NORTHERN IRELAND AMBULANCE SERVICE TRUST

TRUST BOARD - THURSDAY 22 AUGUST 2024 AT 10.30AM

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 27 June 2024

For Approval

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3 Matters Arising

For Decision

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4 Chair's Update

For Noting

5 Chief Executive's Update

For Noting

6 Patient Care Service Improvement

For Noting

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7 Mental Health Practitioners in the Integrated Clinical Hub - update

For Noting

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8 Board Governance Self-Assessment Tool

For Approval

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9 Finance Report (Month 3)

For Noting

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10 Trust Performance Corporate Scorecard (July 2024)

For Noting

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11 DoH letter re: Strategic Priorities 2024-25

For Noting

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12 Committee Business:

For Information

- PFOD Cttee - minutes of meeting on 18 April 2024 & report of meeting on 3 July 2024;

For Information

12 - 01 - People Cttee mins 180424 signed final.pdf ***Page 187***

12 - 02 - People Cttee 030724 report final.pdf ***Page 202***

- ARA Cttee - minutes of meeting on 16 May 2024

For Information

12 - 03 - ARAC mins 160524 final.pdf ***Page 204***

13 Date & venue of next meeting: Thursday 24 October 2024 at 9.30am in the Boardroom, NIAS HQ

14 Any Other Business

Northern Ireland Ambulance Service Health and Social Care Trust

Minutes of NIAS Trust Board held on Thursday 27 June 2024 at 10.55am in the Boardroom, NIAS HQ, Site 30, Knockbracken Healthcare Park, Saintfield Road, Belfast BT8 8SG

Present:	Mrs M Larmour	Chair
	Mr D Ashford	Non-Executive Director
	Mr P Corrigan	Non-Executive Director
	Mr J Dennison	Non-Executive Director
	Dr P Graham	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
In Attendance:	Ms L Charlton	Director of Quality, Safety & Improvement (QSI)
	Ms M Paterson	Director of Planning, Performance & Corporate Services/Deputy Chief Executive (via Teams)
	Mr N Sinclair	Chief Paramedic Officer (left the meeting at 11.30am)
	Mrs C Mooney	Board Secretary
	Mr B Doran	Urgent and Emergency Care Policy Branch, DoH (for agenda item 6 only)
Apologies:	Dr N Ruddell	Medical Director

1 Welcome, Apologies & Declarations of Conflict

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

The meeting was declared as quorate.

2 Previous Minutes (TB27/06/2024/01)

The minutes of the previous meeting held on 9 May 2024 were **APPROVED** on a proposal from Mr Ashford and seconded by Mr Quinn.

3 Matters Arising (TB27/06/2024/02)

Members **NOTED** the Matters Arising.

Ms Paterson advised that progress continued on the development of a matrix to track actions taken across the range of unscheduled care plans. She indicated that the intention would be to submit local plans for each Trust to the Strategic Planning and Performance Group (SPPG) by the start of September.

Mr Quinn asked whether there had been any evaluation undertaken of the Regional Co-ordination Centre (RCC) and its impact.

Responding, Mr Bloomfield reminded the meeting that the RCC, which was hosted by NIAS, had been established through a joint initiative by all six Trusts. He confirmed that a stocktake had been undertaken and explained that the initial intention had been to do an evaluation in March/April but Chief Executives had agreed that this was too early in its operation to give any sense of its impact. Mr Bloomfield said that Chief Executives had instead commissioned an independent stocktake to highlight how the RCC's operation might be improved and added that, as a result of the stocktake, the focus of the RCC had now moved to one of service improvement. He indicated that the daily calls with the RCC had been reduced from two to one call daily and there was more emphasis by RCC associates working with Trusts to make changes around hospital flow.

Mr Bloomfield said that terms of reference had been developed for a full evaluation to be completed later in the year. He noted that the view had been that the RCC had added benefit and said this view was shared with the SPPG as bringing an element of control to the system. Mr Bloomfield said that the daily calls also meant there was a greater awareness of pressures across the system and provided more timely opportunities to assist Trusts.

Continuing, Mr Bloomfield said that the Permanent Secretary had recently joined a meeting of the Trust Chief Executives and had expressed an interest in understanding the benefits of the RCC. He said that the Permanent Secretary was mindful that the RCC was a Trust initiative but was clear that it would be important to start to see evidence of its impact reasonably soon.

Mr Quinn said he would be keen to see the outcome of the evaluation. He referred to the Board's visit to the RCC and its emphasis on control and the shift to quality improvement.

Mr Bloomfield explained that initially there were two daily calls, with the option of a third if required, but feedback from Trusts had been that that arrangement was too labour intensive. He said the decision to move to one daily call was a temporary one and was being monitored.

Ms Byrne explained that the RCC had aligned its staff to assume an 'affiliate' relationship with individual Trusts and to use the information collated based on discussions through the RCC to ascertain the position regarding flow, how ambulance resources could be released early and what was taking place at the 'back door'. However, she acknowledged that the RCC focus needed to be wider.

Mr Bloomfield said it would be important to examine a broad range of evidence to determine the difference the RCC was making

Ms Paterson advised that the RCC had identified four main themes to focus on across Trusts. She advised that one of these was the levelling up of performance and said a baseline exercise was currently being undertaken which would inform the performance targets to which each Trust would adhere. These in turn would filter into the local plans due to be submitted to the SPPG in September 2024.

Mr Bloomfield confirmed that the RCC workplan from April to September 2024 had been agreed by all Trusts. He cited the example of the variation of patient pathways across Trusts and believed the RCC provided the opportunity to bring Trusts together with a view to standardising pathways and consider referral pathways and associated opening hours.

4 Chair's Update

The Chair commenced her update by thanking Mr Quinn for attending the Health Inequalities briefing session organised by the Association of Ambulance Chief Executives (AACE) on 5 June and for his written brief of discussions which had subsequently been shared with the Board.

The Chair alluded to the Board Leadership Programme and the potential for an individual to speak collectively to the Board around governance issues. She said she would include this on the agenda for the Chair and Non-Executive Directors' update on 15 August to discuss the benefits of this.

The Chair thanked those members who had already met with her to discuss appraisals and noted she had yet to meet with Dr Graham and Mr Quinn.

She noted that, as part of her Chair appraisal, she had asked members to complete a Chair evaluation form. The Chair thanked members for doing so and said she had reflected their feedback in her appraisal and would consider it moving forward.

Continuing, the Chair advised that the HSC Chairs wrote a joint public letter in relation to the potential consequences of the budget in terms of having to implement high impact savings plans. She added that Minister Swann at the time had referred to the letter in his subsequent rationale for not supporting the budget put forward by the NI Assembly.

The Chair advised that the HSC Chairs had recently had a positive meeting with Minister Nesbitt.

She said she had also met with DoH colleagues to discuss the Partnership Agreement and was delighted that Mr Doran would join the meeting later to discuss this issue.

The Chair indicated that the Permanent Secretary was leading on work in relation to a new commissioning approach. She explained that two areas of work had been prioritised, namely the commissioning approach and strategic narrative, and said several meetings had been held to discuss both. The Chair explained that a paper which aimed to set out a statement of intent to support

priorities and the Minister moving forward had been developed for the Minister's consideration as well as a proposal to explore the potential to establish Provider Collaborative Boards. The Chair advised that a meeting of HSC Chairs and Chief Executives with DoH colleagues had been scheduled for 1 July to discuss further.

She said it would be important to highlight what this would mean for the Board if the concept of Provider Collaborative Boards progressed. The Chair explained that there was potential for some priority areas to move to a new governance structure overseen by the Provider Collaborative Board. This would mean that the NIAS Board would be part of decisions which may not necessarily be in the interests of NIAS but would be for the benefit of the wider HSC. The Chair said there would then be an onus to ensure discussion took place at the full Board with a view to seeking influence or agreement. She acknowledged that further work was required around the governance structures and emphasised that the HSC Chairs had indicated the need for there to be a considered view amongst Chairs before further discussion would take place. She welcomed any comments from members before the meeting on 1 July.

The Chair said she continued to undertake a schedule of engagements to meet with staff throughout the Trust.

She reported that she had met with Ms Lemon on 30 May and had discussed sexual safety and equality and diversity at length. Ms Lemon advised that Ms Bron Biddle, the national lead for sexual safety, was keen to meet with individual Boards to discuss this work and added it was hoped she would attend the October Trust Board.

The Chair advised that she had met with Ms Lorraine McAteer in mid-June to discuss her Masters in person-centred care. She explained that she had initially met Ms McAteer at the leadership conference in April and had been keen to meet with her to discuss her work further. The Chair said she had commended Ms McAteer on the significant achievement of having her research placed in the library. She said she had asked Ms Charlton and Mr Sinclair to arrange to meet with Ms McAteer to hear more about her work and said she looked forward to hearing about the outcome of their discussions.

Ms Charlton referred to the linkages with the points previously made by Mr Quinn in relation to a human rights approach and learning from other jurisdictions. She alluded to the PHA-led regional work in relation to Shared Decision Making Framework which focussed on person centred care and advised that NIAS was represented on this group.

The Chair suggested that Mr Quinn might avail of the opportunity to join the meeting if he wished.

The Chair said she and Mr Corrigan had attended a session organised by the Chief Executives' and Chairs' Forum in relation to the budget with the Minister of Finance and the Permanent Secretary.

She reported that she had also attended the NHS Confederation Expo in Manchester and welcomed the opportunity to hear at first hand from other colleagues in health and social care.

Concluding her remarks, the Chair advised that she had met with colleagues from Internal Audit to receive an overview of the Board Effectiveness audit which would be commencing in the coming weeks. She alluded to the reference to 'Board Effectiveness' in the Partnership Agreement and advised that she had spoken with another Trust Chair who intended to raise the issue with the DoH.

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

5 **Chief Executive's Update**

Mr Bloomfield commenced his report by updating on operational pressures and advised that there had been a slightly improved position in May in terms of cover and the stack of calls waiting at any time was more manageable. He added that, while handover delays remained an issue, there were fewer extreme delays which had been experienced previously.

Mr Bloomfield said that this position had continued until the second week in June when pressures increased considerably. He indicated that the Trust was experiencing lengthy delays for responses to Cat 2 and Cat 3 calls as well as seeing a large number of calls waiting on the stack. In addition, he said the Trust had implemented its Clinical Safety Plan, escalating to levels 3 and 4 regularly. He

added that delayed handovers had also started to creep up to the hours waiting experienced previously.

Mr Bloomfield advised that, while the Trust had had some recent and short-term staffing challenges to cover, the pressures had been system-wide and not solely an issue within NIAS. He said there had been low discharge numbers from most hospitals and advised that NIAS continued to take measures it could by trying to increase capacity.

Continuing, Mr Bloomfield said that the Trust had definitely seen the benefits of the Integrated Clinical Hub (ICH) during this time and believed that, although the Hub did not resolve the issues, it provided an element of safety and reassurance as well as providing regular updates to callers in terms of maintaining contact with those callers waiting for a response. Mr Bloomfield advised that he had been impressed and reassured by the number of calls resolved by the ICH through Hear & Treat and avoiding the need to send an emergency response. He believed that if the Trust built on the performance of the ICH over the last several months, it would assist the Trust as it approached winter.

Mr Bloomfield said he had been pleased to welcome Minister Nesbitt to NIAS on 11 June 2024 when he had met with members of the Senior Management Team who briefed him on the initiatives being taken by the Trust to address the challenges facing it. He said that the Trust had taken the opportunity to highlight the significant contribution being made by the service to the wider transformation agenda – whether that was through the reconfiguration of services, providing care closer to home or alternatives to EDs, all of which would improve patient care. Mr Bloomfield said that the Minister had also taken the opportunity to visit and meet with staff in the Emergency Operations Control.

Mr Bloomfield said he had previously advised the Board that he was a member of the Road Safety Strategic Forum established by the Department of Infrastructure following an increase in road fatalities. He advised that the Forum had met at the end of May and had agreed a set of actions to be included within the wider Road Safety Strategy. He clarified that the Trust's contribution was mainly around community education and how the Trust might be able to support road safety campaigns by staff describing the traumatic experiences they have responded to. Mr Bloomfield said that,

related to this work, the Trust was participating in an event being organised by the PSNI to highlight the work of the Collision Investigation Unit. He said this was important work which the Trust would be keen to lend its full support.

Continuing his update, Mr Bloomfield advised that a number of officers met with colleagues from the NI Fire and Rescue Service (NIFRS) in mid-June to discuss further the Trust's possible use of the new NIFRS training facility at Cookstown. He added that further work was required by NIFRS in relation to costs and said that NIFRS was confident it could meet the Trust's requirements on an ongoing basis. Mr Bloomfield said that a number of Trust officers were due to visit the Cookstown facilities later in the month and he undertook to keep the Board apprised.

Mr Bloomfield reported that he had attended the NHS Confederation Expo Conference in Manchester on 12-13 June 2024. He said the Conference, which was free to attend, had over 7,000 delegates in attendance and had a number of sessions which were directly relevant to the ambulance sector. He commented that he had been encouraged by several of the keynote speakers, for example, Ms Pritchard and Mr Taylor, both of whom had referenced the ambulance sector in their speeches in terms of the central role the sector could play in the transformation of services.

Mr Bloomfield noted that the Trust Chief Executives had met with the new regional Executive Officers in the Health Service Executive (HSE) in the Republic of Ireland (RoI) on 14 June 2024. He explained that the Republic's health sector had recently been restructured and there were now six regions. He said that there had already been good collaboration through Co-operation And Working Together (CAWT) but that this had focussed on the border Trusts primarily. Mr Bloomfield said this initial meeting had agreed some areas where there was potential value in exploring wider collaboration. He indicated that the intention was to meet 3-4 times per year and he had asked for his counterpart from the National Ambulance Service (NAS) in the RoI to be included in future meetings. Mr Bloomfield noted the already positive engagement with NAS and believed it would be helpful for NAS to be involved in these meetings to consider system issues.

Mr Bloomfield referred to the concept of Provider Collaborative Boards (PCB) and noted that discussions had been ongoing in

relation to how these might operate in NI. He explained that PCBs were common in England and basically were a group of provider organisations which met to agree areas where joint working might be effective. Mr Bloomfield suggested that the RCC might be considered as an example of a PCB and, while not acting as a Collaborative Board, was a good example of collaboration. He cited a potential example as being a number of elective specialties where the waiting time could be one year in one Trust area but five years elsewhere and added that the PCB would work collaboratively to equalise the waiting time in all Trusts for example.

Mr Bloomfield advised that discussions around establishing PCBs had been ongoing for some time and he believed it was now timely to decide on whether a PCB should be established in NI. He noted that the DoH had alluded to PCBs in their revised commissioning arrangements. Mr Bloomfield said that a key issue would be the governance arrangements around the PCB. He commented that a common feature appeared to be the establishment of a Committee comprising one representative from each of the providers and that this Committee would take decisions on behalf of all organisations and report back to respective Trust Boards.

Mr Corrigan emphasised the importance of having effective accountability and governance arrangements.

The Chair alluded to the risk around handover delays and the ability to challenge other Trusts.

Mr Quinn alluded to Mr Bloomfield's reference to his meeting with colleagues from the RoI and said it was his understanding that significant resources were available for cross border collaboration, in particular from a research perspective. He cited the example of the work being taken forward by Mr Sinclair. Mr Quinn acknowledged the significant work involved in applying for such funding but noted the availability of funding.

Mr Bloomfield noted that one of the areas of work agreed by that meeting had been to identify priorities with a view to accessing such funding.

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

6 **Partnership Agreement (TB27/06/2024/03)**

The Chair welcomed Mr Doran to the meeting. Mr Doran said that he had recently assumed responsibility for NIAS policy and sponsorship within the DoH. He thanked the Chair for the opportunity to attend the meeting and said there was a real willingness within the DoH to embrace partnership working.

The Chair reminded the meeting that the Board had had an initial discussion on the Partnership Agreement at the March meeting and had identified a number of concerns. She highlighted the Board's willingness to work in partnership.

Ms Paterson summarised the concerns in relation to the presentation, clarity on meaning and the vocabulary used in the agreement. She cited specific examples which included references to outdated legislation, the need for explicit examples of codes of practice and the necessity for transparency and collaboration.

Ms Paterson advised that, since the Board had first considered the Partnership Agreement, there had been several meetings between the Chair and DoH officials and herself to discuss and agree how best to address and resolve these issues. She pointed out that clarifications and updates had been made to the Agreement to reflect current legislation, specific examples and strategic collaboration frameworks.

Mr Doran indicated that there was currently significant engagement between the Trust and DoH officials and emphasised that this would continue. He said the DoH had provided some additional resources to support the partnership role.

Mr Ashford noted that the Partnership Agreement would replace the current Management Statement Financial Memorandum (MSFM) and asked if there would be a transition period.

Responding, Mr Doran explained that there would not be a transitional period and that, once signed, the Partnership Agreement would come into operation.

Ms Paterson highlighted the importance of the Engagement Plan which would be reviewed on an annual basis.

Mr Ashford agreed that the Engagement Plan was a key element within the Agreement and it would be important to ensure its accuracy.

Mr Doran highlighted the importance of ongoing engagement.

The Chair advised that she had met with Mr Wilkinson who clarified that NIAS would continue to engage with him in his DoH role. She highlighted the need for both parties to continue to engage with each other with a view to fully understanding each other's challenges and opportunities. The Chair pointed out that the Trust had not yet had sight of the DoH Risk Register and alluded to the reference within the Agreement that there would be a 'shared understanding of the risks that may impact on each other, and these are reflected in respective Risk Registers.'

The Chair noted the work being taken forward by Dr Graham, Chair of the Trust's Audit and Risk Assurance Committee, to review the Trust's Corporate Risk Register. She said it would be the Trust's intention to progress this work and engage with the DoH at an early stage around strategic prioritisation with a view to putting the necessary mitigations in place to inform strategic priorities going forward.

Mr Corrigan commented that Partnership Agreements between the DoH and Arms' Length Bodies (ALBs) were not new and had been in place for several years. However, he pointed out that the key action was to ensure the Agreement was given life and resulted in real partnership working.

Mr Doran agreed with Mr Corrigan's comments and said there had been a very positive working relationship between the DoH and NIAS over the years and he intended that this would continue. He agreed that it was very much the behaviours of both parties as opposed to the content of the Partnership Agreement.

Mr Quinn referred to the list of relevant legislation and pointed to the omission of The Health and Personal Social Services (Quality, Improvement and Regulation) (NI) Order 2003 which focussed on the statutory duty of quality as well as describing the accountability arrangements between Trusts and the DoH.

Mr Quinn said he was conscious that quality and safety issues account for a significant amount of risk within Trusts and added he was aware of ongoing discussions around improvements in this area within the organisation. He highlighted the importance of getting to know how the Trust recognised and dealt with quality and safety risks and whether the DoH, in its work with the Trust, also recognised that.

The Chair indicated that the Trust had recognised and responded to risks in the absence of any additional funding or resources from the DoH. She believed that Mr Quinn had made a valid point and reference to the legislation should be made within the Agreement.

The Chair said she would encourage DoH involvement in Trust Committees or attendance at Trust Board meetings and would welcome any feedback for consideration.

Following this discussion, the Board **APPROVED** the Partnership Agreement for signature by the Chair.

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

7 **Draft Corporate Plan 2024-26 (TB27/06/2024/04)**

The Chair welcomed Mr Mullen to the meeting.

Ms Paterson drew members' attention to the draft Corporate Plan which covered a two-year period from 2024-26. She explained that the Plan would be executed through integrated performance management and governance frameworks with various governance structures set up to manage and scrutinise its delivery.

Ms Paterson alluded to the Delivering Value Programme Terms of Reference which would be considered later in the meeting and advised that this would effectively be the governance mechanism for consideration of the key priorities within the Plan. She indicated that Directorate plans would take forward those remaining actions articulated in the Corporate Plan.

Mr Mullen explained that he was seeking Trust Board approval to the Plan which covered a two-year timeframe from 2024-26 and aligned to the remaining timeframe for the Strategy. He alluded to

the Strategic Planning workshop which had taken place in February when members had determined the need to look at and develop refreshed narrative and identify strategic outcomes for the Trust with a view to achieving these over the next several years. Mr Mullen said that these would act as the top priorities to be achieved from the Strategic Plan and said it would be important that the Corporate Plan aligned with these priorities.

Mr Mullen alluded to Slide 5 which represented the Plan on a page. He explained that this had been used as a touchpoint to ensure that all priorities, enablers and performance management framework were integrated into the process.

Continuing, Mr Mullen referred to the six strategic outcomes which impacted on patients, partners and people, ie the Trust workforce. Mr Mullen advised that Slide 8 provided an example of what the implementation plan might look like and explained that adjustments had been made to ensure that any deliverables were connected to the relevant governance and accountability structures.

Mr Ashford highlighted the need to proof-read the document. He referred to page 8 of the draft Plan and the intention to 'establish an effective education and training strategy' and believed this had already been achieved. It was clarified that this was specifically in relation to organisational culture.

Mr Corrigan suggested that the Plan would be helpful when reviewing the Trust's Committee structure to ensure all strategic objectives dovetailed.

Mr Quinn agreed with the points made by Mr Ashford and said he had found elements of the paper difficult to understand.

With regard to Culture and Wellbeing, Mr Quinn was of the view that Staff Wellbeing could be a workstream within Culture. He believed that there should be wider discussions around culture and said it would be important to look at culture in the context of how service users, the public and partners perceived the Trust as well as taking account of their experiences. Mr Quinn alluded to the action points feeding into the wider culture element and said that one issue discussed at the Strategic Planning event had been to undertake a baseline audit or assessment of culture. He acknowledged this would be a major piece of work and the completion of this would

require a specific workstream or objective. Mr Quinn pointed out that there had been some discussion as to how that might be managed moving forward and whether it should form part of a specific workstream with a specific governance structure.

He alluded to Mr Ashford's point around education and said that, from a culture perspective, there were issues on how value-based and behavioural competencies might be incorporated. He believed that the way in which it had been captured within the Plan needed to be expanded and associated action points should reflect how this might be achieved.

Ms Lemon suggested that it might be beneficial to separate this and reflect organisational culture.

The Chair suggested that it might be helpful for Mr Quinn to engage with Mr Mullen in the interim.

Mr Dennison acknowledged the work which had been undertaken to align the draft Plan with the Strategy and suggested that the Plan should focus on outcomes rather than objectives. He asked how progress would be tracked and how the Board might know that these had been achieved. Mr Dennison said he was unsure as to how progress would be measured. He referred to the significant amount of work to be undertaken in a relatively short timeframe and asked how the Board would know that it had been successful.

Responding, Mr Bloomfield explained that the draft Plan attempted to prioritise what needed to be addressed in the remaining two years of the Strategic Plan while the Strategic Plan set out the objectives to be achieved and the rationale for doing so. He suggested that the outcomes might be measured in how the organisation would feel and behave differently when the Strategic Plan was implemented. He acknowledged that it was challenging not to describe the work to be done as a list of objectives but said there was a need to clarify linkages with the benefits and results.

Mr Quinn suggested that it might be helpful to reflect this in the staged map to ensure outcomes were brought more to the fore. He said that, when alluding to outcomes, the Trust was looking to what form these would take in two years' time.

Mr Bloomfield commented that the draft Plan would help the Trust to realise that vision.

Mr Dennison asked what priorities were and suggested that, as currently written, all objectives appeared to be priorities.

Mr Quinn alluded to Mr Bloomfield's earlier reference to pressures on staff and suggested that it might be helpful to identify priorities. He added that it would also be useful to determine the capacity of staff to achieve these. Mr Quinn added that priorities had been suggested at the Strategic Planning workshop.

Ms Paterson clarified that the draft Plan before the Board was public-facing. In terms of the implementation plan, she explained that, when one considered the Delivering Value Programme Terms of Reference, there were quantifiable benefits and Key Performance Indicators articulated against each of the measures and progress on these would ensure the delivery of the strategic outcomes.

Ms Paterson acknowledged the detail contained within Slide 5. However, she believed that the implementation plan would provide further clarity and enable members to understand the metrics and assess delivery towards each objective in the Plan.

The Chair highlighted the importance of streamlining both the Strategic and Corporate Plans with a view to focussing on the outcomes.

Dr Graham suggested that the reference to 'provide clear direction and leadership' should be removed as this should be integral to progressing work within the Trust.

Mr Corrigan believed that the implementation plan would be key.

Dr Graham agreed and said it would be helpful to consider both the draft Plan and implementation plan in parallel.

Following this discussion, the Board **APPROVED** the NIAS Corporate Plan 2024-26.

8 **NIAS Annual Safeguarding Position Report (TB27/06/2024/05)**

Ms Charlton drew members' attention to the Trust's Annual Safeguarding Position Report and explained that all Trusts were required to provide a report to their respective Trust Boards to reflect the organisation's compliance with regional adult and children's safeguarding policies. She advised that a generic template was provided to Trusts for completion and that approval was sought from the Board to the NIAS report.

Ms Charlton said that the report reflected progress against the recommendations within the Improvement Plan from the Regulation and Quality Improvement Authority as well as the recommendations from the peer review undertaken by the London and Welsh Ambulance Services under the auspices of the AACE.

Ms Charlton thanked Mr Quinn, as the Non-Executive Safeguarding Lead, for taking the time to review the report and provide comments in advance of the Safety Committee. She said she would also like to take this opportunity to acknowledge the leadership shown by Mr Flannagan.

Continuing, Ms Charlton explained that the report had been discussed in detail by the Trust's Safety Committee at its meeting on 13 June 2024 and she went on to highlight several salient points.

Continuing, Ms Charlton said that members would be aware of the challenges for staff in navigating multiple welfare referral pathways across Divisions. She indicated that, despite concerted efforts, NIAS had not been able to secure single Trust pathways across the region. However, she advised that, in order to mitigate against the risks and strengthen assurance as well as removing the challenges faced by staff, the Trust had put a new process in place whereby the Safeguarding Navigator would navigate the welfare referral to the appropriate teams within other Trusts. Ms Charlton said that this should also reduce the operational downtime required to make the referral.

Ms Charlton indicated that it was important for the Trust to have a standardised and just approach to dealing with allegations against staff and she advised of the cross-Directorate contributions to the development of policy entitled 'Managing Allegations against People Who Work With Children, Young People or Adults at Risk'. This

had been approved by the Safety Committee at its meeting on 13 June 2024. She said that work was being progressed with colleagues in Human Resources (HR) around the current vetting processes in place. Ms Charlton highlighted the importance of this policy, particularly in light of recent regional and national inquiries.

She advised that the report also made reference to working with HR colleagues to review current vetting processes to reflect any considerations in line with best practice.

Ms Charlton said she was grateful to the Senior Management Team for support to take forward improvements in the Safeguarding Team structure this year with the appointment of a Safeguarding Practitioner and approval to appoint the Safeguarding Navigator post.

She said that members would be aware from the previous position report that the Trust was a significant outlier in terms of benchmarking with other ambulance services in relation to safeguarding referrals per contact. Ms Charlton said it would be important to explore this further as it may indicate a failure to recognise. She reported an 19% increase in referrals in this reporting period compared to last year was to be welcomed, however, the Trust remained an outlier. She added that the Safeguarding Team would continue to work closely with Education colleagues to improve the referral rate and ensure improvements in referral pathways.

Ms Charlton advised that there was a three-year trajectory improvement plan to address the non-compliance in respect of training and education in line with the strategy. She conveyed her thanks to Mr Sinclair and his team for permitting the provision of safeguarding sessions on clinical education days.

The Chair referred to the 19% increase in referral rates and questioned the three-year improvement plan to achieve the provision of Level 3 to all patient-facing staff.

Ms Charlton explained that, in order to prioritise the risk, and in the context of many competing priorities to be delivered within the education programme, it was envisaged three years would be required to deliver the necessary training to all patient-facing staff.

Mr Sinclair acknowledged the challenges faced by the Education Team in terms of incorporating the safeguarding sessions into the clinical education days. However, he said the team would monitor the situation.

Ms Byrne advised that, from an Operations perspective, everything possible was being done to maximise attempting to release staff to undertake training.

Ms Charlton indicated that the Trust continued to deliver training to the AAP programme as well as the three-year programme. She advised that other ambulance sectors were experiencing similar challenges in delivering Level 3 Safeguarding face-to-face education. the programme. Ms Charlton reminded the meeting that the Trust did not have a safeguarding structure until relatively recently and she welcomed the significant progress which had been made in a short timeframe.

The Board **APPROVED** the NIAS Annual Safeguarding Position Report.

9 **Delivering Value Programme – Terms of Reference (TB27/06/2024/06)**

Ms Paterson explained that the Delivering Value Programme was the mechanism by which the Trust would performance manage the delivery of its priorities within the Strategic Plan. She noted that several targets were yet to be completed at 8.1 'Project Structures' and explained that these targets would then allow the development of Key Performance Indicators. This, she said, would be monitored and feedback provided in terms of progress against delivery of these specific areas of work.

Dr Graham commended the Terms of Reference.

Referring to the governance structures, Mr Corrigan alluded to the forthcoming review of the Trust's Committee structure and highlighted the importance of ensuring reports were shared with potentially new Committees.

Ms Lemon pointed out that the majority of work would be delivered through the AD Forum. However, she would continue to oversee absence management with Mr Cochrane.

The Board **APPROVED** the Delivering Value Programme Terms of Reference as presented by Ms Paterson.

10 **Financial Position 2024-25 – verbal update**

Mr Nicholson reminded the meeting that the NI Executive had approved the budget in April and the scale of the reductions required had been unprecedented.

He pointed out that, as the general election had been scheduled for 4 July, there had been a cessation in terms of any public discussion about budgets. However, work had continued in the background.

Mr Nicholson confirmed that, following approval by the Board in May, the Trust had submitted its Financial Plan to the SPPG and added that no formal response had yet been received. He advised that work was ongoing and said he expected there to be significant progress following the election.

Mr Nicholson advised that the Trust had submitted the Month 2 position to the SPPG and confirmed that it was reporting a breakeven position based on a number of income assumptions within the Financial Plan. He reminded the meeting that the Plan had been predicated on addressing ambulance handover times.

Mr Nicholson said that members would be aware of the recent media coverage in relation to the costs associated with community transport. He made members aware that it was likely there would be a focus on non-emergency patient transport over the coming weeks, particularly in relation to taxis and independent ambulance services.

Mr Bloomfield explained that the Trust's Financial Plan had allowed the Trust to submit a breakeven position and said the Trust did not have to consider high impact savings plans. However, he reiterated Mr Nicholson's point that the Plan had been predicated on addressing and improving handover delays. He pointed out that the Trust was now three months into the new financial year and no improvements had been made to date.

The Board **NOTED** the verbal update provided by Mr Nicholson.

11 **Trust Performance Corporate Scorecard (April 2024) (TB27/06/2024/07)**

Ms Paterson referred to the Executive Summary and acknowledged that performance had not improved greatly in several areas. She highlighted the need to consider how, at a strategic level, the Trust might be in a position to influence that and how best to share the relevant information and data with DoH and Trust colleagues. She welcomed the impact of the Integrated Clinical Hub (ICH).

Mr Quinn reiterated his comment about being impressed by the work of the ICH and noted that, indicative of its success, those working within the ICH would also be working under significant pressure. He said he was aware that Mr Sinclair through the education programme was currently progressing work around clinical supervision and felt that, as working at a distance, ICH staff should be a prioritised group for clinical supervision and support.

Ms Byrne pointed out that ICH staff continued to spend some time in the Emergency Operations Control (EOC). However, she agreed to discuss this with Mr Sinclair.

Mr Corrigan alluded to the work being led by Ms Charlton in relation to Patient Care Service (PCS).

Ms Charlton said she hoped to bring a summary of the work to date to the August Trust Board meeting.

Ms Lemon reported on the continued improvement in respect of absence management and advised that May 2024 was the lowest month for sickness absence at 9.64%. She explained that 62% of the Trust's sickness absence was within the categories of mental health; injury/fracture; miscellaneous, influenza and untoward accident. However, the largest category for sickness absence within the Trust was for mental health reasons, with stress being cited as the most common reason.

Ms Lemon alluded to the redeployment of staff and advised that significant progress had been made in this area, with a small number of staff now remaining to be redeployed.

The Chair advised that she had recently met with the new cohort of Station Officers and they had raised the issue of temporary people

in posts. She said that this linked very much to the issue of culture within the organisation. The Chair sought further detail around the Operations restructure.

In response, Ms Byrne advised that a detailed paper would be presented at the PFOD Committee on 3 July with a view to bringing the implementation plan to the Committee at its September meeting.

Mr Bloomfield indicated that it was intended to start recruiting to the new structure in the 2024-25 year.

Ms Byrne reported that there had been some challenges in respect of call answering performance and she advised that performance had reduced to 87% in May. She said there were several causal factors including work/life balance, vacancies and sickness. Ms Byrne advised that there was an active recruitment process underway to stabilise the Control Room, either through the replacement of temporary posts or recruitment of additional staff.

Continuing, Ms Byrne pointed out that the volume of duplicate calls into the Control Room had increased and believed this reflected the pressures being experienced across the HSC system. She said she would engage with Mr Sinclair to determine whether there was a correlation between duplicate call volume, time of day, time of week and the work undertaken by the ICH. Ms Byrne suggested that this might be helpful in providing further evidence as to the benefits of the ICH.

Mr Bloomfield welcomed the progress around absence management and said he was of the view that the pace of improvement would now start to plateau and said it would be important to manage expectations. Mr Bloomfield said that the focus should now be on sustaining the improvements made to date.

The Board **NOTED** the Trust Performance Corporate Scorecard (April 2024).

12 **Committee Business:**

- **Audit & Risk Assurance Committee – minutes of meeting on 1 February 2024 & report of meeting on 16 May 2024;**
- **Safety, Quality, Patient Experience & Performance Committee – minutes of meeting on 25 April 2024 & report of meeting on 13 June 2024 (TB27/06/2024/08)**

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

13 **Date of Next Meeting**

The next NIAS Trust Board will be held on Thursday 22 August 2024 at 10.30am in the Boardroom, NIAS HQ.

14 **Any Other Business**

There were no items of Any Other Business.

THIS BEING ALL THE BUSINESS, THE CHAIR CLOSED THE PUBLIC MEETING AT 3.40PM.

SIGNED: _____

DATE: _____

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD – 27 JUNE 2024

		INDIVIDUAL ACTIONING	UPDATE
	PUBLIC		
1	Chair/NEDs' agenda: - use Corporate Plan as tool to review Committee structure	ML/CM	Ongoing
2	Keep Board apprised of developments with NIFRS re use of Cookstown training facility	MB	Ongoing

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

PRESENTATION OF PAPER

Date of Trust Board:	22 August 2024
Title of paper:	Patient Care Service Improvement
Brief summary:	The PCS Improvement presentation will provide an overview of the PCS Non-Emergency Service and will outline the improvement journey to date.. A brief background of the service will be provided to summarise the regional and organisational drivers for change, commissioning arrangements as well as staff and service users' perspectives. The presentation will focus on current challenges and opportunities whilst outlining current improvement and performance data and will conclude with future considerations for the service.
Recommendation:	**For Approval** ☐ **For Noting** ☒
Previous forum:	SMT – 13/8/24
Prepared and presented by: **Date:**	Lynne Charlton, Director of Quality, Safety & Improvement 15 August 2024

Patient Care Service Improvement

Northern Ireland Ambulance Service
Health and Social Care Trust

Trust Board 22.08.24

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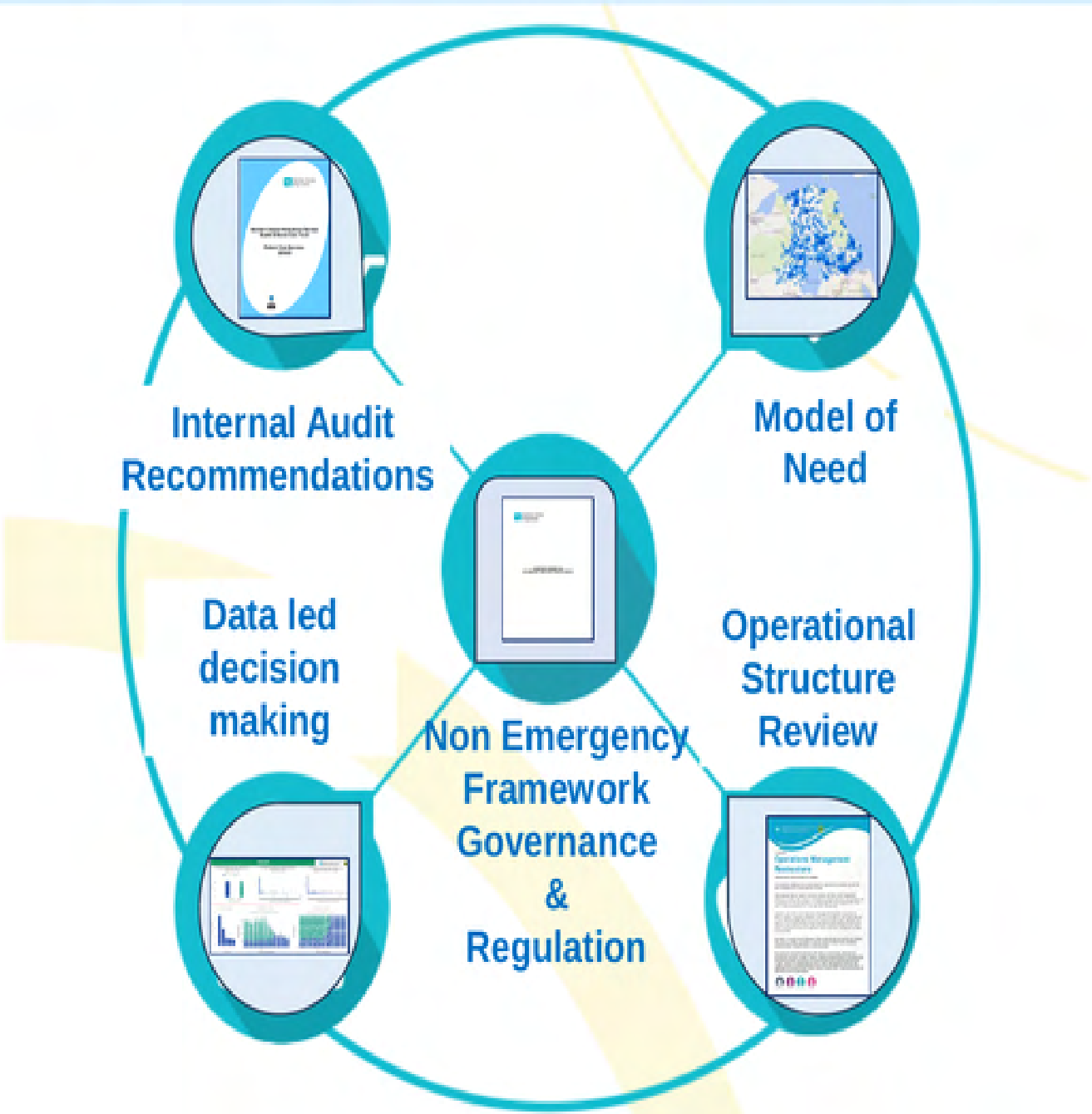
Background

Back to Agenda

Challenges & Opportunities

Challenges & Opportunities



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Further Future Considerations

Thank you

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

PRESENTATION OF PAPER

Date of Trust Board:	22 August 2024
Title of paper:	Mental Health Practitioners in ICH
Brief summary:	This presentation by Karl Bloomer, will provide a high-level update on the Mental Health Practitioners in the NIAS Integrated Clinical Hub (ICH) project to date. Strategic background from the wider HSC mental health strategy, detail of MHP involvement and days of cover will be provided as well as details on numbers and high-level demographics of patient cohorts managed in the initial stages of the project. The paper also sets out the next steps, including the intention to consider widening the scope of the project.
Recommendation:	**For Approval** ☐ **For Noting** ☒
Previous forum:	*SMT – 13/8/24*
Prepared and presented by: **Date:**	Seamus Mullen, Head of Planning Karl Bloomer, Consultant Paramedic Urgent Care 15 August 2024

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Mental Health Practitioners Within the NIAS Integrated Clinical Hub

Strategic drivers:

RCC/HSC Locality Plan

- Improve pre-hospital demand management
- Increase Hear & Treat rates

Protect Life Strategy:

- Reduce suicide rate by 10%
- Provide timely de-escalation services
- Train 50% of frontline staff

Mental Health Strategy:

- Reduction ED attendance due to MH crisis
- Regionally coherent crisis services
- Reduction in number of people waiting more than 2h for support

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NIAS MHP / ICH Pilot Model

- Integration of Mental Health Professionals in control room and ICH
- Testing of mental health professionals dealing with appropriate calls in NIAS EOC.
  - Pilot testing in SEHSCT areas – WHSCT training partly completed
- Test time April 2024 to end March 2026, Friday, Saturday, Sunday evenings 6pm to 2am
- SEHSCT Professionals are operational in the pilot on Friday, Saturday and Sunday evenings.

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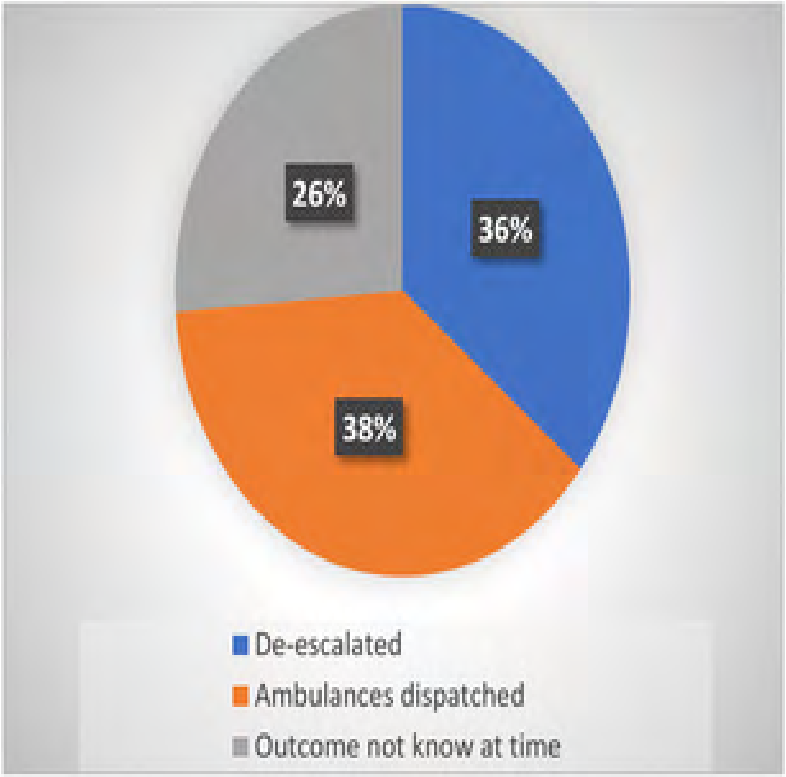
Initial Data

Handling of appropriate calls by MH Professionals (36% H&T rate)

De-escalation of callers and reduce attendance to ED for callers meeting inclusion criteria (conveyance 25%)

Referral to HSCT pathway for callers (26%)



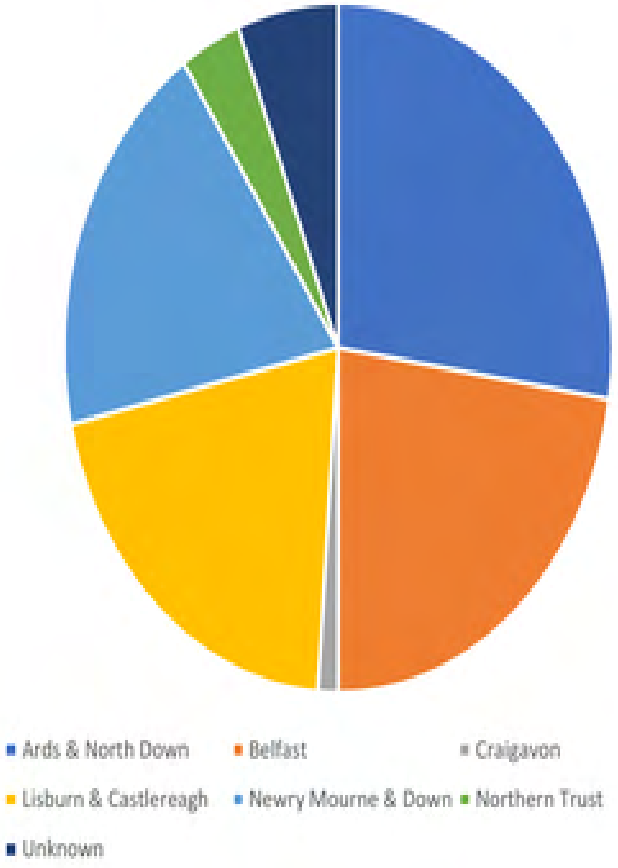
Project Start (15th March to June 22nd inclusive)
SEHSCT data source

- 84 calls completed to date.
- 30 patients de-escalated by service and did not require transport to ED
- 32 Ambulances dispatched
- 22 unknown outcome – 6 of these case discussions with CSD and/or paramedic on site

Northern Ireland Ambulance Service
Health and Social Care Trust

Initial Data

- **Locality of patients managed**
  - 23 Ards & North Down
  - 19 Belfast
  - 1 Craigavon
  - 17 Lisburn & Castlereagh
  - 16 Newry Mourne & Down
  - 3 Northern Trust
  - 5 Unknown



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Additional Benefits Of MHPs

- MHPs have provided informal education day to ICH clinicians on the Mental Capacity Act, Deprivation of Liberty and general Mental Health assessment:
  - Improved confidence of ICH clinicians for MH assessments
  - Plans to further develop and expand sessions

- Peer support for EOC:
  - MHPs have provided peer support or both ICH clinicians and wider EOC staff who have dealt with traumatic calls relating to mental health on shift

Northern Ireland Ambulance Service
Health and Social Care Trust

Next steps:

- Complete WHSCT training and operationalise in EOC
- Independent evaluation, PHA Health Intelligence
- Synchronise and streamline data collection
- Regionalise coverage
- Utilise voluntary sector/Lifeline pathways
- Utilise Provider Collaborative model to consolidate?

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 Board:	22 August 2024
Title of paper:	NIAS Board Governance Self-Assessment Tool (BGSAT) 2023-24
Brief summary:	The Trust is required to complete the BGSAT on an annual basis. The BGSAT for the year ended 31 March 2024 was endorsed by the ARAC at its meeting on 27 June and recommended for approval by Trust Board. The Senior Management Team will oversee the implementation of an action plan to address those areas where further attention is required and will provide an update report to the ARAC by the end of the 2024-25 year.
Recommendation:	**For Approval** ☒ **For Noting** ☐
Previous forum:	SMT – 18/6/24 ARAC – 27/6/24
Prepared and presented by: **Date:**	Carol Mooney, Board Secretary Maxine Paterson, Director of PP&CS 15 August 2024

5. Board Governance Self- Assessment Submission

Name of ALB.....NIAS.....

Date of Board Meeting at which Submission was discussed _22 August 2024___ (Date)

Approved by _____ (ALB Chair)

NIAS
Board Governance Self-Assessment
for
2023-24

DATE: 22 August 2024

1. Board composition and commitment

1.1 Board positions and size

Ref	Prompt	NIAS Assessment	Evidence of compliance with good practice (Please reference supporting documentation below)	Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or areas where additional assurance is required.
GP1	The size of the Board (including voting and non-voting members of the Board) and Board Committees is appropriate for the requirements of the business. All voting positions are substantively filled.	G	Board and Committee papers and minutes			Terms of office for a further two NEDs finished in November 2023, resulting in three NED vacancies on the Trust Board between November 2023 – December 2023. A recruitment exercise was undertaken by PAU in the late summer/ autumn of 2023 and resulted in one NED taking up post on 11/12/23 and a further two NEDs taking up post on 1/1/24.
GP2	The Board ensures that it is provided with appropriate advice, guidance and support to enable it to effectively discharge it responsibilities.	G	Board and Committee papers and minutes	The Trust continues to seek members' views on the information they would wish to have presented.		

GP3	It is clear who on the Board is entitled to vote.	G	Standing Orders Board and Committee papers and minutes			
GP4	The composition of the Board and Board Committees accord with the requirements of the relevant Establishment Order or other legislation, and/or the ALB's Standing Orders.	G	Standing Orders Establishment Order Board and Committee papers and minutes			
GP5	Where necessary, the appointment term of NEDs is staggered so they are not all due for re-appointment or to leave the Board within a short space of time.	G	NED Letters of Appointment			Terms of office for two NEDs will finish while the other three recently appointed NEDs are due to finish in close succession, but at a later date. DoH Appointment Unit should note the need to stagger terms of office.

1.1

Ref	Prompt	NIAS Assessment	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	The Chair and/or CE are currently interim or the position(s) vacant.	G		
RF2	There has been a high turnover in Board membership in the previous two years (i.e. 50% or more of the Board are new compared to two years ago).	G		Full complement of NEDs and Board membership now in place after a period of holding one vacancy
RF3	The number of people who routinely attend Board meetings hampers effective discussion and decision-making.	G		

1. Board composition and commitment

1.2 Balance and calibre of Board members

Ref	Prompt	NIAS Assessment	Evidence of compliance with good practice (Please reference supporting documentation below)	Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or areas where additional assurance is required.
GP1	The Board can clearly explain why the current balance of skills experience & knowledge amongst Board members is appropriate to effectively govern ALB over the next 3-5 years. In particular this includes consideration of the value each NED will provide in helping the Board to effectively oversee implementation of the ALB's business plan.	G	Board and Committee papers and minutes	An independent expert provides financial advice to the Trust's ARAC Independent clinical assurance is provided to the Trust's Safety Committee		With the Board now having its full complement of NEDs, it is envisaged that the Committees' reliance on the Independent Advisers will transition and reduce over the coming months.

GP2	The Board has an appropriate blend of NEDs e.g. from the public, private and voluntary sectors.	G	Board member biographies on website			
GP3	The Board has had due regard under *Section 75 of the Northern Ireland Act 1998 to the need to promote equality of opportunity: between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation; between men and women generally; between persons with a disability and persons without; and between persons with dependants and persons without*.	G	NIAS Section 75 return			
GP4	There is at least one NED with a background specific to the business of the ALB.	G	Board member biographies on website	The Trust has appointed a Senior Clinical Adviser to the Safety Cttee and an Independent Adviser to the ARAC to support NEDs in carrying out their challenge and		Two of the newly appointed NEDs have a Health background either professionally or within a NED previous role

				scrutiny function. See GP1 above.		
GP5	Where appropriate, the Board includes people with relevant technical and professional expertise.	G	Board member biographies on website	Independent expert financial advice and independent clinical assurance are provided to the Trust's ARAC and Safety Committees respectively. See GP4 above.		The Trust Chair has engaged with DoH PAU re NED recruitment. .
GP6	There is an appropriate balance between Board members (both Executive and NEDs) that are new to the Board (i.e. within their first 18 months) and those that have served on the Board for longer.	G	Staggered nature of members' terms of office refer			'Appropriate balance' is not defined. Measures to achieve balance are constrained and outside Trust control as NED appointments are made by DoH PAU.
GP7	The majority of the Board are experienced Board members.	G	Board member biographies on website			
GP8	The Chair of the Board has a demonstrable and recent track record of successfully leading a large and complex organisation, preferably in a regulated environment.	G	Chair's biography on website		.	. Definition of terms used is required

GP9	The Chair of the Board has previous non-executive experience.	G	Chair's biography on website			
GP10	At least one member of the Audit Committee has recent and relevant financial experience.	G	Board member biographies on website	The recently appointed ARAC Chair has recent and relevant financial experience. However, additional arrangements for independent expert financial advice to be provided to the ARAC will continue for the 2024-25 year.		

Ref	Prompt	NIAS Assessment	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	There are no NEDs with a recent and relevant financial background.	G		
RF2	There is no NED with current or recent (i.e. within the previous 2 years) experience in the private/ commercial sector.	G		
RF3	The majority of Board members are in their first Board position.	G		
RF4	The majority of Board members are new to the organisation (i.e. within their first 18 months).	G		
RF5	The balance in numbers of Executives and Non Executives is incorrect.	G		Between 17/11/23 – 11/12/23, the Trust had three NED vacancies.
RF6	There are insufficient numbers of Non	G		Between 17/11/23 – 11/12/23, the Trust had three NED vacancies. However, it was fortuitous that no Committees were scheduled.

	Executives to be able to operate committees.			

1. Board composition and commitment

1.3 Role of the Board

Ref	Prompt	NIAS Assessment	Evidence of compliance with good practice (Please reference supporting documentation below)	Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or areas where additional assurance is required.
GP1	The role and responsibilities of the Board have been clearly defined and communicated to all members.	G	Standing Orders Code of Conduct Induction programme Management Statement	Induction and related documentation for NEDs has been revised and feedback sought from NEDs.		
GP2	Board members are clear about the Minister's policies and expectations for their ALBs and have a clearly defined set of objectives, strategy and remit.	G	NIAS Strategy to Transform 2020-2026 NIAS Corporate Plan 2023-24 Appointment Letters	Strategic Planning day held on 15/2/24 to help inform the Corporate Plan for 2024-25. Regular attendance of Chair at meetings with Minister		
GP3	There is a clear understanding of the roles of Executive and Non-Executive Board members.	G	Code of Conduct Appointment Letters Standing Orders Job descriptions Management Statement	Work ongoing to finalise the Partnership Agreement which will replace the MSFM. Chair has directly discussed the		

				Partnership Agreement with sponsoring dept.		
GP4	The Board takes collective responsibility for the performance of the ALB.	G	Standing Orders Board & Committee minutes and papers			
GP5	NEDs are independent of management.	G	Standing Orders Board and Committee minutes and papers			
GP6	The Chair has a positive relationship with the Minister and sponsor Department	G		Chair attends regular meetings with senior DoH officials. A programme of regular meetings is established between the Permanent Secretary and Trust Chairs – with the restoration of the Assembly these meeting reverted to Minister level and Trust Chairs and are ongoing.		
GP7	The Board holds management to account for its performance through purposeful challenge and scrutiny.	G	Board and Committee papers and minutes	.		
GP8	The Board operates as an effective team.	G	Board and Committee papers and minutes	With full complement of NEDs now in place – NED sessions to		

				receive feedback and discussion on Board effectiveness are scheduled		
GP9	The Board shares corporate responsibility for all decisions taken and makes decisions based on clear evidence.	G	Board and Committee papers and minutes Standing Orders			
GP10	Board members respect confidentiality and sensitive information.	G	Board and Committee papers and minutes	Confidentiality of information is stressed at the start of meetings & reference included on agendas		
GP11	The Board governs, Executives manage.	G	Board and Committee papers and minutes Scheme of Delegation		NIAS Trust Board is a unitary Board, established by statute which includes Executives as Board members	
GP12	Individual Board members contribute fully to Board deliberations and exercise a healthy challenge function.	G	Board and Committee papers and minutes			
GP13	The Chair is a useful source of advice and guidance for Board members on any aspect of the Board.	G	Board and Committee papers and minutes			

GP14	The Chair leads meetings well, with a clear focus on the issues facing the ALB and allows full and open discussions before major decisions are taken.	G	Board and Committee papers and minutes			
GP15	The Board considers the concerns and needs of all stakeholders and actively manages its relationships with them.	G	PPI strategies Board and Committee papers and minutes Section 75 Return A Whistleblowing procedure is in place (this is currently being reviewed on a regional basis).	PPI, Whistleblowing & Speaking Out Champion identified	The Trust actively considers the concerns of stakeholders. The Trust has established a Patient Voice Forum; a Research Public Involvement Cttee; BWV Stakeholder Advisory Panel; Readers List. However, it is acknowledged that patient liaison is a challenge as patients are often unwell whilst in the care of NIAS.	
GP16	The Board is aware of and annually approves a scheme of delegation to its Committees.	G	Scheme of Delegation Committee Terms of Reference Standing Orders			
GP17	The Board is provided with timely and robust	A			The Board receives assurance through the	The Trust acknowledges further

	post-evaluation reviews on all major projects and programmes.				Strategic Implementation Group (SIG) on the delivery of major projects.	improvement is needed in this area.

1.3

Ref	Prompt	NIAS Assessment	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	The Chair looks constantly to the Chief Executive to speak or give a lead on issues.	G		The Chair also looks to Board members to contribute as appropriate.
RF2	The Board tends to focus on details and not on strategy and performance.	G		.
RF3	Board becomes involved in operational areas.	G		There are occasions when Board members need to focus on operational issues, for example when there is reputational risk or significant performance failure.
RF4	The Board is unable to take a decision without the Chief Executive's recommendation.	G		
RF5	The Board allows the Chief Executive	G		

	to dictate the Agenda.			
RF6	Regularly, one individual Board member dominates the debates or has an excessive influence on Board decision making.	G		

1. Board composition and commitment

1.4 Committees of the Board

Ref	Prompt	NIAS Assessment	Evidence of compliance with good practice (Please reference supporting documentation below)	Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or areas where additional assurance is required.
GP1	Clear terms of reference are drawn up for each Committee including whether it has powers to make decisions or only make recommendations to the Board.	G	Committee Terms of Reference Board and Committee papers and minutes Standing Orders			
GP2	Certain tasks or functions are delegated to the Committee but the Board as a whole is aware that it carries the ultimate responsibility for the actions of its Committees.	G	Committee Terms of Reference Board and Committee papers and minutes Standing Orders			
GP3	Schemes of delegation from the Board to the	G	Standing Orders Standing Financial Instructions			

	Committees are in place.					
GP4	There are clear lines of reporting and accountability in respect of each Committee back to the Board.	G	Committee Terms of Reference Board and Committee papers and minutes Standing Orders	Committee highlight report submitted to Trust Board following each Committee in advance of Board receiving approved minutes.		
GP5	The Board agrees with the Committees what assurances it requires and when, to feed its annual business cycle.	G	Committee Terms of Reference Governance Framework and Statement Board and Committee papers and minutes Standing Orders			
GP6	The Board receives regular reports from the Committees which summarises the key issues as well as decisions or recommendations made.	G	Board and Committee papers and minutes	Committee highlight report submitted to Trust Board following each Committee in advance of Board receiving approved minutes.		
GP7	The Board undertakes a formal and rigorous annual evaluation of the performance of its Committees.	G	Role of ARAC extended to include risk. Safety Cttee Chair working alongside senior Clinical Adviser to ensure Cttee members are well briefed on how to approach clinical scrutiny. PFOD Cttee underwent an extensive review both in relation to the	Committees continually evaluate their roles and performance and make adjustments as necessary. The Chair has advised of her intention to review		Not clear on terminology used, ie …'formal and rigorous'

			presentation of financial & HR elements.	Committee structure in summer 2024.		
GP8	It is clearly documented who is responsible for reporting back to the Board.	G	Committee Terms of Reference Board and Committee papers and minutes			

1.4

Ref	Prompt	NIAS Assessment	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	The Board notes the minutes of Committee meetings and reports, instead of discussing same.	G	Board agenda records Committee minutes as being 'For Information' but opportunity is given for the discussion of business conducted at Committee level. The Committee Chairs provide a Committee highlight report to draw Board members' attention to specific issues.	The Board Chair operates an 'open door' policy to NEDs and provides Committee Chairs with opportunity to identify issues which require Board attention.
RF2	Committee members do not receive performance management appraisals in relation to their Committee role.	G	.	Chair appraises NEDs on their Committee roles within their annual appraisal
RF3	There are no terms of reference for the Committees.	G		
RF4	Non Executives are unaware of their differing roles between the Board and Committees.	G		

RF5	The Agenda for Committee meetings is changed without proper discussion and/or at the behest of the Executive team	G		Committee agendas are shared with the respective Committee Chair in advance of meetings and relevant Directors meet with Committee Chairs to discuss agenda content.

1. Board composition and commitment

1.5 Board member commitment

Ref	Prompt	NIAS Assessment	Evidence of compliance with good practice (Please reference supporting documentation below)	Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or areas where additional assurance is required.
GP1	Board members have a good attendance record at all formal Board and Committee meetings and at Board events.	G	Board and Committee papers and minutes Annual Report	Board Secretary maintains Board/Committee attendance register		
GP2	The Board has discussed the time commitment required for Board (including Committee) business and Board development, and Board members have committed to set aside this time.	G	NED Appraisal Board member Job Descriptions			
GP3	Board members have received a copy of the Department's Code of Conduct and Code of Accountability for Board Members of	G	Board and Committee papers and minutes Standing Orders NED Appraisals			

	Health and Social Care Bodies or the Northern Ireland Fire and Rescue Service. Compliance with the code is routinely monitored by the Chair.		Executive Director Appraisal (by Chief Executive)			
GP4	Board meetings and Committee meetings are scheduled at least 6 months in advance.	G	Schedule of Board/ Committee meetings			

1.5

Ref	Prompt	NIAS Assessment	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	There is a record of Board and Committee meetings not being quorate.	G		
RF2	There is regular non-attendance by one or more Board members at Board or Committee meetings.	G		
RF3	Attendance at the Board or Committee meetings is inconsistent (i.e. the same Board members do not consistently attend meetings).	G		
RF4	There is evidence of Board members not behaving consistently with the behaviours expected of them and this remaining unresolved.	G		
RF5	The Board or Committee has not achieved full attendance at at least one meeting within the last 12 months.	G		

2. Board evaluation, development and learning

2.1 Effective Board level evaluation

Ref	Prompt	NIAS Assessment	Evidence of compliance with good practice (Please reference supporting documentation below)	Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or areas where additional assurance is required.
GP1	A formal Board Governance Self-Assessment has been conducted within the previous 12 months.	G	Committee/Trust Board minutes	2022-23 BGSAT was approved by Trust Board in October 2023.		
GP2	The Board can clearly identify a number of changes/ improvements in Board and Committee effectiveness as a result of the formal evaluations that have been undertaken.	G		The Chair has advised of her intention to review the Committee structure in summer 2024. BSO Internal Audit is scheduled to conduct a Board Effectiveness audit in July 2024.		
GP3	The Board has had an independent evaluation of its effectiveness and the effectiveness of its	G		BSO Internal Audit carried out a Board Effectiveness audit in 2021-22. That audit		

	Committees within the last 2 years by a 3rd party that has a good track record in undertaking Board effectiveness evaluations.			constituted the independent review. Recommendation is that an independent evaluation is carried out every three years. As noted above, a further audit of Board Effectiveness is scheduled for July 2024.		
GP4	In undertaking its formal evaluation, the Board has used an approach that includes various evaluation methods. In particular, the Board has considered the perspective of a representative sample of staff and key external stakeholders (e.g. commissioners, service users and clients) on whether or not they perceive the Board to be effective.	R			The Board has not taken the opportunity to consider how input from external stakeholders will be secured.	
GP5	The focus of the evaluation included traditional 'hard' (e.g. Board information, governance structure) and 'soft' dimensions of effectiveness. In the	R	Board papers, agendas and minutes.		As above	

	case of the latter, the evaluation considered as a minimum: • The knowledge, experience and skills required to effectively govern the organisation and whether or not the Board's membership currently has this; • How effectively meetings of the Board are chaired; • The effectiveness of challenge provided by Board members; • Role clarity between the Chair and CE, Executive Directors and NEDs, between the Board and management and between the Board and its various sub-committees; • Whether the Board's agenda is appropriately balanced between: strategy and current performance; finance and					

	quality; making decisions and noting/receiving information; matters internal to the organisation and external considerations; and business conducted at public board meetings and that done in confidential session.					

2.1

Ref	Prompt	NIAS Assessment	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	No formal Board Governance Self-Assessment has been undertaken within the last 12 months.	G		A BGSAT was undertaken in the 2022-23 year.
RF2	The Board Governance Self-Assessment has not been independently evaluated within the last 3 years.	G		BSO Internal Audit carried out a Board Effectiveness audit in 2021-22. That audit constitutes the independent review. A further Board Effectiveness audit is scheduled for July 2024.
RF3	Where the Board has undertaken an evaluation, only the perspectives of Board members were considered and not those outside the Board (e.g. staff, etc).	G	The Chair has advised of her intention to review the Trust's Committee structure in summer 2024. The last review of governance structures at Committee level to assess the effectiveness of the governance and assurance processes within that was carried out in 2021. This was carried out in full consultation with SMT and the findings were reflected in the Trust Standing Orders.	The Trust does not consider it necessary to confirm Board effectiveness in this way.
RF4	Where the Board has undertaken an	G	As above	

	evaluation, only one evaluation method was used (e.g. only a survey of Board members was undertaken).			

2. Board evaluation, development and learning

2.2 Whole Board development programme

Ref	Prompt	NIAS Assessment	Evidence of compliance with good practice (Please reference supporting documentation below)	Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or areas where additional assurance is required.
GP1	The Board has a programme of development in place. The programme seeks to directly address the findings of the Board's annual evaluation (see previous section) and contains the following elements: understanding the relationship between the Minister, the Department and their organisation, e.g. as documented in the Management Statement; development specific to the business of their organisation; and reflecting on the effectiveness of the Board and its	G	Workshops NED appraisal HSC seminars/any other relevant training which NEDs may consider helpful are also available			Acknowledgement that Partnership Agreement is currently being finalised and that this will replace the MSFM. On appointment to role NEDs undertake governance training and refreshers are considered for serving NEDs

	supporting governance arrangements.					
GP2	Understanding the relationship between the Minister, Department and the ALB - Board members have an appreciation of the role of the Board and NEDs, and of the Department's expectations in relation to those roles and responsibilities.	G	Management Statement NED Appraisal Executive Director Appraisal Job Descriptions			The Departmental expectations were discussed at the Strategic Planning event in Feb when Dept officials attended. Acknowledgement that Partnership Agreement is currently being finalised and that this will replace the MSFM.
GP3	Development specific to the ALB's governance arrangements – the Board is or has been engaged in the development of action plans to address governance issues arising from previous self-assessments, independent evaluations, Internal Audit reports, serious adverse incident reports and other significant control issues.	G	Board and Committee papers and minutes Annual Report Governance Framework and Statement Internal Audit Reports	Work is ongoing within the Trust to address IA recommendations		
GP4	Reflecting on the effectiveness of the	G	Board and Committee Papers and Minutes			

	Board and its supporting governance arrangements -The development programme includes time for the Board as a whole to reflect upon, and where necessary improve: The focus and balance of Board time; The quality and value of the Board's contribution and added value to the delivery of the business of the ALB; How the Board responded to any service, financial or governance failures; Whether the Board's subcommittees are operating effectively and providing sufficient assurances to the Board; The robustness of the ALB's risk management processes; The reliability, validity and comprehensiveness of information received by the Board.		Annual Report Governance Framework and Statement Internal Audit Reports Workshop			

GP5	Time is 'protected' for undertaking this programme and it is well attended.	G	Board workshops	Need to forward plan for workshops to ensure availability		
GP6	The Board has considered, at a high-level, the potential development needs of the Board to meet future challenges.	G	NED Appraisals	Need to forward plan for workshops		

2.2

Ref	Prompt	NIAS Assessment	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	The Board does not currently have a Board development programme in place for EDs or NEDs.	G		Ongoing Board workshops. Members have opportunity to identify any training/development they require and to discuss with Chair. Similar arrangements in place for CEx in terms of discussion with EDs. Training/development opportunities are raised at appraisal meetings. The HSC Leadership governance workshops, with input from the Permanent Secretary, is assisting in addressing Board development.
RF2	The Board Development Programme is not aligned to helping the Board comply with the requirements of the Management Statement and/or fulfil its statutory responsibilities.	G		

2. Board evaluation, development and learning

2.3 Board induction, succession and contingency planning

Ref	Prompt	NIAS Assessment	Evidence of compliance with good practice (Please reference supporting documentation below)	Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or areas where additional assurance is required.-0
GP1	All members of the Board, both Executive and Non-Executive, are appropriately inducted into their role as a Board member. Induction is tailored to the individual Director and includes access to external training courses where appropriate. As a minimum, it includes an introduction to the role of the Board, the role expectations of NEDs and Executive Directors, the statutory duties of Board members and the business of the ALB.	G	Induction Programmes Job Descriptions	The induction related documentation for NEDs has been revised and feedback sought from NEDs. Acknowledgement that there was delay in induction sessions with Directors being organised. Learning noted and induction pack amended accordingly.		

GP2	Induction for Board members is conducted on a timely basis.	G	Induction Programme .	Acknowledgement that there was delay in induction sessions with Directors being organised. Learning noted and Induction Pack amended accordingly.		
GP3	Where Board members are new to the organisation, they have received a comprehensive corporate induction which includes an overview of the services provided by the ALB, the organisation's structure, ALB values and meetings with key leaders.	G	Induction Programme	See GP1 above		
GP4	Deputising arrangements for the Chair and CE have been formally documented.	G	Standing Orders Deputy Chief Executive appointed in March 2023		In the Chair's absence at any meeting of the Board, the ARAC Chair shall assume the position of Chair. Deputy Chief Executive in post	
GP5	The Board has considered the skills it requires to govern the organisation effectively in the future and the	R		Discussions will continue with the DoH PAU to ensure the requirements of Board		

	implications of key Board-level leaders leaving the organisation. Accordingly, there are demonstrable succession plans in place for all key Board positions.			positions are kept current and, when required, recruitment exercises are undertaken in good time. The Trust's SMT has also acknowledged the need to have effective succession planning in place within the Trust.		

2.3

Ref	Prompt	NIAS Assessment	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	Board members have not attended the CIPFA "On Board" training course within 6 months of appointment.	G		Arrangements are being made for the new NEDs to attend this training.
RF2	There are no documented arrangements for chairing Board and committee meetings if the Chair is unavailable.	G		Arrangements do not provide for any extended unavailability of the Chair or Committee Chairs. However, in the Chair's absence at any meeting of the Board, the ARAC Chair shall assume the position of Chair.
RF3	There are no documented arrangements for the organisation to	G		Deputy Chief Executive appointed in March 2023 and deputises for Chief Executive when necessary.

	be represented at a senior level at Board meetings if the CE is unavailable.			
RF4	NED appointment terms are not sufficiently staggered.	R		A number of NED terms of office are due to cease at the same time/in close succession. However, this is not within the gift of the Trust as responsibility for NED recruitment/ appointment/terms of office lies with the DoH/PAU.

2. Board evaluation, development and learning

2.4 Board member appraisal and personal development

Ref	Prompt	NIAS Assessment	Evidence of compliance with good practice (Please reference supporting documentation below)	Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or areas where additional assurance is required.
GP1	The effectiveness of each Non-Executive Board member's contribution to the Board and corporate governance is formally evaluated on an annual basis by the Chair	G	NED Appraisal			
GP2	The effectiveness of each Executive Board member's contribution to the Board and corporate governance is formally evaluated on an annual basis in accordance with the appraisal process prescribed by their organisation.	G	NED Appraisal			

GP3	There is a comprehensive appraisal process in place to evaluate the effectiveness of the Chair of the Board that is led by the relevant Deputy Secretary (and countersigned by the Permanent Secretary).	G	Annual Chair Appraisal Mid-year accountability meeting with Permanent Secretary			
GP4	Each Board member (including each Executive Director) has objectives specific to their Board role that are reviewed on an annual basis.	G	Remuneration Committee minutes (for Executive Directors)			There is no requirement for NED objectives outside Committee Chairs or for ED Board roles. DoH guidance required.
GP5	Each Board member has a Personal Development Plan that is directly relevant to the successful delivery of their Board role.	R				No PDP element addressing role as Board member within appraisal template. This issue was raised with PAU in the past.
GP6	As a result of the Board member appraisal and personal development process, Board members can evidence improvements that they have made in the quality of their	G	Board and Committee papers and minutes NED Appraisal		Not part of ED appraisal process but addressed for NEDs at annual assessment with Chair. No PDP element addressing role as Board member.	As for GP4.

	contributions at Board-level.					
GP7	Where appropriate, Board members comply with the requirements of their respective professional bodies in relation to continuing professional development and/or certification.	G	Addressed as part of annual appraisal			

2.4

Ref	Prompt	NIAS Assessment	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	There is not a robust performance appraisal process in place at Board level that includes consideration of the perspectives of other Board members on the quality of an individual's contribution (i.e. contributions of every member of the Board (including Executive Directors) on an annual basis and documents the process of formal feedback being given and received.	G		
RF2	Individual Board members have not received any formal training or professional development relating to their roles.	G	'On Board' training upon appointment as well as any ad hoc training	
RF3	Appraisals are perceived to be a 'tick box' exercise.	G		NEDs or EDs do not consider appraisals to be a tick box exercise.

RF4	The Chair does not consider the differing roles of Board members and Committee members.	G		EDs are not members of any Committee – they are attendees only.

3. Board insight and foresight

3.1 Board performance reporting

Ref	Prompt	NIAS Assessment	Evidence of compliance with good practice (Please reference supporting documentation below)	Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or areas where additional assurance is required.
GP1	The Board has debated and agreed a set of quality and financial performance indicators that are relevant to the Board given the context within which it is operating and what it is trying to achieve. Indicators should relate to priorities, objectives, targets and requirements set by the Dept.	G	Corporate Plan Board and Committee papers and minutes Annual Report Strategic Planning event in Feb 2024			
GP2	The Board receives a performance report which is readily understandable for all members and includes: • performance of the ALB against a	G	Board and Committee papers and minutes Annual Report		Enhancements to Trust Board performance reporting continue.	

	range of performance measures including quality, performance, activity and finance and enables links to be made; • Variances from plan are clearly highlighted and explained ; • Key trends and findings are outlined and commented on ; • Future performance is projected and associated risks and mitigating measures; • Key quality information is triangulated (e.g. complaints, standards, Dept targets, serious adverse incidents, limited audit assurance) so that Board members can accurately describe where problematic services lines are ;Benchmarking of					

	performance to comparable organisations is included where possible.					
GP3	The Board receives a brief verbal update on key issues arising from each Committee meeting from the relevant Chair. This is supported by a written summary of key items discussed by the Committee and decisions made	G	Board and Committee papers and minutes	The Trust receives written Committee minutes (when approved), allowing each Committee Chair to update where necessary. However, a written highlight report, providing a summary of the key items discussed and decisions made, is provided after each Committee to the next Trust Board.		
GP4	The Board regularly discusses the key risks facing the ALB and the plans in place to manage or mitigate them.	G	Board and Committee papers and minutes Governance Framework and Statement			
GP5	An action log is taken at Board meetings. Accountable individuals and challenging/demanding timelines are assigned. Progress against	G	Board and Committee papers and minutes Action Log reviewed at each Board meeting.			

	actions is actively monitored. Slips in timelines are clearly identifiable through the action log and individuals are held to account.					

3.1

Ref	Prompt	NIAS Assessment	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	Significant unplanned variances in performance have occurred.	G	.	
RF2	Performance failures were brought to the Board's attention by an external party and/or not in a timely manner.	G		
RF3	Finance and Quality reports are considered in isolation from one another.	G		
RF4	The Board does not have an action log.	G		
RF5	Key risks are not reported/escalated up to the Board.	G		

3. Board insight and foresight

3.2 Efficiency and Productivity

Ref	Prompt	NIAS Assessment	Evidence of compliance with good practice (Please reference supporting documentation below)	Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or areas where additional assurance is required.
GP1	The Board is assured that there is a robust process for prospectively assessing the risk(s) to quality of services and the potential knock-on impact on the wider health and social care community of implementing efficiency and productivity plans.	G	Board and Committee papers and minutes Annual Report Governance Framework and Statement			
GP2	The Board can provide examples of efficiency and productivity plans that have been rejected or significantly modified due to their potential impact on quality of service.	G				

GP3	The Board receives information on all efficiency and productivity plans on a regular basis. Schemes are allocated to Directors and are RAG rated to highlight where performance is not in line with plan. The risk(s) to non-achievement is clearly stated and contingency measures are articulated.	G G A				Trust Board is considering how best the risks to non-achievement can be articulated and monitored.
GP4	There is a process in place to monitor the ongoing risks to service delivery for each plan, including post implementation reviews.	G	Board and Committee papers and minutes			

3.2

Ref	Prompt	NIAS Assessment	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	The Board does not receive performance information relating to progress against efficiency and productivity plans.	G		
RF2	There is no process currently in place to prospectively assess the risk(s) to quality of services presented by efficiency and	G		

	productivity plans.			
RF3	Efficiency plans are based on a percentage reduction across all services rather than a properly targeted assessment of need.	G		
RF4	The Board does not have a Board Assurance Framework (BAF).	A		Acknowledgement that the BAF needs to be updated. Current version is 2022-23.

3. Board insight and foresight

3.3 Environmental and strategic focus

Ref	Prompt	NIAS Assessment	Evidence of compliance with good practice (Please reference supporting documentation below)	Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or areas where additional assurance is required.
GP1	The Chief Executive presents a report to every Board meeting detailing important changes or issues in the external environment (e.g. policy changes, quality and financial risks). The impact on strategic direction is debated and, where relevant, updates are made to the ALB's risk registers and Board Assurance Framework (BAF).	G	Board and Committee papers and minutes			Acknowledgement that the BAF needs to be updated. Current version is 2022-23.
GP2	The Board has reviewed lessons learned from SAIs, reports on discharge of	G	Board and Committee papers and minutes.			

	statutory responsibilities, negative reports from independent regulators etc and has considered the impact upon them. Actions arising from this exercise are captured and progress is followed up.					
GP3	The Board has conducted or updated an analysis within the last year to inform the development of the Business Plan.	G	Strategic Planning day held on 15/2/24. Corporate Plan 2024-25 to be presented to the June Trust Board.			
GP4	The Board has agreed a set of corporate objectives and associated milestones that enable the Board to monitor progress against implementing its vision and strategy for the ALB. Performance against these corporate objectives and milestones are reported to the board on a quarterly basis.	G	Board and Committee papers and minutes Strategy to Transform 2020-2026 Corporate Plan 2024-25 to be presented to the June Trust Board.			

GP5	The Board's annual programme of work sets aside time for the Board to consider environmental and strategic risks to the ALB. Strategic risks to the ALB are actively monitored through the Board Assurance Framework (BAF).	G	Board and Committee papers and minutes Workshops	Need to forward plan workshops		Acknowledgement that the BAF needs to be updated. Current version is 2022-23.

3.3

Ref	Prompt	NIAS Assessment	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	The Board does not have a clear understanding of Executive/Departmental priorities and its statutory responsibilities, business plan etc.	G		
RF2	The Board's annual programme of work does not set aside time for the Board to consider environmental and strategic risks to the ALB.	G		
RF3	The Board does not formally review progress towards delivering its strategies.	G		

3. Board insight and foresight

3.4 Quality of Board papers and timeliness of information

Ref	Prompt	NIAS Assessment	Evidence of compliance with good practice (Please reference supporting documentation below)	Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or areas where additional assurance is required.
GP1	The Board can demonstrate that it has actively considered the timing of the Board and Committee meetings and presentation of Board and Committee papers in relation to month and year end procedures and key dates to ensure that information presented is as up-to-date as possible and that the Board is reviewing information and making decisions at the right time.	G	Board and Committee papers and minutes			
GP2	A timetable for sending out papers to members is in place and adhered to.	G	Standing Orders			

			Board and Committee papers and minutes			
GP3	Each paper clearly states what the Board is being asked to do (e.g. noting, approving, decision, and discussion).	G	Board and Committee papers and minutes Cover papers (marked For Approval, For Noting, For Information) are drafted to accompany agenda items for consideration by Board and Committees			
GP4	Board members have access to reports to demonstrate performance against key objectives and there is a defined procedure for bringing significant issues to the Board's attention outside of formal monthly meetings.	G	Board and Committee papers and minutes Standing Orders		Board meets on a bi-monthly basis	
GP5	Board papers outline the decisions or proposals that Executive Directors have made or propose. This is supported; where appropriate, by: an appraisal of the relevant alternative options; the rationale	G	Board and Committee papers and minutes			

	for choosing the preferred option; and a clear outline of the process undertaken to arrive at the preferred option, including the degree of scrutiny that the paper has been through.					
GP6	The Board is routinely provided with data quality updates. These updates include external assurance reports that data quality is being upheld in practice and are underpinned by a programme of clinical and/or internal audit to test the controls that are in place.	G	Board and Committee papers and minutes Internal Audit Reports			
GP7	The Board can provide examples of where it has explored the underlying data quality of performance measures that have been RAG rated green.	G	Board and Committee papers and minutes Internal and External Audit Reports			
GP8	The Board has defined the information it requires to enable effective oversight and control of the	G	Board and Committee papers and minutes Assurance Framework	Continued liaison with NEDs to determine the level of information they require		

	organisation, and the standards to which that information should be collected and quality assured.					
GP9	Board members can demonstrate that they understand the information presented to them, including how that information was collected and quality assured, and any limitations that this may impose.	G	Board and Committee papers and minutes			
GP10	Any documentation being presented complies with Departmental guidance, where appropriate e.g. business cases, implementation plans.	G	Board and Committee papers and minutes			

3.4

Ref	Prompt	NIAS Assessment	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	Board members do not have the opportunity to read papers e.g. reports are regularly tabled on the day of the Board meeting and members do not have the opportunity to review or read prior to the meeting. The volume of papers is impractical for proper reviewing.	G		
RF2	Board discussions are focused on understanding the Board papers as opposed to making decisions.	G		
RF3	The Board does not routinely receive assurances in relation to data	G		

	quality or where reports are received, they have highlighted material concerns in the quality of data reporting.			
RF4	Information presented to the Board lacks clarity, or relevance; is inaccurate or untimely; or is presented without a clear purpose, e.g. is it for noting, discussion or decision?	G		
RF5	The Board does not discuss or challenge the quality of the information presented or, scrutiny and challenge is only applied to certain types of information of which the Board have knowledge and/or experience, e.g. financial information	G		

3. Board insight and foresight

3.5 Assurance and risk management

Ref	Prompt	NIAS Assessment	Evidence of compliance with good practice (Please reference supporting documentation below)	Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or areas where additional assurance is required.
GP1	The Board has developed and implemented a process for identification, assessment and management of the risks facing the ALB. This should include a description of the level of risk that the Board expects to be managed at each level of the ALB and also procedures for escalating risks to the Board.	G	Board and Committee papers and minutes Risk Strategy Corporate Risk Register Internal and External Audit Reports			Work is underway to revise the Corporate Risk Register with a view to having this completed in June 2024.
GP2	The Board has identified the assurance information they require, including assurance on the	G	Board and Committee papers and minutes Internal and External Audit Reports			

	management of key risks, and how this information will be quality assured.					
GP3	The Board has identified and makes use of the full range of available sources of assurance, e.g. Internal/External Audit, RQIA, etc	G	Board and Committee papers and minutes Internal and External Audit Reports GIRFT report			
GP4	The Board has a process for regularly reviewing the governance arrangements and practices against established Departmental or other standards e.g. the Good Governance Standard for Public Services.	G	Self-assessment process for Trust Board and Committees .			
GP5	The Board has developed and implemented a Clinical and Social Care Risk assessment and management policy across the ALB, where appropriate.	G	Risk Strategy Internal and External Audit Reports			
GP6	An executive member of the Board has been	G	Job Description			

	delegated responsibility for all actions relating to professional regulation and revalidation of all applicable staff.					

3.5

Ref	Prompt	NIAS Assessment	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	The Board does not receive assurance on the management of risks facing the ALB.	G		
RF2	The Board has not identified its assurance requirements or receives assurance from a limited number of sources.	G		
RF3	Assurance provided to the Board is not balanced across the portfolio of risk, with a predominant focus on financial risk or areas that have historically been problematic.	G		
RF4	The Board has not reviewed the ALB's	G		

	governance arrangements within the last two years.			

4. Board engagement and involvement

4.1 External stakeholders

Ref	Prompt	NIAS Assessment	Evidence of compliance with good practice (Please reference supporting documentation below)	Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or areas where additional assurance is required.
GP1	The Board has an approved PPI consultation scheme which formally outlines and embeds their commitment to the involvement of service users and their carers in the planning and delivery of services.	G	Board and Committee papers and minutes			
GP2	A variety of methods are used by the ALB to enable the Board and senior management to listen to the views of service users, commissioners and the wider public, including 'hard to reach' groups like non-English	G	Board and Committee papers and minutes PPI Strategy Care Opinion feedback			

	speakers and service users with a learning disability. The Board has ensured that various processes are in place to effectively and efficiently respond to these views and can provide evidence of these processes operating in practice.					
GP3	The Board can evidence how key external stakeholders (e.g. service users, commissioners and MLAs) have been engaged in the development of their business plans for the ALB and provide examples of where their views have been included and not included in the Business Plan.	G	PPI Strategy			
GP4	The Board has ensured that various communication methods have been deployed to ensure that key external stakeholders understand the key	G	PPI Strategy Board and Committee papers and minutes			

	messages within the Business Plan.					
GP5	The Board promotes the reporting and management of, and implementing the learning from, adverse incidents/near misses occurring within the context of the services that they provide	G	Board and Committee papers and minutes Public-facing accountability			
GP6	The ALB has constructive and effective relationships with its key stakeholders	G	Board and Committee papers and minutes Annual Report Public-facing accountability			

4.1

Ref	Prompt	NIAS Assessment	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	The development of the Business Plan has only involved the Board and a limited number of ALB staff.	G		
RF2	The ALB has poor relationships with external stakeholders, with examples including clients, client organisations etc.	G		Unclear exactly what this is asking but we have rated it as green as we consider ourselves to have good relationships with external stakeholders.
RF3	Feedback from clients is negative e.g. complaints, surveys and findings from	G		The Trust continues to receive more compliments than complaints. SMT review these, as well as summaries from Care Opinion, at the weekly SMT meetings. SAIs/ Complaints/Care Opinion summaries are also regularly considered and discussed at the Trust's Safety Committee.

	regulatory and review reports.			
RF4	The ALB has received adverse negative publicity in relation to the services it provides in the last 12 months.	G		While there has been media coverage of delayed ambulance handovers at EDs, there is a recognition by the general public that this is as a result of HSC-wide pressures and therefore requires a system-wide resolution.
RF5	The Board has not overseen a system for receiving, acting on and reporting outcomes of complaints.	G		

4. Board engagement and involvement

4.2 Internal stakeholders

Ref	Prompt	NIAS Assessment	Evidence of compliance with good practice (Please reference supporting documentation below)	Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or areas where additional assurance is required.
GP1	A variety of methods are used by the ALB to enable the Board and senior management to listen to the views of staff, including 'hard to reach' groups like night staff and weekend workers. The Board has ensured that various processes are in place to effectively and efficiently respond to these views and can provide evidence of these processes operating in practice.	G	Programme of staff engagement sessions in the 2023-24 year Use of staff WhatsApp group/social media Staff attendance at Board/ Committee meetings Station visits Board and Committee papers and minutes Chair engagement with staff across the Trust		Station visits have recommenced and will increase over the coming months.	
GP2	The Board can evidence how staff have been engaged in the development of	G	Staff engagement meetings in development of Strategy To Transform 2020-26			

	their Corporate & Business Plans and provide examples of where their views have been included and not included.		Engagement with staff around corporate objectives NIAS TDP Involvement of the AD Forum			
GP3	The Board ensures that staff understand the ALB's key priorities and how they contribute as individual staff members to delivering these priorities.	G	Strategy to Transform 2020-2026 NIAS Corporate Plan 2023-24 Annual Report Board and Committee papers and minutes	Work ongoing around staff appraisal		
GP4	The ALB uses various ways to celebrate services that have an excellent reputation and acknowledge staff who have made an outstanding contribution to service delivery and the running of the ALB.	G	Long Service Medal Ceremony (8/2/24) Queens Ambulance Medal Compliments Staff recognition awards/ ceremony	Leadership Conference and Awards Ceremony scheduled for 26 April 2024.		
GP5	The Board has communicated a clear set of values/ behaviours and set out how staff that do not behave consistent with these values will be managed. Examples can be provided of how management have	G	Annual Report Disciplinary Procedures Grievance Procedures Board and Committee papers and minutes			

	responded to staff that have not behaved consistent with the ALB's stated values/behaviours.					
GP6	There are processes in place to ensure that staff are informed about major risks that might impact on customers, staff and the ALB's reputation and understand their personal responsibilities in relation to minimising and managing these key risks.	G	Board and Committee papers and minutes Clinical/Non-Clinical Memos & Updates Emergency Planning Engagement Untoward Incident Reports Serious Adverse Incident Reports			

4.2

Ref	Prompt	NIAS Assessment	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	The ALBs latest staff survey results are poor.	A	'Healthy People, Healthy Place' NIAS Health and Wellbeing Strategy, with associated implementation plan was approved by the Trust Board in August 2022. Trust Board approved the Culture Programme at its meeting in December 2022. Work ongoing to embed new approach to culture within organisation. Recently appointed NED has volunteered to engage and provide oversight to progressing work around culture.	
RF2	There are unresolved staff issues that are significant (e.g. the Board or individual Board members have received 'votes of no confidence', the ALB does not have productive relationships with trade unions etc.).	G		

RF3	There are significant unresolved quality issues.	G		
RF4	There is a high turnover of staff.	G		
RF5	Best practice is not shared within the ALB.	G		

4. Board engagement and involvement

4.3 Board profile and visibility

Ref	Prompt	NIAS Assessment	Evidence of compliance with good practice (Please reference supporting documentation below)	Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas where training or guidance is required and/or areas where additional assurance is required.
GP1	There is a structured programme of events/meetings that enable NEDs to engage with staff (e.g. quality/leadership walks; staff awards, drop in sessions) that is well attended by Board members and has led to improvements being made.	G	Long Service Medal Ceremony (8/2/24) Station Visits	There are opportunities for NEDs to undertake station visits and ride-alongs with staff. It is planned to recommence Leadership Walkabouts in the coming months.		
GP2	There is a structured programme of meetings and events that increase the profile of key Board members, in particular, the Chair and the CE, amongst external stakeholders.	G	Chair diary CX diary			

GP3	Board members attend and/or present at high profile events.	G	Chair diary CX diary Corporate Diary			
GP4	NEDs routinely meet stakeholders and service users.	R	Chair attended PPI meetings		Members of the public can attend Board meetings (wef August 2023).	Acknowledgement that improvement required in this area.
GP5	The Board ensures that its decision-making is transparent. There are processes in place that enable stakeholders to easily find out how and why key decisions have been made by the Board without reverting to freedom of information requests.	G	Board papers and Board/ Committee minutes are made available to the public online			
GP6	As a result of the Board member appraisal and personal development process, Board members can evidence improvements that they have made in the quality of their contributions at Board-level.	G	Board and Committee papers and minutes NED Appraisal Workshops, particularly in relation to the structures of the Board and its Committees and the development of Committee Chair meetings with the Trust Board Chair		The Chair has advised of her intention to review the Committee structure, in particular review the PFOD committee in summer 2024.	See 2.4 GP6

4.3

Ref	Prompt	NIAS Assessment	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	With the exception of Board meetings held in public, there are no formal processes in place to raise the profile and visibility of the Board.	G	Frequent press releases Increased social media activity, Chair Twitter account Attendance at key events and subsequent Trust messaging	Under constant review
RF2	Attendance by Board members is poor at events/meetings that enable the Board to engage with staff (e.g. quality/leadership walks; staff	G		

	awards, drop in sessions).			

6. Board Governance Self- Assessment Submission

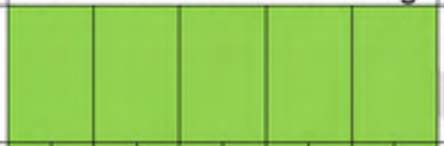
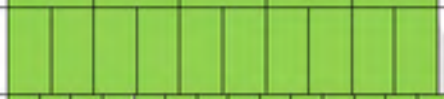
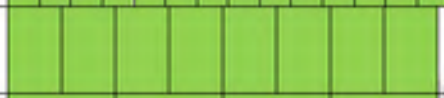
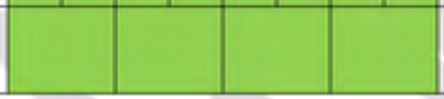
Name of ALB NI Ambulance Service Trust

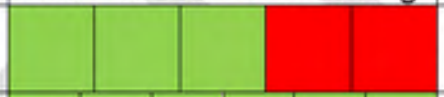
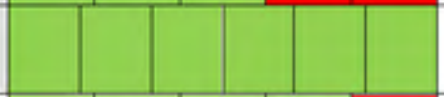
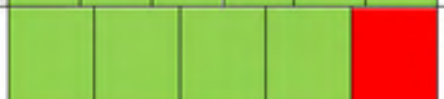
Date of Board Meeting at which Submission was discussed 22 August 2024

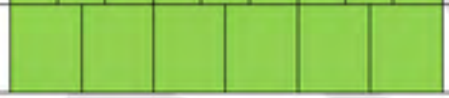
Approved by: _____

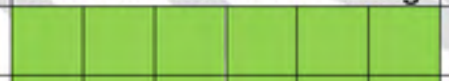
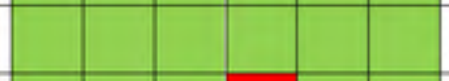
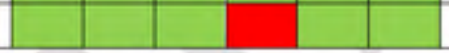
(ALB Chair)

5. Summary Results

1.Board composition and commitment		
Area	Self Assessment Rating	Additional Notes
1.1 Board positions and size		The Board now has its full complement of NEDs.
1.2 Balance and calibre of Board members		
1.3 Role of the Board		Further improvement required in area of PPE
1.4 Committees of the Board		
1.5 Board member commitment		

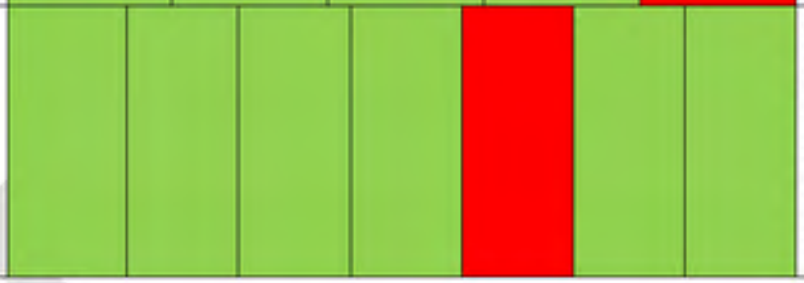
2.Board evaluation, development and learning		
Area	Self Assessment Rating	Additional Notes
2.1 Effective Board level evaluation		Board needs to consider how best to secure input from external stakeholders for this purpose.
2.2 Whole Board development programme		
2.3 Board induction, succession and contingency planning		Further work required around succession planning. Discussions will continue with the DoH PAU to ensure the requirements of Board positions are kept current.
2.4 Board member appraisal and personal development		Consideration to be given to NED Personal Development Plans which are directly relevant to the successful delivery of their Board role.

3.Board insight and foresight		
Area	Self Assessment Rating	Additional Notes
3.1 Board performance reporting		Work continues to enhance the Integrated Quality & Performance Report for the Board. Balanced scorecards are presented regularly at PFOD Cttee.
3.2 Efficiency and Productivity		Trust Board is considering how best the risks to non-achievement can be articulated and monitored.
3.3 Environmental and strategic focus		
3.4 Quality of Board papers and timeliness of information		Efforts continue to ensure Board papers are concise and issued on a timely basis.
3.5 Assurance and risk management		BGSAT completed on an annual basis and any remedial actions identified.

4. Board engagement and involvement		
Area	Self Assessment Rating	Additional Notes
4.1 External stakeholders		Establishment of Patient Voice Forum and other related groups. Use of Care Opinion feedback
4.2 Internal stakeholders		Efforts to continue to adopt various methodologies to engage with staff.
4.3 Board profile and visibility		NEDs do not meet stakeholders/SUs 'routinely'

TRAINING AND/OR ASSURANCE REQUIRED

Areas where additional training/guidance assurance is required		
Area	Self Assessment Rating	Additional Notes

Areas where additional assurance is required		
Area	Self Assessment Rating	Additional Notes
1.3 Role of the Board		Further improvement required around timely and robust PPEs.
2.1 Effective Board level evaluation		The Board needs to consider how input from external stakeholders will be secured.
2.3 Board induction, succession and contingency planning		The Chair will be continuing discussions with the DoH PAU to ensure the requirements of Board positions are kept current.
2.4 Board member appraisal and personal development		No PDP element addressing role as Board member within appraisal template. However, information on potential training courses has been shared with NEDs. The Chair intends to discuss this with individual NEDs at their appraisal.

6. Board impact case studies

6. Board impact case studies

Overview

This section focuses on the impact that the Board is having on the ALB and considers a recent case study in one of the following areas:

1. Performance failure in the area of quality, resources (Finance, HR, Estates) or Service Delivery;
2. Organisational culture change; and
3. Organisational strategy.

6. Board impact case studies

6.1 Measuring the impact of the Board using a case study approach

This section focuses on the impact that the Board is having on the ALB, it's clients, including other organisations, patients, carers and the public. The Board is required to submit one of three brief case studies:

1. A recent case study briefly outlining how the Board has responded to a performance failure in the area of quality, resources (Finance, HR, Estates) or service delivery. In putting together the case study, the Board should describe:
    - Whether or not the issue was brought to the Board's attention in a timely manner;
    - The Board's understanding of the issue and how it came to that understanding;
    - The challenge/ scrutiny process around plans to resolve the issue;
    - The learning and improvements made to the Board's governance arrangements as a direct result of the issue, in particular how the Board is assured that the failure will not re-occur.
2. A recent case study on the Board's role in bringing about a change of culture within the ALB. This case study should clearly identify:
    - The area of focus (e.g. increasing the culture of incident reporting; encouraging innovation; raising quality standards);
    - The reasons why the Board wanted to focus on this area;
    - How the Board was assured that the plan(s) to bring about a change of culture in this area were robust and realistic;
    - Assurances received by the Board that the plan(s) were implemented and delivered the desired change in culture.
3. A recent case study that describes how the Board has positively shaped the vision and strategy of the ALB. This should include how the NEDs were involved in particular in shaping the strategy.

Note: Recent refers to any appropriate case study that has occurred within the past 18 months.

6. Board impact case studies ALB

Name: NIAS Date: _____

Brief description of area of focus	**Absence Management**
Outline reasons / rationale for why the Board wanted to focus on this area	Levels of sickness absence within the organisation have been a critical concern for the Trust, with the peak absence rate reaching 14.65% in October 2023. In response, the Department of Health (DoH) set a target for HSC Trusts to reduce absence rates to 92.5% of the 2022/23 levels by the end of the 2023/24 financial year. For NIAS, this translated to an absence rate target of 11.24%. A strategy was developed that included: the establishment of a Maximising Attendance Project, co-led by the Director of HR & OD and an AD of Operations, this project formed the cornerstone of the absence management strategy. A key element of the strategy was establishing and supporting the central role of the line manager in the management of absence, supported by HR colleagues. This took some time to embed in order to achieve improvement and the Board sought additional assurance and increased accountability in respect of traction and delivery of improvement. Regular reporting mechanisms were established, including monthly updates to the Delivering Value Programme, and bi-monthly detailed reports to the Trust's PFOD Committee and onward updates to Trust Board.
Outline how the Board was assured that the plan/ (s) in place were robust and realistic	• Detailed reporting to PFOD Committee and with data and performance information. This Committee approved and monitored progress against the related Trust Delivery Plan. • **Enhanced Accountability:** The Board sought specific additional assurance directly from the Chief Executive and Director of HROD. The Trust Chief Executive implemented enhanced accountability measures across all Directorates, ensuring each had a clear role in reducing absence rates.
Outline the assurances received by the Board that the plan/(s) were implemented and delivered the desired changes in culture	The PFOD Committee received consistent updates indicating progressive reduction in absence rates. Key milestones included: • **Monthly Absence Rate Reductions:** For instance, from November 2023 to January 2024, monthly absence rates decreased from 14.65% to 13.2%, then to 12.5%.

	• **Line Management leadership and accountability:** Embedding line management leadership and accountability was a key factor in the Trust's Delivery Plan which PFOD committee monitored progress against. • **Cultural Shifts:** Initiatives such as wellness programs, mental health support, and flexible working arrangements contributed to a more supportive work environment. Employee feedback indicated a growing awareness and appreciation of these efforts. Trust Board applied particular scrutiny to performance of this work stream and related progress remains a focus at each Board meeting.

END OF DOCUMENT

Trust Board Finance Report

June 2024 (Month 3)

Northern Ireland Ambulance Service
Health and Social Care Trust

Contents

Executive Summary

* To date, the Trust has received an indicative funding allocation from SPPG of £122.750m (net of £2.475m of savings).

* £2.560m of further income has also been assumed at this stage of the financial year.

* As such, a total income of £125.310m has been used to build opening budgets and estimate expenditure profiles for 2024-25.

Financial Performance June 2024 (Month 3)

* For period ending June 2024, the Trust is reporting both a year-to-date (YTD), and a forecast full year, breakeven position.

* This forecast full year break-even position is predicated on the consistent achievement of a 2-hour handover backstop at Emergency Departments.

* This forecast is also based on the following assumptions:
  1. that all indicative and assumed funding is released to NIAS by SPPG.
  2. that all assumed further income will be realised.
  3. that all savings will be achieved.

Summary of Directorate Positions

Please note that in the following table, columns 1-3 show variances (budget (based on estimate expenditure profiles for 2024-25) vs actual). A negative figure represents an overspend against budget, with a positive figure indicating an underspend. The last column represents YTD actual spend per Directorate.

		YTD Variances				
£ 000s		Payroll	Non-Pay	Total	Forecast	YTD Actuals
Chief Executive's Office		(20)	22	2	1,317	190
Director of Finance		35	6	42	4,003	843
Director of Human Resources		140	12	152	2,577	485
Medical Director		(108)	(29)	(137)	11,977	2,337
Director of Safety, Qual & Imp		57	1	58	2,774	636
Director Of Plan, Perf & Corp		27	(147)	(120)	5,620	1,525
Director of Operations		617	(319)	298	97,716	23,018
Operations HQ		93	(51)	41	7,037	636
Regional Control Centres		109	(284)	(175)	19,075	4,919
Belfast Area Manager		479	32	512	12,237	2,546
North Area Manager		(120)	(46)	(166)	17,849	4,627
South Area Manager		43	1	44	13,477	3,324
Southeast Area Manager		(4)	(30)	(34)	13,376	3,376
West Area Manager		17	59	75	14,665	3,589
Revenue Total		749	(454)	294	126,084	29,034
Contingency		0		0	501	
Unallocated Savings		(294)		(294)	(1,175)	
NIAS Total		455	(454)	0	125,310	29,034

YTD Variances (>£50k)

Variances against budget (based on estimate expenditure profiles for 2024-25)

* Payroll variances due to current vacancies in NIAS.
* Non payroll variances in Planning, Performance and Corporate Services Directorate due to expenditure on computer hardware maintenance.
* Non payroll variances in Operations Directorate due to expenditure on defibrillator consumables, independent ambulance services and voluntary care services.

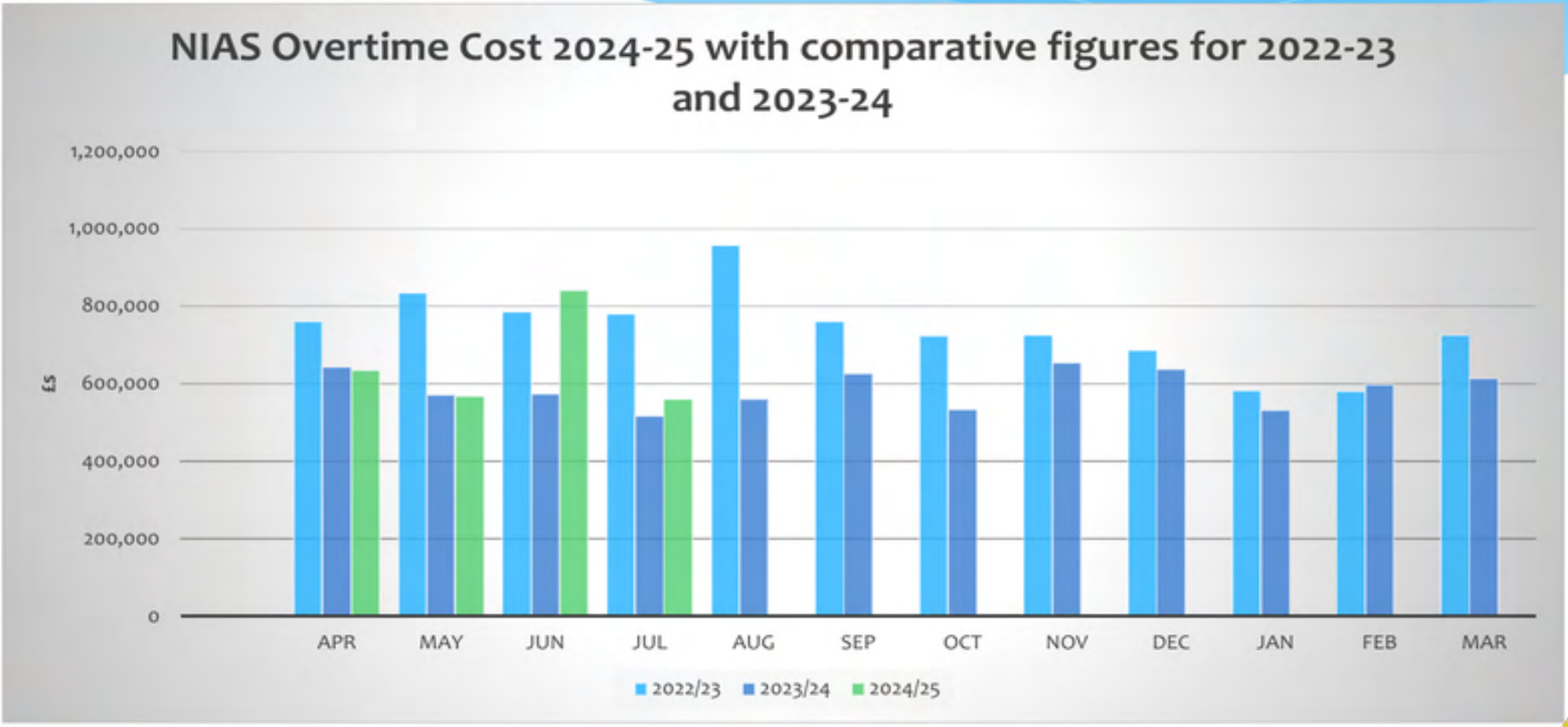
Expenditure Trends

* At this early stage of the year, it is difficult to draw any assumptions from YTD expenditure trends. All expenditure will be monitored closely as the year progresses.

Overtime Expenditure

The Trust relies on the use of overtime for the provision of services. This reliance is for several reasons including vacancies, planned and unplanned absences and additional cover or programmes of work.

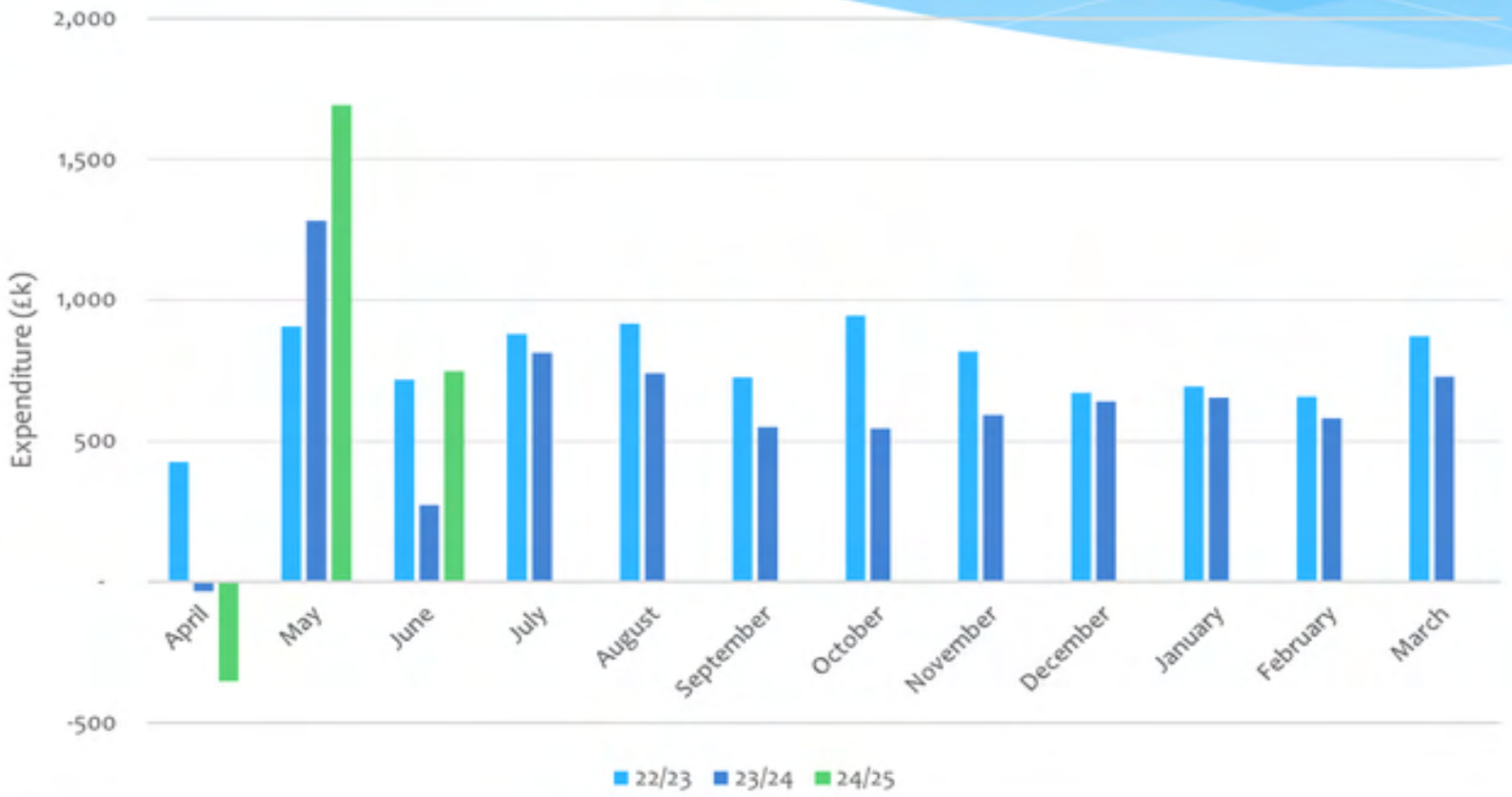
Please note £347k of expenditure in June 2024 relates to the pay award for 2023-24.



Independent Ambulance Service Expenditure

The Trust continues to benefit from the support of Independent Ambulance Service (IAS) Providers. Please note that the monthly IAS accrual was not posted in April 2024 due to the prioritisation of year end accounts work. Total IAS expenditure to 30 June 2024 is £2.089m.

IAS Expenditure



Capital Resource Limit

The Trust has received a Capital Resource Limit (CRL) allocation for 2024-25 of £7.382m.

Expenditure category	Capital Resources Limit Allocation £'k	Forecast Spend £'k
Fleet and Estates	5,700	5,607
Medical Equipment	183	183
Backlog Maintenance	125	125
ICT	1,374	1,374
Total	**7,382**	**7,289**

Prompt Payment of Invoices

The Trust is required to pay non HSC trade creditors in accordance with the Better Payments Practice Code and Government Accounting Rules. The target is to pay 95% of invoices within 30 calendar days of receipt of a valid invoice, or the goods and services, whichever is the latter. A further regional target to pay 70% (increased from 60%) of invoices within 10 working days (14 calendar days) has also been set.

NIAS Prompt Pay Performance 2024-25														
	Final													
Number	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD Cum	Target
Total bills paid	2,706	1,836	2,029										6,571	
Total bills paid within 30 calendar days of receipt of undisputed invoice	2,602	1,782	2,007										6,391	
% bills paid on time 30 days	96.2%	97.1%	98.9%										97.3%	>95%
Total bills paid within 10 working days (14 calendar days)	1,584	1,252	1,363										4,199	
% bills paid on time 10 days	58.5%	68.2%	67.2%										63.9%	>70%
Targets														
30 days	>95%	>90%	<90%											
10 days	>70%	>65%	<65%											

Statutory financial performance targets **The position outlined in this report, and the associated RAG status, is subject to several assumptions.**	RAG status
Manage within allocated Revenue Resource Limit (RRL) / Achieve financial break-even	

For period ending June 2024, the Trust is reporting both a YTD, and a forecast full year, breakeven position. This forecast full year break-even position is predicated on the consistent achievement of a 2-hour handover backstop at Emergency Departments and is based on several assumptions as outlined on page 4. This position will be monitored as the year progresses.

Manage within allocated Capital Resource Limit (CRL)	

The Trust has received a Capital Resource Limit (CRL) allocation of £7.382m.
Provisional forecast figures for expenditure at year end, 31 March 2025 (Month 12), is £7.289m. This represents a forecast underspend against the CRL of £0.093m (1.25% of CRL). This position will be monitored as the year progresses.

Savings target	

The Trust has to achieve £2.475m of savings in 2024-25. This savings target has been included within the current 2024-25 financial plan as follows:

Description	£'m
Non-frontline vacancy management	1.000
Defer medical equipment replacement	0.100
Defer minor schemes backlog maintenance	0.100
Sale of end-of-life vehicles	0.100
Other savings (TBC)	1.175
Total	**2.475**

Financial Management will liaise with Budget Holders over the next number of months to identify opportunities to deliver the £1.175m of 'other' savings.

Prompt payment target-95% of suppliers within 30 days	

Cumulative performance is 97.3% for the period ended 30 June 2024.

End of Report

Northern Ireland Ambulance Service
Health and Social Care Trust

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

PRESENTATION OF PAPER

Date of Trust Board:	22 August 2024
Title of paper:	Trust Corporate Scorecard and Performance Report (July 2024)
Brief summary:	This paper is presented to the Board for noting. The Trust performance report outlines the key performance metrics up to and including 30 June 2024.
Recommendation:	**For Approval** ☐ **For Noting** ☒
Previous forum:	*SMT – 13/8/24*
Prepared and presented by: **Date:**	N Walker, Head of Performance M Paterson, Director PP&CS 15 August 2024

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST CORPORATE SCORECARD

NORTHERN IRELAND AMBULANCE SERVICE

July 2024

for June 2024 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.

Demand:

- Demand for our services remains at a steady state,
  - Call answer demand in EAC for June 2024 increased by 10% when compared to June 2023
  - Incident demand in June 2024 has decreased by 10% when compared to June 2023
  - Patients conveyed to Hospital during June 2024 has also decreased by 2% when compared to June 2023

Response Times:

- Response times In June remain a challenge across all categories, when comparing to the national standards.
- Category 2 response times continue to be of concern remaining high at 52 mins for June 2024. This is compared with June 2023 where category 2 performance was 37 mins.
- This is linked to the following:
  - Delays in Hospital Handovers
  - 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 crew(s) is released from ED; Providing compensatory rest to any crew finished later than 1hr

Clinical Hear & Treat and See & Treat

- The Clinical H&T rate continues to trend positively at over 6% for June 24, which was an increase from May 24. Clinical See & Treat also persisted at 14.2%.

Handover:

- June 24 saw the trust lose >9.7k hrs with handover delays >15mins this is a decrease of 5% compared with May 24, were the trust lost >9.2K.
- The patients waiting longer than 2hrs to handover at Emergency departments increased quarter on quarter during Financial Year 2023.24.
- Q1 2024.25 of 14.9% is a 6% increase in 2hr handovers compared to Q1 2023.24.

Area	Q1 23.24	FY23.24	Q1 24.25
Region	8.8%	15.0%	14.9%

Patient Care Service:

- Patient experience KPIs continue to require attention to improve the experience of our patients being taken to and from appointments.
- Productivity and efficiency in June 24 has fallen back to the patients per shift transported at 3.97 through June 2024.
- Over the past 6 months it must be recognised that productivity and efficiency metrics for the NIAS PCS crews continue to trend positively, reflecting the improvement efforts being carried out in this part of the organisation.

Serious Adverse Incidents, Complaints, Compliments and Care Opinion:

- There have been 5 potential SAIs reviewed, with the Trust notifying zero during June 24. The 8-week timeframe for submission of SAI report to SPPG remains challenging. However, improvements in the process during 23/24 have led to a reduction in delayed final report submission from an average of 62 days overdue to 31 days overdue.
- During June 2024, the Trust received 22 complaints and 31 compliments, along with 11 stories submitted via care opinion during May 2024. 23/24 Performance against the 2-day acknowledgement KPI has been strong at 99% however several factors have impacted on the response within 20-day timeframe (43%). The Trust however have had no cases referred through the Northern Ireland Public Service Ombudsman (NIPSO) and of 234 complaints received in 23/24, just over 1% of cases (n=3) complaints required to be re-opened.

Absence Management:

- The Financial Year Sickness absence rate is 10.06% for the trust. June 2024, monthly for sickness absence rate has increased to 11% from 9.64% in May 2024, However is an improved position when compared to June 2023 of 14.4%
- 62% of the Trusts sickness absence is contained within the following categories (Mental Health, Injury | Fracture, Miscellaneous, Influenza and Untoward accident).
- The largest category for sickness absence within the trust is for mental health reasons, with stress being the prevalent reason.

Northern Ireland Ambulance Service
Health and Social Care Trust

Corporate Scorecard | **Dashboard** | **Key Metrics May 2024**

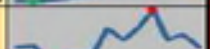
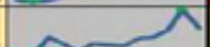
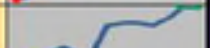
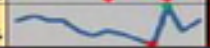
Indicator	Measure	SDP Target 2024.25 (Q1)	Outturn 2023.24	Latest Reported Period		
				This Month	12 Month Trend	This Month RAG
Our Patients will be professionally cared for: Always with compassion and respect						
1.01	Category 1 Mean Response Time	11 mins	11	12		A
1.02	Category 1 90th Centile Response Time	22 mins	22	22		G
1.03	Category 1T Mean Response Time	19 mins	15	15		G
1.04	Category 1T 90th Centile Response Time	30 mins	30	29		G
1.05	Category 2 Mean Response Time	48 mins	48	52		A
1.06	Category 2 90th Centile Response Time	106 mins	107	115		R
1.07	Category 3 90th Centile Response Time	300 mins	338	381		R
1.08	Call Answering Performance	90%	85.0%	89.8%		A
1.09	No. of Calls Answered within Emergency Ambulance Control	N/A	19,209	20,308		
Our Staff will feel positive and proud to work for NIAS						
2.01	Monthly Percentage of Hours Lost	N/A	11%	11%		G
2.02	Cumulative % Hours lost from Sickness	11%	12%	10%		G
2.03	Cumulative % Hours lost from Short Term Sickness	N/A	3%	2%		G
2.04	Cumulative % Hours lost from Long Term Sickness	N/A	9%	8%		G

RAG Status Key:

Green = On or exceeding target	Amber = within 5% of target
Red = Outwith 5% of Target	No Target Agreed

Northern Ireland Ambulance Service
Health and Social Care Trust

Corporate Scorecard | **Dashboard** | **Key Metrics June 2024**

Indicator	Measure	SDP Target	Outturn 2023.24	Latest Reported Period		
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	15 mins	64	76		R
3.02	Lost Hours from Handover delays >15mins	N/A	8,967	9,279		R
3.03	Number of Patients >2hrs for Handover	0	16,286	1,585		R
3.04	Hear & Treat Rate	6.5%	4%	6.2%		A
3.05	See and Treat Rate	14.3%	14%	14.3%		A
3.06	Conveyance Rate	N/A	82%	80%		
3.07	Number of Scheduled journeys made	N/A	12,798	12,374		
3.08	Average Number of Patient Journeys per shift	N/A	3.65	3.97		
3.09	Average Number of Patient transported per Run	N/A	1.19	1.41		
3.1	The Percentage of patient Journeys that arrive on time	95%	30%	51%		R
3.11	The Percentage of patient Journeys that start on time	95%	56%	54%		R
Our Communities will continue to value and trust us						
4.01	Number of potential SAIs reviewed	N/A	135	5		
4.02	Number of SAIs notified	N/A	42	0		
4.03	Number of Complaints	N/A	148	22		
4.04	Number of Compliments	N/A	272	31		
4.05	Nmber of patient stories received	N/A	128	11		
4.06	Forecast Revenue Expenditure	£ -	£ -	£ -		G

Green = On or exceeding target	Amber = within 5% of target
Red = Outwith 5% of Target	No Target Agreed

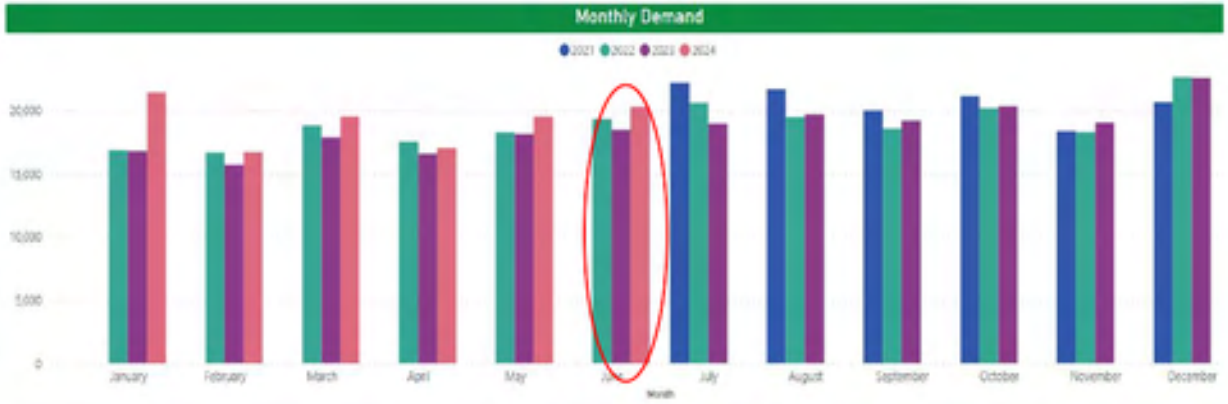
Northern Ireland Ambulance Service
Health and Social Care Trust

Our Patients | Emergency Demand Performance | Operational Demand

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

The analysis below describes: Calls Answered and Call Answering Performance

999 Calls Answered



Call Answering Performance and Duplicate Calls

- **June 24** has seen an increase in demand levels of 10% when compared with May 2023. The call demand into EAC for 2024.25 Financial Year to date has saw an increase of 7% than the Financial Year 2022.23.
- **June 2024** saw an average of 677 calls per day being answered by EAC which is an increase from 615 calls per day in June 2023.
- **Call Answering performance** continued to be a challenge through June 24. However, **June 2024 call answering performance meet the standard at 90%** for the month..
- **Duplicate Calls** increased again and in **June 2024** reached 10,112 which is a **36% increase** when compared with **June 2023**.

Northern Ireland Ambulance Service
Health and Social Care Trust

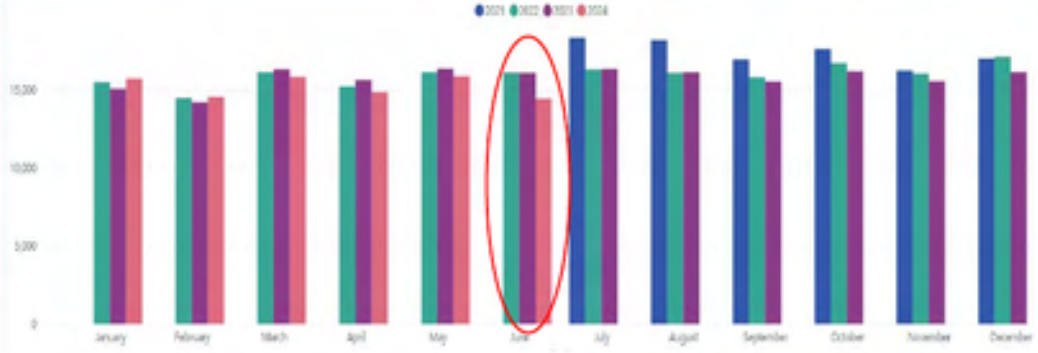
Our Patients | **Emergency Demand Performance** | **Operational Demand**

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: The Demand for Ambulance responses and The numbers of patients conveyed to Hospital

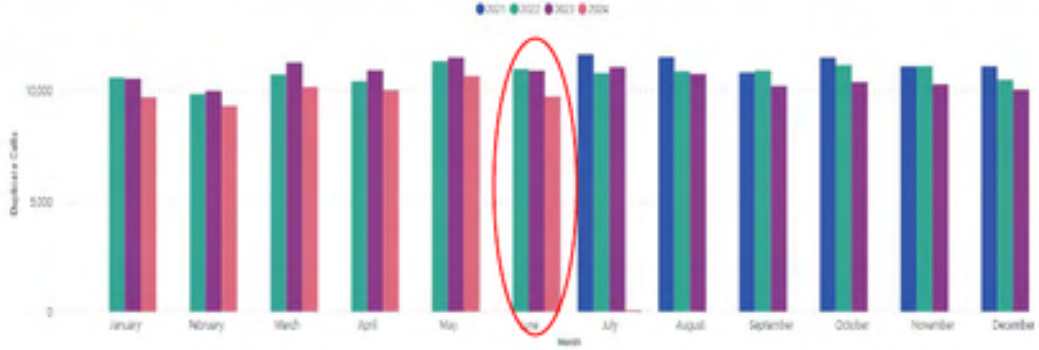
Response Demand

Monthly All Incidents (A7)



Conveyances to Hospital

Monthly Total Patients Conveyed



- **June 24** has seen a decrease in Incident levels of 10% when compared with June 2023. The incident demand for 2024.25 Financial Year to date has also decreased by 6% compared with Financial Year 2022.23.
- **June 2024** saw an average of 480 incidents per day requiring an ambulance response.
- **June 2024** conveyances decreased by 2% when compared with June 2023. The numbers of patients conveyed to hospital 2024.25 Financial Year to date has also decreased by 4% compared with Financial Year 2022.23.
- **June 2024,** saw an average of 355 patients conveyed to hospital per day.

Northern Ireland Ambulance Service
Health and Social Care Trust

Our Patients | 999 Response Time Performance | Response Times Scorecard

Latest Month	Jun-24

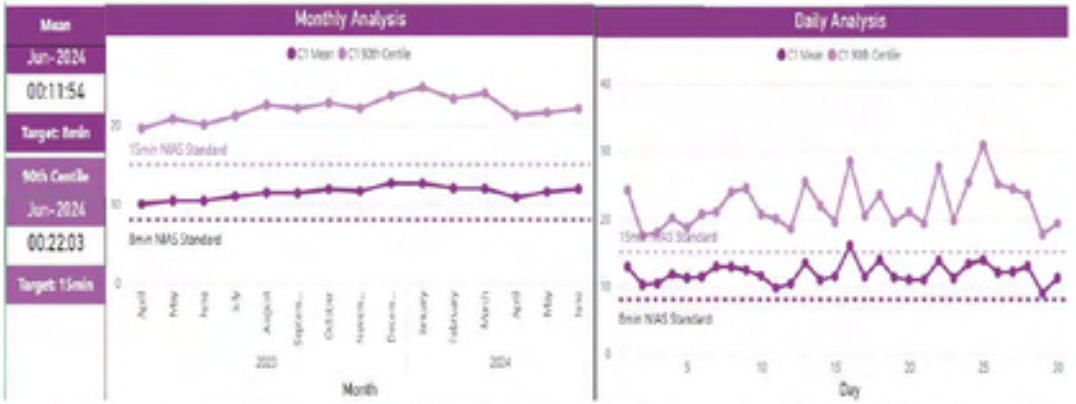
	Target	Current Performance: Latest Month	Current Performance: YTD (from April)	Current Performance: Rolling 12 Month	Benchmarking (Latest Month): National Data	Benchmarking (Latest Month): Best in Class	Benchmarking (Latest Month): Ranking (out of 12)
Category 1 response - Mean	8 Minutes	00:11:54	00:11:34	00:11:45	00:08:21	00:06:48	12
Category 1 response - 90th Centile	15 Minutes	00:22:03	00:22:24	00:22:39	00:14:53	00:11:46	12
Category 1T response - Mean	19 Minutes	00:15:04	00:15:11	00:15:15	00:10:16	00:07:38	12
Category 1T response - 90th Centile	30 Minutes	00:29:20	00:29:58	00:29:46	00:18:37	00:13:05	12
Category 2 response - Mean	18 Minutes	00:52:06	00:48:29	00:50:59	00:34:38	00:26:53	12
Category 2 response - 90th Centile	40 Minutes	01:54:37	01:47:24	01:52:38	01:13:25	00:53:02	12
Category 3 response - Mean	Not a target	02:25:20	02:12:55	02:20:40	02:02:34	01:04:51	10
Category 3 response - 90th Centile	2 Hours	06:21:04	05:40:19	06:04:56	04:51:16	02:35:09	12
Category 4 response - Mean	Not a target	03:11:30	03:40:38	04:02:33	02:20:58	01:17:28	11
Category 4 response - 90th Centile	3 Hours	09:31:04	11:20:02	12:29:12	05:29:11	02:53:52	3

Northern Ireland Ambulance Service
Health and Social Care Trust

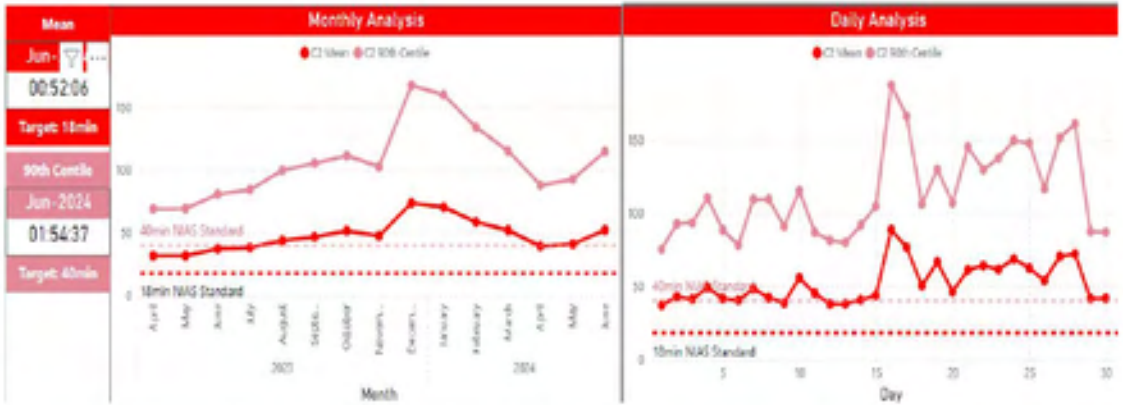
Our Patients | 999 Response Time Performance | Response Times

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

- June 24 Category 1 mean response time was 11 minutes 54 seconds; while the Category 1 90th centile was 22 minutes 03 seconds.
- June 24 continues to see a challenging Category 1 mean response position for the Trust. This is replicated on the Category 1 90th centile performance.

Category 2

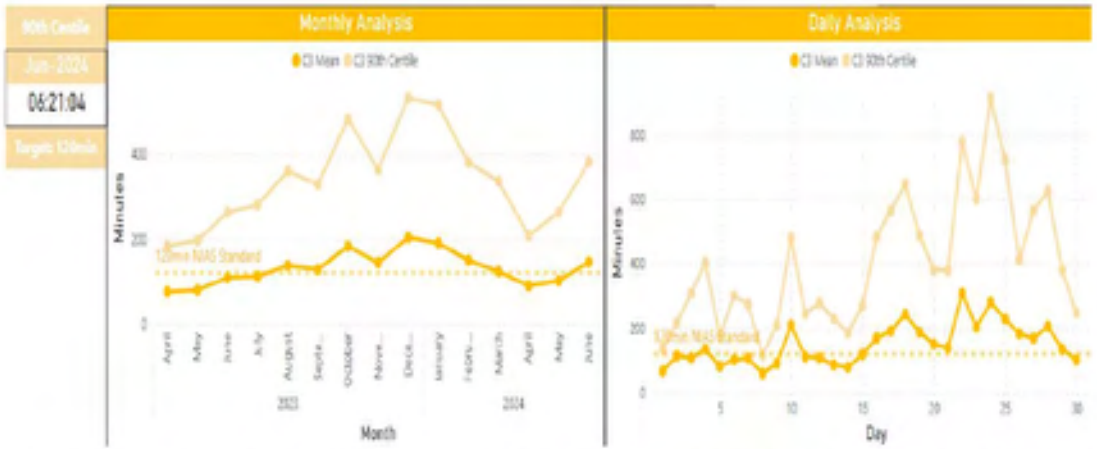
- June 2024 Category 2 mean response time was 52 minutes 06 seconds; while the Category 2 90th centile was 1 hours 54 minutes.
- Both the Category 2 mean and 90th centile response times remain a challenge in June 24. There are a number of actions that have been particularly impactful on performance:-
  - Persistence in handover delays >2hr, outlined in slides further in this paper.
  - Action short of Strike (ASOS) is impacting our category 2 response times.
  - Realising crews at ED at the end of shift with oncoming crews.
  - Providing staff with compensatory rest for those late finishes over 1hr.
- 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

- June 24 Category 3 mean response time was 2 hours 25 minutes; while the Category 3 90th centile was 6 hours 21 minutes and 4 seconds, over 4 hours above target.
- As outlined in the previous slide, category 3 response times are impacted by the same root causes.

Category 4

- May 24 Category 4 mean response time was 3 hours 11 mins; while the Category 4 90th centile was 9 hours 31 minutes and 4 seconds. It must be noted that the volume of Category 4 calls received by NIAS is very low and response times can be impacted significantly on a daily basis.

Northern Ireland Ambulance Service
Health and Social Care Trust

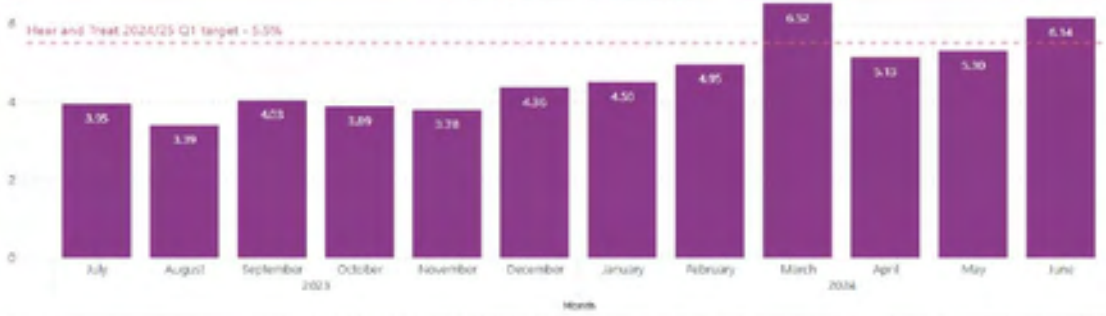
Our Patients | Emergency Demand Performance | Clinical Response

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

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

Clinical Hear & Treat

Monthly Hear and Treat %



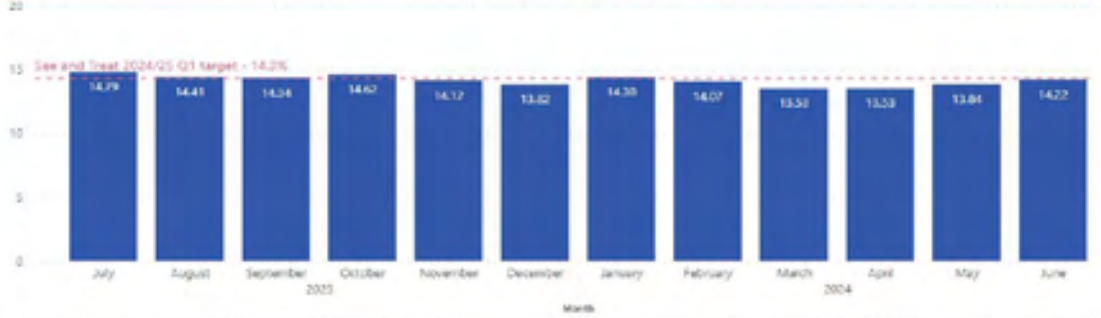
June 2024 saw the Integrated Clinical Hub Clinicians continue to bed into the control room. The Hear and Treat rate increased from 5.3% to 6.1%, call volumes in June returned to more expected levels.

Work continue to explore the optimal approach to the Clinical hub to realise a stepped improvement in the Trust's Hear & Treat rate as we move through 2024.25.

The aimed improvement trajectory is to increase Hear & Treat to 10% by 31st March 2025.

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 to 15.5% by 31st March 2025.

Northern Ireland Ambulance Service
Health and Social Care Trust

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.

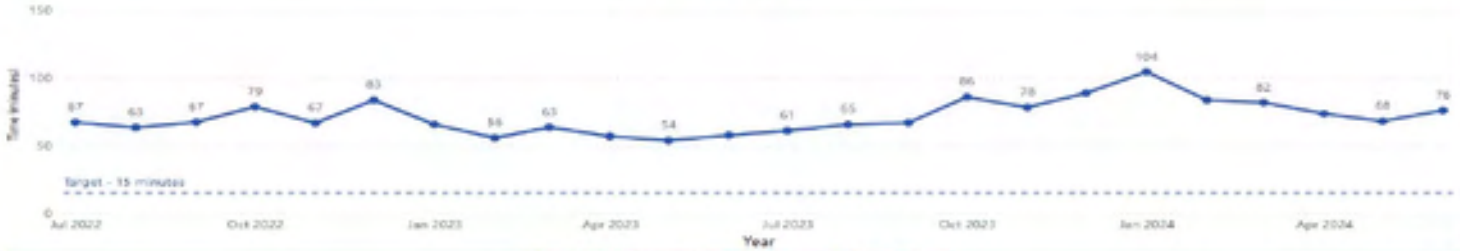
Arrival at Hospital to Patient Handover

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	1299	1299	1209	93.07%	617	47.50%	2,311.99	121.33
CRAIGAVON AREA	1289	1289	1198	92.94%	571	44.30%	1,676.37	92.80
CAUSEWAY	594	594	566	95.29%	271	45.62%	612.76	76.67
ROYAL GROUP	1991	1991	1839	93.37%	909	43.90%	2,026.79	79.79
MATER	395	395	335	89.87%	130	32.91%	320.95	63.81
ANTRIM AREA	1647	1647	1512	91.80%	432	26.23%	1,314.19	62.60
ALTNAGELVIN	1124	1124	1067	94.93%	299	32.06%	671.13	61.29
DAISYHILL	589	589	507	94.06%	141	26.16%	326.73	55.85
SOUTH WEST	569	569	537	91.17%	107	18.17%	262.05	41.37
LAGAN VALLEY	78	78	30	67.37%	4	3.41%	19.34	29.34
RBSC	105	105	74	70.48%	1	0.95%	17.55	23.73
BELFAST CITY	53	53	37	71.15%	0	0.00%	7.10	22.10
DOWNE	33	33	16	48.48%	1	2.03%	4.61	21.09
Total	**9731**	**9731**	**8987**	**92.35%**	**3547**	**36.45%**	**9,775.48**	**74.97**

Total Time Lost (Hours) - Last 12 months

125,882.66

Monthly Handover Times



Monthly Handover Times for Type 1 EDs, by Trust

In June 2024, NIAS experienced a total of 9,775 lost hours. This is the equivalent of 27 shifts per day where crews are waiting with patients outside EDs; 24% of our planned capacity. These lost hours were experienced from 8,987 instances where our crews waited longer than 15mins to handover their patient at ED. 3,547 handovers took longer than an hour in June 2024

In June 24, >75% of the 9,775 lost hours occurred at the four ED sites listed below in order of hours lost:

- *Ulster Hospital (2.3k hours; 93% > 15min; 47% > 1hr)*
- *Craigavon Hospital (1.6k hours; 92% > 15min; 44% > 1hr)*
- *Royal Victoria (2.0k hours; 93% > 15min; 45% > 1hr)*
- *Antrim Area (1.3k hours; 91% > 15min; 26% > 1hr)*

In the last 12 months, >92% of the handovers exceeded the 15min target at our acute EDs, resulting in circa 125k hours lost. The lost hours experienced in June 24 is an increase of 496 hrs or 5% from May 24, whilst the number of instance of delayed handovers also decreased by 2% in the same period.

The 9,775 operational hours being lost are equivalent to 814 12-hours shifts per month, or 27 12-hour shifts per day.

Northern Ireland Ambulance Service
Health and Social Care Trust

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

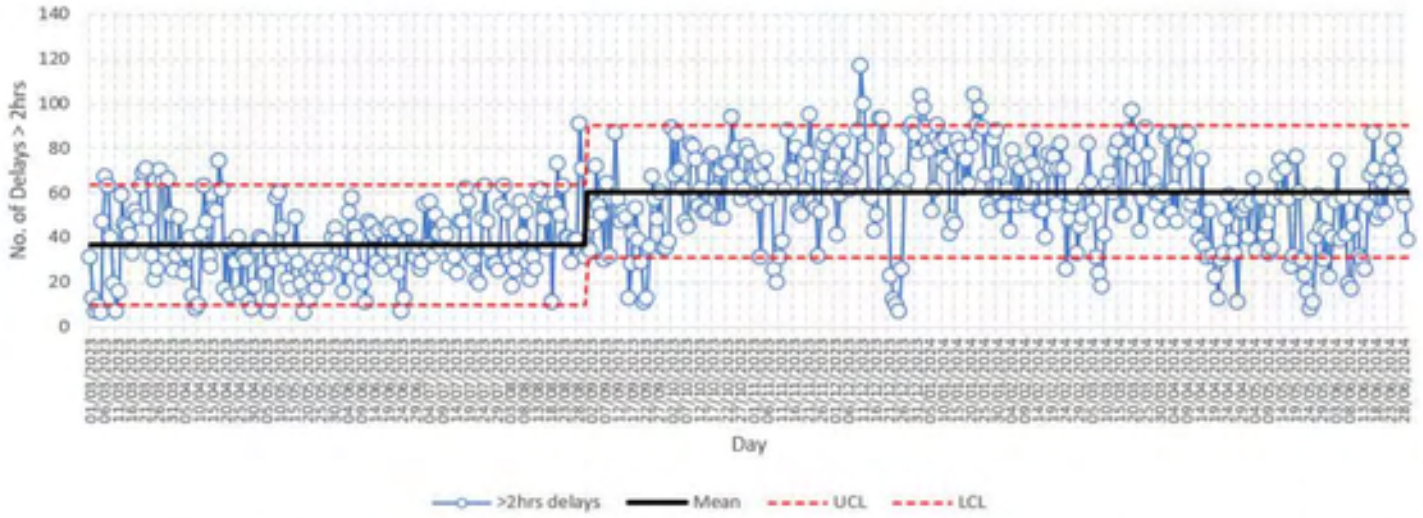
Our operational efficiency is critical to our success. One of our key dependencies is the ability to handover a patient in a timely manner when conveyed to hospital. As such, we must strive to be as efficient as possible whilst always delivering the very best care for our patients.

Area	Q1 23.24	FY23.24	Q1 24.25
South Eastern	21.1%	27.7%	29.6%
Southern	9.5%	17.3%	17.5%
Belfast	6.6%	13.5%	14.6%
Northern	5.4%	11.5%	11.1%
Western	2.8%	6.8%	5.7%
Region	8.8%	15.0%	14.9%

The table shows the deterioration in >2hr delays by trust from March 2023.
Q1 24.25 has saw the 2hr handover **position stagnate** from the Year end position at **14.9% regionally**. However, when compared to **Q1 2023.**24 there is a **6% increase** in 2hr handovers.

There has been a quarter-on-quarter decline since the introduction of the 2hr backstop across the region. In 2023.24 some areas a third of patients have experience a >2hr delay to get into an Emergency department.

Daily Number of Handover >2hrs across the Region | March 23 - April 24



The chart to the left is a statistical Process Control (SPC) chart, outlining the variation in the handover process. Since March 23, the has been a step decline in the 2hr backstop performance.

The trust is now experiencing an average 60 patients per day being delayed >2hrs before being admitted into Emergency departments across the region.

This SPC chart strongly indicates that the processes to reduce the 2hr handover delays are showing no signs of control over the past number of months.

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

Northern Ireland Ambulance Service
Health and Social Care Trust

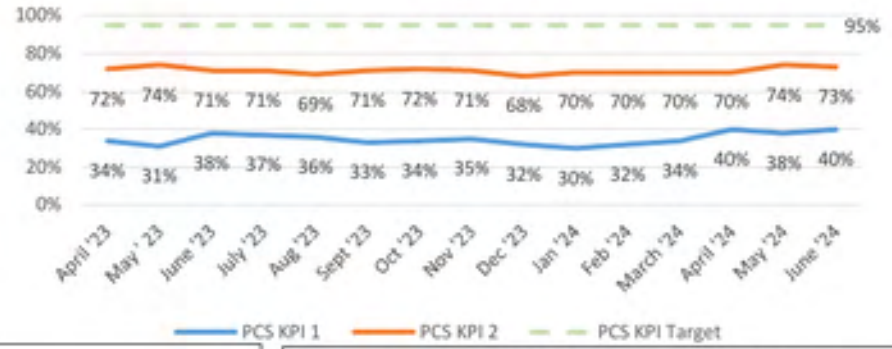
Our Patients

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

Non-Emergency PCS Performance

KPI 1 & 2 Compliance PCS



Analysis:

- During June 2024, 40% of journeys arrived within the 60 mins prior to appointment time.
- An analysis of the journeys that missed compliance shows that 37% of these journeys missed the target by 15 minutes or less, 76% missed the target by 60 minutes or less.
- During June 2024, the target for KPI2 was achieved in 73% of journeys
- 42% of journeys that missed the target where no more than 15 minutes over and 83% missed the target by 60 minutes or less.
- Further analysis is required to understand the outlying data to determine if there are recording issues.
- The Non Emergency Control Room makes contact with the destination Trust to advise when there are anticipated delays to ensure the patient does not miss the appointment.
- There have been no reports or complaints related to patients missing their appointment as a result of a

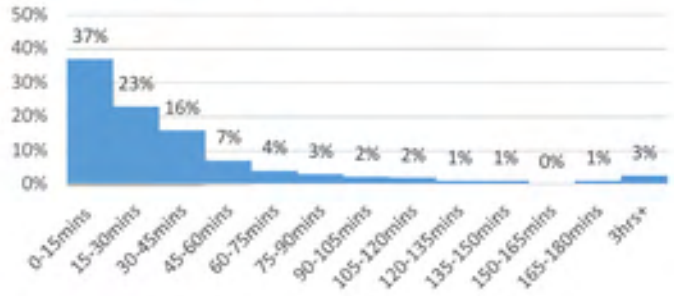
Improving KPIs and timestamp compliance :

Currently the data relating to KPI 1 & 2 is reflective of PCS and IAS journeys only. The following work is currently being undertaken to support improvement:

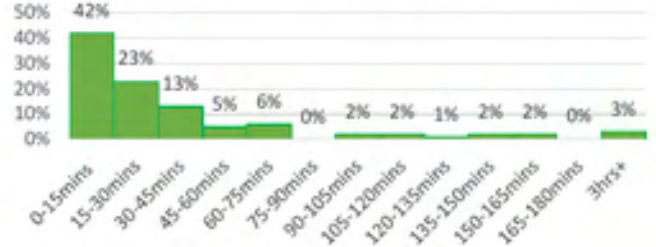
- Where patients are due to travel via PCS, they are now being telephoned and given an expected time to 'be ready to travel' which ensures that departures are as timely as possible.
- There is ongoing improvement work with operational teams to improve the recording of timestamps to ensure the data capture is robust and accurate.
- Clinics/ depts are being encouraged to book ready for return journeys only when ready than pre-emptively
- There is ongoing engagement with all HSC Trusts in relation to appointment times to determine how best we can work together the most responsive service
- The PCS management tier has been reviewed and recruitment to same is progressing, this recruitment will support increased operational oversight to improve KPI performance and timestamp compliance

Patient Experience

KPI 1 Missed Compliance by Time



KPI 2 Missed compliance by time



PCS Timestamp Compliance

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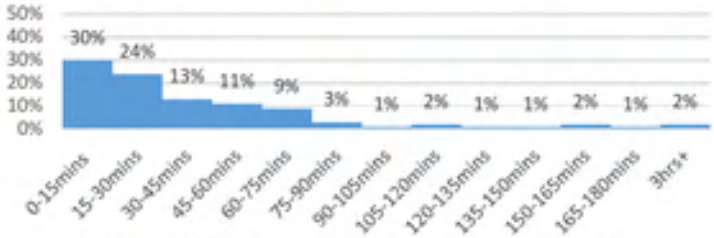
Our Patients | Non-Emergency IAS Performance | Patient Experience

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

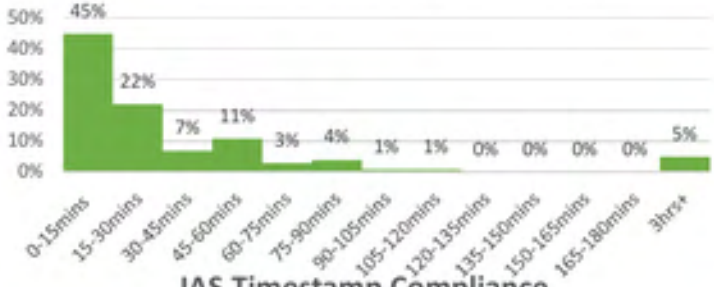
KPI 2 - That 95% of outward journeys will start within 60 minutes of the patient being booked as ready by the clinic/hospital

KPI 1 & 2 Compliance IAS

KPI 1 Missed Compliance by Time (IAS)



KPI 2 Missed Compliance by Time (IAS)



Analysis

- An analysis of the journeys that missed compliance shows that 30% of these journeys missed the target by 15 minutes or less, 78% missed the target by 60 minutes or less
- Similarly, for KPI 2, relating to outward journeys 45% of journeys that missed the target were no more than 15 minutes over this and 85% missed the target by 60 minutes or less
- In the case of KPI 1 where a patient is going to be significantly late for an appointment, the Non Emergency Control Room makes contact with the destination Trust to advise when there are anticipated delays to ensure the patient does not miss the appointment.

IAS Timestamp Compliance

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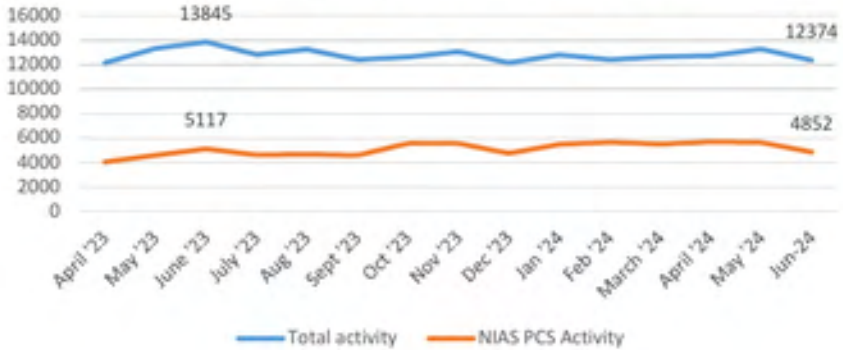
Our Patients | Non-Emergency PCS Performance | Productivity Performance

Non-Emergency Patient Journeys PCS



Total Non-Emergency activity by all modes of transport for June '24 was 12,374 journeys, which is reduced compared to the June '23 total of 13,845. Activity is also down significantly when compared to the May 24 13,289.

In relation to PCS journeys only
June '24 Activity – 4,852 (39% overall non emergency) v
June '23 Activity - 5,117 (37% overall non emergency

Factors that have contributed to this reduction in activity are multifactorial. Outpatient appointments and discharges from the BHSCT during June were significantly also reduced due to the introduction of 'Encompass'. There were reductions in activity across all HSC services including outpatients and day procedures because of 'Strike Action' by medical personnel (Junior Doctors') during June 2024.

Patient Journeys Per Shift PCS

Average Patient Journeys per Shift –
Destination based planning, a new planning methodology for PCS journeys was introduced in Oct 2023. Since this time, journeys per shift have been consistently above 4. During June 24, a decrease to 3.97 journeys per shift has been observed. The reduction in demand has been a factor in this.

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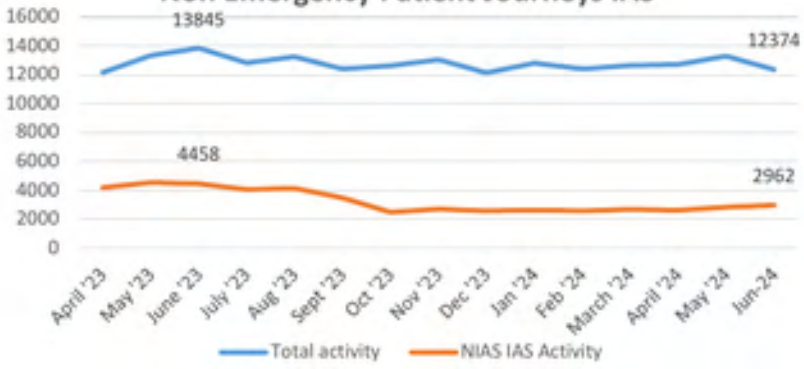
Our Patients | Non-Emergency IAS Performance | Productivity Performance

Patient Journeys Per Shift IAS

Non Emergency Patient Journeys IAS



Average Patient Journeys per Shift –
Monitoring of this activity measure gives an indication of the average workload carried out per crew in a shift.
The IAS journeys are also now planned using the Destination Focused Planning method and improvement is noted from December '23 The new Independent provider contracts came on stream at the end of 2023. June '24 figures of 4.43 continues a slight downwards trend since April'24.

Activity and IAS Share
Total Non-Emergency activity for June 24 is lower than in June 23, 12374 journeys delivered versus 13845 journeys delivered.

The proportion of this activity delivered by Independent Ambulance Providers continues to show a downward trend with 24% of total Non-Emergency journeys being delivered by IAS during June 24 versus 32% of journeys in June 23. This is a result of conscious and sustained improvement efforts in relation to IAS utilisation.

- June '23 Activity 13,845 patient journeys delivered with the IAS share at 4458 journeys or 32%
- June '24 Activity 12,374 patient journeys delivered with the IAS share at 2962 journeys or 24%

Northern Ireland Ambulance Service
Health and Social Care Trust

Our Patients | Emergency Performance | Actions to Improve Performance

- Planning has commenced to identify the key projects for the delivering value programme for 2024.25, service improvements will be identified and implemented through the programme and regular updates will be provided to Trustboard throughout the year.
- Engagement sessions will commence across the organisation to inform staff of the Operational Restructure proposals, that will be implemented within the organisation over the coming months.
- 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 now in post following their training, with the new rota now implemented from March 2024. This Rota is based on call demand for the service, with a focus on ensuring staffing levels meet the call demand as it commences within the trust. Performance management and clinical audit mechanisms have been strategically implemented to quantify and understand the hub's impact, aiming to optimise its full potential.
- 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.
- Recruitment of additional Pathway Leads within the organisation has concluded to support the organisation in improving its See and Treat rates. These posts will work within division as champions for alternative pathways and work closely with the CSO tier to develop decision making within the clinical tiers of the organisation.
- A continued focus on Patient Care Pathways to maximise opportunities, signpost patients appropriately, and contribute to reducing conveyance rates. Meeting planned with SET to audit the clinical presentations of those low acuity patients discharged from EDs. The trust has engaged with GIRFT and regional colleagues to carry out and assessment of alternative care pathways across the region and an outcome from this work is awaited.
- Challenges with Duplicate Call continue to persist at a high levels within EAC as outlined earlier in this report. EAC has reviewed the process and how it can be address, with the implementation of action cards within EAC to deal with these callers, whilst ensuring patient safety. Alongside this, SMS messaging continues to be sent to 999 callers from mobile phones informing the caller to only call back if there is a change in the patient's condition.
- NIAS have committed to work with GIRFT colleagues to develop a full understanding of the regional Directory of Services (DOS) and actions to deliver this recommendations will be taken forward with support from our RCC affiliates.

Northern Ireland Ambulance Service
Health and Social Care Trust

Our Patients

SAIs & Complaints

Serious Adverse Incidents

During June 2024, the Trust reviewed 5 potential SAI's resulting in no notifications to SPPG.
There are currently 6 ongoing SAI's which are all being reviewed at Level 1.

Themes

No SAI's were notified during June 2024 and as such there are no themes to report within this month.
The 3 key National Ambulance Risk and Safety Forum themes remain consistent throughout the financial year and are as follows:
•Delays in call answering and dispatch
•Call Handling & Dispatch Incidents
•Clinical Assessment and or treatment on scene

The top NIAS themes remain consistent and are as follows:
Delayed response out with standard associated with a patient outcome of death
Elderly patients who have fallen
Deteriorating Patient – community

Recommendations & Learning

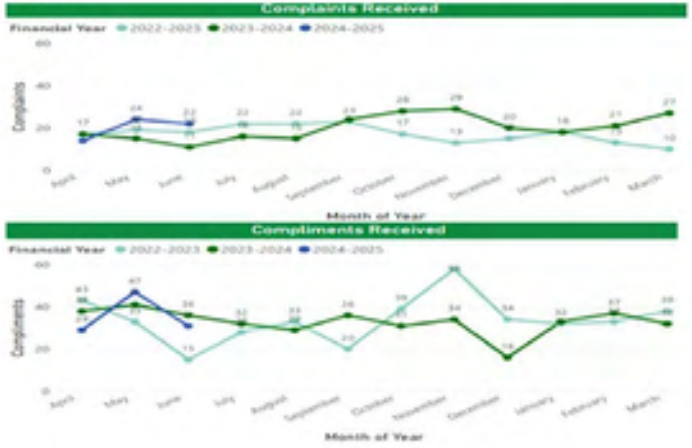
During June 2024, 3 SAI's were closed with the following learning identified:

- Challenges within CSD/CSM staffing and escalation within the Clinical Safety Plan impacting provision of timely welfare calls.
- Importance of adherence to dispatch guidelines and appropriate vehicle allocations with focus on documenting rationale for out of sequence allocations.
- Importance of adherence to the duplicate call process

Implementation and evidencing of SAI recommendations remains an area of focus and to date we have completed and evidenced 88% of the outstanding SAI recommendations.

Complaints, Compliments & Care Opinion

During June 2024, **31 compliments** & **22 complaints** were received.



Timeliness of Process

20 complaints were closed during June 2024.

At the end of June 2024, 44 complaints remained opened with the average number of days opened being 31 working days.

Trends &Learning: Of the 20 complaints closed, 83% were upheld/ partially upheld with some of the following learning outcomes identified: recognition of obstetric emergencies; communication; and adherence to MPDS protocols.

Service Improvement Plans 24/25

- Regional roll out of feedback leaflet for frontline staff to issue to service users
- Development of a new NIAS Complaints policy; systems developments; and, operational training requirements to support the new NIPSO Model Complaints Handling Procedure for Trusts (planned publication date of 01/04/24).

Care Opinion

During June 2024, 11 stories were submitted via Care Opinion.
By 30th of June these stories were viewed 948 times.
The main areas of feedback were:
What's good – Paramedics/ Ambulance crew/ Kindness/Care
Improvements – Delays/Equipment
Feelings – Reassured/ thankful/ well informed

Northern Ireland Ambulance Service
Health and Social Care Trust

Our People | **Absence** | **Sickness**

The Trust continues to significantly prioritise Absence Management and this continues to be managed in a dedicated project management space. Enhanced accountability and performance management arrangements are in place at line manager, director and Chief Executive level.

Priority focus remains on the role of the line manager in ensuring timely engagement and effective management and support for staff who are absent due to sickness. It is notable that following a period of sustained reduction in absence levels, June saw an increased position. This is being carefully monitored including at local divisional/departmental level. Additional areas of focus include monitoring of Occupational Health arrangements and ensuring appropriate employment processes. Significant progress has been made in the area of medical redeployment.

Top 5 Sickness Categories 2024/25*	
Mental Health	32.84%
Injury, Fracture	8.74%
Miscellaneous	7.65%
Accident/Untoward Incident	7.40%
Influenza	5.81%

* Accounts for 62.44% of absence

Miscellaneous includes General Debility (3.24%); Hospital Investigations (1.91%); Post Surgical Debility (1.57%); Post Viral Fatigue (0.89%); Chronic Fatigue (0%)

Mental Health Reasons	
Stress	11.33%
Stress-Work Related	10.60%
Grief/Bereavement	5.00%
Anxiety	2.23%
Other Mental Health	1.84%
Behavioural Disorder	0.68%
Panic attacks	0.68%
Insomnia	0.07%
Depression	0.17%

Sickness absence due to mental health reasons represents 32.84% of sickness absence in 2023/24, with stress and work-related stress accounting for 11.33% and 10.60 respectively. This is an increase from the previous report. 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, a range of processes related to exposure to trauma and offering manager training in the use of the Trust's policy and procedure on managing work-related stress. In this regard a stress risk assessment is undertaken to inform an Occupational Health Referral.

2024/25 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 (2024/25)						TBC%[1]						
2.	Current Status against Target						10.06%						
3.	Cumulative % hours lost (23/24)	14.25%	14.19%	14.25%	14.27%	14.64%	14.60%	14.65%	14.82%	14.90%	14.76%	14.53%	14.23%
4.	Cumulative % hours lost (24/25) (Total)	10.24%	9.64%	10.06%									
4.1	Cumulative % hours lost (24/25) (Non-Covid)	9.94%	9.28%	9.66%									
4.2	Cumulative % hours lost (24/25) (Covid)	0.30%	0.36%	0.40%									
4.3	Cumulative % hours lost (24/25) Short-Term	1.94%	1.89%	2.03%									
4.4	Cumulative % hours lost (24/25) Long-Term	8.30%	7.75%	8.03%									
5.	Monthly % hours lost (24/25) Total	10.24%	9.07%	11.00%									
6.	Average standard working days lost/employee/month	2.19	2.02	2.14									
7.	Average estimated cost per month (£'000)	£527	£481	£644									

[1] Awaiting confirmation of 2024/25 target from DOH

↑ 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 24	May 24	June 24	July 24	August 24	September 24	October 24	November 24	December 24	January 25	February 25	March 25
Call Answer Outturn	93.7%	87.4%	89.8%									
Trajectory	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%

Hear and Treat and See & Treat

	April 24	May 24	June 24	July 24	August 24	September 24	October 24	November 24	December 24	January 25	February 25	March 25
Hear & Treat Outturn	5.2%	5.3%	6.2%									
Hear & Treat Trajectory	5.0%	5.2%	5.5%	6.0%	6.6%	7.5%	7.8%	8.2%	8.5%	8.8%	9.2%	10%
See & Treat Outturn	13.6%	13.9%	14.3%									
See & Treat Trajectory	13.8%	14.0%	14.3%	14.4%	14.6%	14.7%	14.9%	15.0%	15.2%	15.2%	15.3%	15.5%

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 24	May 24	June 24	July 24	August 24	September 24	October 24	November 24	December 24	January 25	February 25	March 25
Category 1 Mean	11mins	12mins	12mins									
Cat 1 Mean Trajectory	11mins	11mins	11mins	11mins	11mins	11mins	10mins	10mins	10mins	10mins	10mins	10mins
Category 1 90th Centile	21mins	22mins	22mins									
Cat 1 90th Centile Trajectory	22mins	22mins	22mins	22mins	22mins	22mins	21mins	21mins	21mins	21mins	21mins	21mins
Category 1T Mean	14mins	15mins	15mins									
Cat 1T Mean Trajectory	19mins	19mins	19mins	19mins	19mins	19mins	19mins	19mins	19mins	19mins	19mins	19mins
Category 1T 90th Centile	28mins	28mins	29mins									
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 24	May 24	June 24	July 24	August 24	September 24	October 24	November 24	December 24	January 25	February 25	March 25
Category 2 Mean	39mins	41mins	52mins									
Cat 2 Mean Trajectory	48mins	48mins	48mins	46mins	45mins	44mins	44mins	42mins	40mins	40mins	38mins	36mins
Category 2 90th Centile	88mins	93mins	115mins									
Cat 2 90th Centile Trajectory	100mins	100mins	100mins	98mins	96mins	94mins	92mins	90mins	88mins	86mins	83mins	80mins
Category 3 90th Centile	208mins	263mins	381mins									
Cat 3 90th Centile Trajectory	300mins	300mins	300mins	290mins	280mins	270mins	260mins	255mins	250mins	243mins	238mins	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 24	May 24	June 24	July 24	August 24	September 24	October 24	November 24	December 24	January 25	February 25	March 25
<=15mins	7.5%	7.8%	7.6%									
<=15mins Trajectory	7.1%	10%	12%	13%	14%	15%	17%	19%	20%	22%	24%	25%
<=30mins	30.2%	31.8%	29.6%									
<=30min Trajectory	27%	30%	32%	23%	34%	36%	38%	39%	40%	43%	44%	45%
<=60mins	65.8%	68.5%	63.4%									
<=60mins Trajectory	59%	62%	64%	66%	68%	70%	73%	74%	76%	80%	82%	85%
>2hrs	15.4%	13.2%	16.2%									
>2hrs Trajectory	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
No of Patients >2hrs	1,545	1,412	1,585									
No of Patients >2hrs Trajectory	0	0	0	0	0	0	0	0	0	0	0	0

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

PRESENTATION OF PAPER

Date of Trust Board:	22 August 2024
Title of paper:	DoH letter re: Strategic Priorities 2024-25
Brief summary:	The attached correspondence from the Minister for Health setting out the DoH Strategic Priorities for 2024-25 is shared with members for their information.
Recommendation:	**For Approval** ☐ **For Information** ☒
Previous forum:	*SMT – 21/5/24*
Prepared and presented by:	Michael Bloomfield, Chief Executive
Date:	15 August 2024

FROM THE MINISTER OF HEALTH

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

HSC Chief Executives

Castle Buildings
Stormont Estate
BELFAST, BT4 3SQ
Tel: 028 9052 2556
Email: private.office@health-ni.gov.uk

Our Ref: SUB-1435-2024

Date: 9 July 2024

Dear Chief Executives,

STRATEGIC PRIORITIES 2024/25

You will be aware that following the closure of the Health and Social Care Board (HSCB) on 31 March 2022, and its migration to the Strategic Planning and Performance Group (SPPG) within the Department of Health, the statutory requirement to produce a Commissioning Plan, and consequently a Commissioning Plan Direction (CPD), ended.

Work has been ongoing in defining a new method for setting the priorities to the system that would replace the CPD, which originated from a process that had become administratively burdensome and resulted in over two hundred targets and indicators, many of which had lost their relevancy.

The development of the Integrated Care System for Northern Ireland (ICS NI) as the new planning framework provided an opportunity to embed both a population health and an Outcomes-Based Accountability (OBA) approach into this work, and ensure that the planning, management, and delivery of services be more agile, flexible, and responsive to identified local needs, as well as less bureaucratic and process-driven as a result.

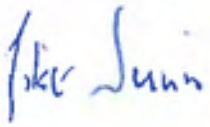
The purpose of this letter is to advise that I have now approved the new approach to setting the strategic direction for the year ahead, which is articulated across two distinct but fully aligned levels:

i. the population accountability is reflected in the introduction of the Strategic Outcomes Framework (SOF), a suite of strategic outcomes depicting the condition of health and wellbeing that we want to achieve for our population in the long-term, and associated key indicators; and

ii. the system-level performance accountability, reflected in the System Oversight Measures (SOMs) which will provide the short-term Ministerial and Departmental priorities to the HSC system.

A copy of the SOF and SOMs is enclosed, setting out the outcomes and objectives for 2024/25, which have been developed in the context of the continuing pressures on financial resources.

Yours sincerely



Mike Nesbitt MLA
Minister of Health

HSC Health and Social Care

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

Integrated Care System NI

Strategic Priorities 2024/25

Incorporating Strategic Outcomes Framework and System Oversight Measures

July 2024

Overview

The following document provides an overview of the strategic priorities for 2024/25, which have been established through a new approach following the closure of the Health and Social Care Board (HSCB) in March 2022and subsequent standing down of the Commissioning Plan Direction (CPD)/Commissioning Plan process for setting the strategic direction to the system.

In the context of the development of the Integrated Care System for Northern Ireland (ICS NI), which is underpinned by both a population health and an Outcomes-Based Accountability (OBA) approaches, the strategic direction to the system has been developed over two distinct but fully aligned levels:

i. the population accountability is reflected in the introduction of the Strategic Outcomes Framework (SOF), a suite of strategic outcomes depicting the condition of health and wellbeing that we want to achieve for our population in the long-term, and associated key indicators; and
ii. the system-level performance accountability, reflected in the System Oversight Measures (SOMs) which will provide the short-term Departmental priorities to the HSC system.

This new process aims at ensuring that the planning, management, and delivery of services is more agile, flexible, and responsive to identified local needs, as well as less bureaucratic and process-driven.

Strategic Outcomes Framework – Strategic Outcomes

The Strategic Outcomes Framework (SOF) reflects, in the context of Outcomes-Based Accountability (OBA), the population accountability of the system, and depicts the condition of health and wellbeing that we want to achieve for the whole population, whether they use our services or not.

It consists of a suite of nine thematic outcomes and supporting key indicators. It should be looked as a whole and not be defined by considering each outcome in isolation. Figure 1 below provides the draft visualisation that was produced at the back of the developmental work, acknowledging the need for further design work to emphasise that all those outcomes are connected, and that the whole population of Northern Ireland can identify with the framework.

Figure 1 – Draft visual illustration of the Strategic Outcomes Framework

It was co-produced through a bespoke engagement programme, and conveys people's perceived needs and priorities in relation to their health and wellbeing, and provides an expansion of the draft PfG outcome *"We all enjoy long, healthy active lives"*.

The concept behind it is as follows:

- a core outcome, to ensure the whole population can identify themselves in the strategic direction and desired outcomes and offering a straight link to the PfG;
- seven thematic outcomes reflective of the key priorities identified through the engagement programme, representing the life course and life journey of an individual through their potential interactions (or non-interactions) with the system; and
- a cross-cutting outcome focusing on health inequalities, linking to the overall public health and ICS objectives, with a particular focus on the wider social determinants of health.

It should be noted that there is no hierarchy between the outcomes, but instead a certain level of complementarity and overlap. Indeed, in many cases, will relate to more than one aspect of health and wellbeing.

Strategic Outcomes Framework – Headline and Secondary Key Indicators

In order to enable the quantification of the impact made by the system on the population's health and wellbeing, existing or desired key indicators were identified and selected through a process of thematic focus groups articulated around the main themes of the strategic outcomes.

The finalised measures are presented in Figure 2 below, with Headline Key Indicators are displayed in bold.

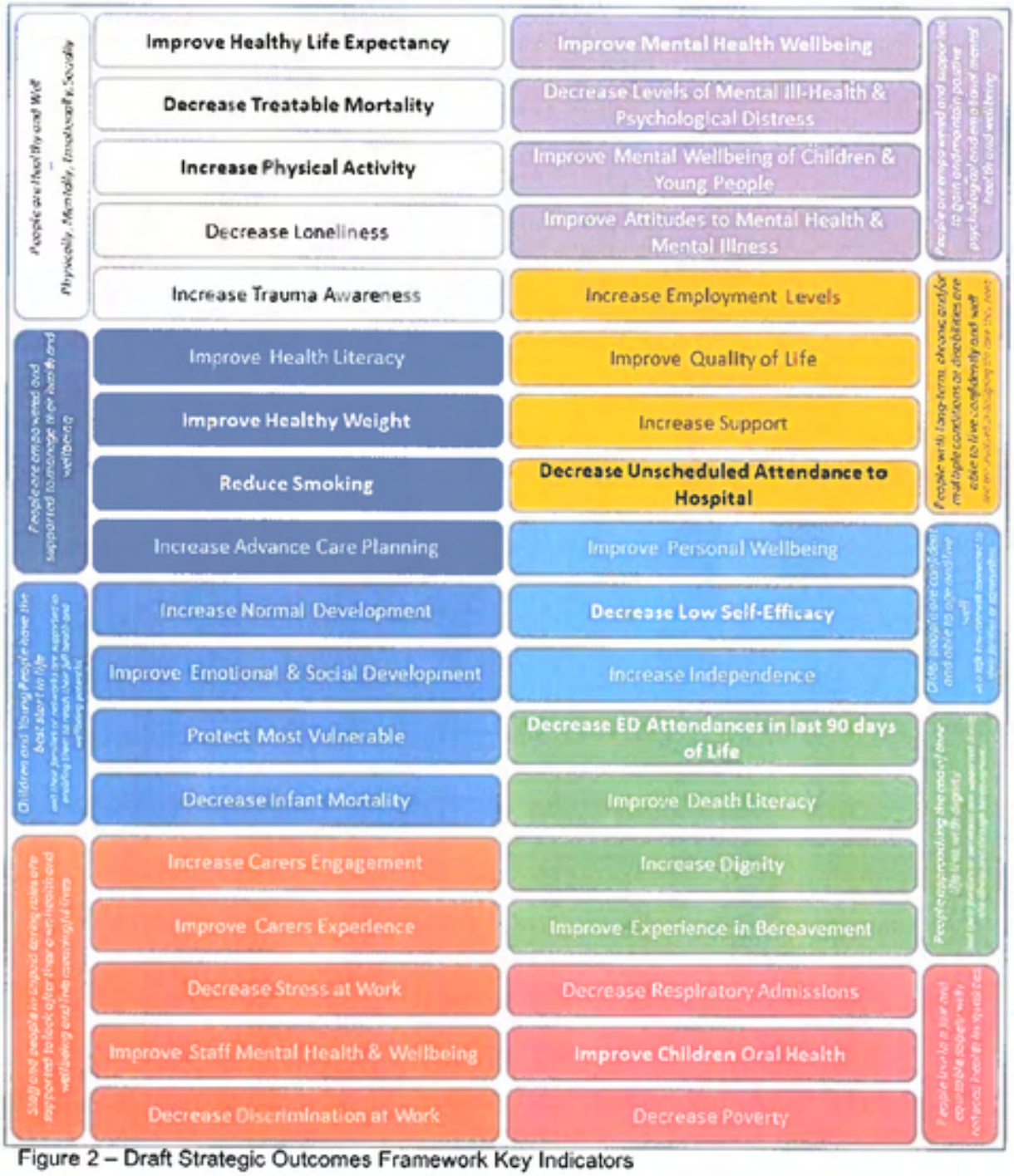


Figure 2 – Draft Strategic Outcomes Framework Key Indicators

System Oversight Measures (SOMs) 2024/25

While the Strategic Outcomes Framework provides the long-term direction to the system, it was essential to also develop a vehicle to convey the shorter-term priorities to the system.

Again, in the context of OBA, these represent the performance accountability of the system's service providers, and while each organisation, each programme, strategy or initiative will have set their own performance expectations in relation to the people or communities they will deliver this service to, those also convey the key Departmental and Ministerial priorities for the year ahead.

In line with the recognised necessity to have a less bureaucratic and more outcome-focused approach, a series of System Oversight Measures (SOMs) were produced through engagement with policy leads and SPPG colleagues.

Those have been articulated around six key domains thus instilling multi-faceted approach to setting the short-term priorities and direction and providing a more comprehensive view of performance across the system, facilitating a better understanding of what is driving current issues and challenges:

- Performance;
- Safety & Quality;
- Finance & Governance;
- Efficiency & Productivity;
- Access Improvement & Tackling Health Inequalities; and
- Workforce.

Whilst the intention from the onset was to provide a more concise and targeted approach, specifications have been added as supporting annexes to ensure the measures are clearly defined and clear baselines and benchmarking rates that providers will be assessed against are set.

The finalised SOMs are presented in Figure 3 below, with the supporting specifications for Acute, Community and Primary Care in the Performance domain as well as specifications for the Safety & Quality domain provided from page 8 onwards.

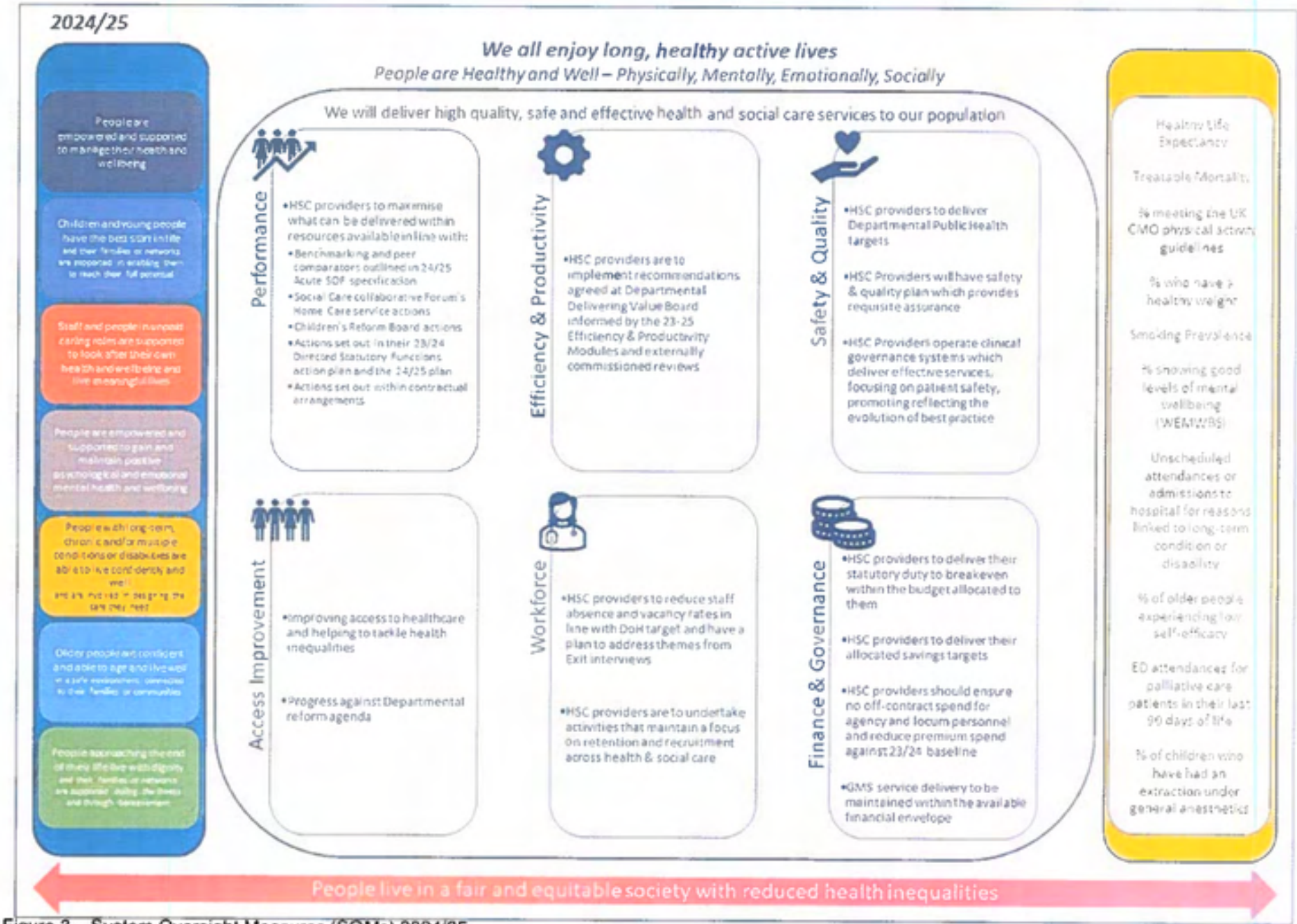


Figure 3 – System Oversight Measures (SOMs) 2024/25

Accompanying Specifications

Acute Specification

Unscheduled Care	**Indicators**
NIAS	
Ambulance Response Times Category 1 and 2	% improvement against 8 min and 18 min standard
Ambulance handover Times	% improvement against 15 min handover standard
Hear and Treat Rates	Achieve 10% rate
Provider Trust	
Patients not waiting in ED	Reduce number of patients who do not wait in ED
12 hour ED delay (delay related harm)	Reduce the number of admitted patients who wait > 12 hours in ED
Simple Delays	Reduce patients waiting >4 hour for discharge
Complex Delays	Reduce patients waiting >48 hours for discharge
Re-admission rates	Reduce number of patients readmitted within 7 days and between 8 and 30 days from discharge
Fracture Neck of Femur – reduce number of patients > 48 hours	Achieve 95% of patients treated within 48 hours
Other Fractures – reduce number of patients > 7 days	Achieve 95% of patients treated within 7 days
Outpatient	**Indicators**
DNA / on the day cancellation rates	- New appointment: 5% (max.) - Review appointment: 8% (max.)
Review appointments - reduce the number of outpatient follow-ups being added to waiting list	25% reduction (against 2019/20 activity levels for agreed specialties)
Expand the use of patient-initiated follow-up (PIFU)	Move 5% of outpatient review attendances to PIFU pathways
Theatres / Inpatients / Day Case	
DNA / on the day patient / hospital cancellations (combined)	All theatre types – main, DPU, endoscopy: 5% (max.)
Theatre utilisation – run and op times	- Run times - main / DPU / endo theatres: 90% - Op time - main theatres: 85%

	- Op time - DPU theatres: 80%
Theatre throughput - ensure adherence to GIRFT recommended theatre throughput rates	As per GIRFT Guidance PowerPoint Presentation (gettingitrightfirsttime.co.uk)
Day case rates – as per British Association of Day Surgery (BADS) recommended rates	- Procedure room/OPP rates for individual procedures – as per BADS rates - Procedures with zero length of stay as per BADS rates NB link below requires log-in: BADS Directory of Procedures and National Dataset
Admissions on day of inpatient surgery	Increase across those specialties currently below CHKS peer group levels
Average length of stay for elective inpatients	Decrease across those specialties currently above CHKS peer group levels (reduce average LOS)

Community Specification

Social Care Collaborative Forum Home Care Service Actions	**Indicators**
Maximize Home Care Capacity	
Early Review of new and increased packages of care and recycling of unused hours to address unmet need	10% reduction in unmet need hours by each HSC Trust by 31 March 25
Digital solution introduced for Trust Home Care Service to manage and reduce unused hours, to strengthen governance and communication and improve the experience for the Service user and their carers	Increase capacity within existing resources by 5% -10% by 31 March 25
Promotion of Direct Payments as an alternative to a traditional package of home care	5% increase in Direct Payments by 31 March 25
Home Care Project Steering Group	
Minimum Regional Definition & Data Set	A detailed regionally consistent Home Care data return to be in place by 31 March 25
Review of Home Care Standards and Access Criteria for home care	Review and agreement reached by all key stakeholders. To be rolled out by 31 March 25
Detailed Drill down on investment in Home Care Services/Demand & Capacity and VFM	Full financial breakdown of costs and spending investment Full Transparency – by 31 March.25
Children's Social Care Reform Board Actions	**Indicators**
Ensure consistent governance around the management of unallocated cases within Children's Services.	Development of regional guidance and a clear accountability framework for HSC Trusts for the management and oversight of unallocated cases in LAC/CWD/GATEWAY/FS by Sept 2024
Agree a regionally consistent model for CAMHS Intellectual Disability	Review current service profile in each Trust by September 2024. Identify what steps each Trust will take to move towards a regionally agreed model by February 2025
Develop an implementation plan for Children with Disability Framework for approval by Reform Board	Develop costs implementation plan with each Trust by September 2024.
Agree a regionally consistent model for Children's with Disabilities Teams	Review current service profile in each Trust by September 2024.

	Identify what steps each Trust will take to move towards a regionally agreed model by February 2025
Work with HSC Trusts to address significant deficits in placement capacity for children in care and short breaks.	Finalise assessment of need through residential workstream of the Children's Services Reform Board Set up monitoring system to track high cost cases and ensure when placement is no longer required funding can be repurposed by February 2025.
Social Care and Children's Statutory Functions	**Indicators**
All Trusts to complete Directed Statutory Function Reports for 2023/24 by end March 2024.	All Trusts DSF Reports to be reviewed and Action Plans to be developed for each of the 5 Trusts by end June 2024. All plans to be implemented and reviewed end March 2025.

Primary Care Specification

Area	Indicators
GMS Activity	
	Compliance with NICAF across a range of domains and indicators, including historic activity levels.
GDS Activity	
	Reduce the percentage of five year old children with caries experience
	Increase the number of newly registering patients with general dental practitioners (under the GDS) over the last 24 months
	GDS activity as measured by the value of item of service (IoS) claims as a proportion of the value of IoS claims in 2019/20 when corrected for SDR fee uplifts.
Pharmacy	
	Number of Community Pharmacy Assurance Framework Declarations (CPAF) completed (target: 100%) and Number of targeted visits (the need for visits is identified from scrutiny of the declarations returned or not returned – required actions would be identified and followed up.) Measure: 100 of required visits.
Ophthalmic	
	Numbers of those certified as Sight-Impaired (SI) or Severely Sight Impaired (SSI)
	Number and nature of Severe Adverse Incidents (SAIs) associated with Ophthalmology services

Safety & Quality Domain Specification

Area	Indicators
HSC Providers	Compliance with SAI Processes
	Level of complaints (trend analysis)
	Reduce severe, avoidable, medication-related harm by 50%
Provider Trust	Reduced acute medical conditions or surgical readmissions to the same hospital <30 days of discharge
	Reduced antimicrobial consumption
	Reduced hospital acquired infections
	Compliance with falls prevention
	Skin bundles for pressure ulcers

Northern Ireland Ambulance Service
Health and Social Care Trust

MINUTES OF THE PEOPLE, FINANCE AND ORGANISATIONAL DEVELOPMENT COMMITTEE HELD AT 9.30AM ON THURSDAY 18 APRIL 2024 IN THE BOARDROOM, NIAS HQ

PRESENT:	Mr P Quinn	Committee Chair
	Mr P Corrigan	Non-Executive Director
IN ATTENDANCE:	Mr M Bloomfield	Chief Executive
	Ms M Lemon	Director of Human Resources & Organisational Development (HR & OD)
	Mr P Nicholson	Director of Finance, Procurement, Fleet & Estates
	Ms V Cochrane	Asst Director HR
	Ms M Paterson	Director of Planning, Performance & Corporate Services
	Mrs C Mooney	Board Secretary
	Ms L Turley	Senior HR Business Partner & Change Manager
	Ms L Donnelly	Asst Director of Finance
	Mr M Cochrane	Asst Director of Operations
	Ms A M McStocker	Health & Wellbeing Project Manager (for agenda item 9 only)
	Ms E Hallissey	Health & Wellbeing, Peer Support Manager (for agenda item 9 only)
	Ms V O'Neill	Health & Wellbeing, Peer Support Officer (for agenda item 9 only)
APOLOGIES:	Mr J Dennison	Committee Chair
	Ms L Gardner	Asst Director HR

1 Apologies & Opening Remarks

Mr Quinn explained that he would be chairing today's meeting in Mr Dennison's absence.

2 Procedure

2.1 Declaration of Potential Conflicts of Interest

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

No declarations of conflict of interest were made.

2.2 Quorum

The Chair confirmed the Committee as quorate.

2.3 Confidentiality of Information

The Chair emphasised the confidentiality of information.

3 Previous Minutes (PC18/04/24/01)

The minutes of the previous meeting held on 29 February 2024 were **APPROVED** on a proposal from Mr Corrigan and seconded by Mr Quinn.

4 Matters Arising (PC18/04/23/02)

The Matters Arising were **NOTED** by the Committee.

Ms Lemon drew the Committee's attention to some of the detail contained within the Employee Relations Update which had been included with papers.

The Chair noted that the title 'Disciplinary Policy' had a more negative connotation and referred to the Trust's efforts to improve culture.

Ms Lemon acknowledged the point made by the Chair but explained that the Trust was required to have Disciplinary Policy and Procedures in place.

Mr Corrigan was of the view that there should not a dilution of language to such an extent where it was not effective and that the Trust needed to have the appropriate mechanisms in place to deal with cases of misconduct, for example. He noted that managers had the right to manage staff.

Mr Bloomfield pointed out that the Trust had adopted this approach in terms of absence management.

Ms Lemon emphasised the need for consistency in approach and the importance of a just culture.

The Chair referred to the Trust aiming to develop leadership skills and acumen from an Operations perspective and noted that a similar approach had been used when dealing with absence management.

Ms Lemon suggested that similar skills were required by managers, for example to enable them to have difficult discussions with staff. She said that skills around building confidence and supporting proportionate risk management decisions. She acknowledged that a fast track approach was also key and noted that performance management was important in this regard.

The Chair noted that it was a regional policy and sought further detail around the involvement of managers.

Responding, Ms Lemon advised that there had been engagement sessions and consultation on the development of the new regional policy.

Ms Cochrane noted that the level of injury allowance claims within the Trust was higher than elsewhere. She explained that this was as a result of exposure to trauma, Post Traumatic Stress Disorder (PTSD) and physical injuries to staff. She explained that there was a specific procedure around injury allowance which involved the hearing of the claim by a panel.

Mr Corrigan enquired whether staff received top-up pay for a maximum of 12 months or 85% of salary if absent with a condition that was wholly or partly work related.

Ms Cochrane explained that, if a member of staff was subsequently redeployed as a result of an injury at work, pay protection did not apply but, in the case of a member of staff who was injured in work, pay protection did apply.

Mr Corrigan referred to the fact that frontline staff received unsocial hours payment and asked if this payment continued if a member of staff was absent from work due to illness.

Mr Cochrane explained that, with regard to unsocial hours payment, a member of staff's pay whilst absent due to illness includes the unsocial hours.

Ms Lemon indicated that the Trust had a number of grievances where applications for injury allowance had been refused. She said the Trust was working with TU colleagues in an effort to resolve issues informally as opposed to following a formal hearing route.

The Chair alluded to the discussion which he and Ms Lemon had in relation to culture. He noted that the recent AACE report on culture had been helpful but had focused on workplace culture as opposed to developing a positive and constructive organisational culture.

Mr Bloomfield agreed and believed that culture needed to cascade from the top of the organisation.

The Chair believed that there was a correlation between culture and absence and noted the need to identify hotspots within the Trust in relation to absence management.

Mr Cochrane advised that there was data to support the correlation and was of the view that this may also be linked to performance management. He cited examples of outstanding responses to Datix, delays in responses to complaints and progressing Serious Adverse Incident (SAI) reports.

Ms Lemon alluded to the absence management project which she had co-chaired with Mr Cochrane and said that this work had focused on the officer level and had identified where there had been inconsistencies. She said she had been grateful to the Business Services Organisation in enabling Ms Turley to join the Trust on secondment. Ms Lemon said she looked forward to re-establishing partnership working relationships with TU colleagues.

Mr Cochrane referred to the Operations Management Restructure and acknowledged that progress had been slow. He explained that there were currently two models under consideration which had been presented to the Senior Management Team (SMT). Mr Cochrane advised that the first model was an enhancement of existing structure to provide 24/7 management cover and strengthen the structures in place. The second potentially combined clinical management and oversight with Operations management roles, providing 24/7 management cover. He pointed out that the overarching aim of both models was to deliver a team approach.

The Chair expressed his interest in a combined clinical and operational model.

Mr Cochrane explained that the current model had clinical and management oversight operating in parallel.

Mr Bloomfield indicated that NIAS was the only ambulance service in the UK not to have 24/7 management cover and acknowledged the associated risks.

The Committee noted that it would receive a detailed presentation on the Operations Management Restructure at its July meeting.

5 **Finance Update (PC18/04/24/03)**

Mr Nicholson predicated his financial update on the fact that all figures were subject to the production of the accounts and noted that the first draft was due to be submitted to the NIAO on 3 May 2024.

Mr Bloomfield alluded to the significance of the NI Assembly having been re-established and reminded the meeting that Permanent Secretaries previously did not believe they had the powers to take the decisions about services and their costs necessary for the system to breakeven.

Mr Corrigan acknowledged that, while there was a statutory requirement to breakeven, there was also a requirement to provide a safe and effective service.

Mr Nicholson said that NIAS would be following the same current indicative financial assumptions as other Trusts in planning for 2024-25.

Responding to a question from Mr Corrigan on whether the £13 million received by the Trust and noted within the presentation was directly linked to Covid-19, Mr Nicholson noted that a specific Covid-19 funding stream had been identified during the pandemic.

Mr Bloomfield reminded the meeting that, during the pandemic, the Trust had increased its expenditure on private providers as only one patient could be conveyed on each PCS vehicle. He said the DoH had recognised the increased pressures on the Trust.

Ms Paterson also pointed out that the additional investment was an acknowledgement of the mitigation put in place by the Trust against the 25% loss in capacity.

Mr Nicholson reminded the meeting that the Trust had been operating at a reduced capacity since handover delays had increased significantly, resulting in circa 25% of funded hours being lost. He said that this equated to approximately £11 million across the five Divisions. Mr Nicholson pointed out that the Trust was also further impacted by the need to support unplanned reconfigurations in the wider HSC, for example, changes to service provision at the South West and Daisy Hill hospitals. This had resulted in additional expenditure on overtime to maintain and enhance ambulance provision.

Mr Corrigan believed it was important to present costs in this way. He noted that, if pressures eased, it would mean the Trust would be able to respond to calls more quickly and acknowledged that this would not result in savings to the Trust.

Mr Nicholson agreed and said that it would release capacity for the Trust as opposed to savings.

Mr Bloomfield acknowledged that if the Trust was able to release lost capacity from handovers, there would be an improvement in performance as well as being able to consider reducing PCS provision to undertake A&E support, thereby negating the need to replace PCS capacity with private providers.

Mr Cochrane noted that one of the reasons for absence was the impact on staff of delayed handovers and the duration of these handovers.

Mr Nicholson clarified that the Trust had not received funding directly linked to the South West Acute Hospital, for example, but had received some additionality within the year. He said the Trust continued to have discussions with commissioners around the need to consider the impact on NIAS services when making such decisions.

The Chair asked whether the Trust had seen any improvements in delayed ambulance handovers as a result of the Regional Co-ordination Centre (RCC).

Mr Bloomfield reminded the meeting that the RCC had only been in place for a relatively short period of time and it was too early to determine whether any improvements could be attributed to the RCC. However, he acknowledged that the Trust had not seen the same level of deterioration as had been evident previously but reiterated that it was too early to confirm that this was due to the work of the RCC.

Referring to the planned deployment of new resources, Mr Nicholson advised that there would be a transition period in the delivery of the additional ambulance provision.

Mr Bloomfield clarified that this provision was linked to the 48 Newly Qualified Paramedics due to join the Trust in September. However, he outlined that, while they would be onboarded in September, they would be supernumerary. Therefore, there would not be an immediate impact of their deployment. He noted that some of them would not undertake their emergency driving until early 2025 and, as such, would not be providing additional activity.

Ms Paterson pointed out that, in terms of planning, the Trust had to demonstrate to the SPPG that the measures being taken would reduce demand and increase capacity.

Mr Corrigan enquired whether there would be any assistance from the SPPG to close the shortfall.

Responding, Mr Nicholson clarified that it had been made clear that it was the Trust's responsibility to ensure it achieved breakeven. He said the Trust had been asked to submit a revised financial plan by the start of May.

Mr Bloomfield said that key to the financial plan, it would be imperative that the Trust reduce its expenditure on private providers and overtime. He added that it remained the DoH view that more could be done in terms of efficiency and productivity.

Ms Lemon alluded to the need to adhere to the Circular on change or withdrawal of services as well as the need to undertake human rights and equality screening.

The Committee **NOTED** the Financial Report as presented by Mr Nicholson.

6 **HR & OD Balance Scorecard (PC18/04/24/04)**

Ms Lemon sought the Committee's view on any other indicators they would like to see included in the scorecard.

The Chair said that he had found the accompanying narrative to be helpful and asked whether it would be possible to correlate the low uptake of flu and Covid-19 vaccines with short-term absence. He added that, as the Trust was adopting a health and wellbeing approach, vaccination should be regarded as part of a public health approach.

Ms Paterson advised that there was correlation with short-term absence.

Ms Cochrane noted that Ms Robb, Infection Prevention and Control Lead, was leading on vaccination within QSI and queried how best to reflect vaccination data on the scorecard. She pointed out that short-term absence was reported in the Trust Performance Report presented to Trust Board. Ms Cochrane said it would be important to avoid duplication and helpful to determine what should be reported at Committee and at Trust Board level.

Ms Paterson welcomed the improvements and enhancements in the performance report to date. She suggested the development of a suite of metrics for the Trust Board corporate scorecard and

consideration to be given to those metrics to be reported at Committee level. She acknowledged that further improvements were required.

Ms Lemon said she was conscious that the Trust reported absence at several different fora and therefore there was potential for it to be reported in different ways. She advised that the report alluded to cumulative absence as that was the target set by the DoH.

Ms Lemon welcomed the reduction in absence and reported that the absence figure for the month of February 2024 was 12.08% overall. She explained that a quantum of this figure pertained to long-term absence and this had been the Trust's rationale for targeting this area in the first instance. Ms Lemon said that the Trust was now also examining those members of staff who had high incidences of short-term absences.

Ms Lemon advised that the Trust was now seeing a high proportion of holiday pay cases being resubmitted for consideration and she said HR was seeking to engage with TU colleagues around these.

Ms Lemon said she was conscious Mr Nicholson provided the financial figures around overtime within his financial reports to the Committee and she suggested that this detail should be removed from the scorecard. She noted that it was not yet possible to populate some elements of the scorecard and suggested that these should be removed until such times as the appropriate data became available.

She indicated that, at the time the scorecard was being developed, some of the indicators being included had been aspirational in nature. She said she would be keen to review the scorecard and present an updated version to the Committee.

The Chair suggested that, for comparison purposes, it would be helpful to have sight of the previous month's data when the report was being presented.

Ms Cochrane stressed the need for figures to be meaningful and advised that staff were working on developing data, for example, around equality breakdown and percentage of qualified paramedics versus unqualified.

The Committee **NOTED** the HR&OD Balance Scorecard as had been presented by Ms Lemon and colleagues.

7 **HR & OD Improvement Plan – April 2024 (PC18/04/24/05)**

Ms Lemon explained that she had been keen to present the Improvement Plan to the Committee to provide a sense of the Directorate workplan. She acknowledged that the Directorate had to divert its attention to absence management and Action Short of Strike (ASOS) and advised that work on the improvement plan had been stood down to allow the Directorate focus on negotiating derogations with TU colleagues around ASOS.

Continuing, Ms Lemon advised that the Transformation Team had been helpful in terms of determining the key functions, the key deliverables and the actions required to deliver improvement. She added that she intended to revisit the RAG rating within the report in the coming weeks.

Ms Lemon said the workplan would give the Committee a sense of the priorities, where progress had been made/needed to be made and those areas which needed to be deferred.

Ms Cochrane noted that several initiatives were 'invest to save' initiatives. She cited the example of improving data sources which in turn would allow the Directorate to make much better use of technology and be able to see performance in all areas of HR.

The Chair acknowledged that the scale of the plan was significant and the way in which information was presented in it was difficult to follow. He sought further detail around the trajectory for the plan and whether consideration had been given to prioritising certain areas of work into more manageable sun-initiatives.

Ms Lemon noted that the timelines within the plan went to 2026 and suggested that the focus should be on how the plan was presented.

8 **Maximising Attendance:**
- Progress Report
- Delivery Plan Update (PC18/04/24/06)

Ms Lemon highlighted the salient points of the progress report on maximising attendance. She pointed out that the need to review the Trust's Attendance Management policy and procedures had arisen from an Internal Audit recommendation to review and update the documentation. Ms Lemon said that, following presentation to the Senior Management Team, there had been agreement that the extant documentation remained fit for purpose.

Mr Corrigan commented that, in his experience, there was potential for issues to arise following the implementation of any policy or procedure. He asked if Internal Audit continued to review this area.

Ms Lemon advised that a robust audit had been undertaken in the 2022-23 year and noted that significant work had been undertaken to address the outcomes of that audit. She suggested it might be helpful to bring an update on progress in addressing the recommendations to a future meeting.

Mr Corrigan believed that the renewed focus on managing absence would filter through the organisation.

Mr Cochrane agreed with Mr Corrigan's comment. He was of the view that staff were now seeing absence being robustly managed and were encouraged by the renewed focus. He added that this was in turn supporting performance.

Ms Lemon explained that an important element of work embedded in the methodology around absence management was seasonal absence. She advised that data relating to staff who tended to be absent from work at regular seasonal intervals had been shared with managers to allow them to follow-up with staff accordingly.

Continuing, Ms Lemon advised that some work had been carried out to improve the Trust's redeployment procedures and, following consultation with TU colleagues, these had been presented to the Senior Management Team. She said it was felt that, as the procedures were operational in nature, there was no need for these

to be considered by the Committee. Ms Lemon said that the Internal Audit recommendations would be updated accordingly.

Mr Corrigan clarified that, for the 2023-24 year, the DoH had set a target of 92.5% of the outturn for the previous year and asked if there was any indication of the current target. He noted that the sickness absence reports were divided by Divisions and non-A&E staff groupings.

Responding, Ms Lemon confirmed that Trusts had not yet been advised of a revised target. She reminded the meeting that the Trust was held to account through the Strategic Planning and Performance Group (SPPG) on this issue.

Mr Cochrane referred to the absence reports and confirmed that the Trust had a split workforce categorised as A&E and non-emergency staff.

The Chair thanked Ms Lemon for the Maximising Attendance update which was **NOTED** by the Committee.

9 **Update on Peer Support & Health and Wellbeing Workstreams (PC18/04/24/07)**

The Chair welcomed Ms McStocker, Ms Hallissey and Ms O'Neill to the meeting and invited Ms McStocker to provide an update on year two of the Trust's Health and Wellbeing Strategy which had been approved by the Board in August 2022. Ms McStocker gave a detailed presentation on the Peer Support and Health and Wellbeing Workstreams.

Members commended Ms McStocker on her presentation and said it had assisted in their understanding of the breadth of the work ongoing within the Trust.

Mr Corrigan alluded to the references to 'critical incident' in terms of Critical Incident Stress Management (CISM) and asked who determined what would be a 'critical incident'. He also sought further detail around the threshold for peer support becoming involved.

Ms McStocker explained that the peer support team would debrief staff involved in a critical incident separately and consider several

areas, for example exposure to trauma and the duration of that exposure. She stressed the importance of the peer support programme being two-way in terms of the peer support team making contact with the member of staff who had been exposed to trauma. Ms McStocker said it was key for the member of staff to know that it was good to speak up and to contact peer support for assistance.

Mr Corrigan asked for a sense of the calls and interactions received by the peer support team and how many were generated by the team and by self-referral.

Responding, Ms Hallissey explained that there were specific incident criteria which would lead the team to contacting staff, for example paediatric resuscitation, out-of-hospital cardiac arrest, incidents for patients under the age of 18 years. She said that the team used to contact staff by phone but, on reflection, had determined that this was not the best way to communicate with staff. She advised that the team now contact staff by text in the first instance and provide an opportunity for a call-back.

Ms Hallissey said that, on occasions, the team might receive a referral from a manager who may be concerned about a member of staff. She indicated that, in terms of self-referral, she had found that by talking to staff initially, the team would eventually receive a self-referral.

Mr Corrigan stressed the importance of peer support and believed the team had credibility with staff because they were paramedics and had served on the frontline. He also alluded to the importance of the manager's role to look after their staff. Mr Corrigan asked how the team ensured they complemented line management.

Ms Hallissey explained that training was provided to managers around having difficult conversations and allowing them to support staff who were struggling and said that peer support complemented line managed through psychoeducation.

Ms Lemon commended the engagement undertaken by Ms McStocker and Ms Hallissey with managers. She said there had been a huge transformation in managers' understanding of and the realisation of the benefit of peer support.

Mr Cochrane noted that this provided another skill for managers in terms of managing members of staff on long-term absence and the support provided by peer support was key.

Ms Turley explained that she was relatively new to the Trust and had been impressed by the peer support arrangements in place within NIAS and what had been put in place with the resources available. She commended the different interventions available at different levels because the capability to copy with mental health varied. Ms Turley advised that she had previously worked with the regional Mental Health Strategy and noted that there had been a 29% increase in demand for mental health services. She believed that NIAS had used its resources to make its peer support services meaningful for staff and provided staff with the ability to cope.

The Chair commended the need to build capacity and resilience in individuals and asked if this was covered in the undergraduate programmes in terms of the importance of coping strategies.

Responding, Mr Cochrane said that the Trust had strongly advocated for its inclusion and acknowledged that it was touched upon during the course. He also pointed out that peer support colleagues would periodically receive referrals for students on placement.

Ms McStocker advised that the peer support team would be invited to speak to the students but said her plan would be to develop a module which could be delivered to students. She pointed out that there was currently a health and wellbeing module but this needed to be strengthened.

The Chair believed that resilience would be an important core capacity for any role. He referred to the HSC staff survey and suggested that there may be a need for a bespoke NIAS survey.

Ms Lemon said it would be important to examine timings and to avoid any internal NIAS survey clashing with the more general HSC survey.

Ms Cochrane pointed out that, in terms of undergraduate education, peer support would have input to the Associate Ambulance Practitioner (AAP) course.

Ms McStocker confirmed that this was the case and that input was usually time limited, for example a few hours. She said her preference would be to develop a module for delivery. Ms McStocker advised that the Health and Care Professions Council (HCPC) had introduced its own Fitness and Wellness module as a core competency. She referred to the onus on staff to be self-aware and ensure they were able to carry out their roles and responsibilities.

Ms McStocker advised that public health recognised that workplaces provided an effective way to promote the health promotion agenda. She said this had driven the HSC Wellbeing Framework for staff and had recognised that if, for example, staff were experiencing domestic violence, the safest place to receive support might be the workplace. Ms McStocker said that the peer support team worked with teams at an administrative level who were also often exposed to traumatic content.

The Chair commented that the team's work was impressive and said he looked forward to further updates. He thanked the team for their attendance and they withdrew from the meeting. The Update was **NOTED** by the Committee.

10 **Date of next meeting**

The next meeting of the Committee is scheduled to take place on Thursday 3 July 2024 at 9.30am in the Boardroom, NIAS HQ.

11 **Any Other Business**

(i) HR&OD Structure

Ms Lemon provided an update in relation to the HR&OD structure.

THIS BEING ALL THE BUSINESS, THE CHAIR DECLARED THE MEETING CLOSED AT 12.30PM.

SIGNED: 

DATE: 3 July 2024

Northern Ireland Ambulance Service
Health and Social Care Trust

'PEOPLE' COMMITTEE REPORT TO TRUST BOARD 3/7/24

The People, Finance and Organisational Development Committee met on Wednesday 3 July 2024.

Issues discussed included:

1	**Finance – verbal update** The Committee received a verbal update on the financial position.
2	**Operations Management Restructure** The Committee received an outline of the model to be implemented within the Operations Directorate for a new leadership structure within the Trust. This model covers both services within operations, Urgent and Emergency Care (UEC) and Patient Care Service Care (PCS) The Committee noted that the implementation plan would be presented at a future meeting of the Committee.
	HR & OD Balance Scorecard The Committee noted that the HR & OD KPI Scorecard had been updated following discussions at the April meeting. Absence information has been rationalised to give in-month and cumulative figures for long-term, short-term and total absence. Those items which were reported via Finance (overtime costs; agency costs) or for which there was no current data source (staff satisfaction; Directorate satisfaction; Trade Unions; statutory duties; policy awareness) have been removed for consideration at a future date. Vaccination data has also been included. Both in-month and previous month data have also been included where available/appropriate. Supporting narrative and a more detailed breakdown of the NIAS workforce were also included as appendices to the paper.

Northern Ireland Ambulance Service
Health and Social Care Trust

Maximising Attendance Progress Report

The Committee noted the progress report which outlined key progress in the management of absence as well as key elements of improvement which included a corporate level downward trajectory in absence levels. The report also highlighted the key priorities in the current year to consolidate and seek to sustain the related improvement.

In addition to the above, a profile of absence levels in April and May 2024 was also included. The Committee was advised that this information was used to identify hotspots and ensure targeted management. In this context, the Southern and Northern areas had higher levels of absence within Operations which was managed through performance management at Station Officer level.

Northern Ireland Ambulance Service
Health and Social Care Trust

MINUTES OF THE AUDIT AND RISK ASSURANCE COMMITTEE (ARAC) HELD ON THURSDAY 16 MAY 2024 AT 9.30AM IN THE BOARDROOM, NIAS HQ

PRESENT:	Dr P Graham	Committee Chair
	Mr D Ashford	Non-Executive Director (joined the meeting at 9.35am)
IN ATTENDANCE:	Mr M Bloomfield	Chief Executive
	Ms R Byrne	Director of Operations
	Ms L Charlton	Director of Quality, Safety & Improvement
	Ms M Lemon	Director of HR & OD
	Mr P Nicholson	Director of Finance, Procurement, Fleet & Estates
	Ms M Paterson	Director Planning, Performance & Corporate Services
	Ms B McAuley	Assistant Director of Finance
	Ms L Donnelly	Assistant Director of Finance
	Ms C McKeown	Head of Internal Audit, BSO
	Ms C Hagan	External Audit ASM
	Ms C Kane	Northern Ireland Audit Office
	Ms L Mitchell	Independent Adviser to Committee
	Mrs C Mooney	Board Secretary
APOLOGIES:	Mr P Corrigan	Non-Executive Director
	Dr N Ruddell	Medical Director
	Mr N Sinclair	Chief Paramedic Officer
	Mr D Charles	Internal Audit, BSO

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.

He noted that, until Mr Ashford arrived, the Committee would not be quorate and therefore unable to approve any agenda items. He suggested that approval of the minutes would be done when Mr Ashford joined.

The Chair stressed the confidentiality of information presented.

3 **Matters Arising (AC16/02/24/02)**

3.1 **Action List**

The Committee **NOTED** the Matters Arising.

Ms Paterson drew the Committee's attention and advised that she had met with the Committee Chair to review the Corporate Risk Register and to discuss the Trust's approach to reporting risk. She drew members' attention to the paper which had been included as a example of the form that future reporting might take. Ms Paterson acknowledged that a workshop would be helpful and she undertook to bring an update to the June meeting.

The Chair commented that the Register appeared more concise.

Mr Ashford joined the meeting at this point.

4 **Previous Minutes (AC16/05/24/01)**

The minutes of the previous meeting held on 1 February 2024 were **APPROVED** on a proposal from Mr Ashford and seconded by the Chair subject to an amendment from Ms McKeown to page 15 which should read '*Mr Jameson said he was also an advisory member of the regional Cyber Security Programme Board.*'

5 Chairman's Business

5.1 ALB ARAC Chairs' Forum – 29 May 2024

The Chair reminded colleagues that he would be attending the above meeting on 29 May and would provide feedback at the June meeting.

6 Standing Items

6.1 Direct Award Contracts:

- **DoH letter re: Delegation of approval of Direct Award Contracts (DAC) below £1 million to Arms Length Bodies (ALB) Chief Executives (AC16/05/24/03)**

Mr Nicholson drew the Committee's attention to the Permanent Secretary's correspondence to ALB Chief Executives advising of the delegation of approval of DACs up to a value of £1 million. He said that the Trust would now need to examine how this would be managed internally.

- **NIAS DAC Register (AC16/05/24/04)**

Mr Nicholson said it was not his intention to go through the Register in detail but acknowledged the magnitude of several DACs.

He referred in particular to the DAC for the command and control infrastructure and advised that the Trust had now gone through the procurement and award exercise for the replacement of that platform which would be implemented in the current calendar year. He noted that this would then conclude the older contract.

Mr Nicholson explained that, due to the specialised nature of the service required, there was only one provider. He noted the need to maintain the platform.

The Chair welcomed the reduction in the number of DACs.

Responding to a question from Mr Ashford, Ms Byrne confirmed that the work was on target to be completed in-year.

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, in terms of the preliminary cases which related to pay or pay-related allowances, all cases had been investigated and closed. She reported that two cases had been referred for full investigation as potential fraud with a long-standing case from 2022-23 investigated and concluded in the last financial year. She indicated two cases carried forward from the previous year had been investigated and concluded with no evidence of fraudulent activity. A further two preliminary cases referred for full investigation had now concluded with one closed with no evidence having been found and the other had been concluded due to being unable to prove a case of fraud to the required standard.

Ms McAuley advised that the Trust was currently examining the recommendations made in relation to secondary employment declarations and disciplinary investigations.

She noted that the Trust had engaged with Counter Fraud Services to deliver training sessions for staff and said that four sessions would take place in May and June.

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

6.3 **Emergency Preparedness, Resilience and Response (EPRR)**

Mr Ashford advised that two further update meetings had been held since the February ARAC meeting and said that progress continued.

While he acknowledged the progress which had been made, Mr Ashford expressed his concern at the delay in appointing the Assistant Director post.

He advised that he had asked for a detailed update to be provided to the next Safety Committee meeting on 13 June in terms of progress against the recommendations and he undertook to keep ARAC apprised.

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

7 Internal Audit

7.1 To advise on key issues

Ms McKeown noted that the key issues to report had been included on the agenda.

7.2 Internal Audit Progress Report (AC16/05/24/05)

Ms McKeown drew the Committee's attention to the Progress Report and noted that Internal Audit had completed its assignments for the 2023-24 year. She highlighted the salient points from the Report for the Committee.

The Chair alluded to the findings of the recent audits and noted that the findings appeared to be a combination of governance and process issues.

Mr Nicholson noted that the requirement for business cases for every element of expenditure was extremely onerous as well as for any contract renewal. He suggested that engagement with the DoH/SPPG was needed to discuss the need for a pragmatic approach to this issue. Mr Nicholson said that the requirement for business cases was replicated across other Trusts and also within the BSO in respect of wider regional contracts.

Mr Bloomfield referred to the significant investments made across Trusts and said that, while he very much appreciated the requirement for business cases for larger elements of expenditure, there needed to be a pragmatic approach taken. He said that the requirement for business cases could potentially lead to delays in implementing various changes and hoped that discussions with DoH/SPPG colleagues would be helpful in this regard.

Mr Nicholson noted that, for larger capital and revenue schemes, the process operated smoothly. However, he said, one would question the requirement for a business case to cover stationery for example. Mr Nicholson thanked Ms McAuley for her work in engaging with colleagues across Directorates around financial management and reporting and said she was also considering reporting structures through SMT, the People, Finance & OD Committee and Trust Board.

Alluding to the potential for delays due to the need for business cases for all elements of expenditure, the Chair said that a strategic decision would have to be taken as to how best to address this issue.

Ms McKeown indicated that she had some sympathy for the sector on the issue of management of revenue business cases and said the audit findings reflected the importance of engagement with the DoH to seek clarity around compliance with Circular requirements for expenditure decisions within budget.

Mr Ashford asked if other Trusts were having similar discussions at their Audit Committees.

Responding, Ms McKeown confirmed that they were. She alluded to the audit on Voluntary Car Drivers which had received a Limited level of assurance and advised that the Trust had recognised the weaknesses within the current processes and systems for management of volunteer drivers within NIAS and were currently taking forward a number of actions to strengthen control in this area.

The Chair acknowledged this and was of the view that it would be straightforward to address the findings in this particular audit.

Ms Byrne acknowledged the work being taken forward by the Voluntary Car Driver Forum and the need to strengthen the governance processes.

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

7.3 Year end Follow Up (AC16/05/24/06)

Ms McKeown reported that, of the outstanding 181 recommendations examined, 138 (76%) had been fully implemented and a further 43 (24%) partially implemented. She said that, from the 67 recommendations reviewed in this follow-up, 28 (42%) related to significant findings which had caused Limited/Unacceptable assurances to be provided. Ms McKeown added that, of the 28 recommendations, 8 (29%) were implemented during the follow-up period (September – March 2024).

Ms McKeown advised that the oldest outstanding recommendations were from 2016-17 audits relating to the Management of Medical Equipment and Unsocial Hours.

Ms Lemon referred to the recommendation around unsocial hours and said that Mr Nicholson had already commented on the work done by Ms McAuley in this regard. She explained that this related to issues around Covid-19 handover, redeployment and to what extent unsocial hours were reflected.

Ms Lemon explained that the Trust had invited Internal Audit to work with it around absence management, particularly around system and process. She noted that, while the new systems and processes had been implemented, it had yet to be reported through to the People, Finance & Organisational Development committee.

Ms Paterson advised that processes had been developed over the last 18 months to address the governance elements identified in the Management of Medical Equipment audit. She undertook to bring back some detail to the next meeting.

Mr Ashford expressed his disappointment that several recommendations had now been outstanding for 6-7 years and felt that the Trust had slipped back slightly in terms of its overall position.

Mr Bloomfield said that Mr Ashford would be aware that prior year audit findings had been a significant issue for the Trust. He acknowledged that, while progress had been made, implementation of 29% of recommendations was too low. Mr

Bloomfield assured the Committee that the Trust would continue to focus on implementation. He said there was a need to revisit the older recommendations to ensure they remained valid and that implementation would prove beneficial to the Trust. He undertook to revisit this and update the Committee accordingly.

Mr Ashford pointed out that there had been 11 Priority 1 recommendations in the current year and only four had been fully implemented.

Mr Bloomfield clarified that only 11 Priority 1 recommendations had been due for implementation by the end of March and he acknowledged his disappointment at the lack of progress.

The Chair suggested that it tended to be human nature not to focus on issues which were long-standing and said he would like focus to be maintained on the older recommendations. He agreed with Mr Bloomfield's suggestion to revisit the older recommendations to determine if they remained relevant.

Ms McAuley noted that she had spent considerable time engaging with colleagues across the Trust in terms of the implementation of recommendations. She assured the Committee that all recommendations had been looked at in detail and work was progressing towards implementation.

She acknowledged that those recommendations outstanding tended now to be the more difficult ones to implement. She said she was aware of several recommendations which the Trust may indicate could not be implemented as they currently stand. Ms McAuley cited the example of late overtime claims and explained that the recommendation was to approve the claims but at the moment this was being done on a sample check basis. She noted that the volume of late claims had increased significantly. She pointed out that the Trust would require significant resources to implement this recommendation as the process of verifying claims was complex. Ms McAuley said the Trust was considering the development of a dashboard which would extract data from different systems to highlight those claims which were outstanding.

The Chair said he was encouraged to hear of the ongoing efforts to address this recommendation and added that he hoped Ms McKeown would also be reassured by the efforts being made.

Mr Nicholson acknowledged that there were several themes permeating the recommendations and reminded members that, during the pandemic, governance arrangements had been relaxed. However, he pointed out that the Trust had worked hard to revert to business as usual. Mr Nicholson commented that Ms McAuley had alluded to sample checking and he explained that this had almost been a theme running through several audits. However, he said that work had been done to ensure the relevant infrastructure was in place to establish the necessary controls. Mr Nicholson said that the focus should be on releasing Operational staff to undertake clinical work and a focus on where the administrative work could be done appropriately elsewhere.

Ms McKeown said that Internal Audit would be happy to engage with Trust colleagues to revisit the older recommendations and noted that such discussions had been ongoing.

Responding to a question from the Chair as to the range of Limited assurance, Ms McKeown explained that partially implemented would signify that work had been done and was ongoing. However, she advised that there had been no progress against any of the recommendations.

The Committee **NOTED** the Internal Audit Follow-Up report for the year ended 31 March 2024.

7.4 **Shared Service Update (AC16/05/24/07)**

Ms McKeown drew the Committee's attention to the Shared Service Update and explained that, given the criticality of Shared Services, the summary of findings was shared across the sector. She pointed out that the recommendations within the report were the responsibility of BSO Management to take forward and the report would be presented to the BSO Governance & Audit Committee.

Ms McAuley noted that, in terms of the several limited findings around payroll, these would not necessarily impact on the Trust.

Mr Nicholson indicated that the system within the BSO was quite aged and significant work had been recently completed to identify new contractors for replacement systems. He acknowledged that this would present its own challenges in terms of implementation but would hopefully deliver a more effective system. Mr Nicholson noted that the implementation of the pay award would be managed over the coming months and said that this did present concerns for the sector.

Mr Ashford referred to the Limited assurance in relation to the Payroll Service Centre and the fact that an element of this related to staffing stability. He acknowledged the significant pressures placed on Payroll throughout the year, but particularly at times of a pay award, and queried the impact on NIAS.

Responding, Ms McKeown said that Internal Audit had reported that 17% of posts were currently vacant. She acknowledged the significant pressures on the team and the risks presented by heavy workloads. Ms McKeown noted that the structure within the Payroll Centre had been review and plans were in place to move forward.

Mr Nicholson noted that the Payroll Centre experienced difficulties relating to recruitment and stability on an ongoing basis.

The Committee **NOTED** the Shared Service Update.

7.5 **HIA Annual Report for the year ended 31 March 2024 (AC16/05/24/08)**

Ms McKeown drew the Committee's attention to the Key Performance Indicators (KPIs) and noted that there had been 100% delivery of annual audit plans against the revised Audit Plan. She acknowledged that, while the KPI for the turnaround time between draft and issue of the final report had not been achieved, this had been missed by a small margin.

She alluded to page 2 onwards of the report which provided a summary of the work undertaken in 2023-24, identifying 16 significant findings in total.

Ms McKeown advised that page 7 of the report summarised the quality assurances processes followed by Internal Audit and focussed on the outcome of the External Quality Assessment.

She advised that page 8 of the report set out her overall opinion as Head of Internal Audit and reported that, for the year ended 31 March 2024, she had provided a Limited assurance on the adequacy and effectiveness of the organisation's framework of governance, risk management and control.

Ms McKeown explained that the overall Limited assurance opinion was because of the number of audits in the 2023-24 year which had received a Limited assurance opinion, many of which were in key areas. However, she acknowledged and recognised the enhancements and investment made in strengthening governance in the Trust over the last number of years and the appropriate usage of Internal Audit to assist in driving further improvement in risk, control and governance arrangements where required. However, she acknowledged that further work was required across the Directorates to fully implement Internal Audit recommendations.

The Chair welcomed Ms McKeown's acknowledgement of the work done to enhance and strengthen governance.

Mr Bloomfield said that he had discussed the overall assurance opinion with Ms McKeown and added that it was not an unreasonable position she had reached, given the outcome of the other audits carried out. However, he expressed his deep disappointment at the outcome given the significant efforts of the Trust over the past couple of years to achieve a Satisfactory assurance opinion.

Continuing, Mr Bloomfield acknowledged that, while the outcome of the audits carried out in 2023-24 did not necessarily present significant risks to the Trust, there was a clear need for the Trust to improve in these areas. He highlighted the fact that the Trust had invited Internal Audit to examine areas which it was felt would benefit from closer examination.

The Chair believed that HEMS should be used as an exemplar to the rest of the Trust in terms of its governance processes. He said that, as ARAC Chair, he very much viewed the audits as work in progress and he commended the Trust for the positive manner in which it had engaged with Internal Audit. The Chair said it would be important for the Trust to focus on implementing recommendations moving forward.

Mr Ashford agreed with the points made by the Chair and believed the Trust had adopted the correct approach in engaging with Internal Audit. He acknowledged that, while several areas were well on target for implementation, there were other areas, for example, the completion of revenue business cases which were outside the Trust's control to some degree.

However, Mr Ashford highlighted the need to focus on addressing the prior year recommendations. He believed it was more difficult to deal with current year recommendations when the prior year ones had not yet been addressed.

Mr Bloomfield said he very much appreciated members' positive comments. However, he stressed the need to address the recommendations made by Internal Audit and said the overall finding would not cause the Trust to change its approach. He alluded to the pressures across the Trust and noted the small teams in place, for example, there was only one individual in Medical Equipment who had recently completed a significant business case worth £7-8 million for defibrillator replacement. He acknowledged that, at a time when the Trust was under pressure, it could be challenging to balance competing priorities.

The Chair said he agreed with Mr Ashford's point in relation to addressing prior year recommendations and was of the view that equal focus and weight should be given to addressing both.

Ms Paterson noted that there were corporate risk specific recommendations and she cited the example of the management and establishment of patient pathways and assurance around that. She alluded to the Integrated Clinical

Hub and the benefits seen in terms of reducing conveyance and the associated programme to determine how the pathways could be better established as a result of learning from the Integrated Clinical Hub.

Referring to ICT incident management, Ms Paterson noted the work which had been done to strengthen the Trust's approach to cyber security. She acknowledged that, while work had been carried out to ensure all the necessary protocols were in place, there were also the recommendations relating to the Network Information Systems (NIS) programme and audit that formed part of the recommendations. She indicated that this straddled ICT and EPRR in terms of business continuity.

Ms Paterson assured the Committee that work was ongoing in the context of the Trust's ability to respond if it lost data and system connectivity and how the Trust would continue to deliver services and added that this work cut across a number of Trust Directorates. She pointed out that ICT was only one element of the Trust response and said it would be important to ensure this was discussed at other Committees.

Ms McKeown said she had pointed out to Mr Bloomfield that the organisation was in a significantly different place to when she had last provided a Limited assurance opinion and added one could clearly see the work which had taken place over the last number of years. Ms McKeown was of the view that the foundations were there for the Trust to improve upon its Limited opinion. She acknowledged that, given the level of Limited opinions in the audits undertaken in the 2023-24 year, she had no choice but to provide an overall Limited assurance opinion. Ms McKeown recognised the work going on within the Trust and noted the mature relationships across the organisation. She acknowledged the competing pressures and the impact of these as well as indicating that the Trust had the tools at hand to ensure an improvement in the overall assurance opinion.

Responding to a question from the Chair as to the level of engagement with Trust officers, Ms McKeown said she was very happy. She urged the Trust to continue its focus on the formal follow-up rounds with Internal Audit and commended Ms McAuley on her work in this regard.

The Committee **NOTED** the HIA Annual Report 2023-24.

7.6 **External Quality Assessment Report (AC16/05/24/09)**

Ms McKeown reported that Mersey Internal Audit Agency (MIAA) had undertaken an external quality assessment of BSO Internal Audit's self-assessment and had found that Internal Audit had generally conformed to the requirements of the Public Sector Internal Audit Standards.

The Chair offered his congratulations on this outcome and the assessment report was **NOTED** by the Committee.

8 External Audit

8.1 **To advise on key issues**

- **Trust Accounts**

Ms Kane advised that External Audit had now received the Trust accounts and would provide detailed commentary in due course on the Remuneration Report and Governance Statement.

- **Audit on Ambulance handovers**

Ms Kane advised the meeting that the NIAO had advised the DoH of its intention to carry out a review of ambulance handovers.

Mr Bloomfield welcomed the NIAO's plans and said he had informed members of this at a recent Board meeting. He indicated that, while the Trust would collate information requested by the NIAO, Trust officers would be happy to meet with NIAO colleagues to discuss further.

Mr Ashford enquired as to the timescales for the review.

Responding, Ms Kane said it was intended that the report would delivered within the current 2024-25 financial year with a view to publishing the report in February 2025.

The Chair said he very much welcomed this focus and looked forward to receiving the report.

9 Annual Report and Accounts

Mr Nicholson explained that there were two distinct elements to this particular agenda item. The first related to the consolidated annual report and accounts for the financial year ended 31 March 2024. The second related to the submission of the draft Charitable Trust Funds accounts for the same time period.

Mr Nicholson emphasised that both documents being presented were draft, unaudited and uncertified and were being presented at the same time as having been submitted to External Audit for review. He indicated that both documents were subject to the satisfactory completion of the audit process and final accounts timetable.

9.1 Submission Letter and Draft, Unaudited, Uncertified, Consolidated Annual Report & Accounts for the Year ended 31 March 2024 (AC16/05/24/10)

Mr Nicholson drew the Committee's attention to this document which not only set out the Trust's accounts but provided a record of the Trust's performance and challenges over the 2023-24 year. He said he would like to take this opportunity to express his thanks to all involved to date in the development of the document, in particular the Finance team who ensured the documents were submitted to External Audit by its deadline of 3 May 2024.

Mr Nicholson explained that the performance report, overview and analysis formed a significant part of the report from pages 7-75 and reflected the breadth of work undertaken across the Trust. He acknowledged that a large proportion of the year had been spent at the highest escalation level and the challenges as a result of this had been significant.

Continuing, Mr Nicholson noted that page 78 of the report set out the 'Accountability Report' which covered three areas, ie the Governance Report; the Remuneration and Staff Report and the Accountability and Audit Report. He thanked Mr Ashford for writing this year's Non-Executive Director report.

Mr Nicholson said the Governance Statement started on page 87 of the report while Section 10 set out the sources of independent assurance. He added that BSO Internal Audit was one of the major sources of independent assurance provided to the Trust and said this had been reflected in the summary of the BSO Shared Services Audit discussed earlier.

Mr Nicholson referred to Section 12 of the report which focused on 'Internal Control Divergences' and explained that this section consisted of three elements, namely the update on prior year control issues which no longer needed to be considered as control issues; prior year control issues which were still considered to be control issues and new control issues which had been identified by the Trust. He pointed out that there had been some work to refocus what was included in the Governance Statement.

Mr Nicholson said he would draw the Committee's attention to page 125, 'Losses and Special Payments' section and noted a loss which had been less than £1,000 and a total of 18 special payments made within the year totalling £430,000.

Mr Nicholson noted the 'Claims and Employers' Liability Costs' section and explained that this related to claims made by employees against the Trust. Employees' liability claims make up the majority of the £430,000 of payments.

Mr Nicholson explained that the blank pages within the report would ultimately contain the audit certification.

He drew members' attention to page 131 onwards which contained the annual accounts and financial statements showing the Trust's operating income of £162 million including pure revenue of £126 million. He noted the non-cash adjustments relating to holiday pay and some non-cash elements which increased the Trust's budget to £162 million.

Mr Nicholson reported a surplus of £95,000 which represented 0.08% of the Trust's Revenue Resource Limit. He advised that the Trust's Capital Resource Limit (CRL) had been £13.6 million and, in his report to Trust Board, he had reported a small underspend of £7,000 against the CRL. Mr Nicholson explained that this was subsequently adjusted by the DoH to

ensure the Trust achieved a breakeven position. He pointed out that, within the £13.6 million, there had been significant expenditure on fleet and medical equipment in-year as well as some expenditure on estate and ICT infrastructure.

Mr Nicholson advised that there would be opportunity to update and refine both documents and he noted that External Audit would provide their detailed commentary in due course. He further noted that DoH colleagues would also undertake a detailed review of the documentation and said the Trust continued to receive revised Circulars detailing what should be included within the accounts. However, he said that the Trust would accommodate these in the drafts and subsequent publication.

Mr Ashford commended all involved and believed that the Governance Statement reflected discussions at the Committee. He recognised the work that was still required but was of the view that the document was a clear reflection of the significant work that had been carried out.

The Chair described the document as 'honest' in the context of describing those areas which needed improvement and the Trust's plans to address such areas. He believed there was potential in sharing the document with Trade Unions and other stakeholders in terms of showing how the Trust was working to deliver services to patients.

The Chair commended the document and suggested that an abridged version could be used as a communications tool for the Trust.

Mr Bloomfield explained that, while the report's format was prescribed by the DoH, the team had managed to ensure the report was readable and enjoyable. He acknowledged that the main areas of the report were the Governance Statement and the Internal Control Divergences and noted that there would be opportunity to review the document until it would be submitted to the June Trust Board for consideration.

Ms Mitchell commented that she had had sight of several annual reports and thought the NIAS report was excellent as well as being user-friendly. She indicated that the Trust had

achieved its statutory financial targets which was commendable and said she was aware, having served as a Director of Finance, of the additional pressures on the Finance team at this time of year.

The Committee **NOTED** the Submission Letter and Draft, Unaudited, Uncertified, Consolidated Annual Report & Accounts for the Year ended 31 March 2024 as presented by Mr Nicholson.

9.2 **Submission Letter and Draft, Unaudited, Uncertified, Charitable Trust Funds Trustee's Annual Report for the Year ended 31 March 2024 (AC16/05/24/11)**

Mr Nicholson reiterated that these accounts were draft, unaudited and uncertified. He drew members' attention to the introduction on page 6 and page 9 which covered the structure, governance and management of the Charitable Trust Funds.

Mr Nicholson noted that page 11 highlighted some of the purposes for which Charitable Trust Funds had been used during the 2023-24 year.

He noted that income during the year had been in the order of £116,000 and explained that the majority of this income had been derived from the NHS Charities Together as well as welcome donations from members of the public totalling £5,000.

Mr Nicholson indicated that expenditure had totalled £170,000 and had covered three main areas, namely the frequent caller project at a cost of £138,000; staff wellbeing totalling £20,000 and welfare comforts for staff at various stations totalling £5,000.

Mr Nicholson reiterated that the content of the report was subject to the satisfactory completion of the audit process and final accounts timetable. He advised that the document would come back to the ARAC meeting on 27 June and would, at that point, would be draft audited, uncertified accounts. Mr Nicholson explained that the ARAC meeting would also receive the extensive report from the External Auditors 'Report To

Those Charged With Governance' which will highlight the audit process and any findings.

The Chair thanked everyone involved in the production of both documents.

The Committee **NOTED** the Submission Letter and Draft, Unaudited, Uncertified, Charitable Trust Funds Trustee's Annual Report for the year ended 31 March 2024 as presented by Mr Nicholson.

10 **Network Information Security (NIS) Audit – verbal update**

Ms Paterson advised that the NIS audit had been postponed until next year.

12 **Closed Meeting**

At this point in the meeting, NIAS Directors left the meeting to allow the Closed Meeting to take place. There were no specific actions from the Closed Meeting.

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

The next meeting of the Audit and Risk Assurance Committee will take place on Thursday 27 June 2024 at 9.30am in the Boardroom, NIAS HQ.

ARAC dates for 2024-25 are as follows:

- Thursday 10 October 2024 (to look at IA recommendations)
- Thursday 5 December 2024
- Thursday 6 February 2025
- Thursday 20 March 2025

All meetings in the 2024-25 schedule will commence at 9.30am unless otherwise advised.

The Chair noted his intention to use the October meeting to have a stocktake on progress in addressing outstanding Internal Audit recommendations. He believed that this would then allow for sufficient time for any remedial action required.

The Chair suggested that there was potential for a further meeting to be scheduled for the last week in January 2025 to allow the Committee take account of the position at that point.

Mr Bloomfield said he was content with the Chair's plans and welcomed the continued focus of the Committee.

14 **Any Other Business**

There were no items of Any Other Business.

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

SIGNED: P. Graham

DATE: 27 June 2024