrors	☐	☐	1 (f)
• Adherence to traffic signs	☐	☐	1 (g)
• Road markings / Traffic Lights	☐	☐	1 (g)
Unit 2: Preparation and driving plans			
• Information Gathering	☐	☐	2 (a)
• Accurate Observation	☐	☐	2 (b)
• Anticipation	☐	☐	2 (c)
• Observation / Action	☐	☐	2 (d)
• Formulation of flexible driving plans	☐	☐	2 (e)
Cornering			
• Principles	☐	☐	2 (f)
• Safety Factors	☐	☐	2 (g)
Control			
• Safe / Smooth Acceleration Sense	☐	☐	2 (h)
• Use of Brakes	☐	☐	2 (i)
• Accurate use of Gears	☐	☐	2 (j)
• Steering	☐	☐	2(l)

	Minor	Serious	Ref.
Positioning			
• Following / Overtaking	☐	☐	2(m/n)
• Positioning for view and safety	☐	☐	2 (o)
Making and Interpreting signals			
• Act on signals from others	☐	☐	2 (p)
• Appropriate use of signals	☐	☐	2 (q)
Overtaking			
• Identify, plan and execute safely on static / non-static vehicles	☐	☐	2 (r)
Unit 3: Motorway and Multi-lane carriageways			
• Joining procedures	☐	☐	3 (a)
• Use of speed	☐	☐	3 (b)
• Recognition of signs	☐	☐	3 (c)
• Exiting procedures	☐	☐	3 (d)
Unit 4: Undertake Emergency Response Driving (ERD)			
• ERD Justified	☐	☐	4 (a)
• Justify Speed exemption	☐	☐	4 (b)
• Use of EWE	☐	☐	4 (c)
• Identify/Analyse hazards	☐	☐	4 (d)
• Anticipate/respond to actions of others	☐	☐	4 (e)
• Communicate with others	☐	☐	4 (f)
• Pedestrian crossings	☐	☐	4 (g)
• Safe & Progressive	☐	☐	4 (h)
• Apply Duty of Care	☐	☐	4 (i)
• Actions are consistent with legal / organisational requirements	☐	☐	4 (j)

Assessor Signature: _____ **Candidate Signature:** _____

SOP: **Driving and Care of Vehicles When Driving on Behalf of the Trust**
Reference: **v1.0**

Appendix 4 Insurance Incident Report Form & UIR1

Willis

Please return to: Willis,
78 -86 Dublin Road, Belfast, BT2 7BY
Telephone: 028 9024 2131
Fax: 028 9032 1087

Claim Reference Number:.....

NORTHERN IRELAND PUBLIC SERVICES
MOTOR ACCIDENT REPORT FORM

Please complete this form fully on both sides. It is a condition of your policy to report all incidents as soon as possible even if you do not intend to make a claim. Any correspondence received in connection with the incident must be submitted immediately

A - Policyholder					
1. Insured Department			Policy Number	RSM*1006	
2. Branch					
3. Division					
4. Sub Division					
5. Contact Names					
6. Address					
7. Telephone Number					
B - Driver or person last in charge if unattended					
1. Name		Occupation		Date of Birth	
2. Address					
3. State Class of Licence held / Groups covered by Licence					
4. Give details of all motoring convictions or prosecutions pending (i.e. charge : date : penalty)					
5. Give details of all accidents or losses in the last three years					
6.Give details of any physical defect, infirmity, defective vision or hearing					
C -Vehicle					
1. Make		Year of make		Registration No.	
Type of Body and No. of seats					
2. For what purpose was the Vehicle being used?					
3. How many passengers were carried?					
D – Damage to Insured's Vehicle					
1. Full details of damage					

Insured with:	Claims handled by
Europa General Underwriters (N.I.) Limited 89-91 Academy Street Belfast County Antrim BT1 2LS	**Europa General Underwriters (N.I.) Limited** 89-91 Academy Street Belfast County Antrim BT1 2LS ***24 Hour Claim Telephone Line: 028 90 320190*** Fax: 028 90 327592; Email: claims@theuropageneral.com

SOP: **Driving and Care of Vehicles When Driving on Behalf of the Trust**
Reference: **v1.0**

E – Description of Accident							
1. Date of incident		Time of incident		AM / PM	Exact place		
2. Speed of vehicles	Yours	mph	Others	mph	Speed limit	mph	
3. Width of road		Conditions		Weather/visibility		Street lights on?	Yes / No
4. What lights was your vehicle displaying?			What lights was the other vehicle displaying?				
5. Did the police take details of the incident?	Yes / No	If "Yes" please give details below					
Officers name		Number		Station			
6. Did you make a written statement?	Yes / No	Was anybody cautioned?	Yes / No				
If "Yes" please give details							
7. Who do you blame for the incident and why?							

F - Please confirm exactly how the incident happened and confirm details of all property damage. If necessary please also provide a sketch of the incident to include the width of the roads, type and position of all road signs & markings, direction of travel of all parties and the points of impact(s)

G - Witnesses
1. Please confirm the names, addresses and telephone numbers of all passengers in your vehicle
2. Please confirm the names, addresses and telephone numbers of all independent witnesses to the incident

H - Other parties involved. Please confirm the names, addresses and telephone numbers of all other parties involved (continue on a separate sheet of paper if necessary)			
1. Name & Address of Owner / Driver			
		Telephone number	
2. Make, model & registration number		Colour of vehicle	
3. Damage / point of impact		Number of Occupants	
4. Name, address & policy no. of insurers			
5. Name & address of injured persons			
6. State whether driver or passenger, and in which vehicle, or if a pedestrian			
7. If a vehicle occupant were seat belts fitted?	Yes / No	If "Yes" were they in use at the time of the incident?	Yes / No
8. Apparent injuries		Taken to hospital?	Yes / No
9. Which hospital attended?		Detained?	Yes / No
10. Name & Address of Property Owner			
		Telephone number	

Declaration: ***I/We hereby declare that the above information and statements are true to the best of my/our knowledge and belief. I/We understand that you may ask for information from other insurers to check the answers I/We have provided. No other insurance is in force and I/We will render every assistance required by the Underwriters.***

Policyholder's or Company Official's Signature		Date	

Standard Operating Procedure

Northern Ireland Ambulance Service
Health and Social Care Trust

SOP: **Driving and Care of Vehicles When Driving on Behalf of the Trust**
Reference: **v1.0**

Appendix 5 Pre-entry Driver assessment form.

Northern Ireland Ambulance Service
Health and Social Care Trust
Pre-Entry Ambulance Driving Assessment

Candidate Name:		Licence Category	B.	C1.	C.	D1.	D.
Assessor Name:		Licence Expiry Date. 4b					
Assessor Signature:		Licence Number					

Date:	Eye Sight Test: Pass / Fail		Vehicle type: B C1 C D1 D	Make:
Location:				
Start. :	Finish. :		Registration:	Call Sign:
Environment	Urban	Rural	Weather Conditions:	

1 Serious Error – Fail. > 4 Minor Errors in any 1 Box – Fail. >14 Minor Errors overall – Fail. Total Errors. ☐

	Minor	Serious
Ancillary Controls	☐	☐
Control.		
Clutch	☐	☐
Steering	☐	☐
Accelerator	☐	☐
Gears	☐	☐
Footbrake	☐	☐
Handbrake	☐	☐
Move Away		
Safely	☐	☐
Under control	☐	☐
Reverse to left or right		
Left/ Right		
Control	☐	☐
Observation	☐	☐
Use of mirrors / rear observations well before		
Signalling	☐	☐
Changing direction	☐	☐
Changing speed	☐	☐
Give appropriate signals		
Where necessary	☐	☐
Correctly	☐	☐
Properly timed	☐	☐
Response to signs and signals		
Traffic signs	☐	☐
Road markings	☐	☐
Other road users	☐	☐
Traffic controllers	☐	☐
Traffic lights	☐	☐

	Minor	Serious
Positioning		
Normal driving	☐	☐
Lane discipline	☐	☐
Junctions		
Approach speed	☐	☐
Turning right	☐	☐
Turning Left	☐	☐
Observations	☐	☐
Judgement when		
Overtaking	☐	☐
Meeting traffic	☐	☐
Crossing traffic	☐	☐
Use of Speed/Progression		
Aggressive	☐	☐
Hesitant	☐	☐
Clearance to obstructions	☐	☐
Positioning for normal stops	☐	☐

Examiners Comments: **E.T.A.**

I acknowledge that the pre- driving assessment process and the assessment form have been explained in detail and I will be advised of the result by the Human Resource Department.

Candidates Signature _____ **Date** _____

SOP: **Driving and Care of Vehicles When Driving on Behalf of the Trust**
Reference: **v1.0**

Appendix 6 – Visual Roadworthiness Inspection Procedure

Basic roadworthiness checks prior to driving a vehicle, in lieu of completion of full VDI (appendix 1) NB. A full VDI should always be completed at earliest opportunity.

1. **EXTERIOR DAMAGE** – There is no exterior damage that interferes with the operation of the vehicle.
2. **WHEELS** – Wheel rims are in good order and nuts can be seen to be secure.
3. **TYRES** – visual checks for damage, depth of tread, obvious signs of loss of pressure.
4. **LIGHTS** – All fitted lights (including emergency warning lights) are in working order. Where duplicate bulbs are fitted, only one needs to be working.
5. **WINDSCREEN** – windscreen not cracked, wipers and washers' function normally.
6. **HORN** – functioning.
7. **GLASS** – glass and mirrors functional and clean.

Northern Ireland Ambulance Service
Health and Social Care Trust

MINUTES OF THE SAFETY, QUALITY, PATIENT EXPERIENCE AND PERFORMANCE COMMITTEE HELD AT 2.00PM ON FRIDAY 17 NOVEMBER 2023 IN THE BOARDROOM, NIAS HQ

PRESENT:	Mr D Ashford	-	Committee Chair
	Mr T Haslett	-	Non-Executive Director
IN ATTENDANCE:	Mr M Bloomfield	-	Chief Executive
	Ms R Byrne	-	Director of Operations
	Ms L Charlton	-	Director of Quality, Safety & Improvement
	Dr N Ruddell	-	Medical Director
	Mrs C Mooney	-	Board Secretary
	Ms R Finn	-	Assistant Director QSI
	Ms M Paterson	-	Director of Planning, Performance & Corporate Services (for agenda item 12 only)
	Mr N Sinclair	-	Chief Paramedic Officer
APOLOGIES:	Mr W Abraham	-	Non Executive Director
	Ms M Lemon	-	Director of HR & OD
	Mr P Nicholson	-	Director of Finance, Procurement, Fleet & Estates
	Mr R Sowney	-	Senior Clinical Adviser

1 Apologies & Opening Remarks

The apologies were noted.

The Chair welcomed members to today's meeting.

2 Procedure

2.1 Declaration of Potential Conflicts of Interest

There were no declaration of conflicts of interest.

2.2 **Quorum**

The Chair confirmed that the Committee was quorate.

2.3 **Confidentiality of Information**

The Chair emphasised the confidentiality of information.

3 **Previous Minutes (SC17/11/23/01)**

The minutes of the previous meeting on 7 September 2023 were **APPROVED** on a proposal from Mr Abraham and seconded by Mr Ashford.

4 **Matters Arising (SC17/11/23/02)**

Members **NOTED** the actions taken against the Matters Arising.

5 **Standing Items:**

(i) **Identification of Risk**

Discussion at 14(i) refers.

6 **Emergency Preparedness, Resilience and Response –Update (SC17/11/23/03)**

The Chair updated the Committee on his meeting with Ms Byrne and Ms Sharpe held on 2 November to discuss progress against the Improvement Plan.

7 **Strategic Review of Clinical Education – final report (SC17/11/23/04)**

At the Chair's invitation, Dr Ruddell took the Committee through the detail of the Final Report of the Strategic Review of Clinical Education. He noted that the review had commenced with the key aim to 'revamp' how the Trust delivered education with an emphasis on setting the future direction. Dr Ruddell said that it was important to transition to the development of staff who, while qualified, lacked clinical experience as they graduated from BSc programmes. He added that it was also important that the Trust considered how it

could assure itself of the quality of the care provided by staff. He reminded the meeting that NIAS was an organisation where staff worked independently most of their working day. Dr Ruddell said REACH would also provide the tools to monitor care in a much more efficient way than previously. He acknowledged that, while the review may have been completed, work continued to implement the deliverables.

The Chair noted the detail within the report and asked that this would be included on the January agenda for more detailed discussion.

Dr Ruddell provided a brief overview of the salient points within the report including the restructure of the training team; increasing the complement of CSOs and ensuring they return to monitoring the clinical care provided by staff and how it was delivered; capacity within buildings/estates. Dr Ruddell said that one of the biggest capacity issues was the capacity to release staff for training. However, he said, given the wealth of training material required for PPE/CCE, it was felt that the current two days per year was insufficient. He added that a plan had been developed for the next five years as to how this might look like.

Mr Sinclair agreed that, in terms of horizon scanning, engagement had taken place with internal stakeholders in terms of the need to increase annual training to five days per year. He recognised that a significant element of the risk related to the Trust's ability to release staff and whether there was the physical space and educators to deliver such training. Mr Sinclair emphasised the need to be realistic in moving forward.

The Chair acknowledged the recommendation to increase training days from two to five and the potential risk associated with not being able to deliver on this in the event of an adverse incident.

Dr Ruddell agreed with this point and commented that training records were often sought in the first instance when an inquiry was undertaken.

Mr Bloomfield emphasised that the Trust would have to identify how this could be implemented. He referred to the recent visit he, Ms Byrne and Mr Sinclair had made to the recently opened NIFRS training facility at Cookstown and said the NIRFS had been keen for

other emergency services to avail of the facility. Mr Bloomfield alluded to the fact that NIFRS colleagues had between 8-14 days training each year depending on their role.

The Chair acknowledged that this was the case and said that staff would be stood down from duty to undertake statutory training if this was outstanding.

Mr Sinclair pointed out that the final report provided a baseline and vision for moving forward and said that training requirements in terms of education and governance and supervision would continue to increase as the Trust's workforce increased.

Mr Bloomfield acknowledged the increasing recognition of the role that paramedics and the ambulance service could play in the wider transformation agenda. However, he said that this would only be possible if the Trust had the appropriate number of staff with the appropriate skills and advanced skills.

Dr Ruddell highlighted the linkages with the full implementation of REACH and the associated outputs from REACH.

Agreeing, Mr Sinclair explained that some work had been carried out to develop dashboards around the minimal criteria expected and, rather than have CSOs manually review PRFs, the review would be dashboard driven, thus allowing CSOs to monitor performance and quality in terms of care bundles patient outcomes etc. He also alluded to the inter-dependencies with the roll-out of REACH.

Ms Charlton commented that the Trust's Senior Management Team recognised the importance of the development and delivery of education and training for Ambulance Care Attendants and how best to ensure that education and training in this context was reflected within the final report to ensure it was explicit about all staff levels.

Mr Sinclair emphasised the importance of all staff being supported with ongoing education and clinical supervision. He referred to members of staff who had completed their initial training and who perhaps had been with the service for a number of years. Mr Sinclair said that it would be important to ensure that the education provided for such staff was flexible and appropriate.

Mr Sinclair alluded to the introduction of a new leadership management team and said that the team had 'gone back to basics' and had undertaken a full review of capacity. He added that work had also been undertaken to align the core framework to the College of Paramedics with the rest of the UK.

Mr Haslett commented that, when considering risks, one tended to prioritise these and noted that the implementation of the strategic review was resource dependent. He suggested that an 'early win' would be the full roll-out of REACH. Mr Haslett also referred to the importance of Estates.

The Chair noted that CRM would alter the Estates element.

Mr Bloomfield clarified that, in this particular case, the Estates referred to was the estate required around training. He alluded to his earlier reference to the visit to the NIFRS Cookstown facility and said that it might be more cost-effective to look to lease the specialist aspect of that facility rather than consider a purpose-built NIAS facility which would not be affordable in the current financial climate.

The Chair said that one of the aspirations of the Review had been around culture and developing a positive culture. He asked Dr Ruddell for his view on whether he believed the culture had changed and how one might know if it had.

Responding, Dr Ruddell said he recognised that, while the education team was not the sole guardian of culture within the organisation, it was for many staff the first point of contact with the organisation and had the ability therefore to set the tone. He said that the review had measured it through feedback surveys from students from the foundation courses etc. Dr Ruddell said it was encouraging to note that feedback from those undertaking the foundation course and the degree course had been positive. However, he accepted that there was always room for improvement.

Dr Ruddell advised that the Trust had held its first example of the new-style education courses with its Cardiac Arrest Master Classes and noted that there had been positive feedback on the new-style and much more engaging type of training. He acknowledged it had

been subjective but, in terms of feedback received, it had demonstrated that education was going in the right direction.

Mr Sinclair alluded to an adult learning approach where members of staff would review each other. He believed that this was a more engaging approach and said that feedback to date had been positive.

Mr Bloomfield said he believed there had been improvements in culture and was of the view that the continued focus and attention to this work was clear. He referred to the appointments of Ms Emma Boylan and Mr Paul Corns and said their new approaches would beneficial.

Mr Bloomfield alluded to the restructuring of the education team and the recent transition of Mr Sinclair to Chief Paramedic Officer with responsibility for this function and to drive forward the recommendations.

Mr Bloomfield said he wished to thank Dr Ruddell for his leadership of this review and clarified that Dr Ruddell would continue to have ongoing responsibility for the quality of skills of staff.

The Chair thanked all involved and said he looked forward to more detailed discussion at the January meeting.

8 **Public and Personal Involvement (PPI) Update (SC17/11/23/05)**

Ms Charlton drew the Committee's attention to the PPI Update and noted that the Trust had recently appointed Ms Maggie Hamilton as the Trust's PPI Officer on a permanent basis. She commended both Mr Gillan and Ms Hamilton on the significant work undertaken to date.

Ms Charlton noted that Mr Haslett had been the NED Champion for PPI and she thanked him for his support.

Ms Charlton reminded members that NIAS was the only Trust which had not received any funding in respect of a Partnership Officer. She advised that, in view of this, the Public Health Agency (PHA) had considered not seeking a progress report from the Trust against the PPI standards. However, the Trust had been keen to reflect its position and had submitted a report. Ms Charlton noted that

progress against a number of standards had been stated as red (at risk/delayed) but advised that a number of these had been progressed in the last few weeks. She said that an aspirational target had been the establishment of the Partner Voice Forum and added that the Trust had been pleased to receive ten Expressions of Interest to participate in the Forum.

Ms Charlton acknowledged that some actions focussed on having strong co-production involvement and said that these would remain red until the Trust was in a position to establish the Forum. She added that she was confident that these actions would transition to blue (complete) over the coming months.

Responding to a question from the Chair as to the timescale for establishing the Forum, Ms Charlton said that she would be keen to have the Forum operational by Quarter 4 of the 2023/24 year. She acknowledged the significant contribution made by Mr Gillan and noted that he had achieved a number of standards with some support from the PHA. Ms Charlton indicated that the appointment of Ms Hamilton would contribute greatly to progress.

Mr Haslett thanked Ms Charlton and the PPI team and acknowledged the progress which had been made over the last few years. He emphasised the importance of PPI and co-production and said it was an important aspect of the Trust's work.

The Committee **NOTED** the PPI Update.

9 **Safeguarding Update (SC17/11/23/06)**

Ms Charlton alluded to the Safeguarding Update and noted that this referred to two areas which had been discussed at length by the Committee. The first related to the RQIA Improvement Plan in place since 2019 and the second to the National Ambulance Service Safeguarding Peer Review Action Plan. Ms Charlton noted that an action which had been categorised as red (at risk/delayed) related to the recruitment process associated with the Safeguarding Manager post. She said that Ms Lemon had advised that the post would be released for recruitment in the coming weeks.

Ms Charlton reiterated the small size of the Safeguarding team and alluded to the ambitious nature of the action plan which was being led by Mr Flannagan and one other member of staff. She noted that

a key risk was that of training and she thanked Ms Byrne for facilitating and enabling Operational staff attendance at training.

Continuing, Ms Charlton advised that the Trust had made some progress around welfare pathways and acknowledged that, while progress had not been at the pace she would have liked to have seen, some of the inability to progress any further related to other Trusts putting appropriate arrangements in place.

Mr Haslett asked Ms Charlton for her view on how the full implementation of REACH would assist.

Responding, Ms Charlton acknowledged the work undertaken by the REACH team to ensure the inclusion of a safeguarding module which supported staff through a set of principles to enable better decision-making in the areas of safeguarding. She added that the use of REACH would ensure staff had the ability to access less onerous welfare pathways and advised that staff were currently having to return to base to submit a Datix report if necessary. Ms Charlton indicated that REACH also allowed for there to be a clear audit trail in relation to the nature of the referral.

Mr Haslett sought further clarification around the funding required for the safeguarding posts.

Responding, Mr Bloomfield acknowledged the need to ensure there was a balance in terms of recruitment across the Trust. He explained that the safeguarding posts were being established to support staff to provide the best quality of care possible and were essential in supporting staff to do their job.

Mr Bloomfield advised that the Trust's Senior Management Team had taken a decision to progress at financial risk and go beyond its funded establishment in respect of the safeguarding posts as they were so critical to the services provided by the Trust. He said that the Trust would continue to monitor the position on an ongoing basis.

Mr Haslett indicated his support for all the safeguarding posts and agreed that this was a critical element of the services provided by the Trust. He was of the view that elements of the Trust's efficiency saving would not become apparent for a number of months.

Mr Bloomfield said there were a few service areas which the Trust had decided to invest in over the last number of years. He cited examples of Infection Prevention and Control, safeguarding and pharmacy – all of which contributed to making services safer and providing support to staff. Mr Bloomfield said he recognised that, while progress had been made, single points of weakness remained.

The Chair thanked Ms Charlton for the Safeguarding Update and noted that, while the Update reflected an improved position, further progress was required.

The Committee **NOTED** the Update.

10 **Quality & Service Improvement Update (SC17/11/23/07)**

Ms Charlton reminded the meeting that the Trust Board had approved the NIAS Quality Strategy in June 2023 and the Strategy had been launched during World Quality week in November. She drew the Committee's attention to the Update which outlined the requirement to demonstrate the assurance framework around the 17 projects identified within the Strategy. She added that the Strategy reflected the work across all Trust Directorates. Ms Charlton alluded to the development of a dashboard which would provide the opportunity to monitor progress across the 17 projects and contribute to subsequent reporting to Trust Board through the Safety Committee.

Continuing, Ms Charlton advised that the DoH also required the Trust to produce an Annual Quality Report which had been included with the Committee papers. She added that this had been submitted to the DoH and published on the Trust's website. However, she acknowledged that some minor amendments were necessary to accurately reflect those projects which now fell within Mr Sinclair's remit as Chief Paramedic Officer.

Mr Haslett commended the Annual Quality Report and believed the report provided a comprehensive analysis of the work which had taken place in the preceding year. He referred in particular the table on page 7 of the report which demonstrated the cross-cutting nature of the projects across Directorates.

Mr Bloomfield noted that, unlike other Trusts, there previously was no dedicated focus or team within the Trust taking forward safety and quality. However, now that the Trust had dedicated posts, it was still important to acknowledge that these two areas were integral to everyone's work. He believed that the report demonstrated the benefit of such an approach.

Mr Haslett alluded to the references to culture within the report and sought Ms Charlton's view on whether producing the report helped staff to focus on the importance of culture within the organisation.

Ms Charlton was of the view that culture would only be changed through staff feeling differently. She referred to the engagement sessions which had recently been held at EDs and the issues raised by staff. She acknowledged that, while there were elements of the report which might be less meaningful to staff, the report reflected the outcome of the 'What Matters To You' discussions held with staff and also provided further opportunity to engage with staff.

Continuing, Ms Charlton acknowledged that, on occasions, it had proved challenging to engage with staff during their working hours. However, she welcomed the fact that twenty staff had recently volunteered to participate in a Quality Improvement group to look at late finishes which was the single most raised issue during the staff engagement sessions. Ms Charlton stressed the importance of ensuring the report was meaningful and staff had confidence in it.

The Committee **NOTED** the Update.

11 **Infection Prevention and Control:**
- Update Report;
- Environmental and Vehicle Cleanliness Report
(SC17/11/23/08)

At the Chair's invitation, Ms Finn took the Committee through the detail of the above reports. She reported that the Trust had achieved 81% against a standard of 90% in relation to hand hygiene audits and said the Trust planned to undertake some work with national IPC colleagues who were of the view that a standard of 90% was ambitious. Ms Finn said she would report back to the Committee on this in due course.

Ms Finn reminded the Committee that an additional KPI of 90% standard for monitoring PPE compliance had been introduced as a result of an action from a BSO Internal Audit report. She reported that the Trust was showing a slight improvement in terms of PPE compliance on a monthly basis.

Continuing, Ms Finn reported on the uptake of the Covid-19 and flu vaccination. She advised that uptake of the flu vaccination was 7.70% against a regional uptake of 16%. She said the Trust had received from feedback from a number of staff around recording details on the Vaccine Management System (VMS) and she would be meeting with PHA colleagues later in the month to address these. Ms Finn said the Trust was hoping to be able to schedule additional vaccination clinics for staff. However, she acknowledged the reluctance from other Trusts to do so due to the low uptake by NIAS staff. Ms Finn said it would be important to have staff on the ground encouraging colleagues to receive the vaccination and added that the Trust would continue to focus on increasing its uptake.

In relation to IPC e-learning, Ms Finn advised that a new Learning Management System (LMS) had been introduced across the HSC and it was hoped that this would enable the Trust to undertake a more detailed drilling into those staff who had undertaken training. She clarified that this was proving an issue for organisations across the region in that the system recorded those staff who had completed training but not those who had yet to undertake it.

Ms Charlton indicated that the Trust would continue to monitor compliance.

The Chair said he assumed that not every member of staff had to undertake each course.

Ms Charlton confirmed that this was correct and clarified that not every course had to be repeated on an annual basis which added to the complexity of monitoring and reporting on compliance.

The Chair enquired whether the reluctance of staff to receive the flu vaccination was a societal issue.

Responding, Ms Finn indicated that the general vaccination uptake rate was lower than in previous years. She advised that an internal

survey had been shared with staff to try to understand the reasons behind the low uptake rate. Ms Finn said that many staff had indicated they had been unwell following previous vaccinations while others had indicated they did not wish to receive it.

Ms Charlton said there was an awareness amongst professional staff and PHA colleagues that NIAS was an outlier in terms of vaccination uptake. She said that it would be important to follow up on anecdotal reports regarding accuracy of recording on VMS to determine if the current 7.70% NIAS uptake rate was robust/accurate. Ms Charlton believed that the Trust's previous approach of having a senior member of operational staff leading on the internal peer vaccination programme may have had a significant impact in achieving positive uptake rates. She commended her IPC colleagues who had made significant efforts to progress discussions with PHA and promote the programme internally to date.

Responding to a question from Ms Byrne as to the reason for the increased uptake rates within the South Eastern Trust area, Ms Charlton reminded the meeting that the South Eastern Trust's workforce differed from NIAS in that the NIAS workforce was mobile and worked across the region. She acknowledged that the South Eastern Trust was a frontrunner in relation to the Covid-19 vaccination. Ms Charlton indicated that, in the past, other ambulance services had provided incentives to encourage staff to receive the vaccination. However, she said it was her understanding that uptake in other ambulance services had also been lower than previous years.

Responding to a question from Mr Haslett re hand hygiene compliance at the Ulster Hospital and whether there had been a fatigue around IPC, Ms Finn advised that good practice had been noted in relation to the hand hygiene technique when undertaken and staff demonstrated a good awareness of when to perform hand hygiene. However, she recognised that further work was needed. She acknowledged that 90% was a challenging standard to achieve and said that it was for this reason that NIAS would be keen to engage with national colleagues to ascertain the KPI standards being used in other ambulance services.

Mr Bloomfield clarified that the figures in the update were not a reflection of Ulster Hospital staff but reflected the observations of the NIAS IPC Team of NIAS staff.

Responding to a question from Mr Haslett around the use of agency staff, Ms Charlton explained that, in order to deliver a robust, efficient and productive service delivery model for both Environmental and Vehicle cleanliness within the Trust, changes had been made to the structure of the team through the cessation of agency contracts and ensuring a more permanent structure was put into place.

Mr Bloomfield acknowledged that further work was required in a number of areas relating to IPC. However, he referred to the significant progress which had been made over the last few years from a position when the Trust had been placed in special measures due to its non-compliance with IPC requirements.

The Committee **NOTED** the Update as presented by Ms Finn.

12 **Annual Health, Safety & Fire Safety Report 2022/23 (SC17/11/23/09)**

At the Chair's invitation, Ms Paterson took the Committee through the detail of the report and explained that it aimed to provide summary information relating to principal activities associated with the promotion and management of corporate health and safety and fire safety for the period 1 April 2022 to 31 March 2023. She added that the report also highlighted the current key priorities for the Risk Management Team going forward.

Ms Paterson acknowledged that, while this particular function fell within the remit of the Trust's Audit and Risk Assurance Committee, it was recognised that the Safety Committee would also have an interest in the detail of the report.

The Chair alluded to the low number of health and safety inspections undertaken and the associated potential for risk. He expressed concern that the number of individuals who attended a fit test in 2022/2023 (344) had fallen significantly below the number of individuals who had been due a repeat fit test in the same period (1324).

Ms Paterson acknowledged that the Trust needed to increase its capacity and resilience in these areas. She added that consideration was currently being given as to how the Trust could

mitigate these and undertook to bring an action plan to the ARAC meeting on 1 February for consideration. She noted the significant amount of work which had been undertaken in the 2022/23 year by the relatively small team.

Mr Haslett referred to the fact that physical assaults on staff had increased while assaults with weapons had tripled. He alluded to discussions at Board level in terms of the dangers faced by staff and said it was clear further action needed to be taken.

Ms Paterson pointed out that the report covered the year 2022/23 and said it was her understanding that the introduction of Body Worn Video had resulted in a welcome reduction in assaults against staff. She undertook to bring some further detail to a future meeting.

Mr Bloomfield welcomed the sight of such information. He said that local media were always keen to support the Trust around any coverage relating to discouraging assaults against staff and added that local elected representatives had also been vocal in their support. Mr Bloomfield also acknowledged that there appeared to have been more custodial sentences handed down to perpetrators.

The Committee **NOTED** the Annual Health, Safety & Fire Safety Report 2022/23.

13 **Date of next meeting**

The next Committee meeting will take place on Thursday 25 January 2024 at 9.30am in the Boardroom, NIAS HQ.

14 **Any Other Business**

(i) Identification of risk

The Chair alluded to the earlier presentation by Dr Ruddell of the Final Report of the Strategic Review of Clinical Education. He accepted that, while he had asked that the report would be discussed in more detail at the January meeting, it was clear that the brief discussion had identified a potential risk around the need for additional days to be assigned each year for training. The Chair indicated that currently there were two days per year set aside for Operational staff to undertake the necessary training. However, the

report was recommending that this should be increased to five days per year. He suggested that this potential risk should be brought to the attention of the ARAC.

(ii) Update on Delayed Handovers

Mr Bloomfield advised the Committee that he, Ms Charlton and Ms Byrne had now met with colleagues from the South Eastern Trust on two occasions to discuss delayed handovers and said it was clear that the South Eastern Trust was committed to doing all it could to address this issue. He added that a meeting had also taken place with colleagues from the Southern Trust. Mr Bloomfield acknowledged that further action was required from all Trusts.

Continuing, he confirmed that the Committee Chair had recently written to his Trust counterparts to express his concern at the impact on delayed handovers on patient safety.

Mr Bloomfield noted that the DoH had prioritised two areas in its Winter Plan, namely ambulance handover delays and delayed discharges. He acknowledged that performance had continued to deteriorate and the Permanent Secretary had emphasised that this position was unacceptable.

Mr Bloomfield advised that the Regional Co-ordination Centre (RCC) had been established specifically to support the go-live of Encompass within the South Eastern Trust. He acknowledged that, while this presented the RCC with a different set of circumstances, the information had shown an improvement in most handovers and response times. However, he said it would be important not to draw comparisons at this stage and agreed that it had been useful to see the outworkings of the Centre at this early stage and to learn from experiences. Mr Bloomfield emphasised the direct correlation between delayed handovers and NIAS response times.

Mr Bloomfield alluded to the recent publication of the Getting It Right First Time (GIRFT) report. He said that the report could not have been clearer in its statements around the impact of delayed handovers on patient safety in that it was 'clearly the single biggest risk to the safety of patients in Northern Ireland'.

Mr Bloomfield said the Chair was keen to discuss GIRFT report in further detail at the December Trust Board. He noted that the

overall trend over the last six months had been one of continued deterioration. Mr Bloomfield advised that he had also written to Ms Gallagher, Deputy Secretary, SPPG, to discuss the increase in ambulance handover times and the associated increased risk to patients which had, on occasions, tragically resulted in deaths.

The Chair thanked Mr Bloomfield for his update.

(iii) Mr Haslett

The Chair alluded to the fact that Mr Haslett's term of office as a Non-Executive Director finished today and he thanked him for his significant contribution to the work of the Trust over the last number of years.

Mr Haslett indicated that he had been a Non-Executive Director with the Trust for eight years and seven months and had seen at first hand the commitment and dedication shown by staff throughout the Trust. He thanked everyone for their good wishes and wished everyone well into the future.

THIS BEING ALL THE BUSINESS, THE CHAIR DECLARED THE MEETING CLOSED AT 4.10PM

SIGNED: _____

DATE: 25 January 2024

Northern Ireland Ambulance Service
Health and Social Care Trust

'SAFETY' COMMITTEE REPORT TO TRUST BOARD 22/2/24

The Safety, Quality, Patient Experience and Performance Committee met on Thursday 25 January 2024.

	Occupational Road Risk & Fleet Safety Policy v1.0 **Driving and Care of Vehicles when driving on behalf of the Trust SOP v11.4** Mr Paul Corns, Consultant Paramedic, and Mr Terry O'Neill, Trust Driving Instructor, presented this agenda item. The Committee approved the Policy and SOP which had been designed to work in tandem to outline the basis for safe and effective driving practices within the Trust. The Policy outlines the core responsibilities for the organisation, various organisational managers, and each individual driver who drives Trust vehicles or drives on behalf of the Trust. The SOP provides further detail on what best practice looks like for colleagues and people who drive on behalf of the Trust. This includes visual daily inspection process, emergency driving, non-emergency driving, and how standards of driver competency will be assessed and monitored. The Committee asked for an implementation plan to be developed and presented to the Committee for consideration. It also acknowledged the challenges in implementing the Policy and SOP and asked that the position would be reviewed in six months' time.
	NIAS Annual Pharmacy Update Ms Catherine Hanna, Pharmacy Lead, joined the Committee to provide her annual update and outline the future for pharmacy within the Trust.
	Emergency Planning, Resilience & Response (EPRR) Update The Committee noted the update on EPRR.
	Strategic Review of Clinical Education – final report The Committee noted the content of the final report and it was agreed that the risk associated with the recommended increase in the number of annual training days from two to five would be highlighted at the Trust's Audit & Risk Assurance Committee. The Committee also asked that bi-

	annual updates on progress would be presented on progress.
	Serious Adverse Incidents (SAIs) Update During the reporting period of 1 April – 31 December 2023, 39 SAIs were notified to SPPG. However, one was subsequently de-escalated leading to a total of 38. This was a 22% increase in reporting compared to the same time in the previous year. Ms Charlton updated the Committee on the number of SAIs which related to a delayed response outwith standard. An overview of the patient outcome was also provided. There has been a renewed focus on family engagement within the current SAI process and improvement as a result has been noted.
	Service User Feedback, Complaints and Compliments Update The Committee had asked that anonymised examples of complaints and compliments were included in the update report. The Committee noted that, during the period 1 April – 31 December 2023, the Trust received 175 complaints compared to 166 complaints during the same period in the previous year. The top four types of complaints received during this period related to concern regarding treatment; staff attitude; delay in A&E response and delay in PCS transport. Ms Charlton gave an overview of performance against DoH Key Performance Indicators (KPIs). The Trust welcomes complaints as an opportunity to learn and to improve services. During the period 1 April to 31 December 2023, 85 recommendations were made as a result of complaint investigations undertaken. Of these 85 recommendations, 51 had been achieved/completed. 293 compliments were recorded for the period 1 April – 31 December 2023. Six fewer than were recorded in the same period in the previous year.
	Independent Ambulance Service Update Ms Charlton gave the Committee an overview of the use of Independent Ambulance Services to support the delivery of scheduled Patient Care Services (PCS) and unscheduled emergency care at the level of A&E

	support. IAS are procured by NIAS through a regionally agreed Framework Agreement of which all six HSC Trusts are members. and contributed to the development of both the Framework Agreement and the Scoping/Specification. Significant progress has been made over the last 24 months in developing systems and processes for governance and assurance for IAS provision/utilisation with NIAS. Ms Charlton reminded the Committee that, whilst the IAS in England were regulated by CQC, there is no such regulation by RQIA in NI. There is now a total of 16 IAS that have successfully joined the Framework. The Committee noted that this had resulted in an increased administrative requirement as well as additional demands in respect of the assurance and governance processes in place. The Committee was advised of the processes in place to strengthen the level of assurance in relation to IAS provision.

Northern Ireland Ambulance Service
Health and Social Care Trust

MINUTES OF THE AUDIT AND RISK ASSURANCE COMMITTEE (ARAC) HELD ON THURSDAY 5 OCTOBER 2023 AT 10AM IN THE BOARDROOM, NIAS HQ

PRESENT:	Mr W Abraham	Committee Chair
	Mr D Ashford	Non-Executive Director
IN ATTENDANCE:	Mr M Bloomfield	Chief Executive
	Ms R Byrne	Director of Operations
	Mr D Charles	Internal Audit, BSO
	Ms C Hagan	External Audit ASM
	Mr S Knox	Northern Ireland Audit Office
	Ms M Lemon	Director of HR & OD
	Ms L Mitchell	Independent Adviser to Committee
	Mr P Nicholson	Director of Finance, Procurement, Fleet & Estates
	Ms M Paterson	Director Planning, Performance & Corporate Services
	Mrs C Mooney	Board Secretary
	Ms B McAuley	Assistant Director of Finance
	Ms R Mulholland	DoH observer (via Teams)
	Mr J Dennison	Chair NIAS PFOD Cttee (via Teams) (for agenda item 5.2 only)
APOLOGIES:	Ms C Kane	Northern Ireland Audit Office
	Ms L Charlton	Director of Quality, Safety & Improvement
	Ms K Keating	Risk Manager
	Ms C McKeown	Internal Audit, BSO
	Dr N Ruddell	Medical Director

Welcome, introduction and format of meeting

The Chair welcomed everyone to the meeting.

1 Apologies

Apologies were noted.

2 Declaration of Potential Conflict of Interest & Confirmation of Quorum

The Chair asked those present to declare any conflicts of interest now or as the meeting progressed.

The Chair noted the fact that, in accordance with the Trust Standing Orders, the Non-Executive Director (NED) membership of the Audit Committee 'shall consist of not less than three members…' and that currently the Committee only had two Non-Executive members.

The Chair also stressed the confidentiality of information presented.

3 Previous Minutes (AC05/10/23/01)

The minutes of the previous meeting held on 22 June 2023 were **APPROVED** on a proposal from Mr Ashford which was seconded by Mr Abraham.

4 Matters Arising (AC05/10/23/02)

4.1 Action List

The Committee **NOTED** the Matters Arising.

5 Standing Items

5.1 Annual Review of Best Practice re ARACs (AC05/10/23/03)

Mrs Mitchell explained that, in February 2022, the Committee Chair had asked her to undertake a regular annual review of best practice to ensure the Committee was fulfilling its Terms of Reference and advised that the initial review had been presented to the Committee in May 2022. She explained that, in order to prepare the 2023 review, she had revisited the actions arising from the 2023 review and took the Committee through the detail of her proposed recommendations, namely:

Recommendation: *ARAC Committee to review Section 3.4 of the Risk Management Strategy to determine that it is fulfilling its remit.*

Mrs Mitchell said that paragraph 3.4 within the Trust's Risk Management Strategy outlined the role of the ARAC and she suggested that it might be helpful for the ARAC members to review this to ensure the Committee was fulfilling its full remit.

Mr Bloomfield highlighted the need to avoid any duplication of work through the various Trust Committees and said it would be important for the relevant Committee to undertake any detailed examination of pertinent issues. He pointed out that the role of the ARAC was to ensure that the appropriate arrangements for oversight were in place, seeking assurance from relevant Committee Chairs as necessary that this was the case.

The Chair suggested that it would be helpful to amend paragraph 3.4 to reflect the nature of the new Committee roles. Ms Paterson agreed to revisit this.

Mr Ashford agreed with the Chair's suggestion that paragraph 3.4 should be amended. He was of the view that, having a relatively small number of Non-Executive Directors (NEDs) meant that, on occasions, it proved difficult to provide the required critical challenge of the risk assurance arrangements for other Committees.

The Chair agreed with this point and alluded to the matter of absence management and the related oversight arrangements on which Mr Dennison would brief the Committee later in the meeting.

Recommendation: *The actions around issuing a formal letter of appointment; ensuring documents are shared with new members and induction to the Committee to be organised as soon as possible. These will be taken once new members are appointed.*

Mrs Mitchell alluded to the new Non-Executive Directors to be appointed in the near future and advised that, in the initial review of best practice, the Committee had decided to take a number of additional actions to ensure compliance with the Audit and Risk Assurance Handbook (NI). She advised that one issue was yet to be implemented upon the appointment of

new members to the Committee and this related to the issue of a formal letter of appointment to the Committee as well as a number of documents to assist in the induction to the Committee.

Recommendation: *The Committee has functioned without a 3rd member since February 2021 and there is need to fill this position to strengthen the Committee preferably with someone who has an accounting qualification.*

The Chair alluded to the reference to having an individual with an 'accounting qualification' and suggested that this should be a 'finance qualification'. He acknowledged that he was not an accountant by profession but had extensive experience and expertise in managing major accounts and projects. The Chair noted that, while the Committee had considered issues around accruals and other technical accounting arrangements, there were individuals supporting the Committee who would be in a position to explain the detail. He believed that the focus should be on the role as opposed to the individual undertaking the role and was of the view that this should be borne in mind when appointing the new ARAC Chair.

Mr Ashford agreed with the points made by the Chair.

Recommendation: *The Committee should critically assess NIAS's progress with environmental, social and governance commitments as well as climate change risks.*

Mrs Mitchell explained that the National Audit Office updated checklist (May 2022) included an additional section on continual improvement. She advised that, following completion of the checklist by the Committee, two primary actions had been identified for the Committee to progress. One related to the earlier recommendation to strengthen the Committee's membership while the other related to the need for the Committee to critically assess the Trust's progress with environmental, social and governance commitments as well as climate change risks.

Recommendation: *Due to the significant expansion of the National Audit Office (NAO) checklist the CIPFA checklist should no longer be completed.*

Mrs Mitchell confirmed that the CIPFA checklist had been completed for the last two years. However, she noted that the National Audit Office checklist had been extensively expanded and, in her view, it would now be sufficient for the Committee to complete this self-assessment only.

Concluding the presentation of the review of best practice, Mrs Mitchell advised that she had spoken to Ms McKeown who had been complimentary about the operation of the Committee, which she believed was functioning well and operating within the remit of the Audit and Risk Assurance Handbook (NI). She said that Ms McKeown had welcomed the proactive approach adopted by the Chair in relation to reviewing progress against prior year Internal Audit recommendations.

The Chair thanked Mrs Mitchell for presenting her review and said the Committee would endorse the proposed recommendations. He said he found it helpful to identify where improvements might be needed and believed that the Committee had greatly benefited from Mrs Mitchell's experience and expertise since her appointment as Independent Adviser to the Committee.

Mr Nicholson said he also wished to add his thanks to Mrs Mitchell and said he took comfort from the additional layer of independence and assurance that this role provided.

5.2 **Update on Trust approach to absence management**

The Chair introduced Mr Jim Dennison, Chair of the Trust's People, Finance and Organisational Development (PFOD) Committee and invited Mr Dennison to outline the arrangements which had been put in place to oversee and address absence management within the Trust.

Mr Dennison advised that absenteeism across the HSC had been highlighted as an issue by the Permanent Secretary and indeed had been highlighted within NIAS by an AACE report as far back as 2019. He said that there was a recognition that absenteeism had been and continued to be a very serious concern for the organisation. Mr Dennison alluded to the target of 11.2% set by the DoH and said there had been an

acknowledgement that the Trust would not be able to achieve this target within the timescales set by the DoH.

Mr Dennison described the arrangements which had been put in place in terms of regular meetings between Operations and HR and added that the Trust's Chief Executive had given a particular commitment to oversee progress. He said that he had asked for assurance to be provided both to the PFOD Committee and to the ARAC by the end of the calendar year and added that an exceptional meeting of the PFOD Committee had been arranged to progress this matter.

Mr Bloomfield thanked Mr Dennison for his overview and reiterated that the detail would be managed through the PFOD Committee. He acknowledged that, while it would not be possible for the Trust to achieve the DoH target, it would be important that the Trust demonstrated an improving trend. Mr Bloomfield said that the context was important and said that Committee members would be very much aware of the impact of delayed handovers and late finishes on staff. He indicated that members would also be aware that he and other Directors had raised these issues with other Trust and SPPG colleagues. Mr Bloomfield pointed out that the absence of a pay award was another contributory factor as was the impact of industrial action/action short of strike.

Continuing, Mr Bloomfield highlighted the importance of consistency of approach in terms of management of absence as opposed to capacity to manage and said the Trust was reliant on managers acting consistently. He said that, although he would be meeting with Ms Lemon and Ms Byrne on a monthly basis as over 80% of Trust staff fell within the Operations Directorate, the issue of absence management also applied to other Directorates. Mr Bloomfield advised that Trusts had been asked to submit action plans to the DoH as to how they planned to address absenteeism and added that the Trust's progress would be overseen by the PFOD Committee.

Mr Bloomfield said it had been helpful for Mr Dennison to attend today's meeting to outline and assure the ARAC of the processes in place.

Ms Lemon thanked Mr Dennison for his summary of the current position. She advised that, in the past, staff had not been required to report being absent from work to their line manager and said that work had been undertaken to change this practice. She said that the cultural shift required to effect such changes should not be underestimated.

Referring to performance management, Ms Lemon explained that high level information in relation to last year's absence target had been distilled down to local management level in terms of what a target might look like for that particular manager.

Ms Lemon advised that she and Ms Byrne met on a weekly basis with managers and their teams to understand the detail behind those areas where absence levels appeared high. She alluded to Mr Bloomfield's earlier reference to the impact of industrial action/action short of strike both on capacity and workforce motivation. Ms Lemon added that the Trust was engaging with Trade Union colleagues in this regard. She advised that work had been undertaken around the risk register and said she would be in a position to update this and said further discussion on this would take place at the PFOD Committee.

Mr Ashford said that, in his experience, the solution lay in the supervisor to middle management level and he highlighted the importance of holding managers to account. He asked what support was being provided to managers.

Ms Lemon highlighted this as an important point and said that, in the past, there had been a different expectation of managers and she agreed that there was a development need to support managers to deliver. She advised that a number of workshops had been held as well as making toolkits, training sessions, leadership development sessions available to managers. Ms Lemon confirmed that between 80-90% of managers had attended the workshops and had been equipped with toolkits and work was now underway to provide support to managers around difficult conversations with staff.

Mr Bloomfield said that he had arranged to meet with senior teams to ensure there was absolute clarity around the

importance of absence management and what was required to address this issue.

The Chair noted that the issue of absenteeism had been an issue within the Trust since his appointment as Non-Executive Director. He referred to previous concerns expressed at the Board in relation to the presentation of absence data and asked if the data presented accurately reflected the current position.

Responding, Mr Bloomfield acknowledged that there had been some technical issues with the absence data presented at the start of the year and said this had impacted on all Trusts across NI. However, he confirmed that the current NIAS absence level was 14.5%.

Ms Lemon advised that, within the Managing Attendance Project, there was a sub-group, comprising the Head of Informatics, Assistant Director of HR and a QSI representative, specifically looking at information with a view to providing assurance around the figures being presented. She said that it was intended to use this information to create a management dashboard in order that managers access live information.

The Chair said that, from an ARAC perspective, he appreciated Mr Dennison's attendance and was content that arrangements were in place for the PFOD Committee to oversee this work.

He asked that consideration would be given to how the risk was reflected on the Risk Register.

Ms Paterson noted that significant work had been undertaken over the last few months and was of the view that the risk had been reflected on the Risk Register. However, she said that Ms Byrne and Ms Lemon could revisit the wording to ensure it accurately reflected the current position.

The Chair referred to the fact that there were a number of outstanding IA recommendations relating to absence management.

Mr Charles confirmed that this was the case. However, he pointed out that the implementation date pertaining to these had not yet passed and noted that some had been partially

implemented. He commented that he would have a better sense of the implementation of these recommendations at the year end.

Ms Paterson said it would be important to ensure that the Risk Register accurately reflected the position and that the programme of work identified would address the outstanding recommendations from a governance and control environment perspective.

The Chair pointed to the importance of wording in terms of satisfying IA requirements.

Mr Dennison noted Mr Bloomfield's earlier suggestion that it was 'consistency' rather than 'capacity' in terms of managing attendance and said he would be content with this wording.

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

6 Standing Items

6.1 NIAS Direct Award Contract (DAC) Register (AC05/10/23/04)

Mr Nicholson drew members' attention to the cover paper summary of the current position and reported that the Trust had nine live DACs, with two having been closed and two new DACs on the Register since the June meeting. He indicated that action was now needed to close several of the live DACs and said it was intended to close one immediately and three within the next quarter.

Mr Nicholson acknowledged that a number of DACs were still required and he advised that HR had engaged and received some advice from a HSC Leadership Centre Associate to increase workforce capacity to complete three Occupational Health DACs. Mr Nicholson added that the other DAC for AACE was currently under development.

Mr Nicholson said that the Trust would continue to monitor expenditure against the DACs. He referred to the number of

live DACs which he believed was acceptable for a Trust of this size.

Responding to a question from the Chair, Mr Nicholson confirmed that no DACs remained relating to Covid-19 and advised that the DACs on the register were as a result of business as usual.

Mr Ashford welcomed the progress made, particularly that the number of live DACs had now reduced to a single figure. He sought clarification around the need for DACs for HR services.

Responding, Mr Nicholson said that there had been a recognition that absence management had been instigated prior to the pandemic and explained that these organisations had been used extensively during the pandemic and it would be important to apply the learning from that time. For example, he said, consideration was being given to whether the Trust needed Occupational Health Services (OHS) or similar services as part of the programme moving forward.

Ms Lemon advised that the experts engaged by the Trust had been helpful and clarified that the service was for staff substitution as opposed to consultancy. She explained that, during the pandemic, it had not been possible to undertake investigations, for example, due to staff shortages and the organisations engaged by the Trust had had experience and expertise of working in particular areas and a knowledge of HSC policies and procedures. Ms Lemon indicated that the intention would be to close these DACs.

The Chair thanked Mr Nicholson for the update on the DAC Register which was **NOTED** by the Committee.

6.2 **Fraud Update – verbal update**

Ms McAuley advised that the two fraud investigations reported at the June meeting had now been concluded by the Counter Fraud Unit who had found no evidence of fraudulent activity. She added that a further three allegations of fraud relating to pay had since been received and had been subject to preliminary investigations. Ms McAuley advised that no further action would be taken in relation to one allegation while the

remaining two allegations had been referred for full investigation.

The Chair thanked Ms McAuley for her report which was **NOTED** by the Committee.

6.3 **Emergency Preparedness, Resilience and Response (EPRR) (AC05/10/23/05)**

Ms Byrne advised that progress against the Improvement Plan continued to be reported to the Safety Committee and said that, as agreed at the Safety Committee, separate meetings had been scheduled with the Safety Committee Chair and Clinical Adviser to update on the recommendations in detail. She added that regular updates were also provided to the Trust's Senior Management Team and to Trust Board through the Safety Committee.

Mr Ashford confirmed that a programme of work was underway and said he would be keen to ensure that the EPRR risk remained on the ARAC agenda so the Committee could be assured of the oversight arrangements in place.

Continuing, Mr Ashford acknowledged that a significant amount of work had been completed but recognised that further work was still required.

Mr Bloomfield confirmed that the Trust's Senior Management Team had approved a number of additional temporary posts at risk until the end of March to provide the additional capacity requested by the EPRR Assistant Directors.

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

7 Internal Audit

7.1 To advise on key issues

Mr Charles noted that the key issues to report had been included on the agenda.

7.2 IA Progress Report (AC05/10/23/06)

Mr Charles noted that audits had been completed in respect of Patient Pathways and the Management of Fleet and Fuel and took members through the detail of the audit findings.

Referring to the Patient Pathways audit, Ms Byrne advised that a number of areas identified in the audit had already been addressed. She cited the increase in clinical presence within EAC as well as engagement with other Trusts in relation to patient pathways. Ms Byrne confirmed that stack cards had been revised and the trajectory of performance in respect of See & Treat and Hear & Treat was on track to be achieved.

Ms Paterson pointed out that formal Key Performance Indicators (KPIs) had been agreed in relation to this.

Mr Ashford sought clarification that the full checklist in respect of See & Treat had not been completed. He also enquired if NIAS staff were not able to identify an alternative pathway, would patients be conveyed to ED. He further asked if there had been feedback from Trusts in relation to the appropriateness of pathways for patients.

Mr Charles confirmed that this was the case and that part of the process had not been adhered to, therefore not ensuring an audit trail around the decisions taken.

In relation to the appropriateness of pathways, Ms Byrne explained that there was no formal mechanism in place whereby Trusts could advise on whether they considered the referral to certain pathways appropriate or otherwise. She indicated that there were more patient pathways in place in other parts of the UK and said NIAS relied on provider Trusts to provide the pathways.

Mr Bloomfield said that this was a significant area for the Trust in terms of development and where much of the focus lay in relation to service redesign and new models of delivery with an emphasis on safety. He explained that, with the appropriate resources in terms of increased clinical presence in the EAC, the Trust would be able to make improvements in this area. Mr Bloomfield said that the DoH had committed to providing

support to the Trust to do so. He reiterated Ms Byrne's earlier comments in relation to the Trust being on track to achieve the performance trajectories set for See & Treat and Hear & Treat.

Mr Bloomfield welcomed the audit findings and said they would help in improving the service. He acknowledged there were a number of issues for the Trust to be mindful of, for example, ensuring there was appropriate recording/documentation. He pointed out that, on occasions, there were 60-70 calls on the stack and said the Clinical Support Desk attempted to identify the most urgent. He said he could understand why certain shortcuts were taken in this process but added the appropriate procedure should be followed in all cases.

Continuing, Mr Bloomfield was of the view that it was not particularly helpful to identify a particular circumstance when another patient pathway would have been more appropriate. He highlighted the judgements made by clinical staff on a daily basis were dependent on the circumstances and other factors at that time.

Mr Bloomfield alluded to the lack of consistency and standardisation across other Trusts in terms of patient pathways and said this did not facilitate the decision-making processes by staff.

Ms Byrne explained that, during the most recent period of industrial action, the Trust had invested in additional clinical presence in the EAC. She said the benefits of doing so were clear and the Trust intended to carry out a 'test of change day' on 9 October by having additional clinical support in the EAC and then carrying out a snapshot audit with a view to revisiting in a few weeks' time.

The Chair noted that this was an area in transition.

Mr Bloomfield agreed this with comment and said there was a nationally growing recognition that ambulance services needed to change in view of the increasing pressures and the fact that not every patient required conveyance to hospital. He said it was important to identify ways of resolving issues elsewhere. Mr Bloomfield pointed out that the Trust's conveyance to hospital rate had halved compared to the same time last year.

Ms Byrne agreed that safe non-conveyance was key.

Ms Paterson commented that, regardless of what tools were used, the Trust continued to need a clinical audit function, governance and control environment. She said the report was helpful in building for the future with a focus on patient outcomes.

Responding to a question from the Chair as to which Committee would oversee this area, Mr Bloomfield advised that it would be the Trust's Safety Committee in terms of implementation and follow-up.

Referring to the audit on the Management of Fleet and Fuel, the Chair asked whether there was any evidence of fuel cards being misused.

Mr Bloomfield said that the Senior Management Team had also discussed this point. He said that the report had exposed potential vulnerabilities in this area and the Trust would have to ensure that, from a system perspective, such circumstances could not arise. However, he said that he was not aware of any incidents or suggested allegations of any inappropriate use.

Mr Nicholson confirmed that there was no evidence of misuse of which he was aware. However, he expressed concern that there appeared to a bypass of some of the controls in place.

The Chair commented that the lack of controls could potentially lead to fraudulent activity.

Mr Nicholson confirmed that the Trust had already taken some steps to address this both within Fleet and Operations. He alluded to the references within the report to MOTs and reminded members that NIAS vehicles were MOT'd on an annual basis, regardless of the vehicle's age, and therefore had to undergo a MOT on an annual basis. He added that this provided an additional layer of assurance.

The Chair alluded to the monitoring of contracts and KPIs and ensuring there was no complacency.

Mr Nicholson clarified that this point focussed more on contract management and meeting with providers as opposed to scrutiny of a contract. He pointed out that formal meetings were held with contractors and said that these were formally recorded.

Mr Charles pointed out that, within the KPIs, there were certain elements stipulated to be provided by the contractor and he added that formal meetings between the Trust and the contractor was one element.

The Chair thanked Mr Charles for presenting the IA Progress Report which was **NOTED** by the Committee.

7.3 **Mid-Year Follow-up Review:**
- Outstanding Internal Audit Recommendations 2023-24
- Cyber Recommendations (AC05/10/23/07)

Mr Charles drew the Committee's attention to page 3 of the report which highlighted that only 4% of the outstanding recommendations had been implemented at September 2023. He pointed out that this correlated with performance across the wider HSC where there had also been a low level of implementation. He indicated that there were linkages between a number of recommendations and cited the example of REACH which, when implemented, would address several recommendations.

The Chair commented that 4% did not appear encouraging and asked whether the Trust was expected to improve on this by year end.

Responding, Mr Charles acknowledged that significant efforts had been made over the last few years to address the outstanding recommendations. He stressed the importance of maintaining a focus on this work and ensuring the quality of evidence provided was appropriate.

The Chair noted that a meeting would be held on 7 December to consider progress against outstanding recommendations.

The Mid-Year Follow-up Review was **NOTED** by the Committee.

7.4 IA Charter (AC05/10/23/08)

Mr Charles explained that the development of the IA Charter was a professional requirement and required to be presented to the Committee for approval on a bi-annual basis. He advised that the Charter effectively defined and formalised Internal Audit's activity's purpose, authority and responsibility.

The Committee **APPROVED** the IA Charter on a proposal from Mr Ashford. This was seconded by the Chair.

7.5 IA General Annual Report 2022-23 (AC05/10/23/09)

The Committee **NOTED** the IA General Annual Report 2022-23 which provided an overview of the work conducted by IA across the HSC. Mr Charles pointed out that the number of audits had increased as well as the number of Priority 1 findings and noted that the management response had been positive.

7.6 Head of Internal Audit Mid-Year Assurance Statement (AC05/10/23/10)

The Committee **NOTED** the HIA Mid-Year Assurance Statement.

7.7 Shared Service Update (AC05/10/23/11)

Mr Charles clarified that the Shared Service Update was being shared with the Committee for completeness and transparency and he noted that any actions therein were the responsibility of the BSO to take forward.

The Committee **NOTED** the Update.

8 External Audit

8.1 To advise on key issues

There were no key issues to highlight.

8.2 **Final Report To Those Charged With Governance (AC05/10/23/12)**

The Committee **NOTED** the final RTTCWG. This had been considered in detail by ARAC at its meeting on 22 June 2023 and this was provided as the final version.

9 **NIAS Mid-Year Assurance Statement (AC05/10/23/13)**

Mr Nicholson explained that the Trust's Mid-Year Assurance Statement would be informed by the discussion at today's meeting. He reminded those present that, during the pandemic, the requirement for Trusts to produce a Mid-Year Assurance Statement had been set aside. However, normal process had now resumed.

Mr Nicholson advised that, following the meeting, he would develop a draft Statement for consideration by the Senior Management Team and would subsequently share the final draft with ARAC members. He indicated that, within the Control Divergences section, there would be a focus on the impact of delayed handovers as well as the impact of late finishes both on staff and patients. He acknowledged that there would also be a focus on absence management and emergency planning.

10 **Board Governance Self-Assessment Tool (AC05/10/23/14)**

Ms Paterson drew the draft Board Governance Self-Assessment Tool to the Committee's attention and advised that the areas of concern within the Assessment had been referenced earlier in the meeting, for example, the need to ensure the full NED complement in terms of Committee membership. She advised that the case study supplementing the Assessment related to the Out of Hospital Cardiac Arrest study.

The Chair proposed that Committee would recommend the Board Governance Self-Assessment Tool to the Board for approval. This proposal was seconded by Mr Ashford and **APPROVED** by the Committee.

11 **Amendment to NIAS Standing Orders (AC05/10/23/15)**

Ms Paterson advised that, under the Trust's Standing Orders, the Committee was required to be advised of any amendments to the Standing Orders.

She asked members to note that, at its meeting on 24 August 2023, the Trust Board approved a proposal to allow the re-admission of members of the public to Trust Board meetings.

Ms Paterson advised that a temporary provision had been made in May 2020 within Standing Orders not to admit members of the public due to Government Covid-19 restrictions at that time.

The Committee **NOTED** the amendment.

12 **Progress on Achieving Business As Usual – presentation (AC05/10/23/16)**

At the Chair's invitation, Ms Paterson presented on the Trust's work to ensure it returned to business as usual following the Covid-19 pandemic. She reminded members that, in April 2022, the Committee had considered how the Trust had maintained quality and safety within the organisation and had exercised appropriate and effective governance arrangements during Covid-19. Ms Paterson pointed out that, since then, 'Achieving Business as Usual' had been included as a standing agenda item. However, she now proposed that, having provided assurance that a robust framework was in place to manage the Trust's rebuilding and recovery from Covid-19, this should be removed as a standing agenda item.

The Chair explained that his rationale for including this on the ARAC agenda had been to ensure that, as the Trust reverted to normal business, the appropriate governance processes were reintroduced. He said that he would be content to remove the item from the agenda and asked Ms Paterson to alert the Committee to any pertinent issues should that be required.

13 **Closed Meeting**

At this point in the meeting, NIAS Directors left the meeting to allow the Closed Meeting to take place.

Following the closed meeting, the Chair noted the continuing positive relationship between the Trust and Internal and External Audit and advised that no issues had been identified.

14 **Any Other Business**

(i) Ms Keating

Ms Paterson advised that Ms Keating would be leaving the Trust to take up another post in November and said she wished to use this opportunity to thank Ms Keating for her significant contribution over the last number of years.

The Chair said that the Committee very much appreciated Ms Keating's input and wished her well for the future.

(ii) Test Drilling 2022-23

Mr Nicholson noted that the DoH had recently written to the Trust to provide the results of the revenue business case test drilling for 2022-23. He advised that one NIAS business case for the Children's Ambulance had been test drilled and had been given an overall 'green' status.

Mr Nicholson said that the correspondence had requested that the results would be shared with the ARAC Chair and he undertook to circulate this to members for their information.

(iii) Chair's Departure

The Chair noted that his term of office was due to cease on 17 November and that this would be his last ARAC meeting. He said the commitment of everyone at the Trust was outstanding and commended everyone on their dedication.

Mr Nicholson said that the leadership and drive shown by the Chair had improved the work of the Committee and he extended his professional and personal thanks to him.

Ms Paterson said that she very much welcomed the challenge the Chair had brought to the Committee's work and wished him success for the future.

15 **Date, time and venue of next meeting**

It was noted that a meeting had been scheduled for Thursday 7 December to allow Trust officers provide an update against Internal Audit recommendations.

The next formal meeting of the Audit Committee will take place on Thursday 1 February 2024 at 10am. Arrangements to be confirmed.

Currently confirmed ARAC dates for 2023-24 are as follows:

- 28 March 2024 at 10am

THIS BEING ALL THE BUSINESS, THE CHAIR CLOSED THE MEETING AT 11.50AM.

SIGNED: *P Graham*

DATE: 1 February 2024

FINAL

Northern Ireland Ambulance Service
Health and Social Care Trust

AUDIT AND RISK ASSURANCE COMMITTEE REPORT TO TRUST BOARD

The Audit and Risk Assurance Committee met on Thursday 1 February 2024 and I would like to bring the following issues to the attention of the Board in advance of the formal minutes.

1.	**Chairman's Business** This meeting was the first comprised of the new members and an opportunity was taken to record that all members had received the up-to-date Terms of Reference for the Committee. The DoH is arranging a meeting of the ALB Audit Chair's Forum and a range of suggested agenda items for the meeting were agreed by the Committee.
2.	**Direct Award Contracts** The DAC Register was presented and reviewed by the Committee.
3.	**Fraud Update** The Committee was given a verbal fraud update.
4.	**Emergency Preparedness, Resilience and Response (EPRR) Risk** This is a standing item on the agenda and the Committee received an update from Dale Ashford who is Chair of the Safety Committee on how the risk is being managed.
5.	**Internal Audit Strategy incorporating the Internal Audit Plan 2024-25** The Head of Internal Audit advised that the Internal Audit Plan for 2024-25 is the 2nd year of the three year Internal Audit Strategy. The original Internal Audit Plan for 2024-25 has been reviewed against the current risk register and management has been consulted on its contents, resulting in no changes. The Committee approved on this basis.
6.	**Internal Audit Progress Report** Internal Audit reported on an audit undertaken in relation to IT Incident Management. A Limited level of assurance was provided and there are 14 Priority 2 recommendations to be implemented all of which management have accepted. Internal Audit reported on an audit undertaken in respect of the Helicopter Emergency Medical Services (HEMS). A Limited level of assurance was provided and there are 12

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	Priority 2 recommendations to be implemented all of which management have accepted. The Head of Internal Audit drew the Committee's attention to the fact that all of the Internal Audit reports issued in 2023-24 have reported limited assurances. The need to focus on addressing prior year recommendations was emphasised and the Committee acknowledged the potential risk to the year-end assurance provided by the Head of Internal Audit to the Trust.
7.	**External Audit Strategy 2023-24** ASM presented the External Audit Strategy for the 2023-24 annual report and accounts. The Committee noted and endorsed the Strategy.
8.	**HSC Cyber Security Strategy 2022-2026 and NIAS Implementation Plan** The Committee received a presentation on the HSC Cyber Security Strategy for 2022-2026, which is a regional document. The Committee approved adoption of the Strategy by NIAS to ensure alignment with the regional approach. The Committee also considered the NIAS Implementation Plan and approved adoption in support of the regional Strategy.
9.	**Corporate Risk Register** The Committee considered the updated Corporate Risk Register and noted the latest updates. A new risk relating to Financial Stability – Achieving Financial Balance 2023-24 rated as high was noted and approved. The Committee agreed that Risk 2 (EPRR) and Risk 3 (Strategic Business Continuity Policy and Planning) will be merged and that Risk 7 (Sickness Absence) will be renamed. In addition, it was agreed that Risk 10 (Staff Competency/Training) would be kept under review to determine if the increase in the training requirement from 2 to 5 days has an impact on the risk rating.
10.	**Health, Safety and Fire Safety Annual Report 2022-23** The Committee noted the report.

Submitted By:
Philip Graham
Chair of Audit and Risk Assurance Committee