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 24/10/2024

For Approval

3 Matters Arising

For Noting

4 Chair's Update

For Noting

5 Chief Executive's Update

For Noting

6 Trust Corporate Scorecard & Performance Report (October 2024)

For Noting

7 Finance Report (Month 7)

For Noting

8 Update on Late Finishes

For Noting

9 Incident Response Plan

For Noting

10 Presentation on Research and Development at NIAS

For Noting

11 Committee Business:

For Information

1. Safety Cttee – mins of meeting on 12 Sept 2024
2. PFOD Cttee – mins of meeting on 26 Sept 2024

12 Date & venue of next meeting:

For Information

20 February 2025 at 09.30am in the Boardroom, NIAS HQ

13 Any Other Business

For Noting

Invitees

Mr. Dale Ashford

Mr. Michael Bloomfield

Mrs. Rosie Byrne

Ms. Lynne Charlton

Mr. Simon Christie

Mr. Paul Corrigan

Mr. Jim Dennison

Dr. Philip Graham

Mr. Nick Henry

Ms. Michele Larmour

Ms. Michelle Lemon

Carol Mooney

Ms. Maxine Paterson

Mr. Phelim Quinn

Dr. Nigel Ruddell

Mr. Neil Sinclair

Northern Ireland Ambulance Service Health and Social Care Trust

Minutes of Trust Board held at 10.30am on
Thursday 24 October 2024 in the Boardroom, NIAS HQ, Knockbracken Healthcare Park, Saintfield Road, Belfast BT8 8SG

Minutes

1	Welcome, Apologies & Declarations of Conflict of Interest	

Present:

- Michele Larmour, Chair
- Dale Ashford, Non-Executive Director
- Paul Corrigan, Non-Executive Director
- Phillip Graham, Non-Executive Director
- Phelim Quinn, Non-Executive Director
- Michael Bloomfield, Chief Executive
- Michelle Lemon, Director of Human Resources & Organisational Development (HR & OD)
- Rosie Byrne, Director of Operations
- Simon Christie Interim, Director of Finance
- Dr Nigel Ruddell, Medical Director

In Attendance:

- Maxine Paterson, Deputy Chief Executive & Director of Planning, Performance and Corporate Services
- Lynne Charlton, Director of Quality, Safety & Improvement
- Neil Sinclair, Chief Paramedic Officer
- Nick Henry, Assistant Director of Governance, Risk and Assurance
- Andoni Arandia, Assistant Director of Planning, Performance and Strategic Transformation

Apologies:
None noted.

Conflicts of Interest:
No conflicts of interest were declared.

2	Minutes of the previous meeting of the Trust Board held on 22 August 2024 **For Approval**	TB24/10/2024/01

A minor change on Page 28 was agreed.

Minutes approved on a proposal from Phelim Quinn and seconded by Paul Corrigan.

3	Matters Arising **For Noting**	TB24/10/2024/02

Matters Arising were discussed.

Succession Planning
The Chair informed members that the Chief Executive has announced his intention to retire at the end of March 2024. Board members collectively thanked Michael for his hard work and contributions to NIAS.

The Chief Executive thanked Board members for their kind words and assured them he will be continuing with business as usual until his retirement.

The Chair advised that recruitment for the Chief Executive and Director of Finance posts will now be progressed. The Chair highlighted that the Department of Health is undertaking a wider review of senior Executive posts, and the recruitment advertisements will reflect this.

Mr Quinn suggested that a more formalised framework on succession planning/talent management would be beneficial for the organisation. It was suggested that this could be discussed at Remuneration Committee and might include aspects such as how to prepare for senior level posts. The Board will consider how to take this forward.

Strategic Outcome Framework
Ms Paterson provided an update on the Strategic Outcome Framework. System Oversight Measures remain in development and should, in time, be focused on outcome measures which will evidence a "shift left" in care for patients. There has been communication with SPPG about how this could be developed. Governance is being maintained through the CEx forum.

Patient Care Services
Board members agreed to close action.

4	Chair's Update **For Noting**	No paper

The Chair provided an update on the Board Effectiveness audit undertaken by Internal Audit and confirmed it had received a satisfactory outcome.

The Chair provided an update on the most recent Chairs meeting with the Minister, and advised that the Chairs of the six HSC Trusts meet on a monthly basis.

The Chair of the Southern Health and Social Care Trust, Eileen Mullan, recently visited NIAS and saw how system pressures and delayed hospital handovers are being managed via the Regional Coordination Centre (RCC).

The Chair advised that she plans to visit the South Eastern Health and Social Care Trust Chair and intends to meet NIAS crews as part of the visit.

The Chair advised she also had a useful discussion with the Assistant Directors Forum and that she intended to attend a further meeting in February 2025.

The Chair updated the Board in relation to the two Independent Advisors who have been supporting the Audit, Risk and Assurance Committee (ARAC) and Safety Committee over the past few years and advised that both roles will come to an end now that there is a full complement of Board members. However, Robert Sowney will be retained to support the

development of NIAS's culture programme for an initial period of six months.

The Chair reported that she had received a letter from Save Our Acute Services requesting that the group's concerns in relation to service reconfiguration at the South West Acute Hospital be drawn to the Chair and NEDs attention. A reply has been sent advising that it would be prudent for the related ongoing RQIA review to conclude and that the Chief Executive has already agreed to a meeting with the group and would keep the Chair updated.

The Chair reported that members of the Northern Ireland Assembly Health Committee had recently had a very positive visit to NIAS HQ, where they got to see the working of the Control Room and hear about the challenges facing NIAS.

The Chair advised she had been on her first 'ride along' with operational crews and met with staff. She said how appreciative staff had been for her visit and advised that two more 'ride alongs' were scheduled in the coming weeks. The Chair encouraged other Board members to consider joining staff on a shift.

5	Chief Executive's Update **For Noting**	No paper

The Chief Executive provided updates on meetings and visits since the last meeting.

He advised that he attended the Badge Ceremony for the first cohort of Paramedic students to graduate and outlined the timeline for the Newly Qualified Paramedics to join NIAS and continue their training before becoming operational in December. The formal graduation ceremony is scheduled for December 2024.

The Chief Executive reported that he had also met with the students at UU entering their final year and the majority had indicated their wish to join NIAS when they qualify. He welcomed the good Paramedic workforce supply for the coming years from this BSc programme.

The Chief Executive advised that he attended the launch of a new Road Safety Strategy by the Infrastructure Minister, along with PSNI and NIFRS as partners in the Strategy. He also highlighted the Road Safe Roadshows for sixth year students jointly run by NIAS, NIFRS and PSNI. He advised these are very powerful sessions and recommended them to Board members.

The Chief Executive provided an update on the first meeting of a new Regional Integrated Care System (ICS) Partnership Forum he attended which has been established to oversee the developments of ICS, and in particular to guide and support the AIPBs which will focus on prevention, working across sectors to address wider health inequalities.

The Chief Executive advised that a tender has been issued to appoint a firm to carry out a formal evaluation of the RCC to inform a decision on its continuation from April 2025.

The Chief Executive referred to the major incident relating to a school bus crash in Carrowdore on 7th October. He highlighted the potentially serious nature of this incident and welcomed that no-one was seriously injured. He praised the response to incident by NIAS and other partners.

The Chief Executive also provided updates in relation to a meeting he and Chief

Executives of Trusts, PHA and BSO had with colleagues from ROI to explore areas for collaboration and sharing good practice; and the Advancing Healthcare Awards at which NIAS staff were finalists in four categories and won two awards.

The Chief Executive reminded Board members that it was International Control Room Week to celebrate and recognise the excellent work of the staff in our Control Rooms and thanked those who had been able to visit EOC.

Paul Corrigan asked if the RCC evaluation will consider the effectiveness of the RCC against its original aims. The Chief Executive confirmed that the evaluation terms of reference made it clear that the impact RCC has made and the value it has added would be addressed.

6	Sexual Safety in the Workplace Implementation Plan 2024 **For Noting**	TB24/10/2024/03

The Chair welcomed Bron Biddle, National Ambulance lead on Sexual Safety, to the meeting.

Bron presented on the work AACE is taking forward with ambulance services across the UK to help develop and embed a culture of sexual safety in the workplace. Bron provided background to the issues, including discussion of workplace cultures in other sectors, including policing, and also shared some of her own story and experience of working within an ambulance service.

She went on to describe the national programme of work and confirmed that NIAS is fully involved in this, including by participating in training for People Professionals and in a newly established Community of Practice.

Ms Lemon and Ms Turley discussed the embedding of this work in the organisational culture work programme and the Chair agreed this must be mainstreamed in this work. Ms Lemon also described the relationship of this to The Executive Office Strategy on Violence Against Women and Girls. The Chief Executive also discussed related sessions and discussion at the recent NICON Conference.

Bron shared detail of some national news coverage and also stories of staff working in the ambulance sector. She recognised that some of the detail was extremely stark and potentially upsetting but highlighted the importance of Boards having the full detail of the seriousness of the associated issues.

The Board were very concerned to note the extremely serious nature of the case studies, research and findings around sexual safety, described by Bron. They agreed that the work must be a high priority for the Trust. They noted the related programme of work described and indicated their desire to be kept abreast of the progress of this within the organisation.

The Chair expressed the sincere thanks of the Board to Bron for travelling to Northern Ireland to present to them and for sharing her own story as well as providing strong leadership of a critical and comprehensive programme of work.

She indicated that the Board would look forward to receiving further updates as the work progresses.

7	Corporate Risk Register	TB24/10/2024/04

	For Noting	

Ms Paterson provided a brief overview of the Corporate Risk Register. Two risks have been added and approved since the register was last considered by Trust Board. Ms Paterson noted that, to address an outstanding Internal Audit recommendation, the Trust's risk appetite statement would be revisited and developed and that a workshop is being held in early December 2024 to inform this piece of work.

Mr Graham commended the current work. He provided an overview of the ARAC's input to and consideration of the papers. He advised that historical risks have now been closed and believes the risk register is now much improved.
The Chair noted the position and welcomed the progress made.

8	Finance Report (Month 4) **For Noting**	TB22/08/2024/05

Mr Christie provided a brief overview on the Finance Report paper. He highlighted the Trust continues to forecast a break even position. Plans are in place to deliver the required level of savings. Mr Christie provided explanation on the format of the attached slides. Profiling work is ongoing, information and intelligence is being received regarding expenditure. Month 6 report will be submitted at the next Trust Board meeting.
The Chair queried if there is a financial risk to two-hour backstop. Mr Christie confirmed there is no current financial risk. However, there remains an issue around capacity, delivery and performance impact and also staff morale.
The Chief Executive stated that the reality is the Trust has limited options for increasing capacity in the short term as the use of IAS and overtime were both being fully utilised.
Paul Corrigan highlighted that while there will always be some time lag, it is important that finance reports are reviewed in as timely a way as possible.
Board members recognised strains and resources.
Chair thanked Mr Christie for his report.

9	Trust Performance Corporate Scorecard (September 2024) **For Noting**	TB24/10/2024/06

Ms Paterson provided an executive summary of the Trust's Performance Corporate Scorecard, highlighting the five key points, percentage figures and statistics as per the tabled paper. The report shows a mixed picture of some positive progress with ongoing challenges.
Paul Corrigan asked if there any performance measures/ compliance built into the non-emergency contract.
Ms Charlton advised that there were KPIs within the current regional non-emergency framework. Ms Charlton also advised of the current arrangements in place within NIAS to strengthen the governance and assurance processes related to use of Independent Ambulance services, including a quarterly assurance meeting with providers and a programme of unannounced inspections in line with the quality and safety aspects outlined within the framework. Ms Charlton referred to SMT discussions regarding the capacity to deliver on this programme with the recent increase of 7 providers to 16.
Ms Charlton also updated members on discussions at Safety Committee related to the absence of regulation of Independent Ambulance Providers in Northern Ireland where the legislation differs to that in place in mainland UK. Ms Charlton also updated on communication with RQIA & DoH in this regard and a recent request from RQIA to meet to discuss.
The Chair asked Mr Christie if there is financial capacity to support a post to strengthen governance and assurance in this context. Ms Charlton advised that a job description had been developed and was currently awaiting Job Evaluation.

Board members discussed the importance of independent regulation.

Ms Lemon provided a brief update on absentee figures. Figures for September are 11.28% - conscious of seasonal absence, this is being made a priority and particular trends are being reviewed.

Ms Charlton advised that an amendment was required to the complaints section of the executive summary to reflect that there was one case accepted by NIPSO for investigation and apologised for the oversight. Papers to be updated accordingly.

Action:
Executive summary to be updated to reflect there is one case for NIPSO.

10	NIAS Draft Locality Plan **For Noting**	No paper

Ms Paterson provided a brief overview for noting. The 'plan' is very brief and work is currently underway to develop a brief for the Minister and a public version which will be displayed on NIAS website.

11	Corporate Plan – Mid Year Progress **For Noting**	TB24/10/2024/07

Mr Arandia provided a high-level update on mid-year progress of delivery of the Corporate Plan to support attainment of the Trust's six Strategic Objectives. Mr Arandia explained that meetings have been held with Senior Management to review progress and advised this would continue as part of the Directorate Accountability Meetings which are scheduled in the coming weeks.

It was reported that the Trust is making strong progress on some strategic outcomes and that others require more attention, as described in detail in the tabled paper.

The Chair asked that any reduction in confidence after the Accountability Review meetings to be drawn to Trust Board's attention.

Action:
Any confidence altered after the Accountability Review meetings to be fed back to Trust Board.

12	Committee Business: • Safety Cttee – minutes of meeting on 13 June 2024. • ARAC Cttee – minutes of meeting on 27 June 2024. **For Information**	TB24/10/2024/08

Safety Committee

Mr Ashford provided a brief overview and update on the work of Safety Committee and advised that EPRR will remain as a standing agenda item going forward. Mr Ashford noted Internal Audit's continued interest and engagement and that this was positive.

ARAC Committee
Mr Graham provided a brief overview and update on the work of ARAC and advised that an extraordinary ARAC discussion will be held on 5 December 2024 to review progress

Northern Ireland Ambulance Service
Health and Social Care Trust

against delivery of Internal Audit recommendations. Mr Christie provided assurance, advising that good progress is being made, but it is important to keep a focus on delivery of all outstanding recommendations.		
13	Date and venue of next meeting: **Thursday 12 December 2024 at 09.00am in the Boardroom, NIAS HQ**	
14	Any Other Business	
The Chair reminded NEDs to take up mandatory NEDs training as required. Action: NEDs to take up mandatory NEDs training required.		

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Health and Social Care Trust

TRUST BOARD – 24 October 2024

		INDIVIDUAL ACTIONING	UPDATE
	PUBLIC		
1	Trust Performance Corporate Scorecard (September 2024): - Executive summary to be updated to reflect there is one case for NIPSO.	LC	LC to provide verbal update.
2	Corporate Plan – Mid Year Progress: - Any confidence altered after the Accountability Review meetings to be fed back to Trust Board.	AA/MP	No change after completion of the Accountability meetings.
3	AOB: - NEDs to take up mandatory NEDs training required.	NEDs	Phelim Quinn and Philip Graham attended CEF's Public Accountability and Governance training for Board members, held 7 November 2024.

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Health and Social Care Trust

TRUST BOARD

PRESENTATION OF PAPER

Date of Trust Board:	12 December 2024
Title of paper:	Trust Performance Report
Brief summary:	This paper sets out NIAS's performance framework as of December 2024 for noting by Trustboard. The Trust performance report outlines the key performance metrics up to and including the 31 October 2024. This paper is presented to Trustboard for noting.
Recommendation:	**For Approval** ☐ **For Noting** ☒
Previous forum:	
Prepared and presented by:	Neil Walker (Head of Performance) Maxine Paterson (Director PPCS)
Date:	4 December 2024

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Health and Social Care Trust

TRUST CORPORATE SCORECARD

NORTHERN IRELAND AMBULANCE SERVICE

November 2024

for October 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.

Operational Performance:

Demand:

- Call answer demand in EAC for October 2024 decreased by 5% when compared to October 2023
- Incident demand in October 2024 has decreased by 13% when compared to October 2023
- Patients conveyed to Hospital during October 2024 has also decreased by 5% when compared to October 2023
- October 2024 saw an average number of patients conveyed to Hospital per day of 326 patients.

Response Times:

- Response times In October remain a significant challenge across all categories, when comparing to the national standards.
- Category 2 response times are extremely concerning remaining significantly high at 58 mins for October 2024. This is compared with October 2023 where category 2 performance was 51 mins.
- This is linked to the following:
    - Increasing 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.
    - Changes to the working arrangements of relief staff at the start 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 Performance:

Clinical Hear & Treat and See & Treat

- The Clinical H&T rate was a challenge due to the decrease in call volume in October with an outturn position of 5.4%, which was a decrease from September 24. Clinical See & Treat also decreased in October 2024 to 13.5% from 13.9% in September 2024.

Complex Cases

- Complex Cases demand remains high with 10% of all calls answered in control being from a known complex case. Financial Year 2024.25 has saw a 29% increase in activity from complex cases compared with Financial Year 2023.24.

Out of Hospital Cardiac Arrest

Please note data only available to Aug 24 due to data lag.

- Increase in the median for Return of Spontaneous Circulation (ROSC) on all workable cardiac arrests from 16.9% to 22.5% from 2022.23 to 2023.24. Along with Increase in the median for ROSC for shockable cardiac arrests from 34.7% to 50% from 2022.23 to 2023.24
- Increase in the 30-day survival rate for cardiac arrest from 5% to 6.8% from 2022.23 to 2023.24. 30-day survival increase for shockable rhythms from 19.9% to 23.8% from 2022.23 to 2023.24

Northern Ireland Ambulance Service
Health and Social Care Trust

Executive Summary

System Performance:

Handover:

- October 24 saw the trust lose >11.6k hrs with handover delays >15mins this is an increase of 2% from the hours lost in September 24, were the trust lost >11.4K.
- The patients waiting longer than 2hrs to handover at Emergency departments are deteriorating quarter on quarter for Financial Year 2023.24 from Q1 14.9% to Q2 16.1%.
- 20% of all arrivals at ED in October 2024 (1,974 patients) waited over 2hrs to be handed over. This is despite NIAS conveying the least number of patients to EDs in the past 24 months.

Non-Emergency Performance:

- The Service is on target to meet the Improvement target of 10% (6000) in PCS journeys, year to date comparison shows 5,100 more patient journeys than 23/24
- Both the Total Non-Emergency Activity and NIAS PCS Activity in Oct was the highest monthly activity figures recorded Post Covid.
- Significant progress continues with the improvement target of reducing staff absence through sickness.
- Test of Change rota lines are proving to be more efficient and are significantly reducing the number of "Cancellations by NIAS"
- Loading Factor remains plateaued at around 1.4. Further improvement will be dependent on progressing issues such as, better matching staff rotas to service need and significantly reducing the vacancy rate of ACA posts. In addition, future consideration is required in respect of understanding loading factor as a measure of efficiency in planned versus unplanned activity (outpatient / scheduled treatments versus discharge/ transfers,) where responsiveness and agility may be more deterministic of same.
- Performance against Patient Experience KPIs remains low. A review with patient representatives of how we should be assessing patient experience is required and planned before the end of 2024.

Independent Ambulance Performance:

Patient Experience

- KPI 1 Inward journeys – Year to date average of 46% compliance an increase from 39% in same period 23/24. Of the non-compliant journeys 60% are within 30 minutes of the target.
- KPI 2 Outward Journeys – Year to date average of 54% compliance a decrease from 68% in same period 23/24. Of the non-compliant Journeys 65% are within 30 minutes of the target.

Productivity

- To date in 24/25 IAS activity accounts for 25% of non-emergency activity compared to 30% for the same period in 23/24.
- However, over the past few months there has been an increase in use of IAS due to ongoing vacancies within the tier and a targeting of reducing cancellation rates. Cancellations by NIAS in October were at the lowest rate since Feb '22

Northern Ireland Ambulance Service
Health and Social Care Trust

Executive Summary

Service Quality and Our People:

Serious Adverse Incidents, Complaints, Compliments and Care Opinion:

- There have been 14 potential SAIs reviewed, with the Trust notifying 4 during October 24. The 8-week timeframe for submission of SAI reports to SPPG remains challenging and the current average time for completion remains unchanged from the 23/24 average of 98 days (14 weeks).
- During October 2024, the Trust received 31 complaints, 45 compliments were received, and 7 stories submitted via care opinion. 24/25 performance against the 2-day acknowledgement KPI has been strong at 100%, however several factors have impacted on the response within 20-day timeframe, which as of the end of October 2024 was averaging at 55%.
- Safeguarding referrals have increased by 28% in FY 2024.25 when compared with the same period in 2023.24. Nearly 400 staff have completed their training with a plan in place to achieve 600 trained staff by March 2025.

Absence Management:

- The Financial Year Sickness absence rate is 10.68% for the trust. October 2024, monthly for sickness absence rate has decreased to 10.05% from 11.28% in September 2024, a decrease in the monthly position from the summer months. There has been a marked improvement in comparing the October Year on Year positions, where October 2023 was 14.65%.
- 60% 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.

Our Infrastructure:

Estates Statutory PPM's

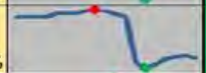
- Quarter 3 and Quarter 4 of 2023.24 the trusts compliance with our statutory PPMs was 100% with all due PPM's being complete within the necessary timeframe.
- Quarter 1 of 2024.25 continued with the trusts being 100% Compliance with its statutory PPM's.

Estates Non-Statutory PPM's

- Quarter 3 and Quarter 4 of 2023.24 the trusts compliance with our non-statutory PPMs was 100% with all due PPM's being complete within the necessary timeframe.
- Quarter 1 of 2024.25 continued with the trusts being 100% Compliance with its non-statutory PPM's.

Northern Ireland Ambulance Service
Health and Social Care Trust

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

Indicator	Measure	SDP Target 2024.25 (Q2)	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 (mins)	11 mins	11	12		A
1.02	Category 1 90th Centile Response Time (mins)	22 mins	22	23		A
1.03	Category 1T Mean Response Time (mins)	19 mins	15	17		R
1.04	Category 1T 90th Centile Response Time (mins)	30 mins	30	32		R
1.05	Category 2 Mean Response Time (mins)	44 mins	48	59		R
1.06	Category 2 90th Centile Response Time (mins)	94 mins	107	132		R
1.07	Category 3 90th Centile Response Time (mins)	270 mins	338	460		R
1.08	Call Answering Performance	90%	85.0%	94.0%		G
1.09	No. of Calls Answered within Emergency Ambulance Control	N/A	19,209	19,376		
Our Staff will feel positive and proud to work for NIAS						
2.01	Monthly Percentage of Hours Lost	N/A	11%	10%		G
2.02	Cumulative % Hours lost from Sickness	11%	12%	11%		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%	9%		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 October 2024

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 (mins)	15 mins	64	87		R
3.02	Lost Hours from Handover delays >15mins (hrs)	N/A	8,967	11,679		R
3.03	Number of Patients >2hrs for Handover	0	16,286	1,974		R
3.04	Hear & Treat Rate	7.5%	4%	5.4%		A
3.05	See and Treat Rate	14.7%	14%	13.4%		A
3.06	Conveyance Rate	N/A	82%	81%		
3.07	Number of Scheduled journeys made	N/A	12,798	14,234		
Our Communities will continue to value and trust us						
4.01	Number of potential SAIs reviewed	N/A	135	14		
4.02	Number of SAIs notified	N/A	42	4		
4.03	Number of Complaints	N/A	148	31		
4.04	Number of Compliments	N/A	272	45		
4.05	Nmber of patient stories received	N/A	128	7		
4.06	Forecast Revenue Expenditure	£ -	£ -	£ -		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

Operational Performance

Northern Ireland Ambulance Service
Health and Social Care Trust

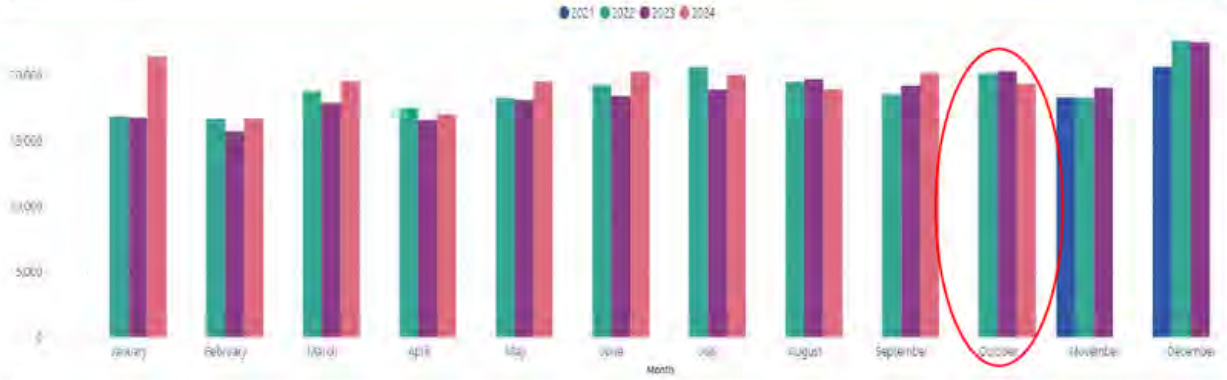
Our Patients | **Emergency Demand Performance** | **Operational Demand**

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

The analysis below describes: Calls Answered and Call Answering Performance

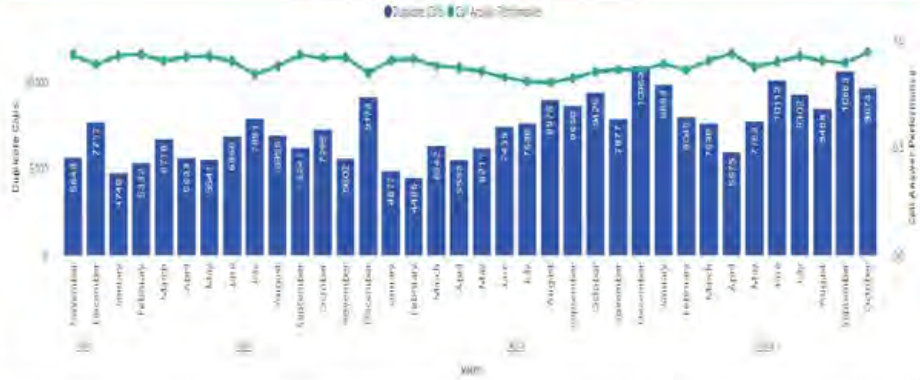
999 Calls Answered

Monthly Demand



Call Answering Performance and Duplicate Calls

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



- **October 24** has seen a decrease in demand levels of 5% when compared with September 2023. The call demand into EAC for 2024.25 Financial Year to date has saw an increase of 3% than the Financial Year 2023.24.
- **October 2024** saw an average of 625 calls per day being answered by EAC which is a decrease from 656 calls per day in October 2023.
- **Call Answering performance** continues to trend strongly in October 24. The **October 2024 call answering performance was 94% which was above the standard** for the month.
- **Duplicate Calls** decreased in **October 2024** to 9,674 which is an increase of 2% when compared with **October 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 Incidents (A7)

Conveyances to Hospital

Patients Conveyed per Month

- **October 2024** has seen a decrease in Incident levels of 13% when compared with October 2023. The incident demand for 2024.25 Financial Year to date has also decreased by 10% compared with Financial Year 2023.24.
- **October 2024** saw an average of 455 incidents per day requiring an ambulance response.
- **October 2024** conveyances decreased by 5% when compared with October 2023. The numbers of patients conveyed to hospital 2024.25 Financial Year to date has also decreased by 8% compared with Financial Year 2023.24.
- **October 2024,** saw an average of 326 patients conveyed to hospital per day.

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Health and Social Care Trust

Our Patients | 999 Response Time Performance | Response Times Scorecard

Latest Month	Oct-24

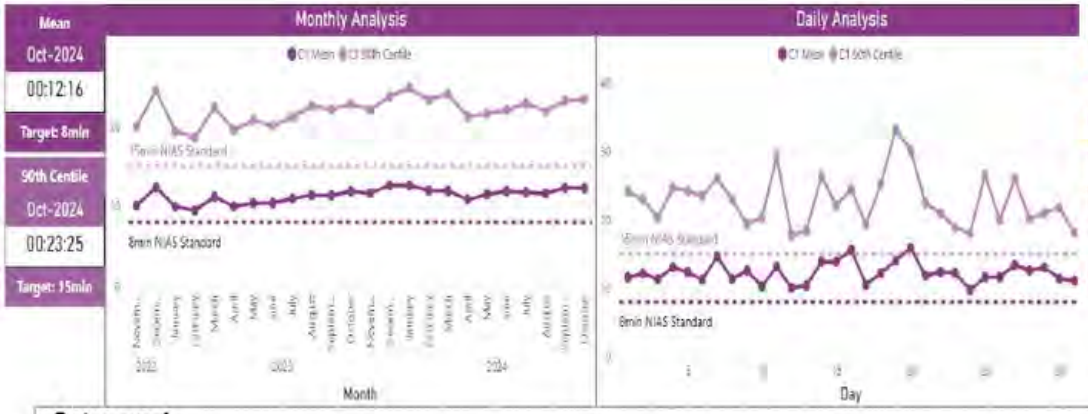
	Target	Current Performance			Benchmarking (Latest Month)		
		Latest Month	YTD (from April)	Rolling 12 Month	National Data	Best in Class	Ranking (out of 12)
Category 1 response - Mean	8 Minutes	00:12:16	00:11:44	00:11:55	00:08:38	00:06:51	12
Category 1 response - 90th Centile	15 Minutes	00:23:25	00:22:25	00:22:55	00:15:24	00:11:57	12
Category 1T response - Mean	19 Minutes	00:16:37	00:15:39	00:15:44	00:10:41	00:07:45	12
Category 1T response - 90th Centile	30 Minutes	00:32:20	00:29:45	00:30:07	00:19:24	00:13:28	12
Category 2 response - Mean	18 Minutes	00:58:53	00:50:44	00:54:43	00:42:15	00:30:09	12
Category 2 response - 90th Centile	40 Minutes	02:11:32	01:52:53	02:01:04	01:30:19	01:01:05	12
Category 3 response - Mean	Not a target	02:43:10	02:11:47	02:23:51	02:41:28	01:18:54	7
Category 3 response - 90th Centile	2 Hours	07:41:25	05:48:34	06:18:33	06:27:24	03:33:11	8
Category 4 response - Mean	Not a target	02:00:28	02:59:18	03:15:19	02:57:18	01:36:55	2
Category 4 response - 90th Centile	3 Hours	03:42:48	08:14:12	08:11:31	06:50:25	04:23:48	1

Northern Ireland Ambulance Service
Health and Social Care Trust

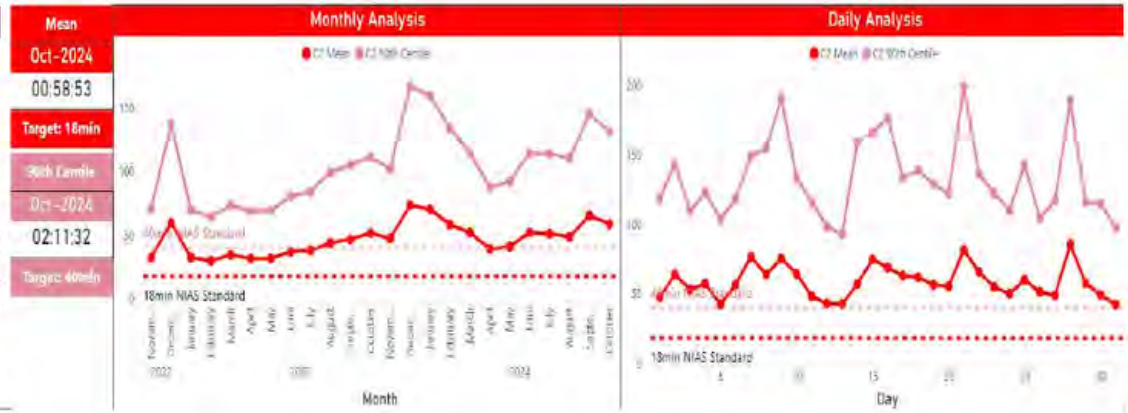
Our Patients | **999 Response Time Performance** | **Response Times**

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

- October 24 Category 1 mean response time was 12 minutes 16 seconds; while the Category 1 90th centile was 23 minutes 25 seconds.
- October 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

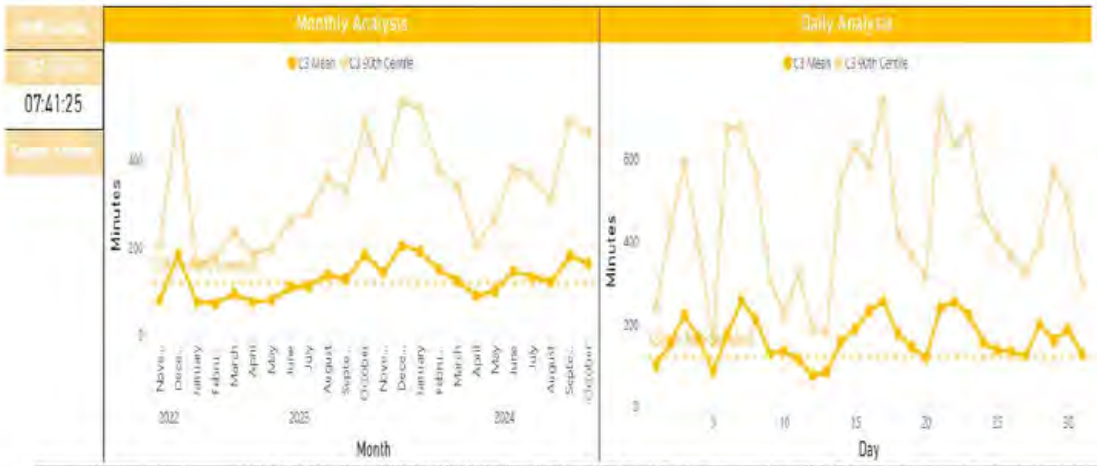
- October 2024 Category 2 mean response time was 58 minutes 53 seconds; while the Category 2 90th centile was 2 hours 11 minutes 32 seconds.
- Both the Category 2 mean and 90th centile response times remain a challenge in October 24. There are a number of actions that have been particularly impactful 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.
  - Changes to the working arrangements of relief staff at the start of shift.
  - 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

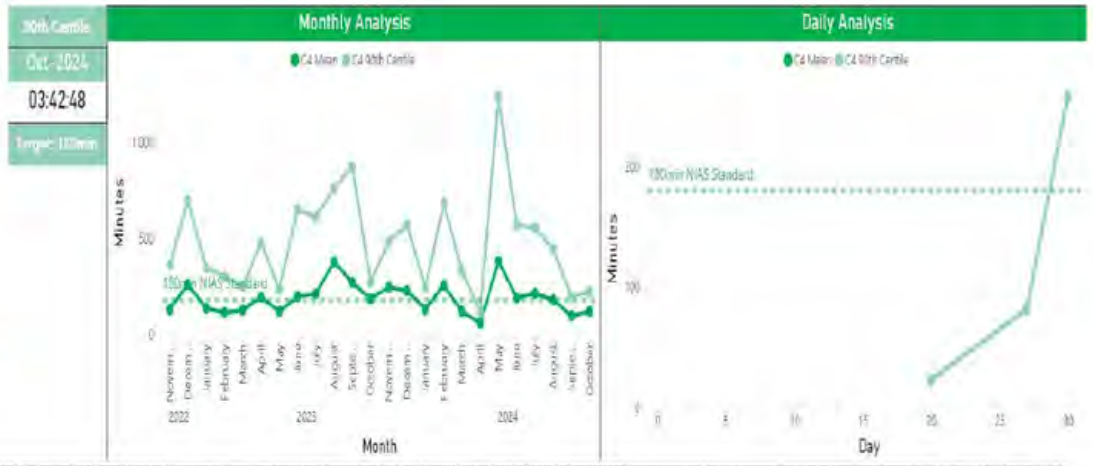
Our Patients | 999 Response Time Performance | Response Times

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

- October 24 Category 3 mean response time was 2 hours 43mins; while the Category 3 90th centile was 7 hours 41 minutes, **over 5 hours above target.**
- As outlined in the previous slide, category 3 response times are impacted by the same root causes.

Category 4

- October 24 Category 4 mean response time was 2 hours; while the Category 4 90th centile was 3 hours 42 minutes. 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.

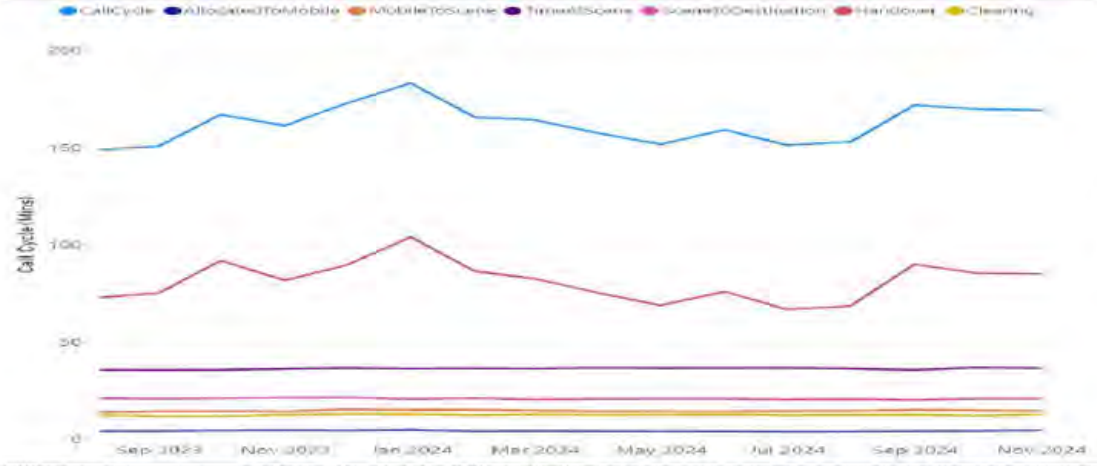
Northern Ireland Ambulance Service
Health and Social Care Trust

Our Patients | 999 Response Time Performance | Emergency Job Cycle Times

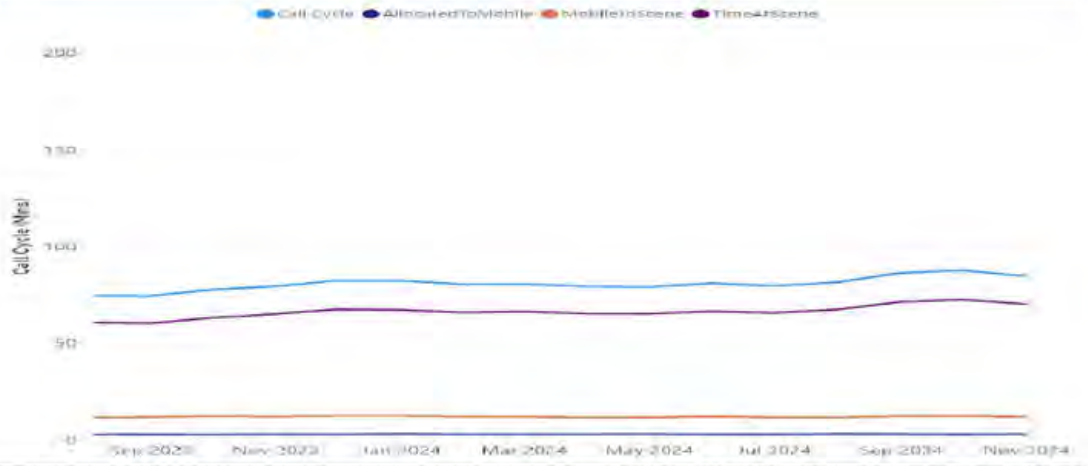
Efficient Job cycle times are critical to our response to patients across the region.

Below is an analysis of the trends in the Average Job cycle times for our emergency calls.

Conveyed Job Cycle Times



Non-Conveyed Job Cycle Times



Conveyed Average Job Cycle Times

- October 2024 Conveyed average job cycle time was 2 hours 49 mins (169mins), when compared with October 2023 the average job cycle time was similar at 2 hours 46 mins (166mins).
- The 2024.25 YTD conveyed average job cycle time is 2 hours 38mins , whilst in 2023.24 the average job cycle time was 2 hours 26mins. This is an increase of 12mins between the two periods.

Non-Conveyed Average Job Cycle Times

- October 2024 Non-Conveyed average job cycle time was 1 hour 27mins (87mins), when compared with October 2023 the average job cycle time was similar at 1 hours 17mins (77mins).
- The 2024.25 YTD Non-Conveyed average job cycle time is 1 hour 22mins, whilst in 2023.24 the average job cycle time was 1 hours 13mins. This is an increase of 9 mins between the two periods.

Northern Ireland Ambulance Service
Health and Social Care Trust

Our Patients | Operational 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 have commenced across the organisation to inform management and Trade unions of the Operational Restructure proposals, that will be implemented within the organisation over the coming months. Communication strategy being developed to inform wider organisation of the proposals.

- 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.
- The Emergency efficiencies improvement group has been established, targeting improvements with Category 1 response times.
- SOP for Category 1 release policy endorsed by AD forum and for sign off by SMT W/C 14th October.
- Emergency Annual Leave SOP complete and endorsed by AD forum for SMT sign off W/C 14th October.
- 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. It is planned that South-East division will go live January 2025.

- Challenges with Duplicate Call continue to persist at a high levels within EOC as outlined earlier in this report. EOC has reviewed the process and how it can be address, with the review of the delay scripts within EOC to deal with these callers, whilst ensuring patient safety. Alongside this, SMS messaging continues to be sent to 999 callers (with exception of Category 1 and HCP calls) 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

Clinical Performance

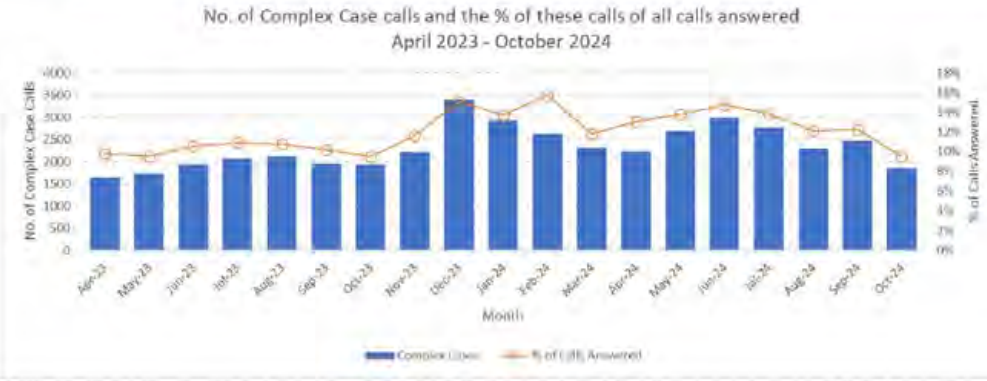
Northern Ireland Ambulance Service
Health and Social Care Trust

Our Patients | **Emergency Demand Performance** | **Prevention**

The level of demand from Complex Cases has a direct relationship to demand in our Control Room. Ensuring we manage these patients effectively 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: Complex Case activity and volumes within the Trust

Complex Cases



October 2024 saw Complex Case calls at **10%** of all the calls answered within the control room, a total of 1,852 calls were made by complex cases.

When comparing **October 2024**, there was a **4% decrease** in activity from these service users than the activity in **October 2023.**

Financial Year 2024.25 has saw a **29% increase** in Complex case activity compared to the same period in **Financial Year 2023.24.**

A recent evaluation of complex cases across the region has noted that these service user's interactions across all trusts are showing an increasing trend. Therefore, interventions to support these service users is critical to manage demand.

Northern Ireland Ambulance Service
Health and Social Care Trust

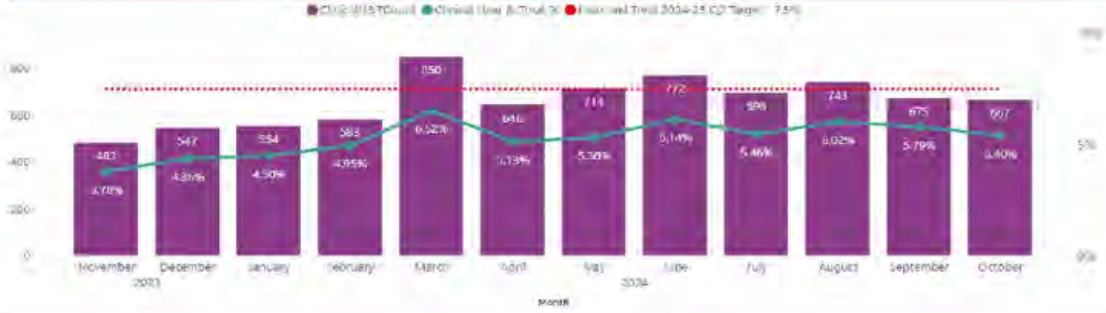
Our Patients | **Emergency Demand Performance** | **Hear & Treat and See & Treat**

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 %



October 2024 saw the Integrated Clinical Hub Clinicians continue to bed into the control room. The Hear and Treat rate continues to trend at 6%, The number of calls being dealt with in the room continues to trend above 650 per month.

Work continues to train and develop the Clinical hub staff to realise a continued improvement in the Trust's Hear & Treat rate as we move through 2024.25.

The test of a new clinical approach within the team with a revised DCR table has commenced.

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

Clinical See & Treat

Monthly See & Treat %

October 2024 See & Treat rate was 13.4% which is a marked step in the wrong direction. Work is ongoing to work with Trusts to improve performance with See & Treat.

The Acute Ambulatory Unit has opened within the Causeway Hospital since the pervious report and the Pathway leads are raising the profile of the new facility throughout the organisation.

An Urgent Care Liaison Desk has been established within the Control room, along with education and development at the divisional and station level through the coming month.

The aimed improvement trajectory is to increase See & Treat to 15.5% by 31st March 2025.

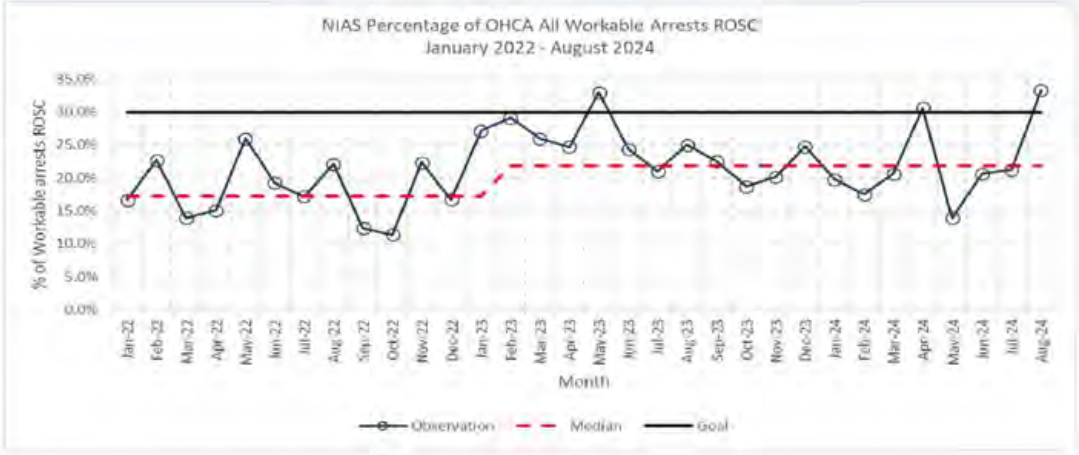
Northern Ireland Ambulance Service
Health and Social Care Trust

Our Patients | Emergency Demand Performance | Out of Hospital Cardiac Arrest (OHCA)

Delivering out of Hospital Care is a core output for NIAS. A small volume of these patients suffers a cardiac arrest, the incidence of mortality from these incidents is high and the NIAS response and management is critical to promote survival.

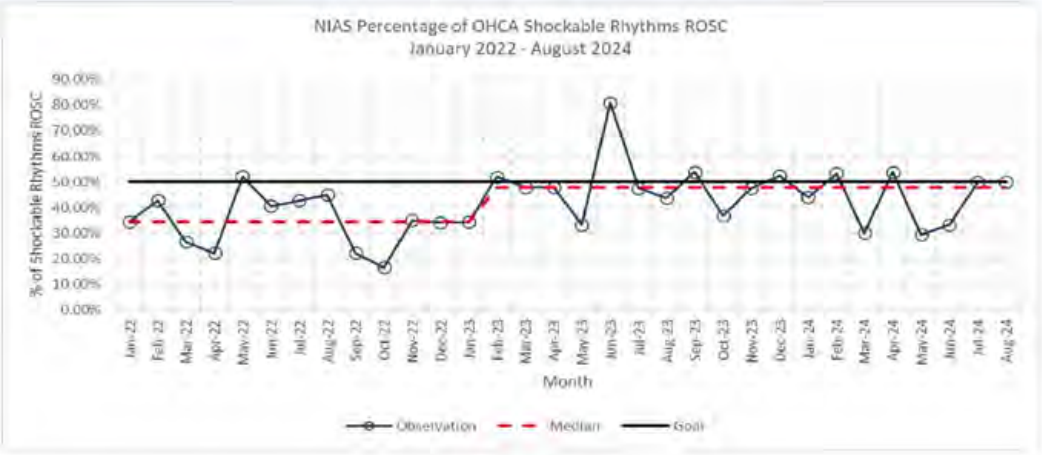
The analysis below describes: NIAS Return of Spontaneous Circulation (ROSC) Rates for Workable Arrests and Shockable Rhythms

ROSC Percentage of OHCA for all Workable Arrests



- The goal of 30% is taken from benchmarking other UK The goal of 30% is taken from benchmarking other UK trusts.
- This graph demonstrates a shift in the median of ROSC onwards from 2022 onwards; 16.9% to 22.54%.
- The impact of the education delivery from March 2023, aligned to other changes defined would be highlighted as changes in practice would explain these changes.
- There is a need to continue the focus on this measure and improve performance.

ROSC Percentage of OHCA for Shockable Rhythms



- The goal of 50% is taken from other UK trusts outcome performance.
- This graph demonstrated an increase in the median for ROSC for shockable cardiac rhythms from 34.74% to 50%.
- Improvement in this patient cohort has been impressive and further work is ongoing to understand how to make these outcomes more consistent and optimise all ROSC opportunities.

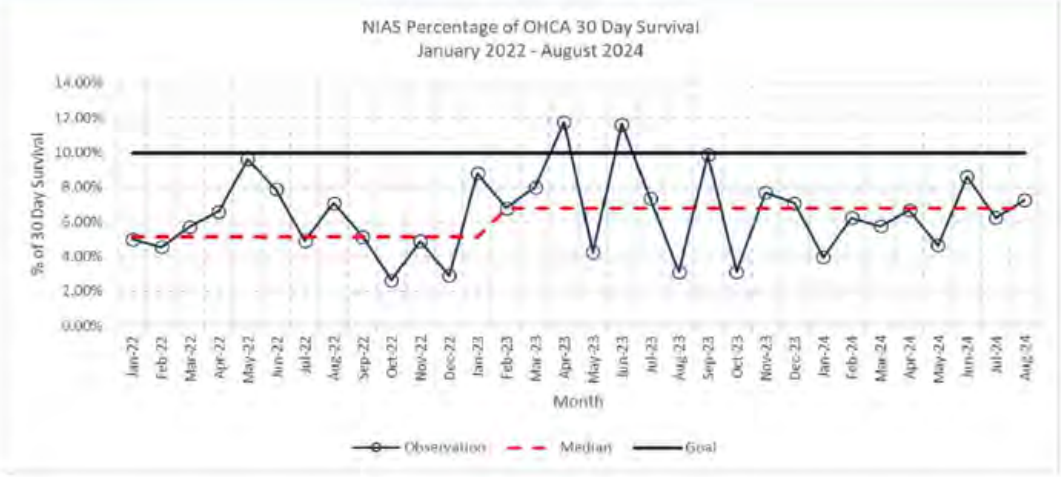
Northern Ireland Ambulance Service
Health and Social Care Trust

Our Patients | Emergency Demand Performance | Out of Hospital Cardiac Arrest (OHCA)

Delivering out of Hospital Care is a core output for NIAS. A small volume of these patients suffers a cardiac arrest, the incidence of mortality from these incidents is high and the NIAS response and management is critical to promote survival.

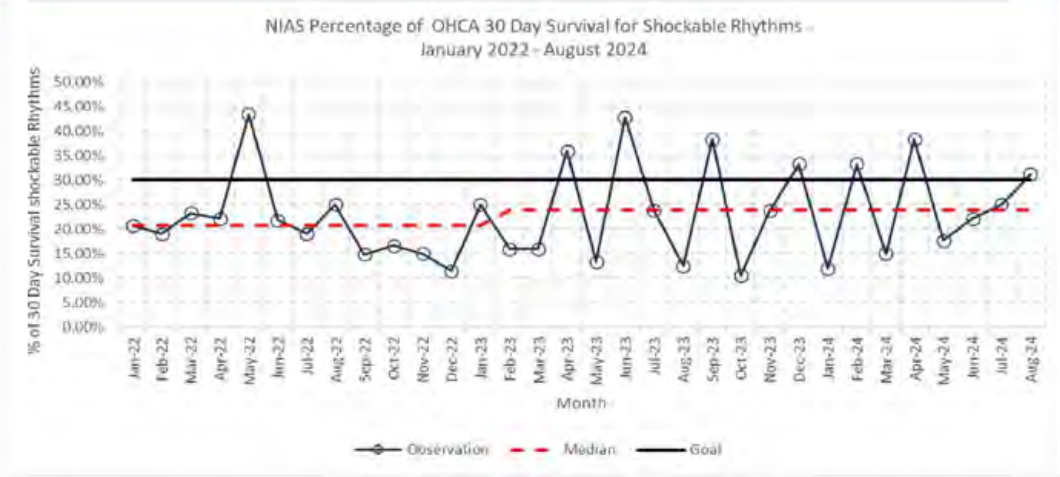
The analysis below describes: NIAS OHCA 30-day Survival and 30-day Survival Shockable Rhythms

OHCA 30-day Survival



- The goal of 10% survival is taken from benchmarking other UK ambulance trusts outcome performance.
- There is an increase in survival from 2022 onwards with an increase from 5% to 6.8%.
- A positive development for the initial years of the improvement programme and onwards trajectory to a minimum of 10% is the focus for the next two years.

OCHA 30-day Survival Shockable Rhythms



- The 30% survival aim is benchmarked from other UK ambulance trusts outcome performance.
- There is a marked change of practice 2022 onwards, with an increase in the median from 19.98% to 23.81%.
- Ongoing work is analysing who to ensure there is consistency with these outcomes and we optimise all opportunities to increase survival.

Northern Ireland Ambulance Service
Health and Social Care Trust

Our Patients | Clinical Performance | Actions to Improve Performance

- Work is ongoing within the complex case team to review the impact of the team to support complex cases within the community to prevent unnecessary contact with the service. Currently the team are evaluating the interventions made with patients to ascertain the areas where investment of time and effort would benefit the service and reduce demand to the control room.
- Recruitment of additional Pathway Leads within the organisation has concluded and successful candidates are in post 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.
- 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.
- The Urgent Care Liaison Desk within Control in now implemented to support crews with clinical decision making and alterative pathways for suitable patients.
- Key focus pathways to support the wider HSC system for 2024.25 are:
    - Hospital at Home
    - Falls
    - Mandatory Referrals
- Urgent Care Oversight Group (UCOG) is now fully established within the organisation and will govern all the improvement work to progress clinical developments within the organisation. The improvements required to increase the use of the Focus Pathways for 2024.25 will be managed and assessed through the UCOG.
- Hospital at Home:
    - Work is ongoing within the Southern Trust to develop a pilot for all patients >75 to be referred directly to the Hospital at Home team.
    - The trust are supporting Belfast in the expansion of their hospital at home team along with service hours available.
    - The trust is actively engaged with the South-Eastern Trust in the expansion of the Hospital at Home team.
- Falls:
    - Trust is working with the PHA to support the developments within the Safer Mobility Group
    - NIAS are establishing a Safer Mobility Group internally to review and develop our response to patients that fall
    - Alignment of clinical practice within the trust to the PHA post fall guidance
- Mandatory Referrals:
    - Target the relevant calls via the Urgent Care Liaison desk within EAC to ensure mandatory referrals are made by staff.

Northern Ireland Ambulance Service
Health and Social Care Trust

System Performance

Northern Ireland Ambulance Service
Health and Social Care Trust

Our Patients | Emergency Performance | Hospital Handover Performance

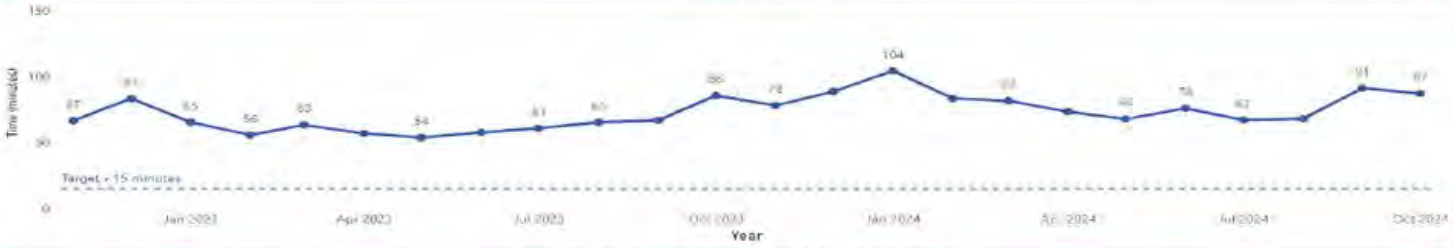
Our operational efficiency is critical to our success. One of our key dependencies is the ability to handover a patient in a timely manner when conveyed to hospital. As such, we must strive to be as efficient as possible whilst always delivering the very best care for our patients.

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	1303	1303	1246	95.63%	702	53.88%	2,586.94	133.95
CRAIGAVON AREA	1258	1258	1193	94.83%	577	45.87%	2,189.85	119.24
ROYAL GROUP	1975	1975	1846	93.47%	963	48.76%	2,502.29	90.71
CAUSEWAY	600	600	575	95.83%	289	48.17%	755.41	90.33
ANTRIM AREA	1680	1680	1593	94.82%	522	31.07%	1,722.03	76.32
ALTNAGELVIN	1124	1124	1067	94.93%	400	35.59%	901.94	62.93
DAISYHILL	525	525	494	94.10%	162	31.43%	382.34	58.48
MATER	494	494	445	90.08%	108	21.86%	300.66	51.16
SOUTH WEST	580	580	535	92.24%	110	18.68%	266.54	41.04
BELFAST CITY	47	47	38	80.85%	3	6.38%	15.08	33.46
LAGAN VALLEY	100	100	72	72.00%	7	7.00%	29.29	31.30
RBSC	99	99	69	69.70%	5	5.05%	20.74	25.95
DOWNE	32	32	21	65.63%	1	3.13%	6.72	25.82
Total	**9826**	**9826**	**9194**	**93.57%**	**3852**	**39.20%**	**11,679.84**	**86.05**

Total Time Lost (Hours) - Last 12 months: 127,804.47

Monthly Handover Times



Monthly Handover Times for Type 1 EDs, by Trust

In October 2024, NIAS experienced a total of 11,679 lost hours. This is the equivalent of 31 shifts per day where crews are waiting with patients outside EDs; 29% of our planned capacity. These lost hours were experienced from 9,194 instances where our crews waited longer than 15mins to handover their patient at ED. 3,852 handovers took longer than an hour in October 2024

In October 24, >77% of the 11,679lost hours occurred at the four ED sites listed below in order of hours lost:

- *Ulster Hospital (2.5k hours; 95% > 15min; 53% > 1hr)*
- *Craigavon Hospital (2.1k hours; 94% > 15min; 45% > 1hr)*
- *Royal Victoria (2.5k hours; 93% > 15min; 48% > 1hr)*
- *Antrim Area (1.7k hours; 94% > 15min; 31% > 1hr)*

In the last 12 months, >93% of the handovers exceeded the 15min target at our acute EDs, resulting in circa 127k hours lost. The lost hours experienced in October 24 is an increase of 257 hrs or 2.2% from September 24, whilst the number of instance of delayed handovers also increased by 8% in the same period.

The 11,679 operational hours being lost are equivalent to 973 12-hours shifts per month, or 31 12-hour shifts per day.

Northern Ireland Ambulance Service
Health and Social Care Trust

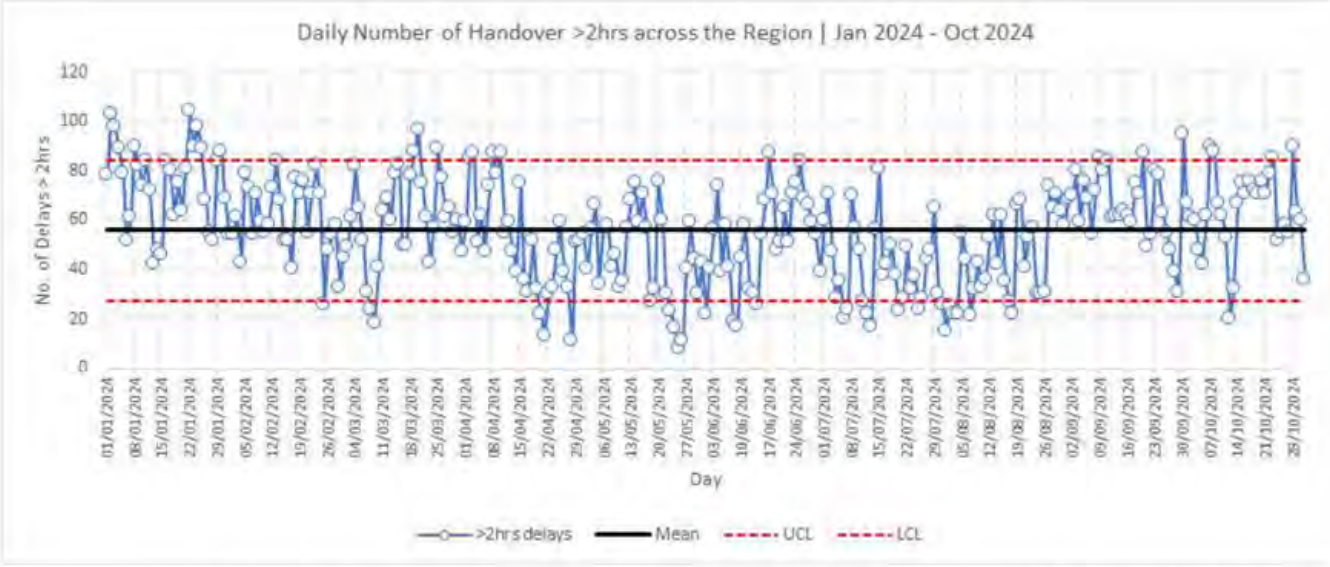
Our Patients | Emergency Performance | 2hr Back Stop Regional Performance

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	Q2 23.24	Sep-23	Oct-23	Q3 23.24	Q4 23.24	FY23.24	Q1 24.25	Q2 24.25	Sep-24	Oct-24
South Eastern	21.1%	23.5%	24.6%	32.0%	32.8%	34.7%	27.7%	29.6%	28.7%	38.7%	35.3%
Southern	9.5%	18.8%	18.8%	25.1%	20.2%	21.6%	17.3%	17.5%	17.8%	27.1%	24.3%
Belfast	6.6%	9.8%	12.6%	18.7%	18.9%	20.1%	13.5%	14.6%	14.0%	20.1%	19.7%
Northern	5.4%	7.2%	7.7%	17.2%	17.2%	17.3%	11.5%	11.1%	16.6%	19.7%	17.7%
Western	2.8%	5.3%	4.6%	9.3%	8.1%	11.1%	6.8%	5.7%	6.5%	9.0%	6.4%
Region	8.8%	12.2%	13.1%	20.1%	19.2%	20.5%	15.0%	14.9%	16.1%	21.9%	20.0%

The table shows the deterioration in >2hr delays by trust from March 2023.
Q2 24.25 2hr handover **increased by 2%** compared to **Q2 23.24. October 24** is a similar position to **October 2023**

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.



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 56 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

Non-Emergency Performance

Northern Ireland Ambulance Service
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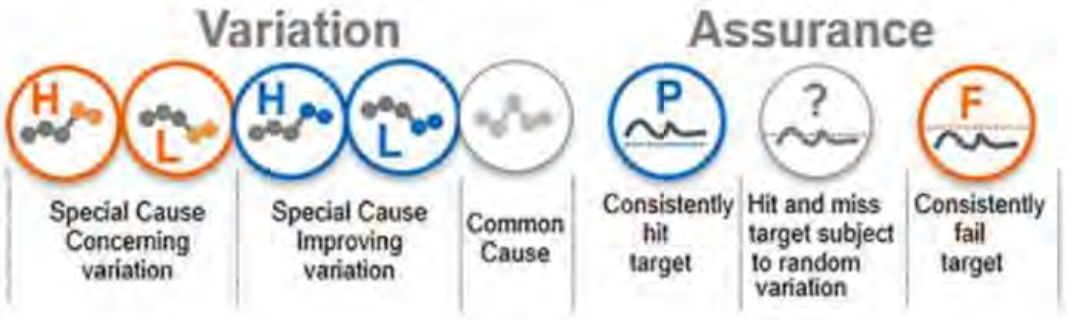
This report uses Statistical Process Control (SPC) charts throughout. SPC is an analytical technique that plots data over time. It helps us understand variation and in so doing guides us to take the most appropriate action.

SPC is a good technique to use when implementing change as it enables you to understand whether changes you are making are resulting in improvement — a key component of the Model for Improvement widely used within the NHS.

SPC is widely used in the NHS to understand whether change results in improvement. This tool provides an easy way for people to track the impact of improvement projects.

SPC charts contain two dotted lines showing the upper and lower control limits, as well as a solid black line indicating the average. If there are also targets associated with the metric these are shown as a red line on the chart. The most recent month's performance and target is shown in the summary table, if there is no associated target this will be denoted with a hyphen (-). An explanation of the icons used is included below:



Northern Ireland Ambulance Service
Health and Social Care Trust

Our Patients | Non - Emergency Performance | Summary Sheet

Improvement Summary/Actions

Positive variations are identified in 6 of the 9 measures this month compared to 3 in the previous month.

It should be noted that some of the improvement measures have inter-dependencies eg Planned recruitment of ACAs will improve the staff in post measure and have a positive effect the amount of non-emergency journeys carried out by PCS and possibly the loading factor measures.

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
KPI 1 Arrivals	Oct 24	38.69%	95.00%			37.07%	32.13%	42.02%
KPI 2 Departures	Oct 24	68.00%	95.00%			66.47%	62.04%	70.91%
PCS Journey's	Oct 24	6043	5500			5196	4159	6233
Cancellations	Oct 24	341	438			836	315	1356
Loading factor Outpatients	Oct 24	1.48	1.80			1.38	1.28	1.48
PCS complaints	Oct 24	5	0			8	-1	16
Loading factor total	Oct 24	1.38	1.80			1.33	1.25	1.41
PCS sickness absence	Oct 24	20	24			37	23	51
PCS WTE	Oct 24	203	265			220	210	231

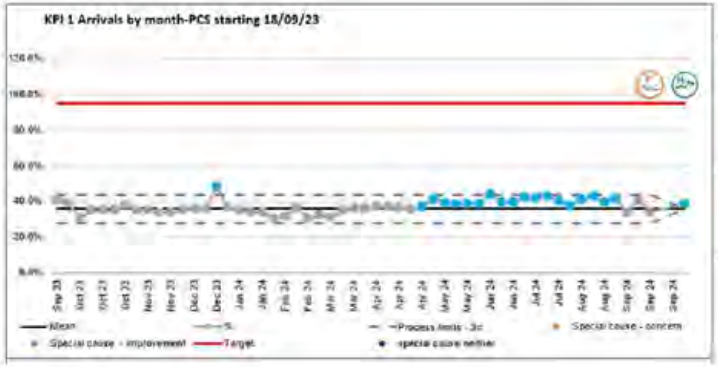
Northern Ireland Ambulance Service
Health and Social Care Trust

Our Patients | **Non-Emergency Performance** | **Productivity Performance**

Patient Experience NIAS aims to review the current Patient Experience measures via our Co-Production Partnership team with a view to having patient representatives help us to design a future suite of Patient Experience KPIs

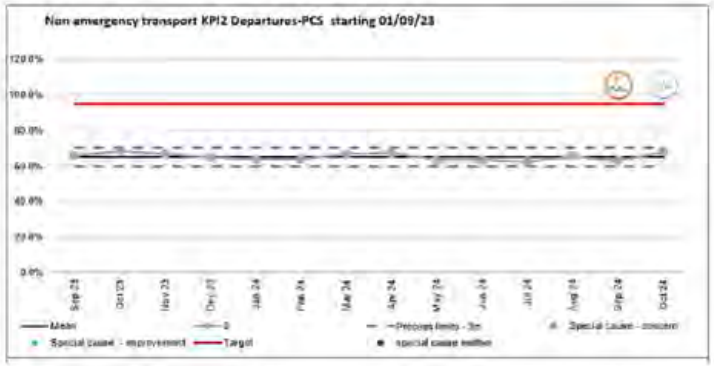
KPI 1 - That 95% of inward journeys will arrive within the 60mins prior to an appointment time.

- Compliance remains low with little variation. Interrogation of the data shows that the majority of non-compliant journeys reach their destination within 30mins of the target.
- Non emergency control staff ensure direct communication between the Control Room and Outpatient Clinics to ensure that patients arriving late are still seen for their appointments.
- Planned patient involvement with our Patient Voices Forum in early 2025 aims to discuss the current patient experience KPIs to determine if they can be improved/amended.



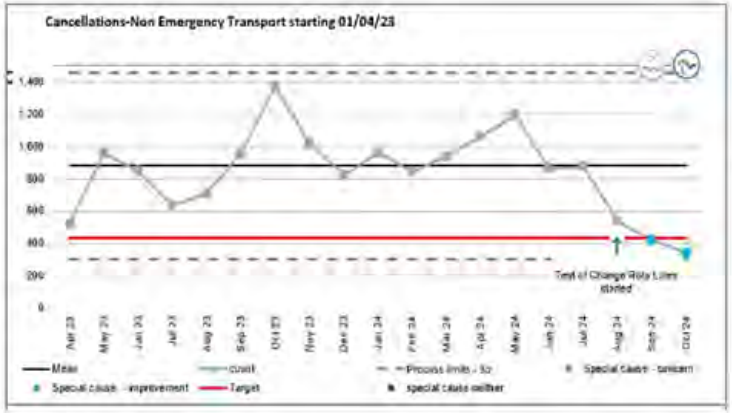
KPI 2 - That 95% of outward journeys will start within 60 minutes of the patient being booked as ready by the clinic/hospital.

Compliance remains below the required level with minimal variance. Interrogation of the data shows the majority of non-compliant journeys are collected within 30 mins of the target.



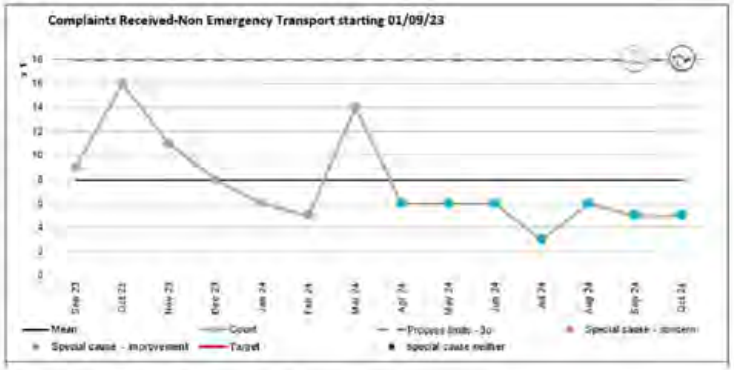
Cancellations by NIAS

- Additional processes to avoid cancellations in particular for journeys such as Renal Dialysis and Cancer treatments are now in place with triggers for additional resources when necessary to prevent these.
- Targeted action to reduce cancellations was instigated in Aug '24 with "Test of Change" Rota lines added to service provision.
- In 2023/4 monthly cancellations averaged 6.4% of service demand, therefore an initial Improvement goal for 2024/25 is to reduce cancellations by 50% therefore improvement trajectory is 3.2% of 20/25 service demand.
- Oct '24 cancellation by NIAS figure is the lowest monthly total since Feb '22.



Complaints

- In the month of October 5 complaints were received relating to Non emergency services. There were a number of reasons for complaints including challenges with renal appointments.
- Whilst the service has an aim of no complaints the current levels ranging between 5-16 per month are in the context of the service providing approx. 13,000 patient journeys per month.



Northern Ireland Ambulance Service
Health and Social Care Trust

Variation

Special Cause Concerning variation | Special Cause Improving variation | Common Cause

Assurance

Consistently hit target | Hit and miss target subject to random variation | Consistently fail target

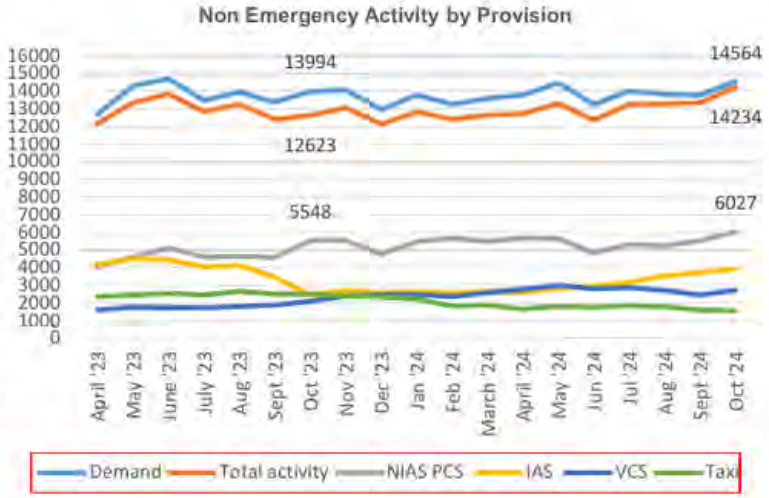
Our Patients

Non-Emergency Performance

Non-emergency transport journeys in Total and by Provision

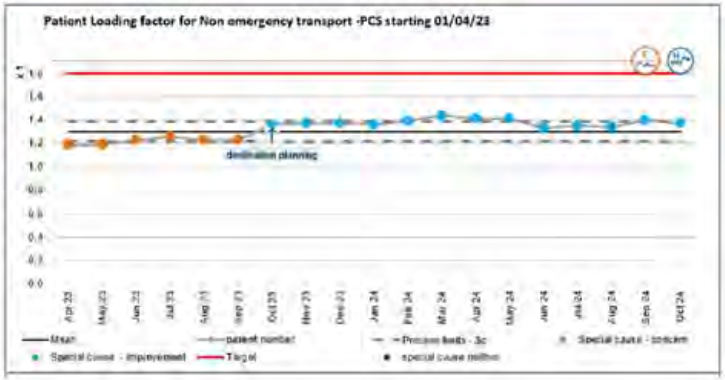
- This comparative graphic is included to illustrate the share of non-emergency activity undertaken via each of the delivery options.
- The underlying objectives are to maximise the activity share completed by NIAS resources either PCS or where suitable the Volunteer Car Service and to meet service demand within contract limits.
- In Oct 23 Activity was 90% of demand in Oct 24 this has risen to 98% of demand
- The increase in the use of IAS resources in recent months is as a result of a number of factors including increased ACA vacancy levels, improvement aim to reduce cancellations & efforts to provide a responsive discharge service and hence flow through hospitals. The Oct '24 activity of 14,234 patient journeys is the highest monthly total post Covid

***NB** The operational definition of Service Demand used at this point is Total Activity + Cancellations by NIAS.*



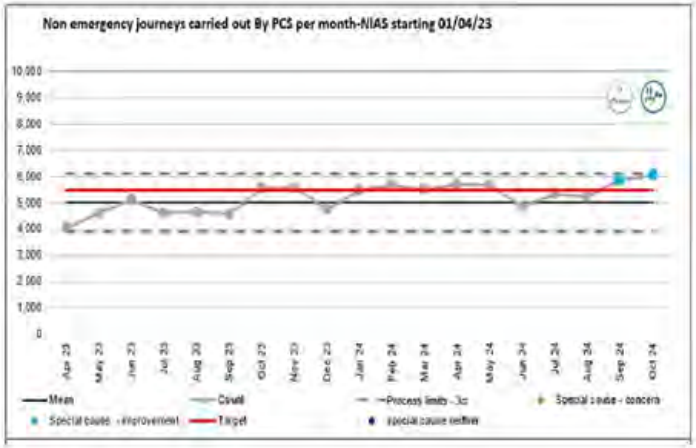
Patient Loading Total

- This measure reflects the average number of patients carried on each non-emergency run. A change in journey planning in October '23 brought about some improvement which has largely been maintained.
- The PCS Improvement Team are currently engaged with the National Non Emergency Patient Transport Services (NEPTS) group to learn from other services. In relation to patient loading factor.
- Other change actions including the reduction in the level of staff vacancies and a revision of staff rotas to better align with service needs will be required to make further progress towards the target



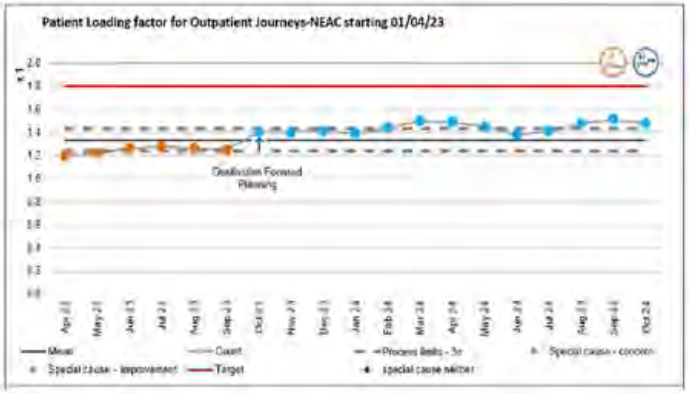
Non emergency transport Journeys completed by PCS

- The Improvement Objective is that PCS activity will increase in 24/25 by 10% from 23/24 this requires approx. 6,000 additional journeys.
- A year to date comparison indicates that at end of Month 7 in 24/25 an addition 5,100 patient journeys have been completed by PCS crews..
- Oct'24 activity of 6053 patient journeys completed by PCS Crews is the highest monthly total post Covid.
- This improvement measure is being met despite a current staff vacancy rate in PCS of over 20%.



Patient Loading Outpatients

As outpatient journeys account for approx. 80% of the non-emergency activity and is the entirety of the pre-booked activity, this measure gives a more accurate indication of the efficiency of the planning of the service and the impact of any change actions

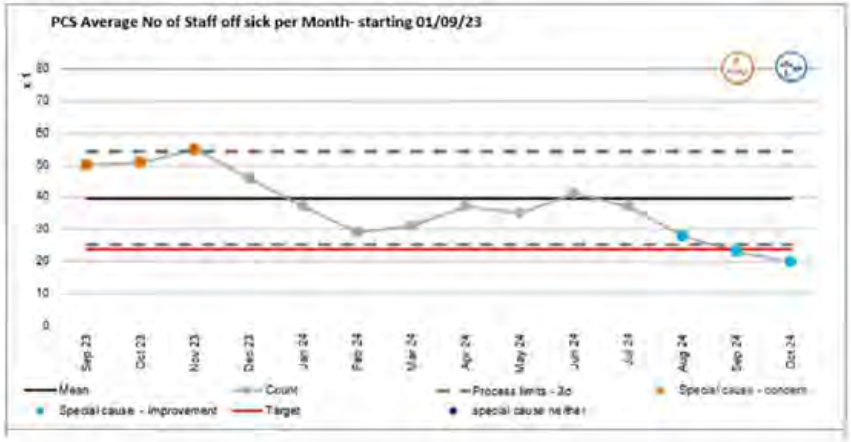


Northern Ireland Ambulance Service
Health and Social Care Trust

Our People | **Non-Emergency Performance** | **Productivity Performance**

Our People

This section currently reflects the DVP Improvement Measures of Reducing the sickness absence level in line with Trust wide targets and recruiting ACAs up to the funded WTE level.
Additional Our People improvement Measures should be set in the areas of training and personal development

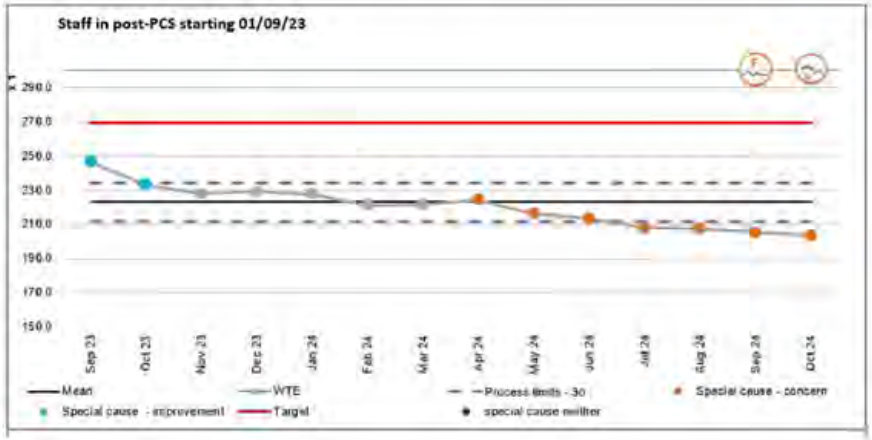


Sickness Absence

This measure illustrates the average number of staff absent through sickness per month. The general trend with the application of Trust wide policies and initiatives continues to be significantly downwards.

NB This data has been sourced from GRS

October in month ACA absence is reported through HRPTS as 9.45% a marked reduction from April 24 in month percentage of 14.97.



Staff in post WTE

- A steady decline of PCS staff in post over the past 12 months is currently being addressed with a cohort of 22 new staff due to commence ACA training in Nov '24
- A further intake of 24 ACA recruits will commence training in Feb '25.
- An evaluation will take place at the beginning of 2025/26 to define any further recruitment targets and strategies.
- NB the information in this graph currently relates to ACA staff working both in non-emergency PCS and A&E support roles

Northern Ireland Ambulance Service
Health and Social Care Trust

Independent Ambulance Performance

Northern Ireland Ambulance Service
Health and Social Care Trust

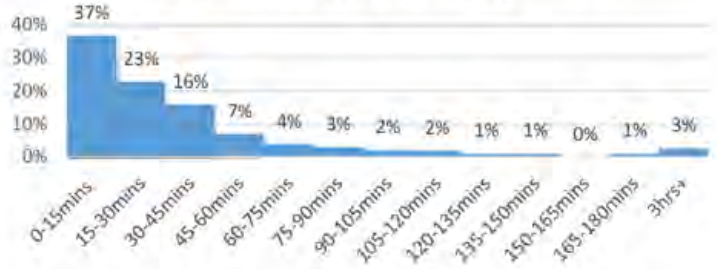
Our Patients | Non-Emergency IAS Performance | Patient Experience

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

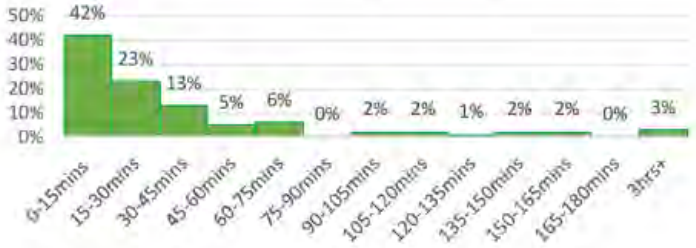
KPI 2 - That 95% of outward journeys will start within 60 minutes of the patient being booked as ready by the clinic/hospital

IAS KPI 1 & 2 Compliance

KPI 1 Missed Compliance by Time



KPI 2 Missed compliance by time



Analysis

- An analysis of the journeys that missed compliance shows that 37% of these journeys missed the target by 15 minutes or less, 83% missed the target by 60 minutes or less
- Similarly, for KPI 2, relating to outward journeys 42% of journeys that missed the target were no more than 15 minutes over this and 83% 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, NIAS Non-Emergency Control will be in contact with the service that the patient is attending to advise of a delay in order that patients do not miss their appointment.

IAS Timestamp Compliance

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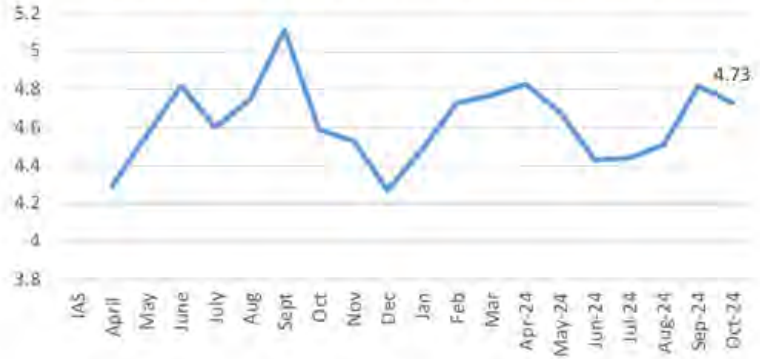
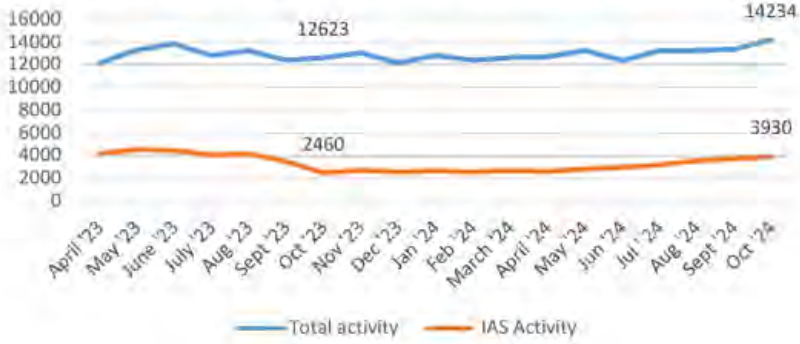
Our Patients | Non-Emergency IAS Performance | Productivity Performance

Average Patient Journeys Per Shift - IAS



Non Emergency Patient Journeys by IAS



Loading Factor IAS

Activity and IAS Share
The proportion of non-emergency activity completed by Independent Ambulances has generally been increasing since May '24, to counter significant staff vacancies in PCS and in a targeted response to reduce cancellations due to no available resources. However it remains below the 23/24 level.

To date in 24/25 IAS activity accounts for 25% of non emergency activity compared to 30% for the same period in 23/24

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. Figures for Aug - Oct show a recovery from a downward trend from May '24

Patients Transported Per Run
This measure also known as loading factor follows a similar pattern as the journeys per shift measure. Showing improvement in Oct '23 with the onset of Destination Focused Planning and showing a recovery again in recent months

Northern Ireland Ambulance Service
Health and Social Care Trust

Service Quality and Our People

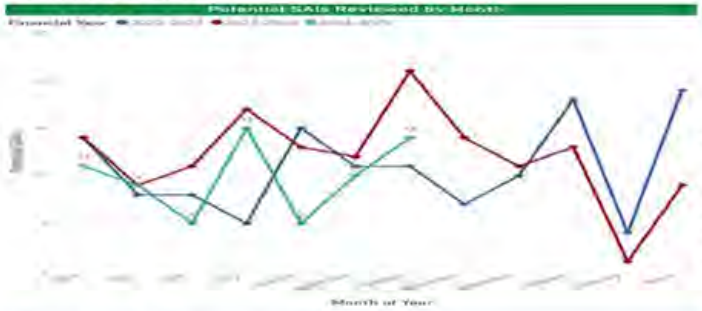
Northern Ireland Ambulance Service
Health and Social Care Trust

Our Patients

SAIs & Complaints

Serious Adverse Incidents

During October 2024, the Trust reviewed 14 potential SAI's resulting in 4 notifications to SPPG.
There are currently 11 ongoing SAI's which are all being reviewed at Level 1.



Themes

Early review of the 4 SAI's notified in October has identified the following themes:

- Delayed response out with standard
- Deteriorating patient within the community

Full review of both incidents is still ongoing which may result in identification of additional themes.

Timeliness of process

1 SAI was completed and closed within October 2024.
The review was completed at Level 1 with a required completion time of 8 weeks.
The completion time was 26 weeks due to competing demands within the team completing the review.

Recommendations & Learning

During October 2024, 1 SAI was closed with the following learning identified:

- Reduction in operational cover within the division, particularly on night shift, impacting ability to provide a timely response.
- Importance of timely provision of welfare calls for patients experiencing protracted delays.

Northern Ireland Health and Social Care (NI HSC) system wide pressures are impacting the ability of NIAS to respond to patients in the community as delays at emergency departments are significantly longer than government recommended standard handover times.

- Learning around adherence to SOP in relation to 'contact failure' particularly for callers who are alone or vulnerable

Implementation and evidencing of SAI recommendations remains an area of focus and to date we have completed and evidenced 90% of the outstanding SAI recommendations. Of the remaining 10%, 3% have not yet reached their due date and therefore remain active. NIAS are also working alongside our health and wellbeing project manager to develop a pathway using a trauma informed approach to support staff involved with the SAI & Rapid Review Group processes.

Complaints, Compliments & Care Opinion

During October 2024, **45 compliments** & **31 complaints** were received and **1 NIPSO complaint** was accepted for investigation.

Timeliness of Process

22 complaints were closed during October 2024.

At the end of October 2024, 43 complaints remained opened with the average number of days opened being 51 working days.

Trends &Learning: Of the 24 complaints closed, 58% were upheld/ partially upheld with some of the following learning outcomes identified: EMD's use of CSP scripts; communication with patients & their families; & driving without due care for other road users.

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 extended from 01/04/24 to 01/07/24 due to other HSC providers now being included in change process).

Care Opinion

During October 2024, 7 stories were submitted via Care Opinion. By 12th of November these stories were viewed 839 times. The main areas of feedback were:

- What's good – Ambulance Staff / Kind / Care
- Improvements – Ambulance wait times/ ED
- Feelings – Thankful/ Annoyed/ secure

Northern Ireland Ambulance Service
Health and Social Care Trust

Our Patients | **Safeguarding Education, Training and Referrals**

Safeguarding Education

- The National Ambulance Safeguarding Group (NASaG) Peer Review (Aug 2023) recommended that the Trust developed a Level 3 Safeguarding (Face to Face) Education Package for all staff involved with the delivery of direct patient care. This recommendation was based on Intercollegiate Adult Safeguarding Guidance: *Roles and competencies for health staff.*
- This recommendation is reflected within the NIAS Safeguarding Training & Education Strategy KPI-. **A minimum of 90% compliance with attendance at Level 3 face to face training every 3 years with ongoing improvement to reach and maintain 100%.**
- A subsequent improvement plan aiming to achieve this KPI over a 3 year trajectory was approved by Safety Committee. Level 3 face to face Safeguarding Education sessions have been delivered from April 24 with almost 400 staff having attended by Nov 24. Plans are in place to have approx. 600 staff trained by end March 25 – this represents in excess of 50% of our staff involved with the delivery of direct patient care.
- Currently, paramedic staff (including SOs, CSD, CSOs and NQPs) account for the largest attendance (70%) with EMT staff the remaining 30%. Further plans are currently being developed to support our ACA staff cohort to attend Level 3 sessions and further work is required to develop a Level 1 e-learning package for NIAS staff not involved in delivery of direct patient care.

Safeguarding & Welfare Referrals

- A National Ambulance Safeguarding Group (NASaG) Benchmarking exercise identified that the trust referral per contact rate was lower than that of other UK ambulance services.
- There has been a 28% increase in referrals received by the NIAS Safeguarding team between Apr-Nov 24 (n = 966) in comparison with the same reporting period 23 (n= 756)
- The increased referrals correlate with the delivery of Level 3 training in 24 which is therefore considered to have impacted, given the expected increase in staff knowledge.

Northern Ireland Ambulance Service
Health and Social Care Trust

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

Sickness absence due to mental health reasons represents the highest proportion of sickness absence in 2023/24, with stress and work-related stress a key issue in this regard. The Trust's Health & Well-Being Team continue to implement the Trust's Mental Health Action Plan as part of the Healthy People, Health Place Strategy, including raising awareness and offering manager training in the use of the Trust's policy and procedure on managing work-related stress.

A comprehensive Delivery Plan is in place with associated enhanced monitoring and accountability in order to support staff and deliver improvement in sickness absence levels.

This includes a focus on the central role of the line manage and ensuring a robust case management approach.

The Trust is also reviewing arrangements for Occupational Health services in order to ensure a timely and effective system which supports staff and related Absence Management processes.

Top 5 Sickness Categories 2024/25*	
Mental Health	31.04%
Injury, Fracture	8.94%
Accident/Untoward Incident	8.13%
Miscellaneous	6.43%
Back Problems	6.44%

* Accounts for 60.98% of absence

Miscellaneous includes General Debility (2.29%); Hospital Investigations (2.00%); Post Surgical Debility (1.54%); Post Viral Fatigue (0.61%); Chronic Fatigue (0%)

Mental Health Reasons	
Stress	38.88%
Stress-Work Related	30.37%
Grief/Bereavement	13.14%
Anxiety	7.81%
Other Mental Health	3.79%
Depression	2.87%
Panic Attacks	1.37%
Behavioural Disorder	0.95%
Insomnia	0.82%

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)	%[1]											
2.	Current Status against Target	10.68% ↓											
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%	10.49%	10.70%	10.79%	10.68%					
4.1	Cumulative % hours lost (24/25) (Non-Covid)	9.94%	9.28%	9.66%	10.03%	10.24%	10.36%	10.27%					
4.2	Cumulative % hours lost (24/25) (Covid)	0.30%	0.36%	0.40%	0.46%	0.45%	0.43%	0.41%					
4.3	Cumulative % hours lost (24/25) Short-Term	1.94%	1.89%	2.03%	2.17%	2.10%	2.13%	2.17%					
4.4	Cumulative % hours lost (24/25) Long-Term	8.30%	7.75%	8.03%	8.32%	8.60%	8.67%	8.51%					
5.	Monthly % hours lost (24/25) Total	10.24%	9.07%	11.00%	11.71%	11.55%	11.28%	10.05%					
6.	Average standard working days lost/employee/month	2.19	2.02	2.14	2.62	2.46	2.30	2.19					
7.	Average estimated cost per month (£'000)	£527	£481	£644	£688	£727	£690	£615					

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

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

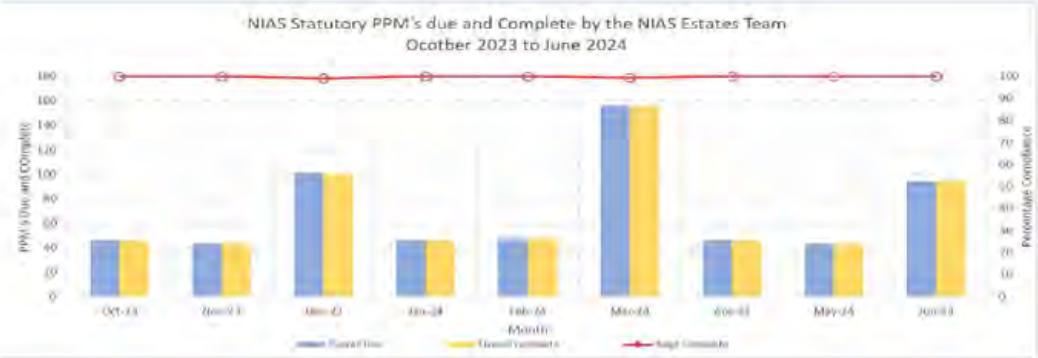
Northern Ireland Ambulance Service
Health and Social Care Trust

Our Infrastructure | Estates Performance | Statutory & Non-Statutory PPM's

Estates Procurement Performance Return (EPPR)

The analysis below describes: NIAS' performance for Estates managing Statutory and Non-Statutory contracts for planned Preventative Maintenance.

Statutory PPM's



- NIAS has achieved 100% compliance with completing all statutory PPM's due within the last two quarters of 2023.24 and the first quarter of 2024.25.
- NIAS estates department actively manage contractors to deliver this maintenance on time and within contractual frameworks.
- Statutory planned preventative maintenance includes managing contracts and contractors that provide the maintenance for fire equipment, legionella testing and heating, ventilation and cooling systems (HVAC).

Non-Statutory PPM's

- NIAS has achieved 100% compliance with completing all non-statutory PPM's due within the last two quarters of 2023.24 and the first quarter of 2024.25.
- NIAS estates department actively manage contractors to deliver this maintenance on time and within contractual frameworks.
- Non-Statutory planned preventative maintenance includes managing contracts and contractors that provide service of a break fix nature.

Northern Ireland Ambulance Service
Health and Social Care Trust

Appendix

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%	92.5%	90.2%	89.4%	94.3%					
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%	5.5%	6.1%	5.8%	5.4%					
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%	14.5%	12.8%	13.9%	13.5%					
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	12mins	12mins	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	23mins	22mins	23mins	23mins					
Cat 1 90th Centile Trajectory	22mins	22mins	22mins	22mins	22mins	22mins	21mins	21mins	21mins	21mins	21mins	21mins
Category 1T Mean	14mins	15mins	15mins	16mins	15mins	18mins	17mins					
Cat 1T Mean Trajectory	19mins	19mins	19mins	19mins	19mins	19mins	19mins	19mins	19mins	19mins	19mins	19mins
Category 1T 90th Centile	28mins	28mins	29mins	30mins	26mins	35mins	32mins					
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	51mins	49mins	66mins	59mins					
Cat 2 Mean Trajectory	48mins	48mins	48mins	46mins	45mins	44mins	44mins	42mins	40mins	40mins	38mins	36mins
Category 2 90th Centile	88mins	93mins	115mins	114mins	110mins	145mins	132mins					
Cat 2 90th Centile Trajectory	100mins	100mins	100mins	98mins	96mins	94mins	92mins	90mins	88mins	86mins	83mins	80mins
Category 3 90th Centile	208mins	263mins	381mins	360mins	312mins	489mins	460mins					
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%	7.7%	7.6%	6.4%	6.3%					
<=15mins Trajectory	7.1%	10%	12%	13%	14%	15%	17%	19%	20%	22%	24%	25%
<=30mins	30.2%	31.8%	29.6%	29.7%	30.3%	25.7%	26.7%					
<=30min Trajectory	27%	30%	32%	23%	34%	36%	38%	39%	40%	43%	44%	45%
<=60mins	65.8%	68.5%	63.4%	66.5%	66.1%	58.8%	60.7%					
<=60mins Trajectory	59%	62%	64%	66%	68%	70%	73%	74%	76%	80%	82%	85%
>2hrs	15.4%	13.2%	16.2%	12.7%	14.1%	21.9%	20%					
>2hrs Trajectory	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
No of Patients >2hrs	1,545	1,412	1,585	1,267	1,376	2,003	1974					
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 Committee:	12 December 2024
Title of paper:	Finance Report – October 2024 (Month 7)
Brief summary:	• Attached is the finance report for month 7 to 31st October 2025. • The Trust is reporting year-to-date (YTD) expenditure of £68.7m with an underspend of £1m against reprofiled budgets. • Easements in pay budgets are expected to continue to the end of the year. This is due to the recruitment of staff not happening as quickly as originally anticipated. • Plans are being made to utilise these funds fully, in consultation with SPPG. • A savings plan to deliver the full £2.475m has been developed and is included in the report. This plan will not impact on service delivery. • In summary, the Trust continues to forecast a break-even position at year end. • The capital budget is under significant pressure with a forecast pressure of £1m. The Trust has bid to the DoH for additional funding. • In the absence of additional funding the Trust has made plans to with within its current Capital Resource Limit (CRL).
Recommendation:	**For Approval** ☒ **For Noting** ☐ *Click the appropriate box*
Previous forum:	*SMT 26/11/2024*

Prepared and presented by:	William Abernethy, Leahann Donnelly and Presented by Simon Christie
Date:	22nd November 2024

Trust Board Finance Report

October 2024 (Month 7)

Northern Ireland Ambulance Service
Health and Social Care Trust

Contents

Executive Summary

* As at October 2024, the Trust has received an indicative funding allocation from SPPG of £123.646m (inclusive of £0.100m from the PHA and net of £2.475m of savings).

* This is an increase of £0.385m on the Month 6 allocation of £123.261m. The additional funding mainly relates to £0.565m for Ulster University Students (originally considered assumed), and a reduction in Covid PPE £(190)k.

* As some of the above funding had previously been assumed, the assumed income figure, which mainly relates to recharges to other Trusts, income from Road Traffic Accidents and income on disposal of fixed assets, has been reduced to £1.713m at this stage of the financial year.

* As such, budgets has been updated to reflect a total funding allocation of £125.360m.

Financial Performance October 2024 (Month 7)

* For period ending October 2024, the Trust is reporting a year-to-date (YTD) expenditure of £68.725m, resulting in a year to date underspend of £1.055m when compared to the profiled budget. A summary of the Directorates position is included on the next slide.

* During the recent detailed profiling and forecasting exercise with all Directorates, several budget pressures and reduced requirements were identified when compared to the opening budget allocation of £125.5m.

* As a result of this work, it is planned that a forecast easement in pay costs as a result of recruitment of staff not happening as quickly as anticipated, will be offset and utilised to support additional activity. This will include further use of the IAS, additional overtime, supporting the regional HSCNI pay gap and additional activity required to help reduce the handover delays at EDs. If affordable NIAS may look to support the other Trusts with unfunded patient transport costs being incurred.

* £0.9m of slippage is forecast from the new workforce funding. This has been reported to SPPG who will claw-back this amount non-recurrently.

* Implementation of the above will result in the Trust continuing to forecast a break-even position at the end of the financial year.

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.

£ 000s	YTD Variances			YTD Actuals	Full Year Forecast	SPPG Allocation	Variance
	Payroll	Non-Pay	Total				
Chief Executive's Office	(12)	69	**58**	695	1,299	1,317	17
Director of Finance	39	98	**137**	1,134	2,889	2,962	73
Director of Human Resources	262	(9)	**253**	1,233	2,615	2,615	0
Medical Director	(32)	(81)	**(114)**	290	373	373	0
Clinical Director	387	(4)	**383**	5,391	11,627	11,627	0
Director of Safety, Qual & Imp	70	2	**72**	1,544	2,785	2,776	(9)
Director Of Plan, Perf & Corp Services	(170)	(212)	**(382)**	4,650	7,779	7,292	(487)
Director of Operations	2,234	(900)	**1,334**	53,788	96,267	97,573	1,305
Operations HQ	*(82)*	*(98)*	***(180)***	*1,799*	*4,982*	*4,606*	*(376)*
Regional Control Centres	*218*	*(999)*	***(781)***	*12,127*	*21,549*	*19,029*	*(2,520)*
Belfast Area Manager	*1,222*	*76*	***1,298***	*5,885*	*10,594*	*12,561*	*1,967*
North Area Manager	*(95)*	*(85)*	***(180)***	*10,669*	*18,459*	*18,330*	*(129)*
South Area Manager	*354*	*57*	***411***	*7,537*	*12,654*	*14,011*	*1,356*
Southeast Area Manager	*359*	*49*	***408***	*7,481*	*13,070*	*13,785*	*715*
West Area Manager	*258*	*101*	***359***	*8,290*	*14,959*	*15,251*	*292*
Revenue Total	**2,777**	**(1,037)**	**1,740**	**68,725**	**125,635**	**126,535**	**900**
SPPG Clawback					900		(900)
Other Savings (See Slide 14)	(685)		(685)		(1,175)	(1,175)	0
NIAS Total	**2,092**	**(1,037)**	**1,055**	**68,725**	**125,360**	**125,360**	**0**

* 'Full Year Forecast' numbers as at October 2024.
* Increased 'Contingency' due to increased profit on disposal of assets.

YTD Variances (>£50k)

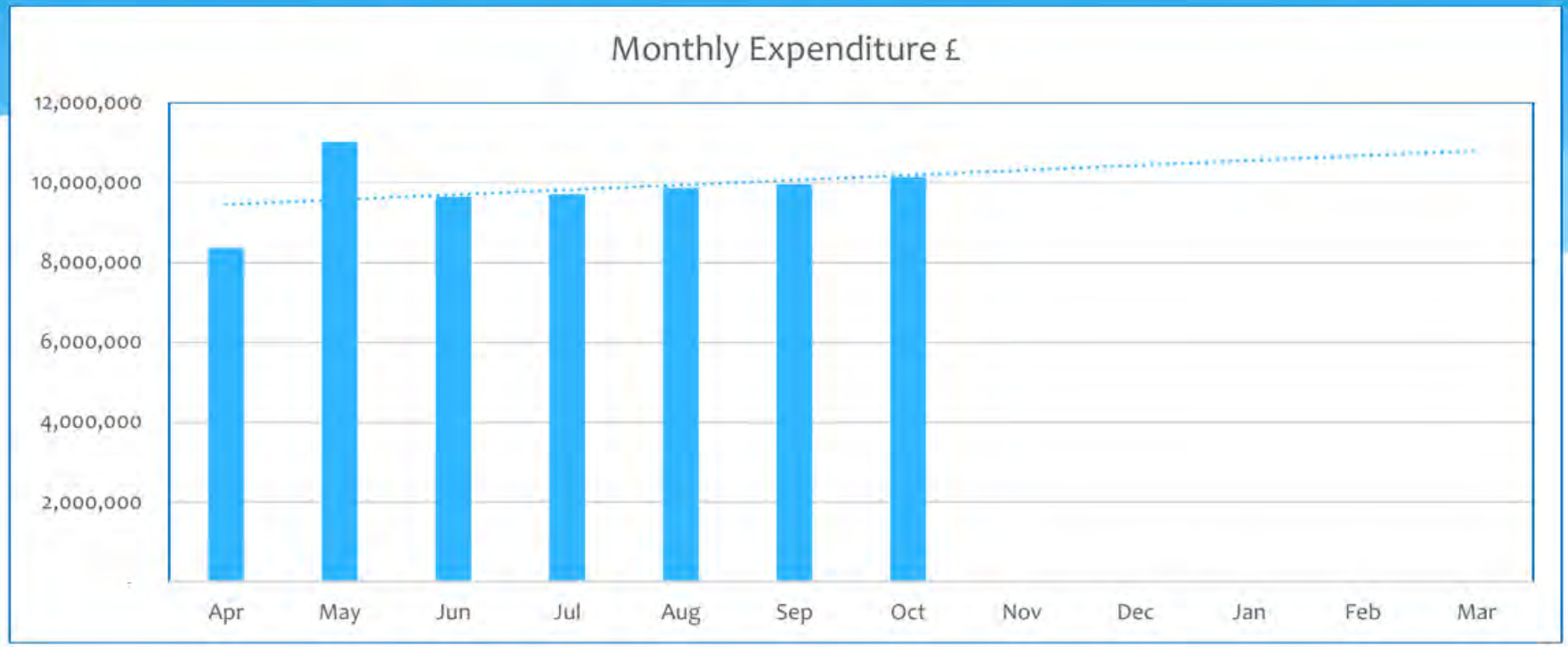
Payroll Variances against budget

* Payroll variances due to current vacancies in NIAS. This is being partly managed through the use of overtime and IAS (see following slides).

Non - Payroll Variances against budget

* **Chief Executives Office** - due to underspend in relation to Regional Coordination Centre (Band 7 Project Management role not utilised).
* **Director of Finance** – due to timing difference between profiled budget and actual expenditure regarding the Car Leasing Scheme and Minor Schemes.
* **Medical Director** - due to overspend of M&S Equipment.
* **Planning, Performance and Corporate Services** - due to increased expenditure on computer hardware maintenance and vehicle expenses (maintenance and repairs, and accident repairs).
* **Operations:**
* **HQ** - due to increased expenditure on vehicle expenses (fuel and maintenance and repairs) and training expenses.
* **Regional Control Centre** - due to increased costs on Independent Ambulance Services and Voluntary Car Services (see following slides).
* **North Area** - due to increased costs on vehicle expenses (maintenance and repairs).
* **Belfast, South and West** - decreased costs in Estates (heat, light and power, and cleaning) and also travel and subsistence.

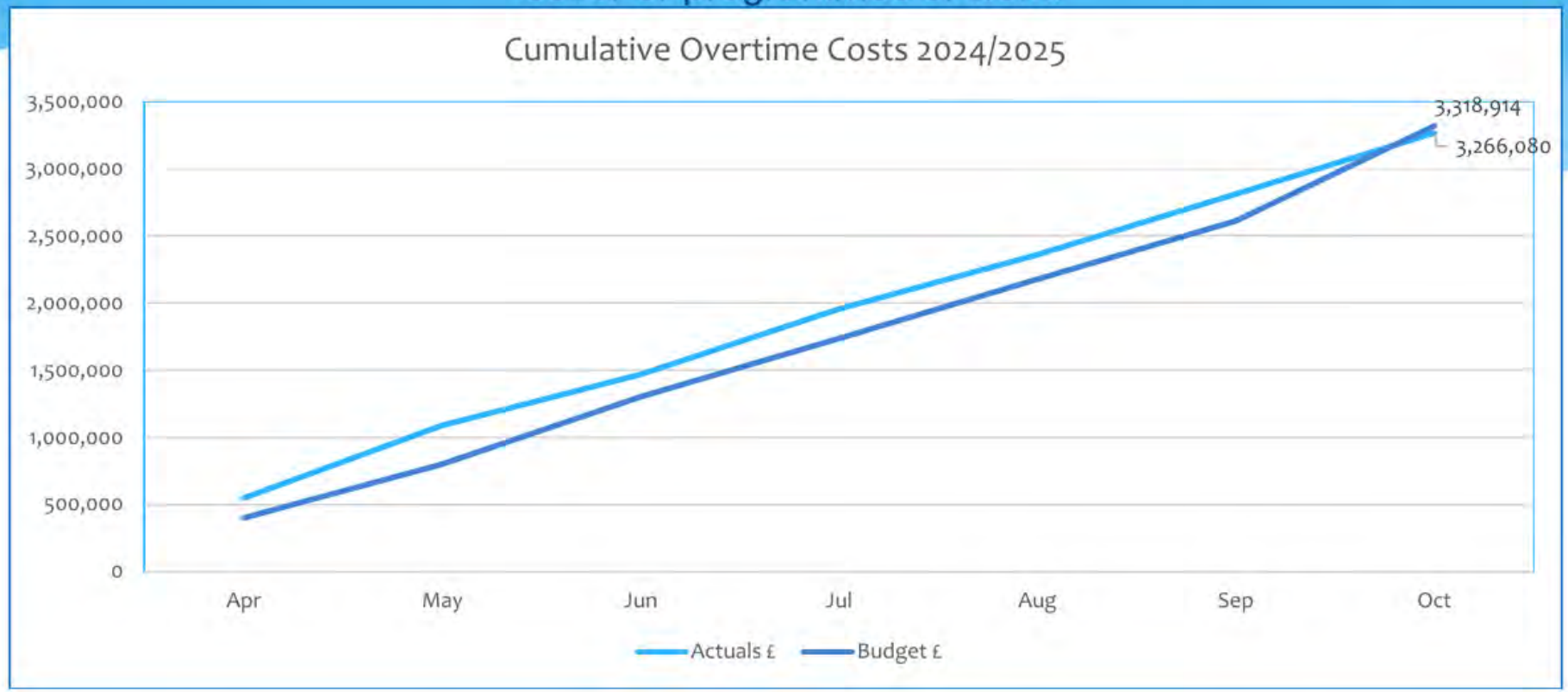
Expenditure Trends



* YTD expenditure is averaging £9.8m a month. Expenditure expected to increase in the coming months due to planned intake of newly qualified Paramedics (NQPs, started late October) and Ambulance Care Attendants (ACAs, 22 in November and 25 in February), filling of vacancies together with additional winter pressures.
* Monthly finance meetings have been scheduled with Directorates to review the YTD position and to attain up to date forecasts.

Overtime Expenditure

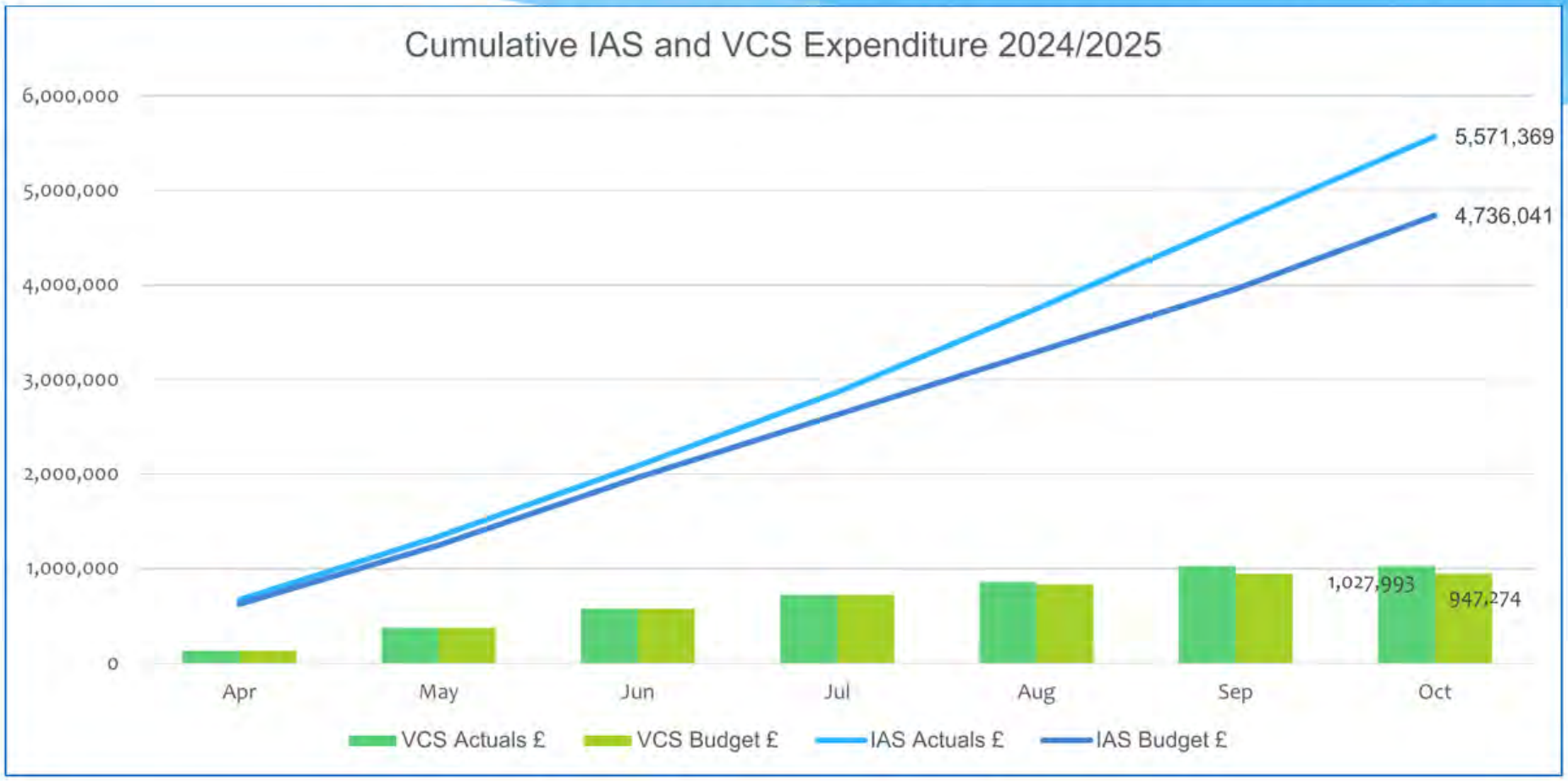
The Trust relies on the use of overtime for the provision of services. This reliance is for several reasons including vacancies, planned and unplanned absences and additional cover or programmes of work.



* Note this is net overtime number and excludes National Insurance.
* Budget in the month of October includes overtime for Driver Training, due to be incurred in November due to late start of 48 NQP.

Independent Ambulance Service and Voluntary Car Service Expenditure

The Trust continues to benefit from the support of Independent Ambulance Service (IAS) Providers and Voluntary Car Service (VCS).



Capital Resource Limit

The Trust has received a Capital Resource Limit (CRL) allocation for 2024-25 of £7.501m.

Expenditure category	Capital Resources Limit Allocation £'k	Forecast Spend* £'k
Fleet and Estates	5,700	6,837
Medical Equipment	183	183
Backlog Maintenance	125	125
ICT	1,374	1,374
R&D	82	82
Leases	37	37
Total	**7,501**	**8,638**

* Forecast spend is subject to receipt of additional capital from the DoH as part of January Monitoring Round.

Capital Pressures

* Capital pressures of £1.138m have been identified.
* These pressures relate to Conversion of PCS Ambulance; Ventilators for NIAS HEMS; Power X Stretchers; Strabane Modular and a HALO office at the UHD ED.
* A bid was submitted to the DoH on 18 November as part of the January monitoring round, requesting the above £1.138m of funding.
* Details of the capital bid to the DoH are outlined on the next slide.
* The outcome of the January Monitoring Round will inform the final capital plan for 2024/25.
* Finance meet regularly with the Capital Budget holders to monitor progress and ensure timely and effective budget management decisions.

Capital Bid to DoH

Priority*	Name of Project	Bid £000
HIGH	Conversion of PCS Ambulances	303
HIGH	Ventilators for NIAS HEMS	28
HIGH	27 x Power X Stretchers	392
HIGH	Estates - Strabane Modular	385
HIGH	Estates - HALO office at UHD ED	30
Total 2024/25 capital bid		**1,138**

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	2,763	2,186	3,045	2,894						17,459	
Total bills paid within 30 calendar days of receipt of undisputed invoice	2,602	1,782	2,007	2,669	2,119	2,987	2,820						16,986	
% bills paid on time 30 days	96.2%	97.1%	98.9%	96.6%	96.6%	98.1%	97.4%						97.3%	>95%
Total bills paid within 10 working days (14 calendar days)	1,584	1,252	1,363	1,670	1,224	2,105	2,410						11,608	
% bills paid on time 10 days	58.5%	68.2%	67.2%	60.4%	56.0%	69.1%	83.3%						66.5%	>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 October 2024, the Trust is reporting a YTD expenditure of £68.725m. Following a recent forecast process easements have been identified in pay budgets. NIAS will surrender £900k of the new workforce funding to SPPG non-recurrently in 2024-25. NIAS are engaging with SPPG with regards to the utilisation of other forecast easements in pay budgets.

Manage within allocated Capital Resource Limit (CRL)

The Trust has received a Capital Resource Limit (CRL) allocation of £7.501m.
Provisional forecast figures for expenditure at year end, 31 March 2025 (Month 12), is £8.638m. This represents a forecast overspend against the CRL of £1.138m (15% of CRL). Additional funds have been be requested as part of the January monitoring round.

Savings target

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

Savings Plan 2024/25	Plan £m	YTD Actual £m	Full Year Forecast	Variance
Non-Frontline Vacancy Management	1.134	0.660	1.131	0.00
Defer Medical Equipment Replaceme	0.048	0.014	0.025	-0.02
Frontline savings due to vacancies	0.780	0.453	0.777	0.00
Sale of End-of-Life Vehicle	0.200	0.156	0.200	0.00
Income	0.100	0.000	0.100	0.00
Uniforms	0.154	0.075	0.197	0.04
Travel and Expenses	0.059	0.016	0.076	0.02
TOTAL	2.475	1.374	2.507	0.032

Prompt payment target-95% of suppliers within 30 days

Cumulative performance is 97.3% for the period ended 31 October 2024.

End of Report

Northern Ireland Ambulance Service
Health and Social Care Trust

Trust Board

Update on Late Finishes

PRESENTATION OF PAPER

Date of Trust Board:	12 December 2024
Title of paper:	Update on Late Finishes
Brief summary:	At NIAS End-Year Accountability Review meeting with the Permanent Secretary in September2024, the Trust highlighted how ambulance handover times across the Region have continued to deteriorate across both Q1 and Q2 of 2024/25 to a point where in September, 21.9% of all handovers took in excess of two hours. This is despite daily efforts coordinated through RCC and HSC Trust colleagues to focus on avoidance of two-hour breaches. During October Trade Unions also indicated that, if late finishes were not addressed, their intention would be an escalation of existing action short of strike actions which would further impact ambulance response times. The Trust provided assurance that all possible actions were being taken to address this issue, including a particular focus on releasing crews at the end of shift, supported by the Department of Health, SPPG and Trusts Trade Unions agreed to pause the proposed additional actions to assess the impact of these actions. On 29th October 2024, the Chief Executive wrote to the DOH Permanent Secretary to highlight his concerns and that immediate action needed to be taken to address the position. This led to NIAS facilitating discussions between DOH colleagues, SPPG Chief Operating Officer and HSC Trust Chief Executives and resulted in an agreement that RCC would coordinate the Trusts in developing a new approach to hospital handovers, with particular emphasis on end of shift periods in the first instance. This paper provides an update on the position since the implementation of actions taken on 19 November 2024.

Recommendation:	**For Approval** ☐ **For Noting** ☒
Previous forum:	
Prepared and presented by: **Date:**	Dean Sullivan 04 December 2024

Contents

SMT Management Team

NIAS Incident Response Plan

1.0 Executive summary:

The current NIAS Major Incident Plan had not been updated in a number of years. Following recommendations from AACE and to ensure that recommendations as highlighted by the Manchester Arena Inquiry were adopted, NIAS EPRR undertook a re-write of the Trust's Major Incident Plan. This plan, now renamed as the Incident Response Plan incorporates a number of best practice processes and seeks to address recommendations in relation to the following:

- Introduction of a 'Significant Incident'
- Standardisation of terminology – 'potential major incident' replaced with 'major incident standby' for example.
- Adoption of TST/MITT triage tools
- Clear roles and responsibilities for commanders in keeping with Command and Control Guidelines
- Embedding of JESIP Principles
- Introduction of NARU Action Cards

2.0 Background

The NIAS IRP was previously submitted to SMT in August 2024. At this time SMT had highlighted an incongruence between the detail in the plan and NIAS current on-call structures. The on-call structures have now been amended and are reflective of the terminology and expectation of commanders as detailed in the Plan.

There is currently an ambitious staff training exercise being undertaken by NIAS EPRR to embed the plan and its principles amongst NIAS operational staff.

3.0 Proposal

SMT to approve the revised NIAS Incident Response Plan and for the Plan to be tabled at the next Trust Board on 12 December 2024.

Once approved the plan will be digitally formatted and shared as appropriate across HSC and partner agencies – anticipated early January 2025.

Period of bedding in across all agencies & Trusts January / February 2025

Go Live date proposed of March 2025

4.0 Financial Implications

Financial burden on the Trust arising from the extensive training initiative has been supported by DoH who provided funding in the training of NIAS staff in TST/MITT.

5.0 Risk

Failure to meet legislative and inquiry recommendations and requirements.

6.0 Publication under freedom of information

Public domain:

This paper has been made available under the Freedom of Information Act 2000.

7.0 Next steps and recommendation

The SMT approves the NIAS Incident Response Plan

Northern Ireland Ambulance Service
Health and Social Care Trust

1.0 Background

1.1 At the NIAS End-Year Accountability Review meeting with the Permanent Secretary in September2024, the Trust highlighted how ambulance handover times across the Region have continued to deteriorate across both Q1 and Q2 of 2024/25 to a point where in September, 21.9% of all handovers took in excess of two hours. This is despite daily efforts coordinated through RCC and HSC Trust colleagues to focus on avoidance of two-hour breaches.

1.2 The associated loss of capacity is impacting directly on:

1.2.1 Ambulance response times across all categories and
1.2.2 Staff welfare, particularly as a result of late finishes due to handover delays at the end of shift.

1.3 The position is further complicated by ongoing action short of strike by a number of Trade Unions who highlight the issue of safe staffing levels as an unresolved issue. This has resulted in restrictions on categories of calls that can be responded to in the last hour of a shift. NIAS has been attempting to reduce the frequency and duration of late finishes by deploying crews at the start of their shift to relieve crews still at hospital. Late finishes often result in compensatory rest for the next shift, to ensure staff are properly rested before recommencing duty. All of these factors have a direct impact on our ability to respond to waiting calls and further impacts negatively on response times.

1.4 During October Trade Unions also indicated that, if late finishes were not addressed, their intention would be an escalation of existing action short of strike actions which would further impact ambulance response times. The Trust provided assurance that all possible actions were being taken to address this issue, including a particular focus on releasing crews at the end of shift, supported by the Department of Health, SPPG and Trusts Trade Unions agreed to pause the proposed additional actions to assess the impact of these actions.

1.5 On 29th October 2024, the Chief Executive wrote to the DOH Permanent Secretary to highlight his concerns and that immediate action needed to be taken to address the position.

This led to NIAS facilitating discussions between DOH colleagues, SPPG Chief Operating Officer and HSC Trust Chief Executives and resulted in an agreement that RCC would coordinate the Trusts in developing a new approach to hospital handovers, with particular emphasis on end of shift periods in the first instance.

2.0 What was agreed?

2.1 Each of the geographical Trusts were asked to review existing processes and develop plans which were focused on ensuring that no ambulance crew was waiting to handover at 06:30hrs/18:30hrs, and for those waiting there was a definitive plan to handover waiting patients in a timely manner. This would allow these crews to make ready their ambulance and travel back to their base Station to complete their shift on time.

2.2 NIAS was asked to consider implementation of a number of additional support measures that were focused on supporting Trusts to improve flow within their hospitals, as well as supporting the Trusts at their EDs:

2.2.1 Hospital destination for GP patients to be determined by NIAS unless clinically indicated – this was agreed through our Clinical/Medical Directorate and SoPs amended to support EOC staff

2.2.2 Hospital destination for other patients to be determined by NIAS unless clinically indicated - this was agreed through our Clinical/Medical Directorate and SoPs amended to support EOC staff

2.2.3 HALO capacity by site to be reviewed and enhanced as appropriate – where possible, HALO cover was adjusted to provide enhanced cover from 06:00hrs through to 22:00hrs each day. This was further enhanced by having an Operational Manager on site for the late handover period (18:00hrs – 20:00hrs) and during week 1 a Director or Assistant Director was present on the majority of the five larger sites

2.2.4 Ambulance support for discharges to be enhanced, to include the facility to make anticipatory bookings – this was implemented through NEAOC and further supported with an additional discharge vehicle daily in each of the Trust areas secured via IAS

2.2.5 Geographical Trusts to potentially provide an identified area for cohorting of patients to release crews. NIAS began planning arrangements for this contingency, however in due course the 5 Acute Trusts indicated they would not be supportive of this approach and it did not proceed

2.3 The Trust has developed a new Standard Operating Procedure (SoP) to support these changes which was shared with all relevant NIAS staff to support consistency of approach and Trade Union colleagues to demonstrate efforts planned to address the challenges. This includes a provision for escalation through RCC during normal operating hours and SPPG on call arrangements.

2.4 A process for capturing and reporting daily operational data was agreed between RCC and NIAS BI and operational Teams.

3.0 Implementation

3.1 The new procedures were introduced on Monday 18th November at 18:30hrs. This was a 'soft launch' to test the arrangements and facilitate discussion with staff.

3.2 The formal launch commenced on Tuesday 19th November with a focus on

3.2.1 Ambulances waiting at each ED @ 06:30hrs. 07:00hrs and 07:30hrs replicated for end of late shift.

3.2.2 How long it took to clear each of the ambulances that had been waiting @ 06:30hrs replicated for end of late shift

3.3 Data is supplied daily to RCC for analysis and onward sharing with each of the Trusts.

3.4 Throughout the day, and as part of their normal function, RCC continue to monitor handovers and support Trusts to minimise delays.

3.5 An additional meeting has been held each day @ 17:00hrs chaired by RCC to monitor the regional position and provide assurances that, every effort is being made to clear all crews in advance of 18:30hrs and, where challenges exist, to understand operational actions to resolve same.

Back to Agenda

4.0 Impact and Results

At the time of writing, the procedure has been in place for less than two weeks.

Managers and staff report an increased focus on hospital handovers from ED colleagues across a number of sites and a recognition from NIAS operational staff that the Trust is actively attempting to address this staff welfare issue.

Further data will be available at Trust Board to track the extent of any improvements in reducing hospital handovers at these two periods of the day together with the resulting impact on NIAS shift completion times.

5.0 Review

Process to be agreed.

Northern Ireland Ambulance Service
Health and Social Care Trust

Trust Board

NIAS Incident Response Plan

PRESENTATION OF PAPER

Date of Trust Board:	12 December 2024
Title of paper:	Incident Response Plan (IRP)
Brief summary:	This paper seeks approval for the re-wite of NIAS Incident Response Plan to be accepted by the Trust for presentation to Trust Board. Provides an update to Trust Board on the minor amendments to the IRP following feedback to EPRR team. **Major Incident Plan** As per the AACE Phase 1 recommendations and recommendations as highlighted in the Manchester Arena Inquiry, NIAS EPRR have updated the Major Incident Response Plan, now entitled the **Incident Response Plan** in keeping with other ambulance services. This plan has been shared with partner agencies prior to completion including SPPG/PHA/DoH and blue light partners for comment. **Summary of Key changes to version 0.52 (11 November 24) to include:** Addition of 'Significant' as an incident category Introduction of Pre-determined Attendances to incidents Changes in terminology –e.g. Major Incident Standby replacing Potential Major Incident Introduction of the use of NARU Action cards Embedding of JESIP Principals.
Recommendation:	**For Approval** ☐ **For Noting** ☒
Previous forum:	• SMT 27 August and 03 December 2024 • Summary update provided to EPRR enhanced meeting November 2024.
Prepared and presented by:	Heather Sharpe / Rosie Byrne
Date:	04 December 2024

Contents

NIAS Incident Response Plan

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Failure to meet legislative and inquiry recommendations and requirements.

6.0 Publication under freedom of information

Public domain:

This paper has been made available under the Freedom of Information Act 2000.

7.0 Next steps and recommendation

The SMT approves the NIAS Incident Response Plan

Northern Ireland Ambulance Service
Health and Social Care Trust

Northern Ireland Ambulance Service

Incident Response Plan

Emergency Preparedness, Resilience and Response Department

November 2024

Version 0.35

IF A MAJOR INCIDENT HAS BEEN DECLARED

REFER IMMEDIATELY TO YOUR

MAJOR INCIDENT

ACTION CARDS

Northern Ireland Ambulance Service
Health and Social Care Trust

Title:	**Incident Response Plan**		
Author(s)	J. McClure, H. Sharpe J McArthur, P. Woodrow, J. Smylie		
Ownership:	Operations Directorate		
Date of SEMT Approval:		Date of Trust Board Approval:	
Operational Date:		Review Date:	
Version No:	V0.36	Supersedes:	
Key words:	Planning / Recovery / Preparedness / Risk / Incident Management / Critical / Significant / Major Incident / Mass Casualty / Commander / EPRR / Response / Emergency		
Other Relevant Policies & Plans	Risk Management Policy Business Continuity Policy / Strategy and Plans Clinical Safety Plan Resource Escalation Action Plan (REAP) NIAS Strategy to transform		
Distribution methods	SharePoint / Email / Teams / Education days		

Amendment History			
Date	Version	Author(s)	Amendments
03/11/2023	0.1	J McClure	Initial draft created
07/11/2023	0.2	H Sharpe / J McArthur / J McClure	Initial draft amended
03/12/2023	0.3	H Sharpe	Document amendments
07/12/2023	0.4	P Woodrow	Document amendments
19/12/2023	0.5	P Woodrow	Further amendments
21/12/2023	0.6	P Woodrow	Additional amendments
03/01/2024	0.7	P Woodrow	Additional amendments
16/01/2024	0.8	P Woodrow	Additions to document
19/01/2024	0.9	H Sharpe	Amendment history updated
23/01/2024	0.10	H Sharpe	Tracked changes
25/01/2024	0.11	J McClure	Tracked changes
06/02/2024	0.12	J McArthur	Tracked Changes and comments
08/02/2024	0.13	H Sharpe	Tracked changed adopted comments added
09/02/2024	0.14	J McArthur	Additional amendments and comments
10/02/2024	0.15	J McArthur	Additional amendments
14/02/2024	0.16	H Sharpe	Formatting and comments. Document divided into sections for clarity
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27/3/2024	0.21	N/A	Draft circulated for comment
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2/5/2024	0.24	S Graham	Formatting and update of IOR/Stay Safe
21/5/2024	0.25	J McClure	Additional Editing
11/6/2024	0.26	J McClure	External Partner Comments Collation
26/06/2024	0.27	J Smylie / H Sharpe	Additional editing - consistency of terminology and formatting
02/08/2024	0.29	H Sharpe	Mass Casualty definition changed following discussion with PHA
12/08/2024	0.30	J McClure	NACC No. and Mutual Aid Process clarified, Annexes Identified.
09/09/2024	0.31	H Sharpe	Mass Casualty Definition revert to previous
03/10/2024	0.32	H Sharpe	Additional amendments and comments
29/10/2042	0.33	H Sharpe	Additional amendments and comments
01/11/2024	0.34	EPRR Team	Team read through and additional editing
15/11/2024	0.35	J McArthur	Updated images added
27/11/2024	0.36	S Graham	TST/MITT added

Contents

Foreword

The Northern Ireland Ambulance Service (NIAS) has an obligation to be prepared to respond and manage incidents of all types and sizes. In such cases there may be little or no warning.

This Incident Response Plan has been prepared in light of guidance from the Northern Ireland Civil Contingencies Framework (Revised 2023), Joint Emergency Services Interoperability Principles and builds on the Civil Contingencies Act 2004, as well as lessons identified by Coroner's Inquests and Public Inquiry recommendations.

The arrangements outlined in this document form the basis and underpinning detail for responding to an incident, or in support of other services and organisations, occurring in the operational area covered by NIAS. It should be emphasised that the NIAS operational area contains a wide variety of hazards and that no two incidents will produce the same scenario. It is important therefore, to remember that it may be necessary to fit or adjust the plan to the incident.

The Trust Board are committed to embedding and maintaining a culture of preparedness within NIAS, which will ensure we have robust emergency response and management systems in place, capable of dealing with a range of scenarios. To do this, all staff, including managers and directors, should be aware of and familiar with this plan and their particular role within it, and to understand the principles of command and control including Joint Emergency Services Interoperability Principles (JESIP).

It will be necessary to periodically update this plan in light of experiences gained from incidents and training exercises. This plan will be subject to a bi-annual review process initiated by the Emergency Preparedness, Resilience and Response (EPRR) Department.

Signed by the CEO

Signed by the Chair

SECTION 1

Introduction

It is the nature of major incidents or emergencies that they are by definition unpredictable, and each will present a unique set of challenges. NIAS forms part of the Northern Ireland Health and Social Care response to such incidents and acts as the gateway to the wider health network.

This document outlines the arrangements that exist within NIAS that support a high level of preparedness in the event of increased demand due to a significant, major, or mass casualty incident or where the disruption to service delivery due business continuity incidents has escalated beyond being managed through normal processes.

All staff must familiarise themselves with the contents of this plan.

This document should be read in conjunction with the Trust's Business Continuity Management Plans and supporting documents, including: the Clinical Safety Plan and Resource Escalation Action Plan (REAP), and Incident Response Action Cards, which are available on the NIAS information sharing platform, SharePoint.

Legislation and Guidance

Following the introduction of a UK legislative framework for civil protection in 2004, The Northern Ireland Ambulance Service (NIAS) established an Emergency Planning Department, now known as the Emergency Preparedness, Resilience and Response Department, to manage the Trust's obligations in this area.

The Northern Ireland Civil Contingencies Framework (NICCF) revised 2023, sets out the most recent Northern Ireland arrangements for effective emergency management, identifying the processes involved in preparing for, responding to and recovering from an emergency and provides generic guidance for all types of emergencies. The NICCF is complementary to the Civil Contingencies Act (CCA) of 2004 and provides guidance for those responsible for developing emergency plans. The NICCF draws upon best practice and lessons learned from previous emergencies, both within Northern Ireland and from Great Britain (GB), Republic of Ireland (ROI) and global experiences.

NIAS Civil Contingency Obligations

The Civil Contingencies Act of (2004) and the NICCF (revised 2023) places specific duties on Category 1 responders. Category 1 responders are those organisations at the core of emergency response, the revised NICCF identifies NIAS as a de facto Category 1 responder and as a result, NIAS have a duty to:

- assess risk
- maintain emergency plans
- maintain business continuity plans
- communicate with the public
- share information with partner agencies
- co-operate with partner agencies

Underpinning principles for NIAS EPRR

The underpinning principles for EPRR are set out in NHS Emergency Preparedness Resilience and Response Framework (NIAS accepts this document as good practice and will adopt these principles) and they are;

Preparedness and Anticipation – NIAS is required to anticipate and manage consequences of incidents and emergencies through identifying the risks and understanding the direct and indirect consequences, where possible. Individuals who respond to incidents should be prepared, including having clarity of roles and responsibilities, specific and generic plans, and rehearsing arrangements periodically.

Continuity – the response to incidents (of any scale) should be grounded within NIAS existing functions and familiar ways of working – although inevitably, actions will need to be carried out at greater pace, on a larger scale and in more testing circumstances during response to an incident.

Subsidiarity – decisions should be taken at the lowest appropriate level, with coordination at the highest necessary level. Incident Commanders should be the building block of response for an incident of any scale.

Communication – good two-way communications are critical to an effective response. Reliable information must be passed correctly and without delay between those who need to know, including the public.

Cooperation and Integration – positive engagement based on mutual trust and understanding will facilitate information sharing. Effective coordination should be exercised within and between organisations and local, regional, and national tiers of a response. This includes active mutual aid between organisational, national, and international boundaries as appropriate.

Direction – clarity of purpose should be delivered through an awareness of the strategic aim and supporting objectives for the response. These should be agreed and understood by all involved in managing the response to an incident in order to effectively prioritise and focus the response.

Role and Purpose of the Incident Response Plan

This Incident Response Plan will replace the NIAS Major Incident Plan (2018).

The aim of this Incident Response Plan is to ensure the NIAS response to incidents or emergency situations is patient focussed, clinically led and effectively managed. It is principally designed around the immediate medical needs of those involved and as appropriate, subsequent transportation to definitive treatment centres.

Adherence to this plan will enable NIAS to respond to significant, major and mass casualty and business continuity incidents by maintaining critical functions and essential services to patients and providing and receiving mutual aid on a local, regional and national level.

The objectives of this plan are:

- To ensure NIAS responds as an integral part of the Northern Ireland Health and Social Care System
- To provide suitable guidance and information to NIAS staff and other Health and Social Care staff
- To enable an effective and coordinated response to significant, major or mass casualty incidents and business continuity incidents
- To ensure an effective command and control structure is established
- To assist in the identification and mobilisation of specialist capabilities assets
- To provide assurance and demonstrate compliance against statutory and regulatory obligations and guidance.

Risks, Threats and Planning Assumptions

This Incident Response Plan has been produced to reflect the planning assumptions detailed within the UK National risk register, the Northern Ireland risk register and community risk registers across Northern Ireland

Specific risks identified within NIAS operating geography include;

- Major transport hubs such as Belfast International Airport, Belfast City Airport and Belfast Harbour
- Extensive road and rail infrastructure
- Crowded places, entertainment and sporting venues
- A number of industrial sites which are managed under the Control of Major Accident Hazards (CoMAH) regulations
- Additionally, malicious attacks (terrorism), pandemics, coastal and fluvial flooding, adverse weather events, cyber-attacks and IT/ Critical Infrastructure failures all pose a risk to routine service delivery for NIAS.

Incident Classification

The following list provides commonly used classifications of incidents. The list is not exhaustive and other classifications may be used as appropriate. The nature and scale of an incident will determine the appropriate incident levels.

• **Business continuity/internal incidents** – fire, flood, breakdown of utilities, significant equipment or critical Infrastructure failure and acquired infections.

• **Big bang** – a serious transport accident, explosion, terrorist attack, public order breakout or a series of smaller incidents

• **Rising tide** – a developing infectious disease epidemic, capacity/staffing crisis or industrial action.

• **Cloud on the horizon** – a serious threat such as a significant chemical or nuclear release developing elsewhere and needing preparatory action.

• **Headline news** – public or media alarm about an impending situation, reputation management issues.

• **Chemical, biological, radiological, nuclear and explosives (CBRNE)** – CBRNE terrorism is the actual or threatened dispersal of CBRN material (either on their own or in combination with each other or with explosives), with deliberate criminal, malicious or murderous intent.

• **Hazardous materials (HAZMAT)** – accidental incident involving hazardous materials.

• **Cyber-attacks** – attacks on systems to cause disruption and reputational and financial damage. Attacks may be on infrastructure or data confidentiality.

Joint Emergency Services Interoperability Principles (JESIP)

This document is written in line with the JESIP joint doctrine, the purpose of which is to provide multi-agency incident commanders with a framework to enable them to effectively respond together. The joint doctrine has been designed so that it can be applied to smaller scale incidents, wide area emergencies and pre-planned operations.

Joint Doctrine

Public inquiries and inquests from numerous major incidents have identified that emergency services should work better together and display greater co-operation and coordination.

The JESIP Joint Doctrine focuses on the interoperability of HM Coastguard, police, fire, and ambulance services in the early stages of a response to a major or complex emergency. It is also acknowledged that the emergency response is a multi-agency activity, and the resolution of an emergency will usually involve collaboration with other responders.

The Joint Doctrine sets out what responders should do and how they should do it in a multi-agency working environment to achieve a successful joint response.

All NIAS operational staff are mandated to complete and maintain JESIP training.

Principles of Joint Working

Commanders must adhere to the principles of joint working when planning and delivering incident response.

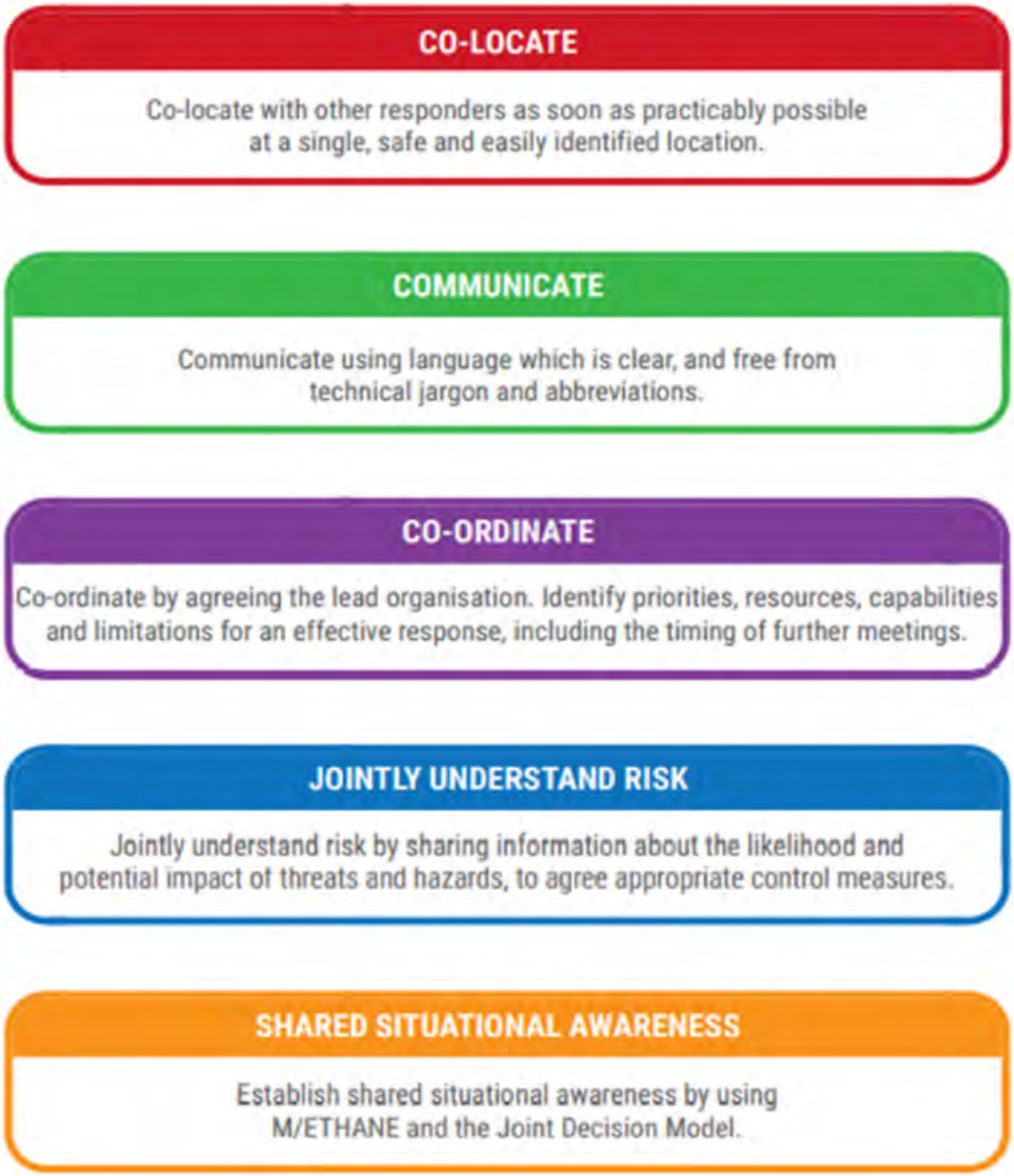

Figure 1: Principles of Joint Working

M/ETHANE

The M/ETHANE model is an established reporting framework which provides a common structure for responders and their control rooms to share major incident information. It is recommended that M/ETHANE be used for all incidents as it forms the initial information and intelligence of the Joint Decision Model (figure 3).

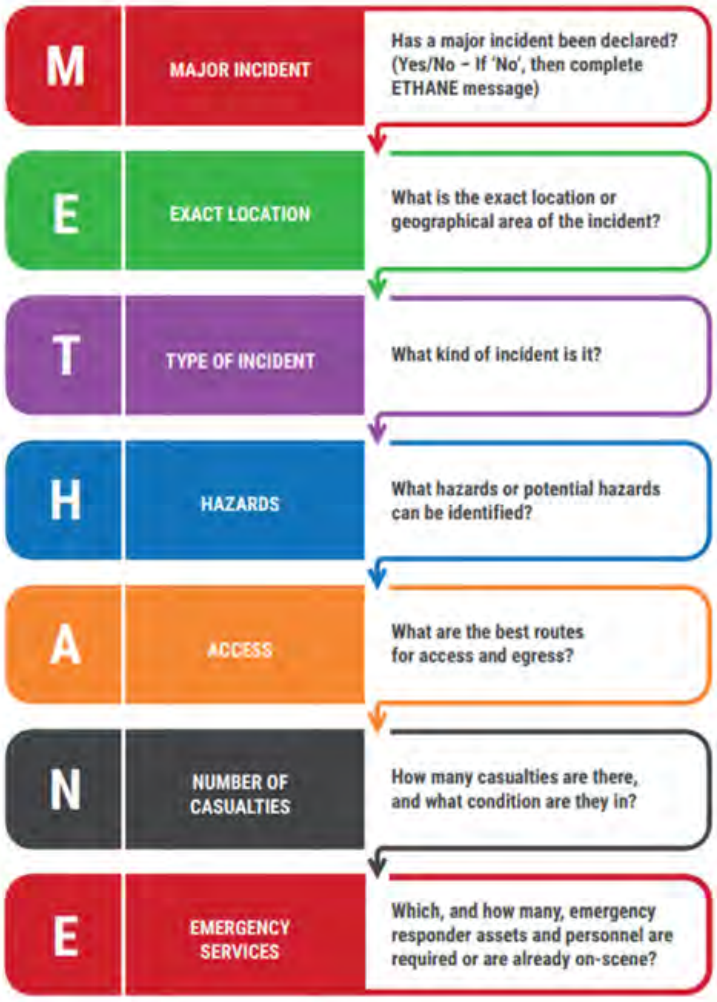

Figure 2: M/ETHANE

The Joint Decision Model (JDM)

One of the difficulties facing commanders from different organisations in a joint emergency response is how to bring together the available information, reconcile objectives and make effective decisions together. The JDM, has been developed to enable this to happen and JESIP recommends that during an incident the multi-agency Commanders must utilise the JDM to assist with decision-making.

The JDM is organised around three primary considerations:

Situation: what is happening, what are the impacts, what are the risks, what might happen and what is being done about it? Situational awareness is having an appropriate knowledge of these factors.

Direction: what end state is desired, what are the aims and objectives of the emergency response and what overarching values, and priorities will inform and guide this?

Action: what needs to be decided and what needs to be done to resolve the situation and achieve the desired end state?

NIAS Commanders shall undertake appropriate JESIP training and will be subject to 3 yearly refresher training.

Figure 3: The Joint Decision Model (JDM)

Duty of Care

Ambulance Services have an established legal duty to provide a reasonable standard of care to patients without unreasonable delay[1]. This 'Duty of Care' requires ambulance clinicians and commanders to achieve a careful balance. They must take reasonable steps to ensure they are as safe as is realistically possible, but they must also be prepared to accept some risk to deliver effective care to patients in the pre-hospital setting.

In addition, Article 2 of the Human Rights Act 1998 creates a positive duty on public sector organisations including the ambulance service to do all they reasonably can to protect those they know, or ought to know are at real and immediate risk.[2]. However, there may be occasions where it is justifiable not to act immediately to save someone's life if to do so would result in a responder sacrificing their own.

Ambulance commanders therefore should consider the following when discharging their obligations:

- **Providing a reasonable standard of care to patients without unreasonable delay**
- **Ensuring safe systems of work and associated procedures are in place to protect responders**

[1] The Duty of Care for Ambulance Responders. NARU, (2021:4)
[2] The Duty of Care for Ambulance Responders. NARU, (2021:4)

SECTION 2

Incident Definitions and Associated Plans

Incident Definitions

Significant Incident

NIAS defines a Significant Incident as;

An incident which from initial information and / or intelligence indicates it may require an attendance of several ambulance resources or a specialist / dedicated response along with a management / command presence.

Major Incident

In keeping with the JESIP definition of a Major Incident, NIAS defines a Major Incident as;

An incident which due to its scale or complexity presents a serious threat to the health of the community, requiring an extra-ordinary response by NIAS and special arrangements to be implemented across Health and Social Care.

Any operational member of staff may declare a Major Incident or Major Incident Standby. However, it is the responsibility of the Emergency Operations Centre (EOC) Duty Manager to implement the Incident Response Plan.

The EOC Duty Manager will become the EOC Commander

If a major incident is declared by other services, NIAS will respond appropriately, which may or may not include the declaration of a Major Incident.

Mass Casualty Incident

A Mass Casualty incident is an incident (or series of incidents) causing casualties on a scale that is beyond the normal resources of the emergency and healthcare services' ability to manage.[3]

A Mass Casualty Incident is described as one which;

> **Will involve hundreds or thousands of casualties, with a range of injuries, the response to which will be beyond the capacity of normal major incident procedures and requires further measures to appropriately deal with the casualty numbers.**

The Northern Ireland Mass Casualty arrangements contain pre-arranged casualty distribution procedures which should be adhered to in the event of a Mass Casualty Incident.

Business Continuity (BC) Incident

A Business Continuity Incident is an event or occurrence that disrupts, or might disrupt, an organisation's normal service delivery, to below acceptable predefined levels. This would require special arrangements to be put in place until services can return to an acceptable level. Examples include surge in demand requiring temporary re-deployment of resources within the organisation, breakdown of utilities or significant equipment failure or acquired infections. There may also be impacts from wider issues such as supply chain disruption or provider failure.

BC Critical Incident

A BC Critical Incident is any localised BC incident where the level of disruption results in the organisation temporarily or permanently losing its ability to deliver critical services, or where patients and staff may be at risk of harm. A Critical Incident is principally an internal escalation response to a Business Continuity Incident.

NIAS will manage Business Continuity and BC Critical Incidents in accordance with NIAS Business Continuity Plans in the first instance.

[3] NHS England EPRR Concept of Operations for managing Mass Casualties

Associated Plans

The following plans are intended to work with each other to determine a series of actions and options to assist in executing an effective response to an incident.

Resource Escalation Action Plan (REAP)

REAP is a national action plan and should be underpinned with departmental action cards agreed by each Director or Head of Department, relative to each internal structure. REAP should be both a dynamic tool based on an unplanned, unexpected event as well as a seven-day forward view taken through a formal review process on a weekly basis under the direction of the Director of Operations.

Clinical Safety Plan (CSP)

The Clinical Safety Plan provides a framework that ensures a consistent application of actions required to maintain clinical safety during periods when demand exceeds available resource.

Business Continuity Plan

The focus of any business continuity response will be to minimise the disruption to services, maintain prioritsed activities, patient safety and quality of care, whilst implementing effective recovery solutions.

Directorate / service area business continuity plans form part of a local escalatory process in managing a disruption, augmenting standard operating procedures utilised on a daily or frequent basis. Normal processes for dealing with business continuity issues should be followed in the first instance.

SECTION 3

Incident Response Plan Activation

Significant Incident

Definition

NIAS defines a Significant Incident as;

An incident which from initial information and / or intelligence indicates it may require an attendance of several ambulance resources or a specialist / dedicated response along with a management / command presence.

For example:

- Single location incidents with more than 6 patients
- Public order incident
- Marine / Waterways / Railway incidents

These examples are not exhaustive, other types of incidents may meet the definition of a Significant Incident.

If an incident develops and continues to escalate in its nature and type a **Significant Incident** can be upgraded to a **Major Incident** and the arrangements for a Major Incident will be followed.

Declaration

Any operational NIAS member of staff may declare a significant incident, including staff in the Emergency Operations Centre, if sufficient information and intelligence is available to suggest that the definition is met. An ETHANE message must be provided by responders at the earliest opportunity and shared with other responders and agencies through the EOC.

Standard Messaging for Significant Incidents

To ensure clear understanding communications relating to a significant incident will be as follows:

Significant Incident declared

Significant Incident stand down

Response

Pre-determined Attendance (PDA) for a Significant Incident

The purpose of the PDA is to ensure appropriate resources are mobilised at the initial stages of an incident. Further resources can be mobilised on the basis of additional information. The EOC Commander should dynamically assess the appropriateness / feasibility of the PDA using the Joint Decision Model and record any variation from the PDA in the incident log.

Significant incident Pre-determined attendance (PDA)

MOBILISE	CONSIDER
3 x Double Crewed Ambulance	HEMS
2 x RRV	Advanced Paramedic(s)
2 x Operational Commanders	ICS / PCS
HART Incident Response Unit	NILO
	Mobile Control Vehicle
	Tactical Commander
	HART Advisor

Notification of hospitals

Normal operational processes should be followed for the notification of hospitals e.g., update from Incident Commander, crews requesting clinical standby etc.

Significant Incident Stand down

Any operational member of staff may stand down a significant incident, including staff in the Emergency Operations Centre if sufficient information and/or intelligence is available to suggest that the incident no longer meets the significant incident definition, or the incident has been resolved.

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Major Incident

Definition

In keeping with the JESIP definition of a Major Incident, NIAS defines a Major Incident as;

An incident which due to its scale or complexity presents a serious threat to the health of the community, requiring an extra-ordinary response by NIAS and special arrangements to be implemented across Health and Social Care.

Standard Messaging in Major Incidents

To ensure clear communication using plain English, in keeping with JESIP principals, NIAS messaging relating to major incidents will be as follows:

Major Incident – Standby
Major Incident – Declared
Major Incident – Scene Clear
Major Incident – Stand Down

Major Incident - Standby

This was previously known as **Potential Major Incident**. The terminology has been changed to reflect terminology used across the UK.

It is acknowledged that in the early stages of an incident there may not be sufficient information or intelligence to meet the major incident definition. Whilst it is more likely for a Major Incident Standby to be identified by the EOC, it is possible that NIAS responders may consider this an option as they begin to gather more intelligence from the scene.

A Major Incident Standby will alert the wider HSC and other blue light partners that a major incident **may** need to be declared.

Major incident Standby is likely to involve the participating HSC organisations in making preparatory arrangements appropriate to the incident, whether it is a 'big bang', a 'rising tide' or a pre-planned event.

As soon as reports indicate that a major incident ***may*** have occurred, the Incident Response Plan may be initiated through a 'Major Incident Standby' message cascade as detailed within the EOC Commander action card.

NIAS resources should be identified and 'held' awaiting further information. The EOC will effectively activate the Incident Response Plan and processes required to prepare the service for a Major Incident - Declared response.

The NIAS Clinical Hub Manager will support the EOC Commander with the implementation process and will continue to manage the call stack to allow allocation of NIAS resources to the incident response (See appendix I)

NIAS will inform receiving HSC Trusts / Hospitals of the NIAS plan activation, any subsequent decisions the HSC Trust/ Hospitals make in relation to their major incident declaration lies with them.

Remember, it is easier to 'stand down' from a major incident standby than it is to escalate when it is too late - it is better to bring the plan into operation early, rather than to delay.

Response STANDBY

Pre-determined attendance (PDA) – Major Incident -Standby

The purpose of the PDA is to ensure appropriate resources are mobilised at the initial stages of an incident. Further resources can be mobilised on the basis of additional information. The EOC Commander should dynamically assess the appropriateness / feasibility of the PDA using the Joint Decision Model and record any variation from the PDA in the incident log.

MOBILISE	CONSIDER
5 x Double Crewed Ambulance	Incident Support Units (MCV/EEV)
3 x RRV	HALOs to receiving hospitals
3 ICS / PCS vehicles	HEMS
3 x Operational Commanders	Advanced Paramedic Practitioner
HART Incident Response Unit	Specialist Response, CBRN/MTA
HART Advisor	**NOTIFY**
	Strategic Commander notification
	Tactical Commander notification
	Relevant hospitals
	NILO

Major Incident - Declared

Any operational member of NIAS staff may declare a Major Incident, including staff in Emergency Ambulance Control, if sufficient information and/or intelligence is available to suggest that the definition is met.

A M/ETHANE message must be provided at the earliest opportunity and shared with other responders and agencies.

When a major incident is declared, the EOC Commander will ensure that the words **'Major Incident - Declared'** are contained in all initial mobilisation messages.

Response DECLARED

Pre-determined attendance (PDA) – Major Incident - Declared

The purpose of the PDA is to ensure appropriate resources are mobilised at the initial stages of an incident. Further resources can be mobilised on the basis of additional information. The EOC Commander should dynamically assess the appropriateness / feasibility of the PDA using the Joint Decision Model and record any variation from the PDA in the incident log.

MOBILISE	CONSIDER
7 x Double Crewed Ambulance	Specialist Response, CBRN/MTA
5 x Operational Commanders	
5 x RRV	
3 ICS / PCS vehicles	**NOTIFY**
HART Incident Response Unit	Strategic Commander
HEMS	Tactical Commander
Advanced Paramedic Practitioner	Loggist – where available
HALOs to receiving hospitals	Relevant hospitals
Incident Support Vehicles (EEV/MCV)	NILO
HART Advisor	

Notification of hospitals

Major Incident Checklist processes should be followed for the notification of hospitals e.g., M/ETHANE message, number and priority of patients.

Major Incident – Scene clear

The phrase 'Major Incident – Scene Clear' is used to inform the NIAS command team and all receiving hospitals that all live casualties have been removed from the site. Major Incident scene clear should also be communicated to relevant partner agencies.

Where possible, the Ambulance Incident Commander will make it clear whether any casualties are still en-route to hospital.

It should be noted that the major incident status can endure for a period of time after the scene is clear of casualties. NIAS Command and Control structures may remain in place to support the wider management of the incident.

While ambulance services will notify the receiving hospital(s) that the scene is clear of live casualties, it is the responsibility of each HSC organisation to assess when it is appropriate for them to stand down.

Major Incident Stand Down

If a major incident declaration or standby message has been initiated, it can only be stood down on the authorisation of the Ambulance Incident Commander/EOC Commander If sufficient information and intelligence is available to suggest that the definition is no longer met.

It should be noted that NIAS may stand down from Major Incident Standby or Major Incident Declared while continuing to respond to the incident.

If an incident does not meet the definition of a **Major Incident** but rather that of a **Significant Incident,** then arrangements for a Significant Incident will be followed.

Partner agencies and receiving hospitals must be notified of Major Incident stand down.

Major Incident declared by another agency

When an external agency informs NIAS that they have declared a major incident (or Major Incident - Standby), the EOC will ensure that the NIAS Strategic Commander and 'the Tactical Commander / Senior On Call') is informed. An appropriate response should be made to the incident based on the information and intelligence available and what impact it may have on NIAS. Where deemed appropriate, partner organisations (e.g., Public Health Agency, HSC Trusts) should be informed to allow them to assess the impact on their own organisation. It must be noted that a major incident for another agency may not necessarily be a major incident for NIAS; however, NIAS does have a responsibility to support other responders as outlined in the NICCF (Revised 2023).

Mass Casualty Incident

Definition

A Mass Casualty incident is an incident (or series of incidents) causing casualties on a scale that is beyond the normal resources of the emergency and healthcare services' ability to manage.[4]

A Mass Casualty Incident is defined as one which;

> **May involve hundreds or thousands of casualties, with a range of injuries, the response to which will be beyond the capacity of normal major incident procedures and requires further measures to appropriately deal with the casualty numbers.**

Declaration

Where information and/or intelligence indicates that a Major Incident has escalated to a Mass Casualty Incident the Ambulance Incident Commander should declare a Mass Casualty Incident, and the necessary METHANE message passed.

When a mass casualty incident is declared, the EOC Commander will ensure that the words **'Mass Casualty Incident - Declared'** are contained in all initial mobilisation messages.

If a Mass Casualty Incident is declared, the EOC must inform ALL Northern Ireland Emergency Departments of the declaration.

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[4] NHS England EPRR Concept of Operations for managing Mass Casualties

Standard Messaging in Mass Casualty Incidents

Mass Casualty Incident messaging will mirror Major Incident messaging.

Major Incident – Standby

Major Incident – Declared

Mass Casualty Incident – Declared

Mass Casualty Incident – Scene clear

Mass Casualty Incident – Stand Down

Response DECLARED

Pre-determined attendance (PDA) – Mass Casualty Incident - Declared

The purpose of the PDA is to ensure appropriate resources are mobilised at the initial stages of an incident. The EOC Commander should dynamically assess the appropriateness / feasibility of the PDA using the Joint Decision Model and record any variation from the PDA in the incident log.

MOBILISE	CONSIDER
Maximise A/E vehicle response	Specialist Response, CBRN/MTA
Available Operational Commanders	Mutual Aid
Available RRV	
ICS / PCS vehicles	**NOTIFY**
HART Incident Response Unit	Tactical Commander
HEMS	Strategic Commander
Advanced Paramedic Practitioners	Loggist – where available
HALOs to receiving hospitals	All hospitals
Incident Support Vehicles (EEV/MCV)	NILO
HART Advisor	

Mass casualty distribution plans

The Northern Ireland Mass Casualty Distribution Plan, developed in conjunction with the Public Health Agency (PHA), the Regional Trauma Network, and the other Health and Social Care Trusts will help to inform NIAS commanders and Medical Advisors on the most suitable route and location for the distribution of casualties from a **mass casualty** incident.

The plan details the numbers of P1and P2 casualties which may be received by Northern Ireland acute hospitals in the first two to three hours following the declaration of a mass casualty incident.. In

addition to casualty reception numbers, the document also details the clinical specialities of each receiving hospital.

Mass Casualty Scene Clear

Notification of scene clear will mirror that of a Major Incident The phrase 'Mass Casualty – Scene Clear' is used to inform the NIAS command team and all receiving hospitals that all live casualties have been removed from the site. Mass Casualty scene clear should also be communicated to relevant partner agencies.

It should be noted that the declared mass casualty incident status can endure for a period of time after the scene is clear of casualties. NIAS Command and Control structures may remain in place to support the wider management of the incident.

While ambulance services will notify the receiving hospital(s) that the scene is clear of live casualties, it is the responsibility of each HSC organisation to assess when it is appropriate for them to stand down.

Mass Casualty Stand Down

Stand down will mirror that of a Major Incident i.e. if a Mass Casualty Incident Declared has been initiated, it can only be stood down on the authorisation of the Ambulance Strategic Commander following liaison with other agencies, if sufficient information and intelligence is available to suggest that the definition is no longer met. Partner agencies and receiving hospitals must be notified of Mass Casualty stand down.

Structured Approach to Incident Management

The first responders to significant, major or mass casualty incidents will be put under considerable pressure, so it is important that staff remain focused and follow structured procedures.

It is important to stress that incident management, while structured, should remain flexible to enable Commanders to adapt and develop responses in an uncertain and complex environment.

Principles of Incident Management

The MIMMS© principles of incident management, described in the NARU Command and Control Guidance (2024) are:

- **C**ommand and control
- **S**afety
- **C**ommunication
- **A**ssessment
- **T**riage
- **T**reatment
- **T**ransport

These key principles provide Commanders with a structured approach for dealing with any incident. Actions can be taken concurrently rather than chronologically.

CSCATTT

Staff should use the 'CSCATTT' mnemonic to remind them of the structured approach to incident management (Appendix A).

Northern Ireland Ambulance Service
Health and Social Care Trust

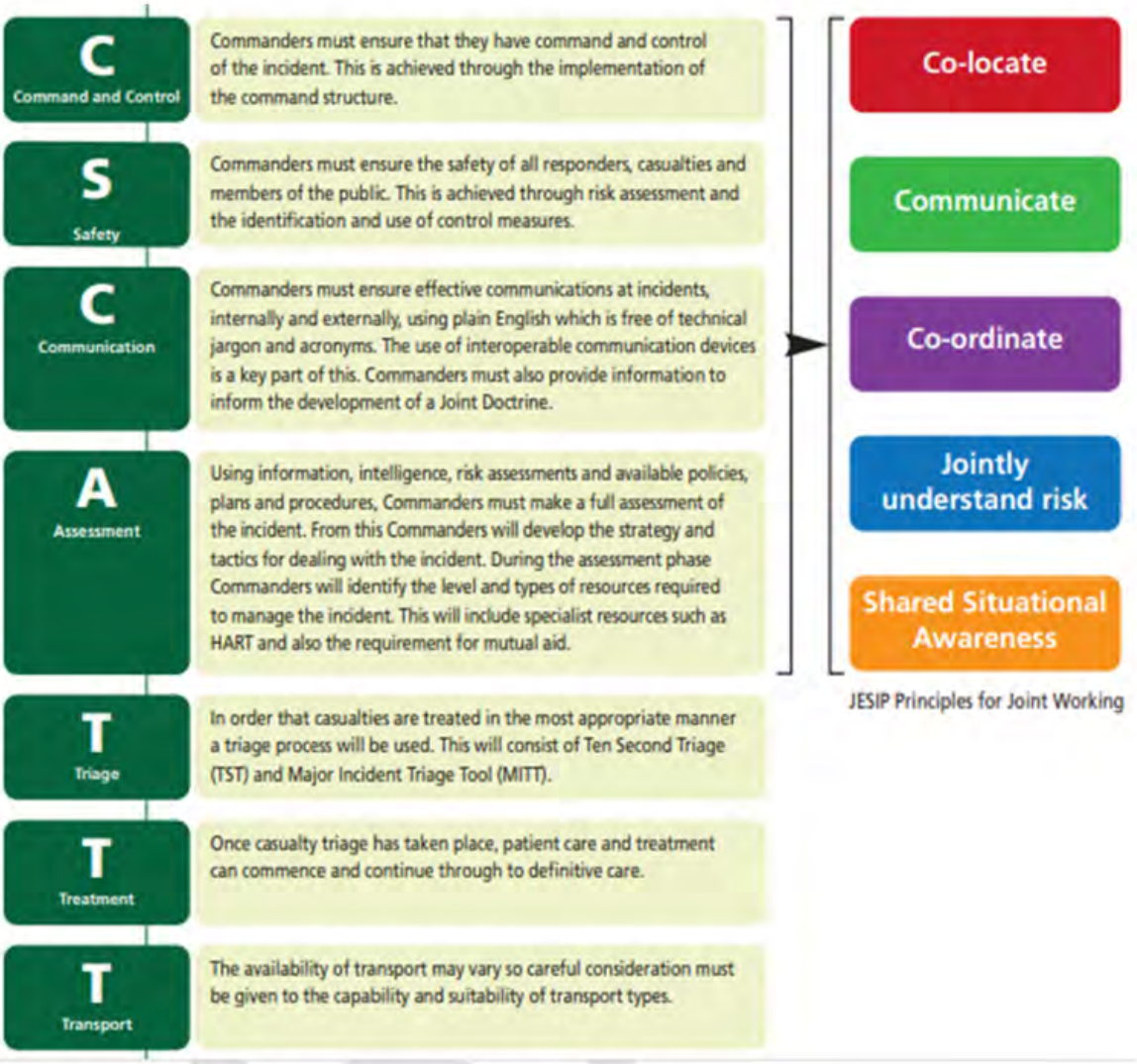


Figure 4: CSCATT Mnemonic

First resource on scene

Windscreen report

The first resources at scene should provide an initial "windscreen report" to the EOC before leaving the vehicle, **DESCRIBING EXACTLY WHAT YOU CAN SEE.**

The windscreen report should be followed up with a M/ETHANE message to the EOC as soon as possible. This information will support shared situational awareness and assist the EOC and Commanders in coordinating an effective response.

Acting Incident Commander

The attending crew member from the first resource on scene will follow the First Resource on Scene Action Card and assume the role of **Acting Incident Commander** until relieved by an appropriate ambulance commander.'

The Acting Incident Commander should not become involved in treating patients but concentrate on establishing initial command and control of the incident.

At the earliest opportunity the Acting Incident Commander should co-locate with commanders from other responding organisations and prepare a brief for the Ambulance incident Commander

First resource on scene – Driver

The driver from the first resource on scene if a double crewed ambulance (DCA) will establish a communication link between the Acting Incident Commander and the EOC and maintain communications.

The driver will stay with their vehicle, **keep their vehicle blue lights flashing** and be the initial point of contact for further resources attending the incident.

The first crew on scene should not attempt to rescue or treat casualties until relieved of their initial "First on Scene" roles by an Ambulance Commander

Shared Situational Awareness

Shared situational awareness is a common understanding of the circumstances, immediate consequences, and implications of an emergency, along with an appreciation of the available capabilities and the priorities of the emergency services and responder agencies.

Achieving shared situational awareness is essential for effective interoperability. Establishing shared situational awareness is important for a common understanding at all levels of command, between incident commanders and control rooms.

M/ETHANE

Following from the early 'windscreen report', the first crew on scene at any of the Incidents covered in this plan should provide a M/ETHANE report to the EOC at the earliest opportunity. To ensure shared situational awareness and understanding it is important that the EOC share the information with responding NIAS resources and relevant partner agencies at the earliest opportunity.

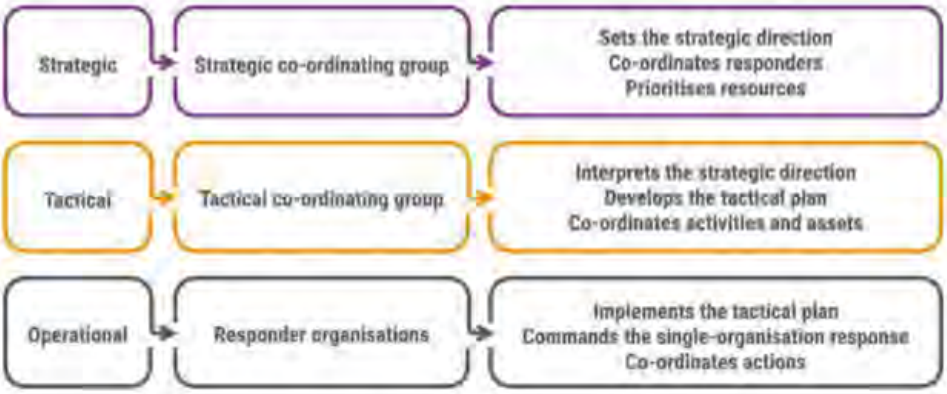
Sharing of M/ETHANE

Any METHANE message received must be shared by the EOC with responders and partner agencies:

Continual assessment of the scene should be carried out to ensure that ever changing challenges and priorities are identified. The METHANE message should be regularly updated and communicated to EOC.

NIAS Command and Control Arrangements

NIAS employs a 3-tier command system comprising of Strategic (Gold), Tactical (Silver), and Operational Commanders (Bronze). This is a hierarchical system whereby individuals are empowered through their role within the structure, providing with them with specific authority for the duration of the incident or event.



When a command structure is activated to manage an incident, the day-to-day rank or title of the individual changes to that person's role within the incident [5]

If an individual is suitably qualified, experienced and empowered by the Trust to undertake the role, then there is no reason for them to be replaced by a more senior officer / manager.

The nature of the incident will determine whether all levels of command are required.

Most significant or major incidents will require a multi-agency approach to command and control.

REMEMBER THE COMMANDER ROLE HAS AUTHORITY

Command roles must be fulfilled by competent and credible personnel; that have been trained and exercised to discharge these functions to a suitable standard

Command decisions have the greatest impact on the performance at the scene of major and complex incidents. These decisions also directly affect clinical outcomes, survivability, and staff safety.

[5] NARU Command and Control Guidance Version 5.0 2024

Command Roles

When responding to an incident there is a pre-identified chain of command with associated command roles and supporting structures.

Command roles are clearly identifiable and individuals fulfilling them are responsible for co-ordinating activity at that level of command.

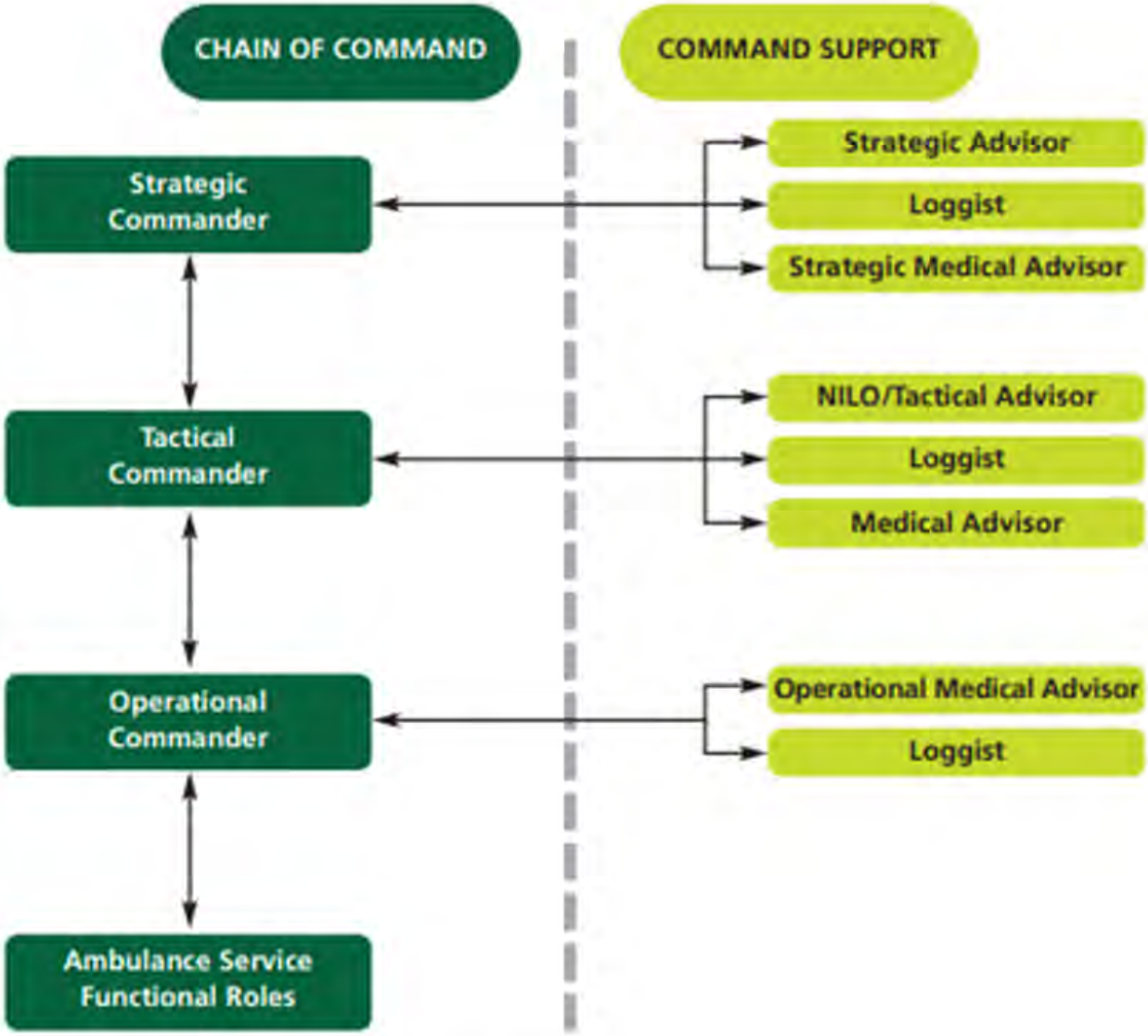


Figure 5: The Chain of command and supporting structures.

NIAS Command Support roles will be filled where possible.

Command Structure Discipline

In the event of Significant, Major or Mass Casualty Incident (Standby or Declared) messages being given, experience has shown that managers not directly involved in the initial response will offer their services via the EOC.

Though there are benefits to this, it is essential that the Trust follows the identified Incident Response Plan and the set Command and Control procedures in the initial stages.

In addition, managers not directly involved in the initial response may contribute to the longer-term management of the incident through relieving those managers who may have formed the initial response to the incident or by coordinating the securing of additional staff. These managers may also be utilised as part of the longer-term recovery phases. The Tactical Commander in consultation with the Strategic Commander should consider the appropriate use of these resources and skills.

It is critical that managers do not self-deploy and become involved in the response phase without the direction of the EOC, Strategic or Tactical Commander

Span of Control

Span of control refers to the number of communication lines or direct reports an individual is expected to manage. Five reporting lines are commonly recognised to be the optimum number for one person. It is possible however that given consideration to the environment, type of incident and the level of resource, a Commander could manage up to seven lines, although due to the same factors this may be as low as two or three due to the nature, scale and complexity of the incident [6]

[6] *NARU Command and Control Guidance, Version 5.0 page 25*

Strategic Commander

NARU Action Card 18.0 outlines the Strategic Commander's key responsibilities.

The action card must be used during the management of an incident.

Personnel discharging the Strategic Commander role must be capable of directly representing the interests of the Trust Board. They must be capable of committing the Trust to a course of action without the need for further authority during an emergency situation (i.e., without making a phone call). Whilst this role and function may be supported by several people, the Strategic Commander must be a single individual that is easily identifiable as the person with overall Executive responsibility for the organisation at any point in time.

The Strategic Commander has overall responsibility for the command, response and recovery for any major incident for their organisation. They will take strategic command of the Trust during a Major Incident and will ensure that service policy is adhered to. Decisions at this level will be communicated to senior officers from other emergency services and communicated via the command structure for implementation by the Ambulance Tactical Commander. The Strategic Commander must consider the normal workload of the Trust and the recovery phase of the incident and if necessary, invoke a business continuity group. The Strategic Commander will develop a communication strategy to inform other HSC partners. They will invoke the request for mutual aid as required, and will have oversight of the arrangements for receiving VIPs, Ministers, MLAs etc.

The Strategic Commander will set the Trust's strategic aims for the incident - i.e. develop a Strategic Plan. This provides a framework for the Tactical Commander(s) to work within. Trust Directors may wish to offer support in the development of an overall strategy but the responsibility for this continues to rest with the Strategic Commander.

The Strategic Commander is required to communicate the NIAS strategy to the Tactical Commander and ensure that it is effectively converted into a functional and achievable Tactical Plan. Regular dialogue between the Strategic and Tactical Commanders is necessary to ensure that the tactics being employed remain effective in the management of the incident. If the dynamics of the incident have resulted in the formulation of a tactical plan before the Strategic Commander is in place, then this plan should be reviewed in line with the emerging strategy. The frequency of communication between the Strategic and Tactical Commanders will be determined by the type of incident, the complexity of the

situation or resource requirements, the need for support to be sourced from external partners (in line with overall strategy) and the stage of the response in terms of time elapsed.

To ensure multi-agency communication and coordination during a major incident or event, the Strategic Commander may consider attending and effecting command from the multi-agency Strategic Coordinating Group (SCG), if formed. However, where an incident only affects the health service and no SCG is sitting then the Strategic Commander may decide to manage the incident from a Trust location such as the Emergency Operations Centre (EOC). The Strategic Commander must set out in their incident decision log the rationale on where to be based during an incident.

It should be remembered that although the Police Strategic Commander will generally lead on coordination of an incident during the response phase, a Strategic Commander from any organisation may request that an SCG is established. The Chair of the SCG is likely to be a senior Police Officer but this may vary by Emergency Preparedness Group (EPG) and type of incident and may even change by rotation for protracted incidents.

For incidents such as severe weather or wide area flooding when more than one SCG may have been established, then additional Commanders who are suitably trained can be called to attend as a liaison between the NIAS Strategic Commander and an SCG. Command resilience will always be a consideration should incidents become protracted, and rotas of all command levels will be drawn up to ensure that cover is maintained and to augment the formal on call rota.

The Strategic Commander should consider the arrangements contained with the Resource Escalation Action Plan (REAP), Clinical Safety Plan (CSP) and internal departmental Business Continuity arrangements.

It is vital that the Strategic Commander maintains discipline in the chain of command and does not attempt to contact those not directly under their command or outside the span of control unless a sound rationale or necessity exists. Such actions should be logged with a detailed description of the background to this decision.

The Strategic Commander should be able to contact the following as key communications lines or partners in order to effect command;

- Strategic level representatives of multi-agency partners e.g., HMCG, Police, Fire and Rescue Service, Military, Health, regional and local government
- NIAS Tactical Commander
- NIAS Emergency Operations Centre
- NIAS Directors
- NIAS Communications On Call
- NIAS Loggist
- NIAS Strategic Medical Advisor
- National Ambulance Resilience Unit (NARU) on call officer
- Scientific & Technical Advisory Cell

Whilst it is not the responsibility of the Strategic Commander to make tactical decisions, they have responsibility for ensuring the tactics which are being employed are effective.

THERE WILL BE ONE NIAS STRATEGIC COMMANDER

NIAS Strategic Command structure:

Strategic Group option for Gold / Strategic Commander

The strategic group can be made up with representatives from across the Trust departments and directorates. Their role is to provide the Strategic Commander with information, support and advice to ensure their respective departments continue to function or to assist with staff redeployment to support other essential areas of the organisation. They should support the recovery phase following the incident and assist with the planning for protracted incidents to ensure resilience for critical functions. Legal Services support and guidance should be engaged early pending any public enquiry which is likely to follow an incident. The Strategic Commander should have an appropriately trained Loggist assigned to them as soon as possible.

Strategic Medical Advisor (SMA)

The SMA is not a command role but purely an advisory role. The role of the SMA is principally the responsibility to monitor overall hospital capacity and ensure the tactical level has access to the clinical resources it requires, particularly if national mutual aid is required from other sectors of the HSC. The Strategic Medical Advisor role will be taken up by a senior member of the NIAS Medical directorate, where available. The SMA is responsible for authorising the invocation of the P4 (Expectant) category in liaison with the Medical Advisor. The SMA will be located alongside the Strategic Commander if deployed.

Specialist Advisory Roles

Specialist Advisors may provide command support to all levels of command during an incident, including Business Continuity incidents. An advisor is not a commander or a decision maker. The responsibility for the decisions and course of action taken rests with the relevant commander. However, the advisor is a subject matter expert (NILO/HART/MTA/CBRN) who is both responsible and liable for the advice they provide.

Tactical Commander

NARU Action Card 16.0 outlines the Tactical Commander key responsibilities.

The action card must be used during the management of an incident.

Tactical Commander

The Tactical Commander is responsible for coordinating and directing the work of the Trust during a Significant, Major or Mass Casualty Incident and should be located at an appropriate site away from the scene where they can achieve situational awareness, effect command and direct the overall management of the incident(s). The Tactical Commander should ensure a suitable Incident Commander (Operational/On-Scene) is assigned to each incident. The Incident Commander will be directly accountable to the Tactical Commander managing the scene. The Tactical Commander will be responsible for representing the Trust on any Tactical Co-ordinating Group (TCG) meetings. The Tactical Commander must set out in their incident decision log the rationale on where to be based during an incident.

Due to the dynamics of a major incident the Tactical Commander may develop and put in place a tactical plan before the Strategic aims have been set out. Where this is the case, the tactical plan should be reviewed against the Strategic aims once they become available. The tactical plan provides a framework for the Incident Commander to operate within. The Tactical Commander supports the Incident Commander to achieve their objectives and to manage the incident effectively. The Tactical Commander should not get involved in the direct operational management of the incident.

There may be incidents where it is appropriate for the NIAS Tactical Commander to co-locate alongside other emergency service's Tactical Commanders, to ensure a multi-agency approach to the management of the incident.

In order to assist in the decision-making process or tactical plan development, the Tactical Commander may request the assistance of a NILO to provide advice with regards to those options and specialist resources that may be available and appropriate to the management of the incident.

The key communication lines and partnerships for the Tactical Commander are:

- Tactical level representatives of multi-agency partners e.g., Police, Fire and Rescue, HMCG
- Military, Health, national and local government
- NIAS Strategic Commander

- NIAS NILO
- NIAS Incident Commander
- NIAS Medical Advisor
- NIAS Emergency Operations Centre
- NIAS Communications On-Call
- NIAS Loggist
- NIAS Non-Emergency Ambulance Operations Centre

THERE SHOULD ONLY BE ONE NIAS TACTICAL COMMANDER PER INCIDENT

NIAS Tactical Command Structure:

National Inter Agency Liaison Officer

A NILO may advise the Tactical Commander on specialist personnel or equipment that could assist in the management of a Significant, Major or Mass Casualty incident and provide advice and support on matters relating to emergency planning and HSC requirements. They are also available to offer advice on partner agency capabilities.

Medical Advisor

At the tactical level, the Medical Advisor (where available), will work alongside the Tactical Commander to aid in the distribution of casualties to appropriate medical facilities. Both the Tactical Commander and the Medical Advisor may be located at the TCG alongside the other Tactical Commanders from the other agencies involved.

Ambulance Loggist

NIAS has a number of Logistics across the Trust who are able to maintain accurate incident management logbooks and records in accordance with legal standards and best practice. Located alongside either the Strategic or Tactical Commander when requested, the Loggist will record information, decisions, the Commander's rationale and actions taken during the incident.

Incident Commander (Operational/On Scene)

NARU action card 4.0 outlines the Incident Commander's key responsibilities.

The action card must be used during the management of an incident.

The NIAS Incident Commander has responsibility for the activities undertaken at the scene. As such they will be co-located with the on scene commanders from other responding agencies at a Forward Command Point. The Incident Commander must ensure regular multi-agency face to face briefings take place to aid prompt resolution to any challenges as they arise.

When NIAS Tactical Command has been established the Incident Commander is responsible for ensuring that the objectives set by the Tactical Commander are carried out. They must understand the requirements of the Tactical Plan and the overarching objectives contained within it. They must understand and be able to discharge their responsibilities in line with the Tactical Plan and problem solve within the parameters of the Plan. As the Incident Commander they will provide leadership and management to the operational staff in attendance, other NIAS functional role officers and any other direct reports.

To achieve this the Incident Commander will need to nominate a number of different operational/functional roles; these are traditionally officer roles but can be performed by other appropriate NIAS personnel. Before assigning these roles, the Incident Commander must consider the relevant skills and experience of personnel. During a Significant Incident or the initial stages of a Major or Mass Casualty Incident, the Incident Commander will be responsible for implementing the actions of a number of functional roles including, Sector Commander and Casualty Clearing until those posts have been filled by other appropriate NIAS personnel.

The key communication lines and partnerships for the Incident Commander are:

- Operational Commanders from multi-agency partners e.g., HMCG, Police, Fire and Rescue
- (Tactical), Military, local authorities
- NIAS Tactical Commander
- NIAS Casualty Clearing Officer

- NIAS Casualty Clearing Station Medical Lead
- NIAS Primary Triage Officer
- NIAS Secondary Triage Officer
- NIAS Parking Officer
- NIAS Loading Officer
- NIAS Safety Officer
- HART Advisor
- NIAS Decontamination Officer
- NIAS Equipment Officer
- Forward Doctor
- Health, wellbeing and peer support team and Welfare Team

For complex incidents (e.g., rail crash) or multi-sited incidents (e.g., terrorist attack) the incident may be divided into sectors. This will require a separate Commander for each sector. These Commanders, would report to the Incident Commander managing the incident scene.

Decision Making and Logging

Commanders are personally responsible and accountable for the recording of all decisions that they make in relation to an incident in their incident decision log. Comprehensive logging should be made of all events, decisions, rationale, and actions taken. Logging is essential to facilitate operational debriefing, and to provide evidence for criminal investigations, public inquiries, inquests and to identify lessons for the future. If possible, Incident Commanders should identify someone in the early stages of an incident to assist in the logging of their decisions and actions until a loggist arrives at scene.

NIAS Operational Command Structure

The Operational Command Structure is designed as a scalable and flexible response to enable the appropriate provision of command support to any incident. Using the CSCATTT model ensures that all functions are carried out across the incident and can be implemented by one Incident Commander. It complements the initial actions of the 1st, 2nd, and 3rd Ambulance staff to arrive on scene.

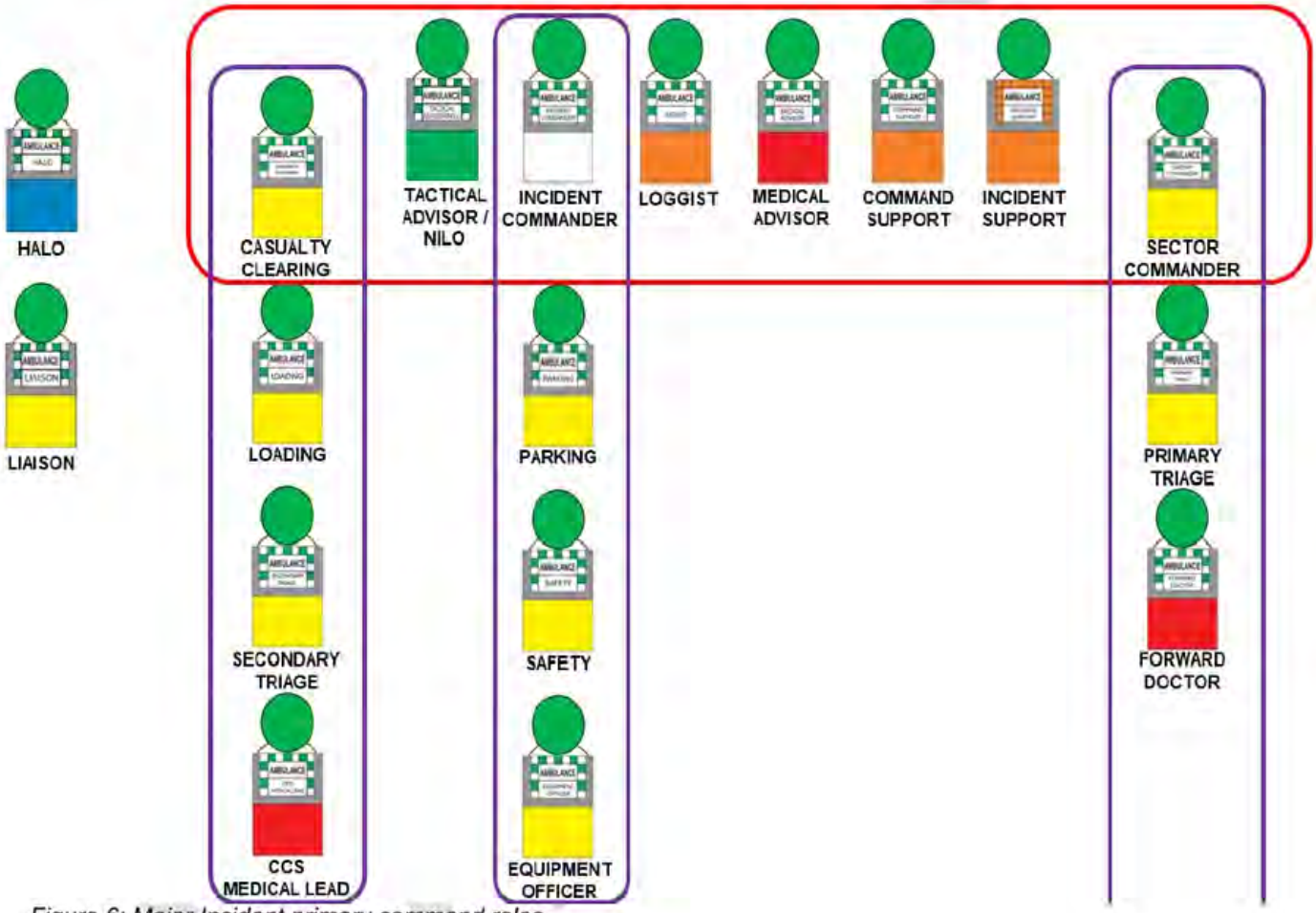


Figure 6: Major Incident primary command roles

Functional Roles

individual functional roles are undertaken to support the response to an incident. Although they may not always be required, they should be considered by the Incident Commander to support the Tactical Commanders objectives. The roles listed below give a very brief overview of their objectives, should a member of staff be given a role to undertake during a major incident they must follow the relevant action card for that role. In order to ensure that appropriate roles are easily identifiable to NIAS staff and commanders from other services arriving at the scene of an incident, NIAS utilise Incident Command tabards. The wearing of tabards should be considered for any incident where it is necessary for the commander and other relevant command roles to be identifiable.

Additional information on each role can be found in the NARU National Ambulance Command and Control Guidance V 5 (2024).

N.B It should be noted that depending on resources / type of incident, not all of the following roles may be allocated.

Functional Role	Description	Action Card
Sector Commander 	It may be necessary to divide an incident into different sectors. Where this is the case, each sector should have a sector commander. This will reduce the number of reporting lines into the Incident Commander ensuring the span of control is not exceeded. When deploying a sector commander to a complex incident involving the interoperable capabilities (HART / SORT) such as a collapsed structure or working at height, the sector commander must be qualified and competent in the specific capability being deployed.	5.0 Sector Commander
Safety Officer 	The officer with specific responsibility for the safety of personnel at the scene of an incident. The Ambulance Safety Officer is responsible for the health and safety of all NHS responders entering and working within the cordons of the incident. The Ambulance Safety Officer will work closely with the Incident Commander ensuring appropriate control measures are employed to mitigate against identified risks through the risk assessment process. The Safety Officer should, where possible, work alongside Safety Officers of the other agencies.	6.0 Safety Officer
Primary Triage Officer	Responsible for coordinating the initial Ten Second Triage (TST) of all casualties at the incident. The Triage Officer should work closely with the Casualty Clearing Officer. Dependent on the size of the incident, there may be a requirement to allocate an Officer for Primary	7.0 Primary Triage Officer

	and Secondary triage. The Triage Officer is responsible for maintaining a record of the number and categories of casualties triaged.	
Casualty Clearing Officer 	The Casualty Clearing Officer is an Ambulance Officer who, in liaison with the Operational (On Scene) Medical Advisor, ensures an efficient patient throughput at the Casualty Collection Point (CCP) or Casualty Clearing Station (CCS), if established. A Casualty Clearing Station (CCS) should only be considered if there is an unacceptable delay in patient transportation. Responsible for the management of the CCP/CCS, they work closely with the Triage, Parking and Loading Officers and the Casualty Clearing Medical Lead to ensure an efficient triage and treatment of all casualties, and the appropriate use of available transport resources. The Casualty Clearing Officer is responsible for keeping a log of the number and categories of casualties who pass through the CCS.	8.0 Casualty Clearing Officer
Secondary Triage Officer 	Responsible for coordinating the secondary triage using NHS Major Incident Triage Tool (MITT) of all casualties within the CCS. The Triage Officer should work closely with the Casualty Clearing Officer and Operational Medical Advisor. The Secondary Triage Officer is responsible for maintaining a record of the number and categories of casualties triaged and	9.0 Secondary Triage Officer

	the regular re-triage of casualties (at least every 15 minutes).	
Parking Officer 	The Ambulance Parking Officer is responsible for the facilitation of a clear and functional parking area. They will ensure vehicles and crews are logged into the area and will, at the request of the Casualty Clearing Officer, move appropriate resources to the Casualty Collection Point (CCP) or Casualty Clearing Station (CCS), if established, to effect the transportation of casualties.	10.0 Parking Officer
Casualty Loading Officer 	The Casualty Loading Officer is responsible for the management of vehicles and the controlled onward transportation of casualties from the Casualty Collection Point (CCP) or Casualty Clearing Station (CCS), if established. The Casualty Loading Officer works very closely with the Casualty Clearing Officer to ensure that casualties who require transportation from the CCS are accommodated. The Casualty Loading Officer is responsible for keeping a log of the number and destinations of casualties transported from the CCS.	11.0 Casualty Loading Officer
Equipment Officer 	The Equipment Officer will ensure the supply and re-supply of equipment to all responding NHS resources.	12.0 Equipment Officer

Hospital Ambulance Liaison Officer (HALO) 	The Hospital Ambulance Liaison Officer will liaise with hospital medical and nursing staff regarding arrangements for reception/discharge of casualties and the availability of beds for casualties and ensure that this information is made available to the Ambulance Incident Commander, and Police documentation team, if deployed. The HALO assists at A&E Departments to maintain efficient ambulance turnaround and re-equipping of ambulances. They will also liaise with the police documentation teams. An important role is to arrange relief for members of staff suffering from fatigue or stress on arrival at the hospital. The Hospital Ambulance Liaison Officer (HALO) will liaise with the hospital Management Team to ensure it is aware of the hospital's capability to receive casualties and relay information back to the Emergency Operations Centre. This officer's job is to also keep EOC updated with the current status of the hospital's Resus Bays, Theatres and ITU.	14.0 Hospital Ambulance Liaison Officer
Tactical Advisor / NILO 	The Tactical Advisor will utilise their depth of knowledge regarding Trust incident response plan; other relevant doctrine, policies and procedures; working knowledge of local partner agencies capabilities; Trust specialist and non-specialist capabilities and the associated risks and benefits of deploying/utilising such capabilities to provide concise advice to Commanders. The Tactical Advisor is not a	17.0 National Interagency Liaison Officer / Tactical Advisor

	Commander or decision maker with responsibility for decisions resting with the relevant Commander. However, the Tactical Advisor is both responsible and liable for the advice they provide. A National Interagency Liaison Officer (NILO) should have a similar skill set to the Tactical Advisor and have undertaken additional nationally recognised training to liaise with other agencies. The NILO can provide advice and support to various levels of the Ambulance Command structure on how to work effectively with other agencies and help other agencies to interface effectively with the NHS aims and objectives.	
Loggist 	Responsible for capturing key information and decision making made by the ambulance command team during an incident.	Command Support 1.0 Loggist
Press (Media Liaison) Officer 	All incidents have the ability to attract media interest. The Media Liaison Officer will develop and coordinate the release of Ambulance Service media statements. This will often be achieved in a multi-agency setting; however, it should always be done in line with the Ambulance Service Strategy.	Command Support 4.0 Ambulance Strategic Media Command Support 5.0 Ambulance Press Officer

Operational (On Scene) Medical Advisor 	Responsible for providing the Incident Commander with medical advice. The Medical Advisor will oversee and coordinate the advanced clinical practitioners which will include forward clinical teams and clinical teams within the Casualty Collection Point (CCP) and the Casualty Clearing Station (CCS), if established.	Medical 2.0 Medical Advisor
Forward Doctor 	Responsible for ensuring the most appropriate medical management of casualties is undertaken within the area they are designated to (may include CCP, CCS or incident ground). Working closely with the Medical Advisor and Incident Commander and ensuring appropriate records are maintained for casualties.	Medical 3.0 Forward Doctor
Casualty Clearing Station Medical Lead 	Responsible for coordinating, supporting and advising paramedics and medical staff in the Casualty Clearing Station (CCS) to optimise the clinical care of all casualties attending the CCS and appropriate onward journeys to suitable receiving hospitals.	Medical 4.0 Casualty Clearing Station Medical Lead
Decontamination Officer	Where casualties require decontamination, a Decontamination Officer will be nominated to manage that facility. This will also require the appointment of a suitably trained individual to undertake the Entry Control Officer role (ECO). The Decontamination Officer role must only be	CBRN 1.0 Decontamination Officer

	discharged by staff trained and competent in the relevant discipline.	
Entry Control Officer (ECO) 	The Entry Control Officer ensures all NHS resources are logged in and out of an incident through an agreed Entry Control Point. This may be a Fire & Rescue Service Officer where local agreement is in place. The Entry Control Officer role must only be discharged by staff trained and competent in the relevant discipline.	CBRN 2.0 Decon Entry Control Officer
Command Support 	Command support may be used to describe roles (other than those specified) which can provide support to various levels of the Ambulance Command structure, with the aim of assisting Commanders to maintain command, control and coordination of incidents. This may include roles such as Communications Officer whose responsibilities would include the provision of robust communications at the scene of the incident. This may include the deployment of any mobile control units where available.	
Incident Support	Incident support may be used to describe roles (other than those specified) which can provide support to management of the incident. Incident support roles may include logistics and ensuring necessary supplies, equipment, personnel, and transportation are readily available to effectively handle the incident.	

		
Liaison Officer 	In circumstances where it is not possible for the Ambulance Tactical Commander to meet face to face with all of their Tactical counterparts, a Liaison Officer may co-locate with other agencies Tactical Commanders to represent the interests of the Ambulance Tactical Commander.	

Safety

Safety of all responding staff, partner agencies and the public must be a priority at the scene of any incident. From the time of the first 999 call to arrival at any incident consideration should always be given to 'Recognise, Assess, React, 'Remove, Remove, Remove' and 'Run, Hide, Tell' (See Appendix B/C).

Scene Safety

Scene safety is the responsibility of all responding personnel however the overall responsibility lies with the designated Incident Commander at the incident, as the Ambulance Service has overall responsibility for all healthcare personnel at scene of any incident (including any voluntary aid staff working under NIAS direction).

The Incident Commander must appoint an appropriate person who ideally has the necessary training, experience, and knowledge as the Ambulance Safety Officer, early in the Command and Control set up to ensure that health, safety and welfare of all medical personnel is observed.

The Ambulance Safety Officer should be aware of the potential hazards at scene, ensuring that appropriate equipment is available, monitoring environmental conditions, record any actions taken and ensure all personnel are wearing the appropriate PPE. Where possible, the Ambulance Safety Officer should work alongside the Safety Officers from other agencies.

All responders entering the scene of a Major Incident should be briefed using the IIMARCH briefing tool (Appendix D) either by the Incident Commander, or (if delegated) the NIAS Safety Officer. The briefing must ensure that methods of communication are checked, and emergency evacuation signals confirmed. The evacuation signal should be agreed and consistent for all responding agencies.

Dynamic Risk Assessment (DRA)/Hierarchy of Control Measures

A Dynamic Risk Assessment (DRA) is a process for assessing risk; it is a continuous throughout the process. When selecting a safe system of work utilise the control in a hierarchical order to control risks present at an incident.

A useful tool for supporting the management of risk is the 'ERICPD' mnemonic, (Appendix E) which when used in conjunction with the Dynamic Risk Assessment may help in agreeing a co-ordinated approach with a hierarchy of risk control measures. Those undertaking a DRA should ensure that its detail is logged.

E	**Eliminate** By complete removal of the hazard get rid of the hazard; replace it with something less hazardous
R	**Reduce** The level of risk by reducing the nature of the hazard e.g. use small quantities, lower voltage.
I	**Isolate** The hazard from people or the people from the hazard.
C	**Control** Exposure to the hazard by controlling who has access or use procedure/protocols limiting exposure time.
P	**PPE** Issue Personal Protective Equipment, PPE should always be seen as the last resort in order to control a hazard.
D	**Discipline** Ensuring that employees follow safe systems of work and procedures. Ensure all control measures are monitored, subject to review and enforced.

Cordons

Cordons are an effective way of controlling access and maintaining safety. During an incident, cordons may be established depending on the hazards involved. The incident is usually divided into two distinct areas, an inner cordon, and an outer cordon.

Inner Cordon

The inner cordon denotes the hazard area and controls access to the immediate scene of operations. This provides an increased measure of protection for personnel working in that area. Incidents where a higher degree of control is required, will be subject to entry control requirements overseen by the Incident Commander or Safety Officer (if in place) and must only be entered if deemed appropriate following a risk assessment and appropriate control measures being implemented. The inner cordon is usually managed by the Fire and Rescue Service.

Outer Cordon

An outer cordon may be established around the vicinity of the incident to control access to a wide area. This cordon limits access to an area being used by the emergency services and other relevant agencies, allowing them to work unhindered and in privacy.

The following are usually located outside of the inner cordon but within the outer cordon:

- Forward Command Post (FCP)

- Casualty Collection Point (CCP)
- Casualty Clearing Station
- Ambulance Loading Point
- Ambulance Parking Point
- Equipment Resupply Area

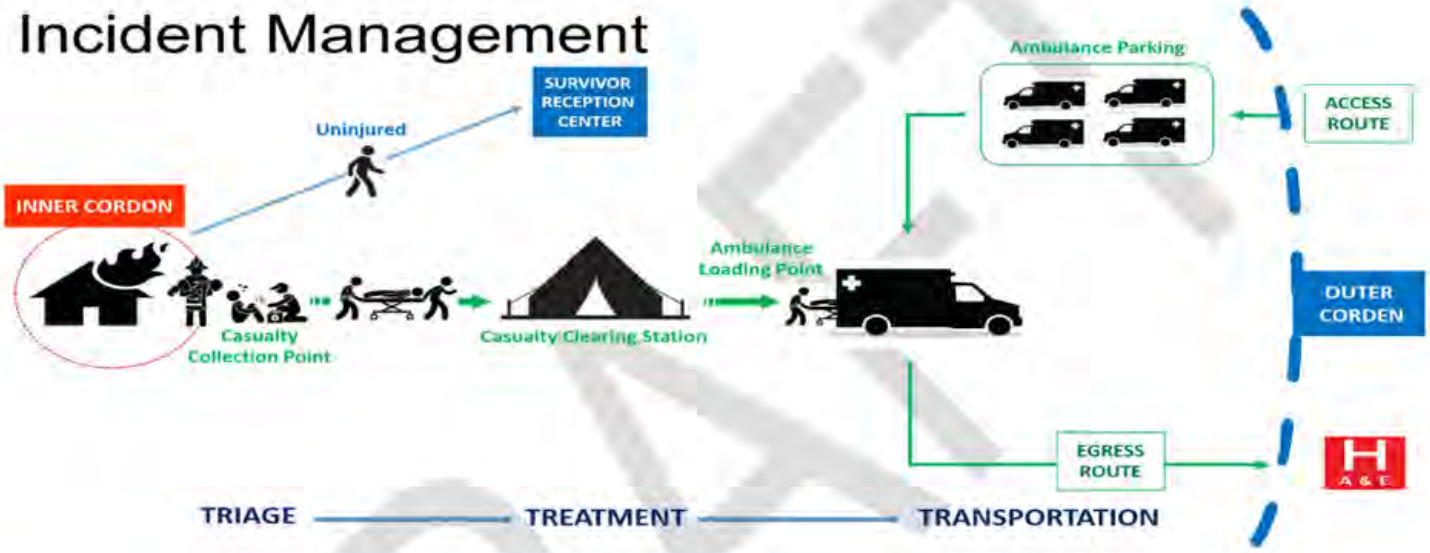


Fig Incident Management

The police will control outer cordons and may also establish traffic cordons to prevent unauthorised vehicular access. Access through the outer cordon for essential non-emergency service personnel should be by way of an access control point, members of the public not involved in the incident should not be allowed past this point, although it is recognised that in some cases prior to cordons being established, they may want to enter the scene to help those injured. The safety of these individuals should be considered by the Incident Commander or Safety Officer (if in place) in conjunction with multi agency partners.

Zoning of Incidents

At certain incident types (Hazmat/CBRN/MTA) there may be a need to establish hot, warm and cold zones. This will depend on the level of risk faced by emergency responders and the range of corresponding control measures identified and implemented. The use of these zones should be agreed by all emergency responders.

The use of the Joint Decision Model (JDM) will enable shared situational awareness and a joint understanding of risk. At certain incident types (e.g. CBRN/Hazmat or MTA) this will inform decisions regarding appropriate use and designation of zones (cold/warm/hot) and/or limits of exploitation (LoEs) as well as decisions on the use of non-specialist or specialist responders. Deployment of Ambulance responders into zones should be based upon the joint understanding of risk and an urgent need to save life.

The decision to zone an incident is dynamic and based upon type of incident including substance, attack methodology and the threat. Dependent on the type of incident, e.g. CBRN/Hazmat or MTA, definitions of zones and control measures, such as levels of PPE, may differ. Guidance and operational procedure documents for specific incident types such as CBRN/Hazmat or MTA should be referred to for definitions of zones.

It should be remembered that not all incidents may require zoning or the use of all three zones. The application of zones, including LoEs, should enable commanders to proactively deploy responders to a scene in order to minimise risk to the public whilst providing a basic structure which supports them in maximising the safety of the responders. At some incidents, e.g. MTA, if commanders do not believe that the use of zones will aid the deployment (such as in a low sophistication incident), they should not be used. Limits of Exploitation (LoEs) should also be considered in the same manner. LoEs can also be used without the use of zones.

Where initial zones have been set by the first responding agency, a full review of zones should be undertaken at the earliest opportunity. The size, location and necessity for zones should be continuously reviewed and every effort should be made to reclassify zones to accurately reflect the evolving threat and risk, particularly if zones are preventing access or contributing to delays in deployment.

Personal Protective Equipment

All personnel engaged on duties at a Significant, Major or Mass Casualty Incident must don the correct PPE for their task and location including but not limited to, protective footwear, high visibility clothing and protective helmets. The requirement for additional PPE will be informed by the Incident Commander or Safety Officer.

ANY AMBULANCE OR MEDICAL PERSONNEL, REGARDLESS OF SENIORITY, WILL ONLY BE ALLOWED TO ACCESS AN AREA TO WHICH THEY HAVE THE APPROPRIATE LEVEL OF PPE

Specific incidents (MTA/CBRN/HazMat) may require specialist PPE to be utilised. Where circumstances require personnel to deploy in specialist PPE only individuals (HART/MTA/CBRN operatives) trained in its use should employ such measures.

All staff attending the incident scene or command location must be in possession of an official NIAS identity card. **Failure to provide proof of ID may result in denial of access through the outer cordon or to an official building.**

Communication

Incident Communications (Alerting)

When a major or mass casualty incident is declared or major incident standby declared, the EOC should communicate with responders on the Major Incident talk group (once established). All responding resources should change to that talk group.

Mobile Control Vehicle

For incidents which are likely to become protracted or for some pre planned events it may be necessary or beneficial to establish a forward command point. This allows the EOC to continue to manage its core business with as little impact from the incident as possible. The forward command point will need to have the appropriate number of resources allocated to it in order to support the incident commanders in management of the incident. The DTR talk-groups used for communications will be allocated by the EOC desk dealing with the incident. It may be necessary for an Ambulance Control Officer to attend at the forward command point for the coordination of communications in support of the incident commanders. The main duties of the Ambulance Control Officer are to provide robust communications between the incident site, the EOC, ambulance/medical resources at the incident site and the other partner agencies present. The Mobile Command vehicles will normally be used to establish the forward command point.

Communication with other emergency responders

Where appropriate, dependent on the type and scale of the incident, the EOC Duty Control Manager should consider requesting a communications link is established between NIAS EOC and other responding agency (HMCG, PSNI and NIFRS) Control Rooms. This can be through the use of telephones or, via a Tetra Radio Interoperability Talk group.

Tetra capacity management in major incidents

Consideration should be given to the consolidation of talk groups and/or the use of Direct Mode Operation (DMO) as each mast has a certain number of time slots available which is related to how many simultaneous talk groups or Point-to-Point (P2P) calls can be used at single point in time.

The Point-to-Point facility can be utilised for communications on a one-to-one basis. This functionality should only be used if sanctioned by the Tactical Commander, as once a call is initiated the user is unable to detect if another caller is trying to contact the user and these calls may not be recorded by EOC unlike normal TETRA transmissions.

Tetra Radio Multi-agency Interoperability

Multi-agency interoperability allows Commanders and control rooms to communicate with counterparts from other emergency services.

Tetra Radio is the preferred tool (where face to face is not practical) as a means of interoperable communications. Identification of an appropriate interoperability talk-group should be an early consideration for the commanders at the scene of an incident.

Procedures have been agreed by all four Emergency Services in Northern Ireland in relation to TETRA Interoperability which pre-designates the talk-groups to be utilised. Any service can initiate this facility via their Commander/Control Room.

Mobile Phones

Although mobile phones aid NIAS in daily operations, their use in significant /major or mass casualty incidents must be limited to communications between the Strategic and Tactical Commanders unless an emergency arises. Person to person mobile phone conversations will not be recorded unless via the EOC therefore all such calls must be logged.

Other managers not involved in the incident must refrain from contacting the EOC or the Tactical / Incident Commander. Deviating from this procedure may seriously compromise the effective management of the incident.

Staff should adhere to the NIAS Social Media Policy in relation to the use of mobile phone at the scene of an incident.

Alerting – SMS Alerts/Pagers

SMS Alerts/Pagers are used as a method of cascading initial activation information from the EOC to appropriate managers in accordance with the EOC Duty Control Manager Action Card EOC 1.0. SMS Alerts/Pagers must not be used in isolation, as the sole method of communication as a sent message is not a confirmation of receipt. On call managers must have their NIAS Mobile Phones/Pagers (for those staff retaining pagers) with them when they are on duty or on call. These devices must be switched on with the appropriate alerting tones and volumes set.

Catastrophic Communications Failure

Using 'Runners'

During a communications failure 'staff runners' may be utilised to take messages to and from key commanders. In the event of this system being adopted, it is essential to ensure the following:

- Consideration of using appropriate levels of personnel to undertake this role
- The 'runner' is adequately briefed on the task and its requirements
- All messages are recorded and documented within the relevant Incident Management Logs

NIAS Communications Officer

The Trust has in place an established Communications Plan which provides a 24-hour capability, and which encompasses actions in the event of a major incident. The NIAS Communications Officer will handle media enquiries as well as provide advice to the Strategic Commander and if appropriate, in liaison with other HSC Trusts

The police will generally lead the media response to major incidents with partner agencies participating in any established Media Cell. The NIAS Communications Officer will support the multi-agency media response after consultation with the NIAS Strategic Commander.

The Trust Communications Officer will coordinate corporate communications in relation to any incident both externally and internally, liaising with all other agencies to ensure joint agency communications as well as supporting the NIAS Commanders on all media enquiries; providing briefing and updates to the media when required; setting up press conferences; and contributing to joint press statements.

The Communications team will have a standing press statement within **thirty minutes** of a major incident being declared and will aim to update the statement at least every hour.

During the early stages of a major incident there is the potential for media and the public to be present at the incident scene. Crews must be mindful of this and act accordingly.

NIAS Control Centres

NIAS Emergency Operations Centre (EOC) and EOC Commander

The main responsibilities of the EOC Commander relate to ensuring appropriate levels of resources are deployed to the incident in line with the information received. Where the incident relates to a fixed site e.g., COMAH, The Radiation, Emergency Preparedness and Public information Regulations (REPPIR), Airport, Sports Ground or other site where a response plan exists, the agreed pre-determined attendance (PDA) (where one exists) should be mobilised, and site-specific arrangements activated in accordance with that plan.

The EOC Duty Control Manager will become the EOC Commander and will ensure that the designated actions and procedures are followed in line with any relevant action cards and its subsets.

The EOC Commander will ensure that all relevant HSC Trusts are informed as per action cards to include the Public Health Agency on declaration of a Major or Mass Casualty incident.

Through maintaining an overview, the EOC Commander will provide support to the Strategic and Tactical Commanders, highlighting any possible risks or challenges and taking in account of the implications to NIAS core business.

To assist with maintaining situational awareness the EOC Commander should inform other emergency services' control rooms following declaration of a major incident/significant incident. Where appropriate, a multi-site communications link should be established between the control rooms and maintained until a dedicated command structure is in place to manage the incident.

Any updates to M/ETHANE reports should be shared with partner agencies and relevant HSC Trusts.

Staff Recall to Duty

Experience from previous large-scale incidents has demonstrated the willingness of off-duty staff from across all Trust departments to return to work in support of the NIAS response. Whilst it may sometimes be necessary to recall staff duty, either in support of the incident response or to support the ongoing day to day workload, it is essential that this is carried out in a coordinated manner.

It is vital that staff do not self-deploy to an incident

General points for consideration by all staff when volunteering to return to work include:

- Overriding principle of 'do not self-deploy.' You may not be required immediately or know where you should go to. If required, RVPs or holding areas may be established. Self-deployment creates a staff welfare issue, in that NIAS may not know of your intentions, location, status and thus increases personal risk. You may inadvertently cross a cordon or into an unsafe area. This may also create liability and insurance issues for the Trust.
- Unless directed to do so, Officers must not go straight to scene – monitor your normal Tetra Radio talk group for instructions or await contact from the EOC.
- Do not overwhelm the EOC with calls asking what to do – they will be inundated with other contacts.
- Do watch/listen to the broadcast media news feeds and check official NIAS Social Media feeds and website for specific instructions on how to volunteer and who to call for information.
- Do not take an NIAS vehicle without being directed to do so by the EOC/NIAS Commander
- If on duty on a vehicle await deployment instructions and watch out for MDT messages
- Consider that you may be required to support a longer-term response to a protracted incident so standing by or getting some rest can be essential preparation to be called the next or subsequent day. Do not take a PCS/ICS vehicle without being told to and if such a resource is used officially, ensure it is returned to its home station in a fuelled, stocked and cleaned condition ready for its next period of duty
- Do not volunteer for duty if you are due on shift in the next 12 hours or have finished your previous shift within the last 11 hours.
- If already on duty, the EOC will monitor any extensions to shift but note that staying on duty over normal shift changeover may deprive a 'fresh crew' of a vehicle if a replacement is not readily available.
- If you are deployed to scene, you should be told where the RVP is or who/where you should report to. Don't forget appropriate PPE, Action Cards, tabards, and any specialist equipment that might be required (Triage Packs or Trauma Kit from your service vehicle). Service identification must also be carried at all times.
- Staff volunteering to return to duty may be required to undertake core business to support Trust service delivery.
- All information regarding available staff will be made available to the Tactical Commander who in conjunction with the EOC / RMC will determine the best use of the resources obtained through this process; this may include a gradual introduction of resources over a period of time to assist in a prolonged incident and the recovery stages.

Care must be taken not to utilise staff/managers whose normal shift may be affected by them assisting in this incident.

Resilience Direct

Resilience Direct is a free web-based communication tool for Category 1 and 2 and other equivalent responders to share information securely (accredited to OFFICIAL SENSITIVE) as required by the Civil Contingencies Act 2004 and Civil Contingencies Framework NI 2023 in both planning stages or during incident response.

The application will allow NIAS to store internal and appropriate multi-agency plans in secure folders, allowing accredited staff (NIAS on call commanders and EOC Commander s) to access information on plans and incidents from any location where a standard internet connection exists.

Assessment of Incident

Using information, intelligence, risk assessments and available policies, plans and procedures, Commanders must make a full assessment of the incident. From this commander will develop the strategy and tactics for dealing with the incident. During the assessment phase, Commanders will identify the level and types of resources required to manage the incident. This will include specialist resources such as HART and also the requirement for Mutual Aid.

Initial Assessment

The quality of the first information that is passed from the scene will be important in determining the speed and adequacy of the subsequent response and can be achieved through;

First NIAS resource on scene:	Windscreen report to EOC
First NIAS resource on scene:	Gather enough information and intelligence to inform a M/ETHANE report, including confirmation of the type of incident (e.g. significant and major incident)
First NIAS resource on scene:	Establish early NIAS command
First NIAS resource on scene:	Share M/ETHANE with EOC
Incident commander:	Apply JESIP principles, use JDM to inform decision making • Gather information and intelligence • Assess risks and develop a working strategy • Consider policies and procedures • Identify options and contingencies • Take action, review what happened.
Incident commander:	Maintain communication with EOC, update M/ETHANE including confirmation of the type of incident (e.g. significant, major or mass casualty incident)

Continued Assessment

The Tactical Commander and NIAS EOC will require continuing updates from the scene relating to casualty details, hazards on scene and the suitability of resources, so as to ensure the right care is provided. Assessment of the incident may be informed by;

- Scene assessment and incident type e.g. flooding, RTC, MTA
- METHANE and other available information
- Impact assessment
- Scale, REAP level, thinking ahead, mutual aid
- Casualty typing e.g. paediatrics, burns, geriatric, trauma

An assessment of risks to ambulance responders and the implications to core business should be carried out. The Incident Commander should continue to refine and update the assessment of the scene. As further resources arrive and it becomes possible to establish the command and control structure, the Incident Commander needs to ensure that subordinate commanders are briefed to feed continual updates from their areas of control. In addition, the Incident Commander should continually liaise with other service commanders to glean health-related information.

Triage

In keeping with its responsibility for coordinating the initial health response[1] to significant, major or mass casualty incidents, NIAS recognise that the provision of effective casualty triage is essential for managing and prioritising casualties to maximize survival and efficiently allocate limited resources. NIAS will achieve effective casualty triage though the use of Ten Second Triage (TST) and Major Incident Triage Tool (MITT)[1]. Once casualty triage has taken place, patient care treatment can commence and continue through to definitive care[1].

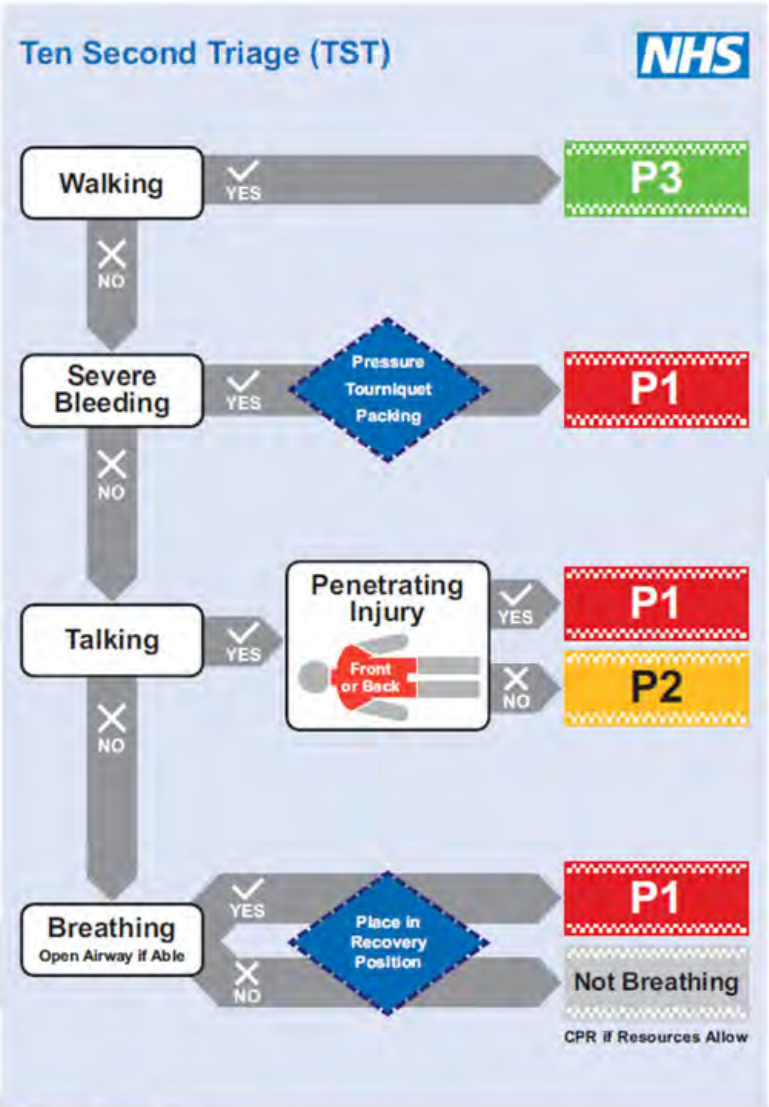
Primary Scene Triage

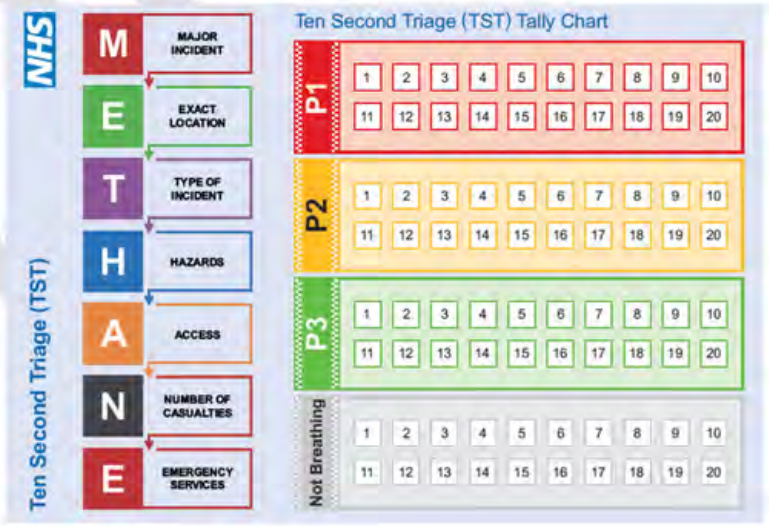
Primary scene triage (using TST) is used in multiple casualty incidents to identify the most severely injured casualties, prioritise those who need immediate Life-Saving Interventions (LSIs) and to help guide evacuation decisions. It provides a simple framework for an approach to a chaotic scene that will help all responders optimise their ability to move quickly and efficiently from one casualty to the next in order to save as many lives as possible[2]. During the early stages of an incident, the use of TST allows for early and accurate inter-agency reporting of casualties allowing Ambulance Services to make informed decisions regarding casualty management and resource deployment.

Previously, in the UK triage was limited to use only by Ambulance Services. However, TST has been developed for use by all first responders to any incident with multiple casualties, meaning that in addition to Ambulance Services, other emergency services including Police, Fire and Rescue Services (FRS), Voluntary Aid Agencies and the UK Armed Forces will be able to adopt Ten Second Triage (TST) as the initial triage for any multiple casualty incident. TST should be used to direct casualty treatment and evacuation priorities for any multiple casualty scenario prior to arrival of health care assets or under the guidance of health care assets, when present[2].

Arriving healthcare resources should expect that other emergency services already present, may have begun to perform triage with TST. TST training will be similar for all services and TST does not need to be repeated unless the casualty has obviously changed triage category (e.g., is no longer walking but has a P3 tag in situ)[2].

TST Algorithm





Secondary Triage

While primary triage may be undertaken by all first responders, secondary triage (achieved through use of MITT) will only be performed by ambulance staff. MITT is intended to aid clinical decision making where demand/resourcing precludes senior clinician-led decision making (or if enhanced / critical care is not available)[2]. TST should be completed on all casualties that staff can access before considering the use of MITT[2].

Once TST is complete and casualties are being extricated to a Casualty Collection Point (CCP) or Casualty Clearing Station (CCS), the main decision for the on scene ambulance commander will be whether to follow up TST with[2];

1. Business as usual (BAU) standard clinical practice, or
2. MITT

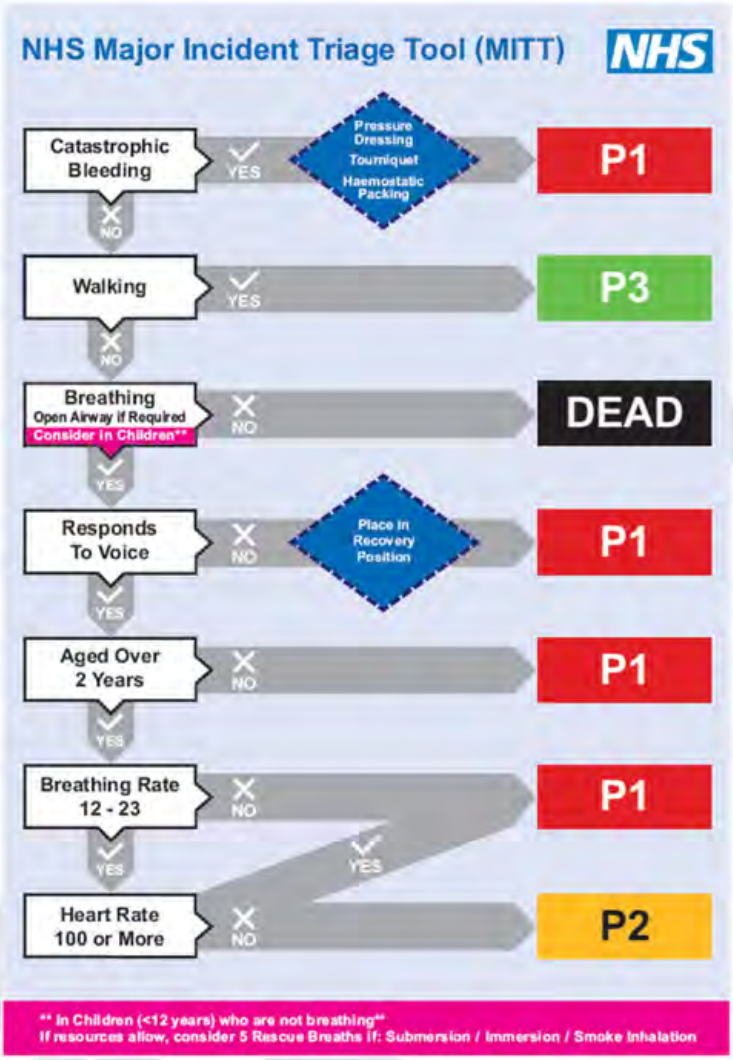
The decision to switch to MITT will be made by the on scene ambulance commander and should only be instituted once casualties reach a CCP or CCS rather than being performed on scene[2]. Some of the factors that will influence the decision to utilise MITT include the:

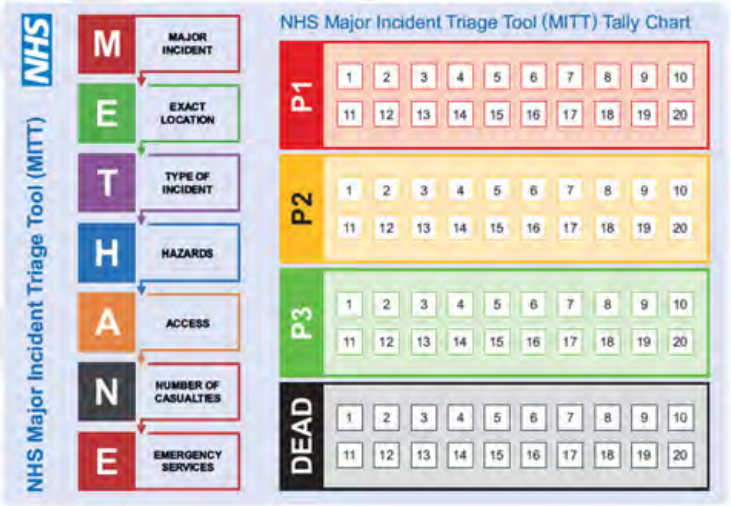
- Number of patients
- Number of clinical resources
- Ability to transport to definitive care

Regardless of whether TST is followed by BAU or MITT, the priorities should be[2];

- Rapid evacuation of high acuity TST P1 patients to definitive care
- Re-triage of Silver 'Not Breathing' patients to Dead or viable for resuscitation (P1)

MITT Algorithm

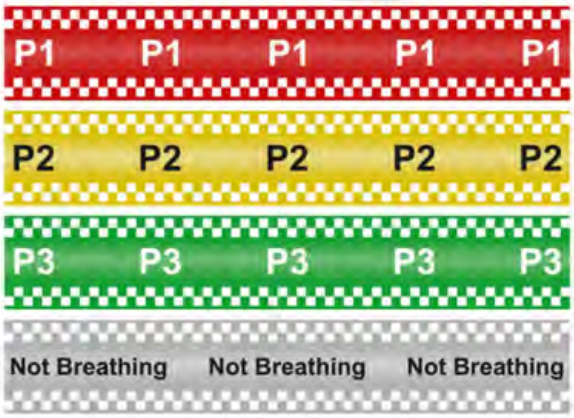




Triage Labelling

All casualties who have been triaged should be marked with the agreed method. For TST this is with a Triage Band with a checked border and for MITT a solid coloured triage card, with space to write treatment notes. Triage labelling should be attached to a casualty's wrist (unless injured or amputated — in which case an ankle or lower leg or would be a suitable compromise). Responders should ensure bands are as visible as possible. If MITT is instituted, the solid colour triage card will be used with the TST band being left in situ[2].

TST Labelling



MITT Labelling

Deceased Casualties

TST does not have a DEAD category unlike other triage systems. Even for healthcare professionals, in the initial phase of an incident the time required to fully and carefully assess whether a 'Not Breathing' casualty is amenable to any treatment is not sufficient to adequately make this important decision. This is a concern that has appropriately been raised by families at recent inquests and inquiries, and reinforces the need to allow CPR if resources allow initially. Once all initial triage and life saving interventions have been carried out, a considered decision can be made by a clinician to whether a casualty is amenable to further ongoing resuscitation or not. Therefore, within TST, which will be used by all responders, the Not Breathing category is used to simply illustrate the objective finding of a breathing check, rather than to label a casualty as not amenable to ongoing treatment or 'Dead'[2].

Where a full assessment shows that ongoing resuscitation will be futile or resources required to allow any chance of successful resuscitation are not available, then casualties will be recognised as dead at this point. If only TST has been carried out and post-TST care is 'business as usual' procedures, then the deceased will be recognised and managed as per usual protocols, including Verification of Death (also referred to as ROLE, Recognition of Life Extinct). If decision was made to move to MITT (following TST), then an appropriately completed black DEAD tag must then be applied that will contain the time and date and be signed and applied to the casualty. Regardless of use of TST or MITT, all casualties identified as DEAD will require Verification of Death (as per usual protocols) to be carried out at the earliest reasonably practicable time.

The deceased should not be moved during the triage process unless it is the only way of reaching a live casualty or if the body may become further damaged or lost. Any significant / major / mass casualty incident may be considered a crime scene until discounted by the police and therefore consideration should be given to minimising disturbance of potential evidence whilst rescuing or treating patients.

Covering of those who are believed to be dead

In multi-casualty incidents (such as significant, major or mass casualty incidents), the public in general, healthcare providers (such as event medical providers) and emergency service responders should not cover the deceased. The step of covering those believed to be deceased should only be undertaken after assessment by ambulance service personnel (such as Paramedics) or other healthcare professionals. Should ambulance service personnel attend an incident where those believed to be deceased have been covered prior to their arrival they should inform others present that only healthcare professionals should cover those believed to be dead[3].

Uninjured people

Uninjured should be directed to a place of safety and asked to remain there until their welfare can be confirmed and their details collected by the police. Such individuals may not be physically affected but may need other support in respect of their exposure to traumatic circumstances. They may also prove to be vital witnesses for the police in any subsequent investigation.

Survivor Reception Centre (SRC)

Uninjured people and if necessary, casualties with minor injuries may be moved away from the immediate scene to a Survivor Reception Centre (SRC). The SRC provides a secure area in which survivors not requiring acute hospital treatment can be taken for short term shelter and first aid.

Expectant Category

Where casualty pressures at an incident site dictate, it may be necessary to categorise casualties as P4 (Expectant – they are not expected to survive) either as a direct consequence of the limited nature of the medical resources available (e.g., immediate surgery is required but unavailable), or because the input required would make such demands on these sparse resources that the lives of other less seriously injured patients would be jeopardised.

Responsibility for invoking the expectant category lies with the Strategic Medical Advisor following discussion with the Medical Advisor, Strategic and Tactical Commander.

Treatment

To assist the Incident Commander and functional roles to assign clinicians appropriately at the scene and provide a clinically safe service, the clinical grade of staff must be clearly visible on their reflective jackets.

All Trust clinicians **must** operate within their scope of practice, following trust policies and procedures. Any exception must be authorised by the Strategic Medical Advisor in conjunction with the Strategic Commander.

Casualty Flow

It is important that all casualties are managed effectively on scene and cared for through a structured casualty clearing process. A casualty will take a distinct route from the incident site through to receiving definitive care at the most appropriate receiving hospital where possible. This route has been designed to allow clinical care to be given throughout the journey and to make the best use of the available clinical resources at the scene.

Casualty Collection Point (CCP)

The CCP process originated from the response to specialist incidents such as CBRN/Hazmat or Marauding Terrorist Attack (MTA) scenarios, its use is now commonplace for any multi-casualty incident. The CCP is designed to provide basic care for life threatening injuries prior to a casualty being moved to the Casualty Clearing Station (CCS) or direct to hospital.

Following Triage Sieve, all casualties will be evacuated in priority order to either a CCP or directly to the Casualty Clearing Station (CCS) for treatment, prior to transport to hospital or discharge.

In the early stages of an incident prior to the establishment of a CCS, the Loading Officer may locate at the CCP, and casualties may be transferred directly from the CCP to hospital if necessary.

Casualty Clearing Station (CCS)

Establishing a CCS must be considered an early priority for commanders due to the length of time it may take to set up. Where possible one larger CCS should be established, which will allow limited personnel and equipment to be centralised.

Treatment within the CCS should aim to stabilise the casualty with a view to getting them to a definitive point of care as soon as possible.

When determining a suitable location for the CCS, safety considerations such as the integrity of buildings or land, vehicular accessibility, and environmental considerations such as wind direction must be made.

Liaison should take place between the Incident Commander, Casualty Clearing Officer and the NIAS EOC to ensure the correct distribution of casualties.

Vulnerable Persons

The Northern Ireland Civil Contingency Framework has identified the requirement for responders to plan for and meet the needs of those who may be vulnerable in emergencies.

NIAS responders may be called upon to assist with the evacuation or treatment of the vulnerable during a major incident and their identification should be an early consideration for the Tactical Coordinating Group.

NIAS responders should be cognisant of their duties under the NIAS Safeguarding Policy and report any concerns as soon as practicably possible.

Specialist NIAS Teams & Resources

These are teams that can assist with the response to an incident with specialised equipment, resources, or knowledge.

Hazardous Area Response Team (HART)

HART operations should be seen as a functional role within the NIAS response. Although the HART response is supervised by the HART Manager / Advisor, the Command and Control of HART resources fall under that of the Incident Commander.

The purpose of a HART response is to provide life-saving medical care within the inner cordon at a range of emergency incidents, including those involving CBRN or hazardous materials (HAZMAT), those requiring an Urban Search & Rescue (USAR) capability in areas of difficult access, or environments that pose other types of hazards for which HART is suitably equipped and trained to deal with.

Responding within the inner cordon of a scene, particularly at a major, hazardous incident, requires different working practices, equipment and systems of work to a conventional ambulance response. HART personnel have a range of PPE and clinical equipment suitable for use in these conditions, and the skills and knowledge necessary to operate safely within these environments.

The Urban Search and Rescue (USAR) capability of HART extends the areas or environments in which paramedics can operate safely and provide clinical intervention to include those where access and egress is difficult and requires specialist equipment and training.

NIAS HART will embed with partner agencies to deliver these functions.

Incident Support Units

Mobile Control Vehicles

NIAS has two Command and Control vehicles based in Belfast and Derry/Londonderry, these vehicles will provide a command location at the scene of an incident, they have additional features such as radios, telephones, computers, cameras and shelter to support the management of the incident.

Emergency Equipment Vehicles EEV

NIAS has three emergency equipment vehicles. They are currently based in Broadway Ambulance Station, Dungannon Ambulance Station, and Westland Road Standby Point.

Each vehicle contains enough medical equipment to provide emergency treatment for:

- 50 Casualties (Broadway Ambulance Station)
- 30 Casualties (Dungannon Ambulance Station and Westland Rd. Standby point Derry/Londonderry)

The equipment ratio is based on planning assumptions of incidents involving 80% adults to 20% paediatrics casualties.

The vehicles contain shelters as well as a range of equipment that will assist in the response to a major incident.

Shelters

In the event of there being no natural 'shelters' available at the required location, the use of the Trusts' major incident casualty clearing shelters can be used to provide the desired facility. These shelters are located on the Emergency Equipment Vehicles. The shelters themselves, in addition to the supporting equipment required to operate them, require specific manual handling arrangements. Procurement department staff members may be deployed to assist in the erection of temporary structures.

Certain site-specific locations e.g., airports have their own mobile shelters or pre-determined locations for use as a shelter area.

Pod Vehicles

NIAS has an arrangement with the Department of Health (NI) to distribute the Northern Ireland based UK National Reserve Stock for CBRN . NIAS maintains two lorries based at POD storage locations to enable them to do this as part of their 'Officer on Call' arrangements.

Transport

Patient Movement

The decision on the destination of patients will be made in consultation between the NIAS Tactical Commander, Medical Advisor, Casualty Clearing Officer and EOC Commander. Consideration should be given to the following:

- Suitability of hospital / medical facility to take appropriate triage category (P1, P2 and P3)
- Location of the receiving hospital and specialisation (Trauma/Burns/Paediatrics, etc.)
- Current bed status / capacity of hospital
- Infrastructure – i.e., road network and helicopter landing sites
- Possibility of self-presenters causing congestion
- Depletion of medical resources at receiving hospital

The Loading Point Officer should keep a log of patients leaving the scene and their destination at that time, this information can be shared with PSNI using agreed documentation.

During a significant / major / mass casualty incident NIAS staff must ensure they notify the EOC in the usual way when arriving/leaving scene and arrival at hospital so that accurate records are maintained.

Methods of Transport Available

The transport of patients during a major incident will depend on number and severity of casualties and the available resources. Options other than NIAS resources to be considered include;

- Non statutory ambulance services
- Public Transport, e.g., buses, rail, taxis
- Military assets
- Air assets e.g., HEMS / HMCG SAR Aircraft
- Commercial operators

The decision to utilise these resources should be made by the Tactical Commander in consultation with the relevant agency and the Strategic Commander.

Patient Care Service (PCS)

Patient Care Service resources are highlighted in Pre-determined Attendance charts. These vehicles and staff can be utilised to provide support and transport for less acute patients in the event of a major incident. Utilisation of PCS however may impact on their business-as-usual function and this could cause disruption to this service resulting in non-emergency journeys being cancelled or delayed

In the initial stages of the incident the EOC Commander in consultation with the Ambulance Incident Commander should optimise the use of PCS where appropriate but also be mindful of the potential long-term impact.

Once established, maintenance of the emergency and non-emergency business as usual functions should be considered by the Strategic Commander. Where appropriate the Strategic Commander should consider utilising independent ambulance services to:

- Provide support to the EOC (responding to appropriate calls as per current procedures)
- Provide backfill support to the PCS, maintaining a non-emergency service.

It should only be in extremis that the Strategic Commander should consider cancelling planned outpatient journeys.

If any PCS vehicles are utilised out of hours by responding crews then they should be returned to their base station in full readiness for duty (cleaned, fuelled, and stocked) so that PCS obligations are not compromised.

Independent Ambulance Services

NIAS has contractual arrangements with a number of independent ambulance services to supply resources to support core business on a daily basis. These resources may be used to support NIAS during a major incident at the discretion of the EOC / NIAS Tactical Commander. IAS should be utilised under normal business as usual arrangement and may be requested to attend the scene of a major incident to assist with patient transport. If dispatched to the scene, IAS should work within the parameters of the non-emergency framework and the associated Memorandum of Understanding (MOU).

Under no circumstances should IAS providers self-deploy to a major incident or work outside the scope of practice as detailed in the non-emergency MOU.

Air Support

Air ambulances can provide an additional resource to the transportation of casualties or medical resources to the scene. Additional air resources e.g., HMCG/PSNI/Military may be available.

The Tactical Commander and the Medical Advisor will identify the most appropriate use of air resource in consultation with the Police. This may include dedicated or predetermined landing sites.

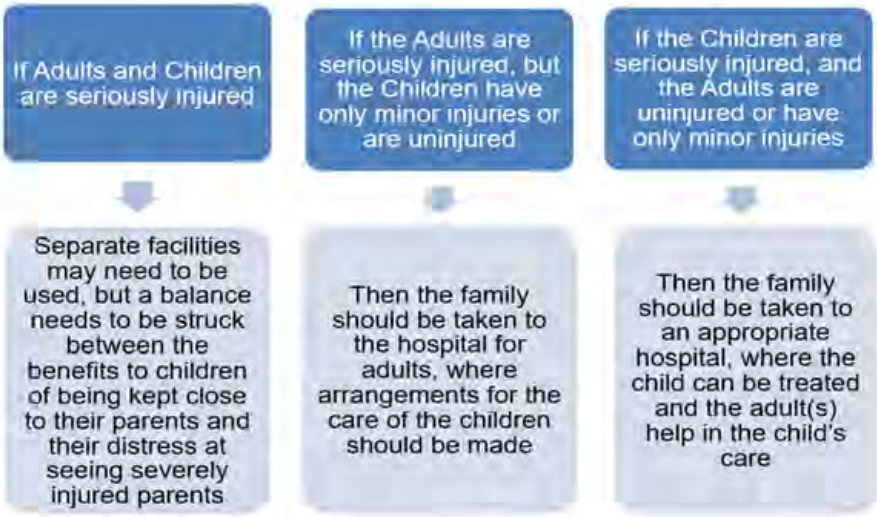
If NIAS Air Ambulance transports any casualties, they must be logged by the Ambulance Loading Officer.

Children in Major Incidents

Where children are involved in a major incident they will need comfort from familiar adults, and wherever possible, the family should be kept together.

It is essential that receiving hospitals are notified at the earliest opportunity that children may form part of the casualty numbers. As a general principle, children involved and injured at a Significant / Major or Mass Casualty Incident will follow the Trust's **'Major Trauma Decision Tool'** and be conveyed to the appropriate receiving hospital.

The following diagram may assist in the development of casualty conveyance plans on occasions when adults and children from the same family are involved in Significant / Major or Mass Casualty Incidents and the facilities for adults and children are in separate hospitals.



Always try to accommodate parents' wishes to remain with their children. Parents are likely to want to have close contact with their child, no matter how serious the injury may be. However, the medical needs of both adults and children are the paramount consideration when planning where casualties should be taken.

Appropriate escorts may need to be sought for unaccompanied children, whether they are injured or not. The Police and Social Services should be informed at an early stage of the presence of unaccompanied children to allow for appropriate welfare arrangements to be made.

Regardless of the incident which they are attending, NIAS staff must adhere trust policies and Procedures with regard to the transportation of children.

Anyone involved in the response to a Significant / Major or Mass Casualty Incident may suffer from stress. This is particularly important in incidents where children are involved. Ambulance staff and parents, as well as the children involved, may be greatly distressed, and counselling and support will be required.

Casualty Dignity

A Major Incident presents unique challenges to the responding clinicians due to the numbers of casualties and complexity of the incident, coupled with the potential for stretched resources at the scene. However, while undertaking the care of the casualties it is important that we place their needs at the centre of our actions and as far as practicable be respectful of their dignity.

Cultural and Religious Diversity

Whilst the health and safety of casualties should be the paramount consideration at the scene of a Significant / Major / Mass Casualty Incident, it is important that staff should remain sensitive at all times to the concerns and requirements of different cultural and religious groups, however clinical priority will take precedence.

Police Casualty Bureau

The Casualty Bureau (CB) Incident Room is the central point where all information related to an incident is received, collated and assessed. This includes information about people believed to be involved in the incident. (College of Policing, 2024).

The primary aims of the Casualty Bureau are to:

- Provide information for the investigation process;
- Trace and identify people involved in an incident;
- Reconcile missing person reports with casualty and survivor/evacuee details.

Once the Casualty Bureau has been established contact details will be publicised through the media. It is important for the Trust to co-operate with this function and assist where possible with information gathering.

The Tactical Commander should pass on information of receiving hospitals and patient distribution to the Police Incident Commander. The PSNI will utilise the nationally available Major Incident Public Portal (MIPP) to collate information.

Mutual Aid

NIAS is party to the NHS Ambulance Service National Mutual Aid Memorandum of Understanding (MoU) (2015). NIAS also has a memorandum of understanding with the National Ambulance Service in the Republic of Ireland for support during a major incident.

A Significant / Major / Mass Casualty incident will place additional pressures on any responding organisation therefore an early consideration will always be given by the Tactical Commander in conjunction with the EOC Duty Control Manager and/or Strategic Commander for 'mutual aid' assistance from the National Ambulance Service and/ or from Great Britain or the independent ambulance sector.

Specific arrangements exist for requesting mutual aid from Great Britain, requests can be made through the National Ambulance Coordination Centre (NACC) however this must be accompanied by a parallel request to the Dept. of Health (UK) through the Emergency Planning Branch in the Department of Health in Northern Ireland at the earliest opportunity.

United Kingdom National Ambulance Coordination Centre (NACC)

The NACC is facilitated through the London Ambulance Service and coordinates the UK ambulance service response to incidents, events or pre-arranged triggers that have an impact across more than one Trust. In the event of a critical / major / mass casualty incident the NACC is responsible for the coordination of any interoperable national response and allocation of Mutual Aid between Ambulance Trusts. The NACC can be contacted though the National Ambulance Resilience Unit On-Call Officer.

The NARU On-Call Number is :- 0300 373 0195

Recovery

As part of the response to a Significant / Major / Mass Casualty Incident, it may be necessary to form a Recovery Team. It is expected that the Recovery Team will utilise the Trust Business Continuity arrangements as required to ensure the return to normal operations as the operational response to the incident reduces in the return to normal.

This team will consider, but not be limited to, the following:

- Managing the return to normal service and establishing what resources are required to achieve this
- Ensuring clinical oversight is in place to support the prioritising of outstanding non-incident related calls
- The management of requests for secondary transfers
- Resourcing levels in the immediate, and near future
- Management of staff welfare including the provision of appropriate physical and psychological support, this will be addressed through the NIAS Health, Wellbeing and PEER Support Team.
- Restocking of supplies and equipment
- Auditing and reporting of the incident
- Post Incident Procedures

Post Incident Activities

Post Incident, the following operational activities will be carried out:

- A 'hot debrief immediately after the incident, preferably led by the Incident Commander
- Provide appropriate post incident psychological intervention and onward referral for all ambulance personnel involved.
- Cleaning, Restocking and Refuelling of trust vehicles in order to maintain readiness of the fleet
- The re-stocking of all Trust areas involved in the response, including the replenishment of drugs, consumables and equipment as required
- The re-stocking of all specialist response assets, including Emergency Equipment Vehicles and Command Vehicles
- The collation of all paperwork, voice recordings and Emergency Operations Centre Logs to form an initial response record
- All Incident Commanders to submit a report, in accordance with relevant functional or other role.

Debriefing Activities

The full debriefing process should include arrangements to hold In-Service, HSC and Multi-Agency debriefs to review the response overall, in order to identify any lessons learned, and any revision requirements to the Incident Response Plan.

The debriefing process will be documented, and any actions identified through lessons learned will be processed through an Action Plan to ensure that any changes are implemented, and the integrity of the Incident Response Plan is maintained.

The EPRR Team will be responsible for co-ordinating and documenting the debriefing process, and for incorporating learning into the Incident Response Plan.

Post Traumatic Activities

Post incident, the Trust has a moral and legal duty to consider the health needs, including psychological and emotional needs of staff following exposure to a potentially traumatic incident. Managers should be vigilant for symptoms of stress in staff who have participated in an Incident and utilise NIAS Health, Wellbeing and PEER Support Team Practitioners to provide debriefs as appropriate.

Managers are also advised to be alert to staff booking sick and should arrange for immediate referral to Occupational Health if the reasons are related to stress, post-traumatic or otherwise, resulting from the incident. Early referral offers a far higher chance of recovery.

HR Support post incident

The Human Resources Department will ensure the following actions are carried out:

- Actively promote the staff support services during sickness and welfare review meetings;
- Support Line Managers in making any necessary referrals to staff support providers or where appropriate, our Occupational Health provider
- Manage the delivery and oversight of NIAS Health, Wellbeing and PEER Support Team
- Ensure all staff are assessed and supported to access the most appropriate care pathway

Legal Considerations

The legal aftermath to any Major Incident can involve:

- A Public Inquiry
- A Health & Safety Executive investigation
- An investigation by other regulatory body
- An Inquest
- A Civil Claim
- A Criminal Prosecution

Some of these will be completed in a matter of weeks or months, whilst others may well go on for many years. In addition to the legal aftermath, there is also "Trial by Media" which will follow the incident over a relatively short space of time. The Trust will become involved in the legal aftermath.

Commanders should ensure that all records, including log books and other documentation relating to the incident is submitted to the EPRR department for storage.

Appendix A: CSCATTT model

The CSCATTT model supports a system of work to ensure key functions are established early in the incident and must be followed by commanders when managing an incident.

C	Command and Control	Commanders must ensure that they have command and control of the incident. This is achieved through the implementation of the command structure
S	Safety	Commanders must ensure the safety of all responders, patients and the public. This is achieved through risk assessment and the identification and use of control measures
C	Communication	As a Commander you must ensure effective communication both internally and externally. The use of airwave interoperability can be used to ensure joint operational awareness.
A	Assessment	As a Commander use the intelligence available, risk assessments, policy and procedure, and plans if available to gain an overall assessment of the incident. During this phase you will assess the resources you require and if any specialist resources could be utilised HART/SORT etc.
T	Triage	To ensure that casualties are treated appropriately and in priority order, this phase will look at triage sieve and sort. Some incidents such as MTA or CBRN may involve a modified triage system due to the environment and threat level.
T	Treatment	Once casualty triage has taken place, patient care can commence and continue to definitive care.
T	Transport	The availability of transport may vary, so careful consideration to the capability and suitability of transport types.

Appendix B: Initial Operational Response (for Chemical, Biological and radiological Incidents)

The primary objectives of the Initial Operational Response (IOR) are to:

- Maximise the safety of the public and save lives
- Minimise the operational risks to responders.
- Ensure an effective transition to the Specialist Operational Response.

The initial actions taken following a hazardous substance incident have a significant effect on the outcome for all involved. The following principles will aid first responders:

R – RECOGNISE the indicators of a hazardous substance incident;

- 5 Ws – What, Where, Why, Who, When

A – ASSESS the incident to inform an appropriate response strategy;

- Substance assessment using BADCOLDS – Behaviour, Appearance, Dissemination, Colour, Odour, Likeness, Deliberate, Symptoms
- Casualty assessment using CRESS – Consciousness, Respiration, Eyes, Secretions, Skin

R – REACT appropriately to reduce the risk of further harm.

- Remove, remove, Remove

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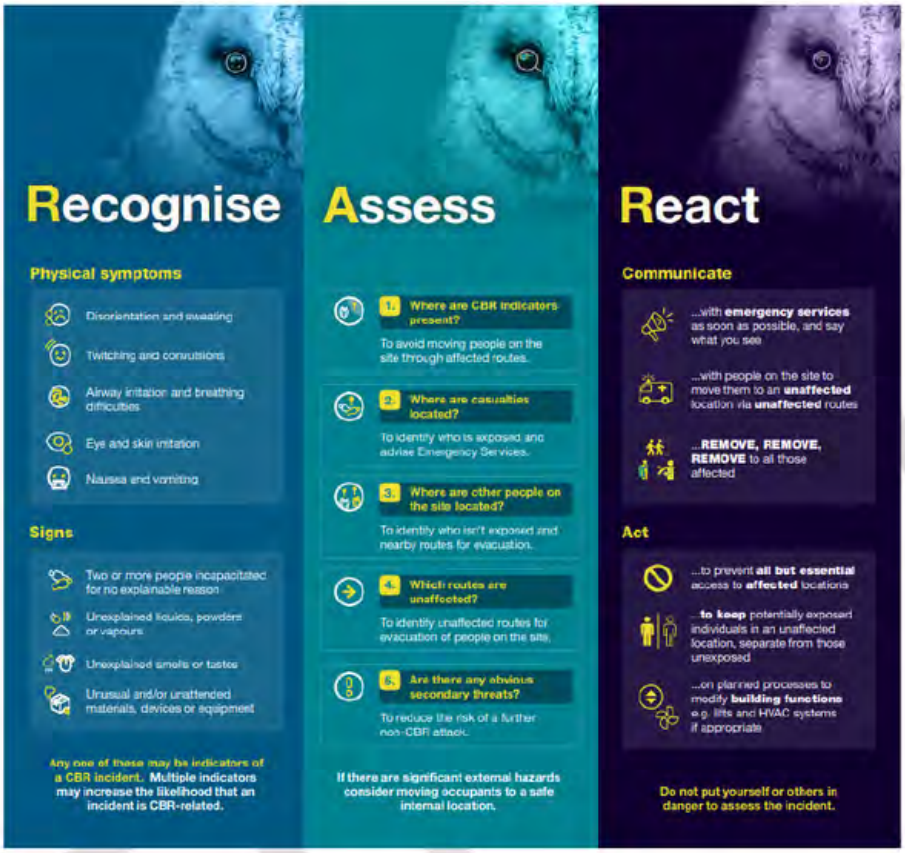

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If you think someone has been exposed to a **HAZARDOUS SUBSTANCE**

Use caution and keep a safe distance to avoid exposure yourself.

TELL THOSE AFFECTED TO:

REMOVE
THEMSELVES...

...from the immediate area to avoid further exposure to the substance. Fresh air is important.

If the skin is itchy or painful, find a water source.

REPORT... use M/ETHANE

REMOVE
OUTER CLOTHING...

...if affected by the substance.

Try to avoid pulling clothing over the head if possible.

Do not smoke, eat or drink.

Do not pull off clothing stuck to skin.

REMOVE
THE SUBSTANCE...

...from skin using a dry absorbent material to either soak it up or brush it off.

RINSE continually with water if the skin is itchy or painful.

REMEMBER: Exposure is not always obvious. **SIGNS CAN INCLUDE:**

The presence of hazardous or unusual materials.

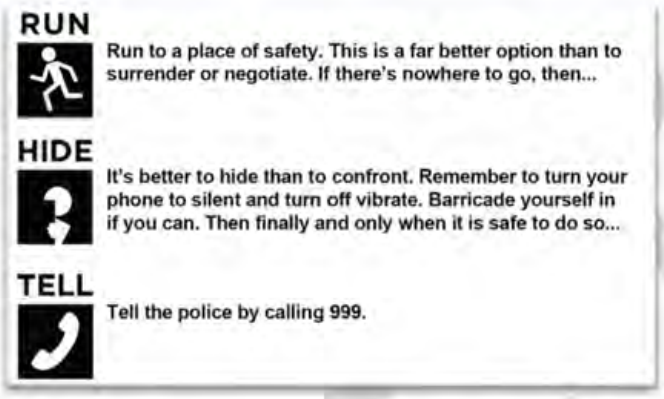
A change in environment, such as unexplained vapour, odd smells or tastes.

Unexplained signs of skin, eye or airway irritation, nausea, vomiting, twitching, sweating, disorientation, breathing difficulties.

ACT QUICKLY. These actions can **SAVE LIVES.**

Appendix C: Stay Safe Guidance

In the event of a terrorist attack, the RUN HIDE TELL guidance provides advice to the public and sets out three key steps for keeping safe which can be applied to many situations and places.



Remaining aware of a positive duty to act, Stay Safe Guidance for Emergency Services recognises that response to incidents may include both non-specialist and specialist multi-agency responders and aims to save life by minimising the risk to the public (including the injured) whilst maximising the safety of responders. Therefore, messaging for Emergency Services focusses on 'Stay Safe, See, Tell, Act,'.

- Stay Safe - Think about your own and the public's safety.
- See - What is happening and where.
- Tell - Communicate, describe incident/type of weapon.
- Act - Stay Safe, update, observe, patient care (if safe to do so).

Appendix D: IIMARCH Briefing Tool

I	**INFORMATION** What, where, when, how, how many, so what, what might? Timeline and history (if applicable), key facts reported using M/ETHANE
I	**INTENT** Why are we here, what are we trying to achieve? Strategic aim and objectives, joint working strategy
M	**METHOD** How are we going to do it? Command, control and co-ordination arrangements, tactical and operational policy and plans, contingency plans
A	**ADMINISTRATION** What is required for effective, efficient and safe implementation? Identification of commanders, tasking, timing, decision logs, equipment, dress code, PPE, welfare, food, logistics
R	**RISK ASSESSMENT** What are the relevant risks, and what measures are required to mitigate them? To reflect the JESIP principle of Joint Understanding of Risk and using the ERICPD hierarchy for risk control as appropriate
C	**COMMUNICATIONS** How are we going to initiate and maintain communications with all partners and interested parties? Other means of communication, understanding of inter-agency communications, information assessment, media handling and joint media strategy
H	**HUMANITARIAN ISSUES** What humanitarian assistance and human rights issues arise or may arise from this event and the response to it? Requirement for humanitarian assistance, information sharing and disclosure, potential impacts on individuals' human rights

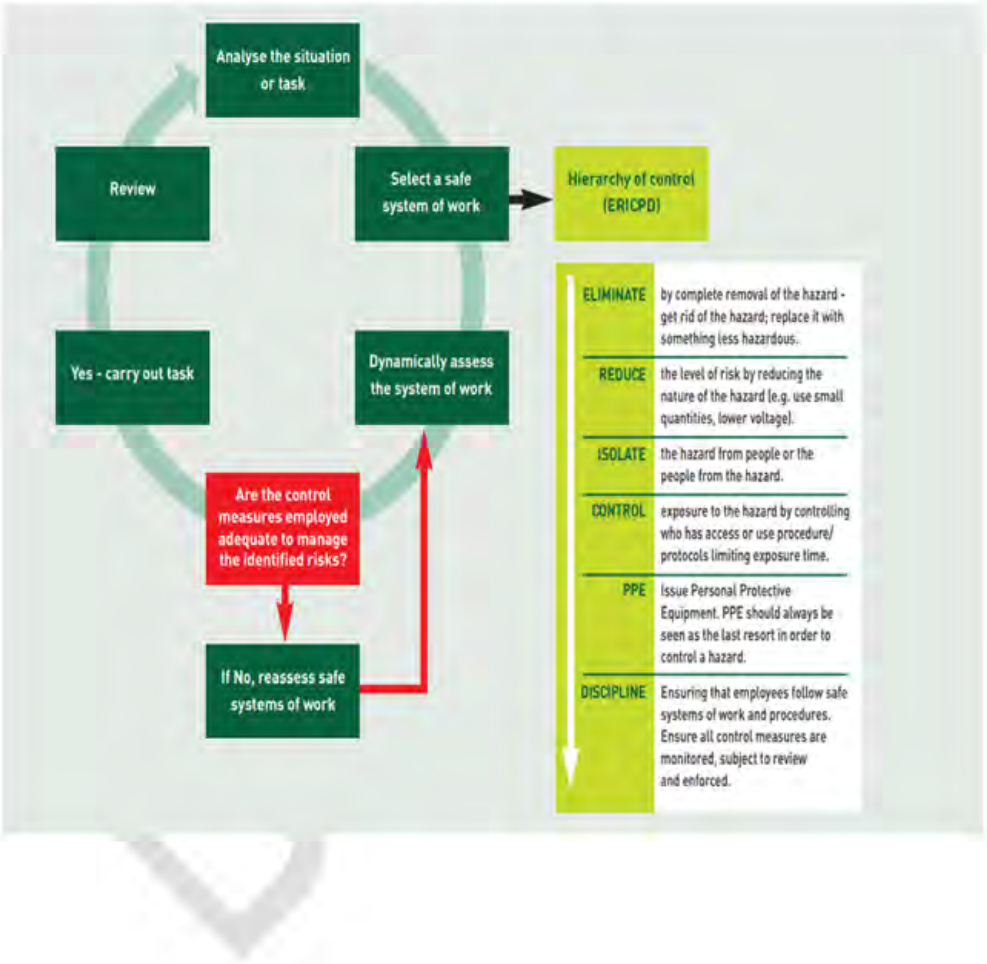
When using IIMARCH to prepare a briefing it is helpful to consider the following:

- Brevity is important – if it is not relevant, leave it out

- Communicate using unambiguous language free from jargon and in terms people will understand
- Check that others understand and explain if necessary
- Consider whether an agreed information assessment tool or framework has been used.

Appendix E: ERICPD - Hierarchy of Control Measures

The figure below provides an overview of how Commanders and responders will approach assessing and then controlling the hazards and risks present at the scene.



Appendix F: *Generic Ambulance Strategic Intent

It is the intention of the Northern Ireland Ambulance Service (NIAS) to deal with any incident in an appropriate manner which promotes and saves life, reduces humanitarian suffering and is compatible with the vision and values of NIAS. Through effective co-ordination, sound planning and good leadership the Strategic Commander will:

- Maintain public confidence and minimise the impact of any occurrence by ensuring that NIAS are responding rapidly and effectively to the event and / or incident
- Ensure that the NIAS response is coordinated and integrated with the wider health system and other responding agencies where applicable
- Maintain effective capacity management within the routine Emergency and Urgent Care Service, the Emergency Ambulance Control and PCS services.
- Assess and identify any gaps in the response capability of the organisation for dealing any incident.
- Through the identification and use of mutual aid, minimise the impact on the Emergency Ambulance Control, PCS Services and normal operational functions.
- So far as is reasonably practicable, take all measures to safeguard the following people under the terms of health and safety legislation
    - NIAS staff and other responders
    - Local communities
- Ensure public messages are co-coordinated with other agencies and partners and maintain a positive reputation for the trust
- Ensure effective Business Continuity and recovery arrangements are in place across the organisation and review where necessary
- Provide support and representation at the strategic coordination centre (SCG) where appropriate
- Create and maintain a well-documented, auditable plan and decision log for the event and / or incident at all levels of command

**Adapted from Annex 7: National Ambulance Service Command and Control Guidance V5.0, 2024*

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Appendix G: NI HEMS

NI HEMS was established in 2017. The HEMS Clinical Lead is supported by a number of consultants, a mix of Anaesthetic and ED consultants from across all 5 Health Trusts in NI. The HEMS Operational Lead is supported by a number of Paramedics. There is a dedicated Air Desk in Emergency Ambulance Control staffed by one of the HEMS paramedics. The call sign for NIHEMS is Heli-Med 23, the team can also respond by road using an RRV Call sign Delta 7.

NIHEMS currently operate one critical care team out of Maze Long Kesh site (MLK) in Lisburn, covering all of Northern Ireland. They are available for 12 hours per day primarily between 7:00 and 19:00.

NIHEMS respond to seriously ill and injured patients and provide critical care interventions and support.

NIHEMS are likely to be dispatched to any significant/major incident standby/declared major incident as part of the initial response. The NIHEMS role in a major incident is two-fold, due to the speed of response it is likely that the HEMS team will arrive as the incident is developing and NIAS Command and Control structures are not fully established, in this instance members of the HEMS team may be best placed to assume some of these roles. *EG Medical Advisor, Casualty Clearing officer, Incident Commander, Primary Triage Officer.*

When sufficient incident management resources have arrived the HEMS team may then be able to resume their clinical role and provide advanced clinical care and transport.

The role of the HEMS team at a significant/major incident will be determined by the Ambulance Commander and Medical Advisor to ensure NIAS deliver the maximum benefit to the maximum number of casualties.

In the event of a Major Incident being declared by NIAS it is a probability that available staff will be requested to return to duty, any off duty HEMS Paramedics responding to such a request should report to their nearest ambulance station as per the NIAS Major Incident plan and not MLK. Off Duty HEMS Doctors should follow the guidance contained in their own Trust Major Incident Plan.

There may be the opportunity for HEMS to deploy a Doctor/ Advanced Paramedic team from MLK outside current HEMS Operational hours . Any such deployment will be strictly co- ordinated by the HEMS Operational/ Clinical Leads and cannot be guaranteed.

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Appendix H: Specialist Response

Marauding Terrorist Attack /Chemical, Biological Radiological Nuclear Incident

In the event a Major Incident is declared in response to an MTA or CBRN incident the relevant response plan will be implemented, and reference made to the EOC Action Cards in relation to the respective incident type in order to ensure that the correct specialist resources and equipment are deployed in addition to the Major Incident Response.

MTA

NIAS maintains a 24/7 MTA Response capability in compliance with MTA Joint Operating Procedures Edition 3

CBRN

NIAS maintains a CBRN response capability lead by the Hazardous Area Response Team, NIAS has a limited number of CBRN Commanders who can manage CBRN Incidents.

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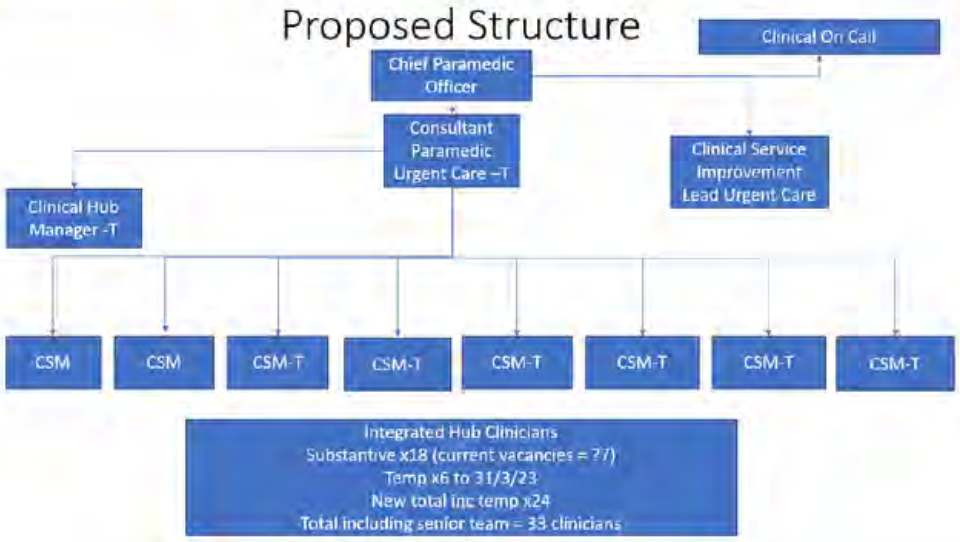
Appendix I: NI Clinical Hub

The NIAS Integrated Clinical Hub (ICH) forms a key element of the Trust's contribution towards the DoHs strategic aim of 'Getting it Right First Time'. Clinicians assess 999 calls at the point of contact to determine the most appropriate healthcare needs, in many cases without requiring an ambulance response to scene. Additionally, the ICH team, led by Clinical Support Managers during peak demand times, review waiting 999 calls to ensure patients at risk of deterioration or requiring a higher acuity response are allocated the appropriate priority. This will be particularly important during a significant/major incident response where the risk in the waiting 999 stack is increased.

Proposes structure??



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Appendix J: NIAS Peer Support.

The NIAS peer support team provides support to staff following traumatic incidents,

The peer supporter is present in a neutral capacity, not to advise or counsel the individual.

They are there as a listening ear and to comfort them if they become distressed. The peer supporter is bound by strict confidentiality and does not keep any written record of the occasion. They cannot be called upon at any point to ask for their opinion, or provide what may deemed as evidence which may be used in forming a decision for or against the individual. The exceptions to this are if the staff member discloses any intention to harm them self or others, then a healthcare professional must be informed.

Peer support can be reached via email: staff.peersupport@nias.hscni.net or

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For PSNI use only

Uploaded to MIPP

Name	
Date	
Time	

Appendix K: Casualty Loading Point Documentation.

Appendix 1: Ambulance Loading Point Documentation Form

NIAS/PSNI Ambulance Loading Point Documentation Form

Instructions for use:

- Once the Ambulance Loading Point is established a hard copy version of this form should be used to record those going to hospital by ambulance. **Print in A3 landscape when possible. Complete in pen in BLOCK CAPITALS. Leave details blank if currently unknown.**
- The form can be completed by NIAS or PSNI depending on available resources. PSNI will identify an officer with responsibility for uploading an image of each form to the Major Incident Public Portal (MIPP) and PSNI resource to then type this information into the MIPP.
- If a friend/family member is travelling with the patient in the vehicle, please enter their details on the form so they can be accounted for.
- If the patient is saying they need to report a friend/family member missing, enter this below so that PSNI can arrange for a missing person report to be completed or by recording the initial detail in their personal notebook and uploading an image of this to the MIPP.

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Completed by: Name:			NIAS ☐ PSNI ☐	Date:		Location:			Sheet No.:
Patient Name (if known)	NIAS Vehicle Fleet No.	Receiving Hospital	Current Triage Status (P1/2/3)	Male / Female / other	Under 18? Y/N	Conscious? Y/N	Friend/ family in ambulance? Y/N (if Y, enter name)	Patient missing a friend/family member? Y/N (if Y, take note on misper or personal note book)	*If in use:* Stick a copy of the patient's cruciform barcode

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Appendix L: Emergency Operations Centre Procedure's/SOP's

Significant Incident Checklist

Major Incident Checklist

Mass Casualty Incident Checklist

Appendix M: Glossary of Terms

BASICS British Association for Immediate Care Schemes

BCM Business Continuity Management

BIA Business Impact Analysis

BRC British Red Cross

C2 Command and Control

CCSML Casualty Clearing Station Medical Lead

CSCATTT Mnemonic – Command & Control, Safety, Communications, Assessment,

Triage, Treatment and Transport

CBRNE Chemical, Biological, Radiological, Nuclear and Explosives

CCA Civil Contingencies Act 2004

CCF Civil Contingencies Framework 2023

CCMA Casualty Clearing Medical Advisor

CCP Casualty Collection Point

CCS Casualty Clearing Station

CLP Casualty Loading Point

DMO Direct Mode Operation

DH Department of Health

DMP Demand Management Plan

DRA Dynamic Risk Assessment

IRU Incident Response Unit

ISU Incident Support Unit

M/ETHANE Mnemonic – Major Incident (Declared or Stand-by), Exact location, Type of

Incident, Hazards, Access, Number of casualties and Emergency Services

(required and present)

MA Medical Advisor

MCA Maritime & Coastguard Agency

MCV Mobile Control Vehicle

MIMMS Major Incident Medical Management and Support

MoD Ministry of Defence

MOU Memorandum of Understanding

MRT Mountain Rescue Team

MTA Marauding Terrorist Attack

NACC National Ambulance Coordination Centre

NARU National Ambulance Resilience Unit

NIHEMS Northern Ireland Helicopter Emergency Service.

NIAS Northern Ireland Ambulance Service HSC Trust

PPE Personal Protection Equipment

PTS Patient Transport Service

RD Resilience Direct

REPPIR Radiation Emergency Preparedness and Public Information Regulations

RRV Rapid Response Vehicle

SCC Strategic Coordination Centre

SCG Strategic Coordinating Group

SJA St John Ambulance

SOP Standard Operating Procedure

SORT Special Operations Response Teams

SMA Strategic Medical Advisor

STAC Science & Technical Advisory Cell

SRC Survivor Reception Centre

TCC Tactical Coordination Centre

TCG Tactical Coordinating Group

ERICPD Mnemonic – Eliminate, Reduce, Isolate, Control Measures, PPE and Discipline

EOC Emergency Operations Centre

EP Emergency Preparedness

EPRR Emergency Preparedness, Resilience and Response

FCP Forward Control Point

FD Forward Doctor

HALO Hospital Ambulance Liaison Officer

HART Hazardous Area Response Team

HAZMAT Hazardous Materials

IIMARCH Mnemonic – Information, Intention, Methodology, Administration, Risk,

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TRUST BOARD

PRESENTATION OF PAPER

Date of Committee:	12 December 2024
Title of paper:	NIAS Research and Development
Brief summary:	Presentation on Research and Development activities at NIAS, presented to Trust Board on 12 December 2024.
Recommendation:	**For Approval** ☐ **For Noting** ☒
Previous forum:	SMT 3 December 2024
Prepared and presented by:	Julia Wolfe Neil Sinclair
Date:	29 November 2024

NIAS Research & Development

Julia Wolfe

R&D Manager

November 2024

Northern Ireland Ambulance Service
Health and Social Care Trust

BE PART OF RESEARCH

Why is research important for NIAS?

Research-active healthcare organisations have:

- **Better outcomes** for patients, e.g. **reduced mortality rates** (Ozdemir et al. 2015, Jonker and Fisher 2018)
- **Improved organisational performance** (Boaz et al. 2015, Jonker et al. 2021)
- **Improved staff performance** (Harding et al. 2017)
- **Improved staff satisfaction** (Harding et al. 2017)
- **Reduced staff turnover** (Harding et al. 2017)

What does research look like in the NHS?

- Advanced Paramedics in Critical Care (APCC)
- Advanced Paramedics in Urgent Care (APUC)
- Consultant Paramedics

- Advanced Practitioners NMAHP

NIAS R&D Milestones

HSC Northern Ireland Ambulance Service Health and Social Care Trust

BE PART OF RESEARCH

NIAS R&D Milestones

Governance → C&C → R&D Strategy → R&D Oversight Group → RPIC → 1st Research Paramedic → 2nd Research Paramedic

R&D VISION

Our vision is to realise the research potential of NIAS in order to improve the quality of care we provide for our patients.

R&D MISSION

Our mission is to develop a highly skilled and knowledgeable workforce to deliver innovative research, within a culture that supports research excellence throughout the Trust, in order to improve the quality of care we deliver.

STRATEGIC AIMS

- To develop the confidence, skills and workforce required to conduct high quality, robust research
- To build the infrastructure to facilitate high quality, robust research
- To conduct and implement high quality, robust research

Skilled, Confident and Sustainable Workforce	***Research Infrastructure***
Research Implementation	***Research Aligned with Clinical Practice***
Culture of Research Excellence	

NIAS Research Public Involvement Committee (RPIC)

- Established in Feb 2023
- 5 members of the public
- Meet at least 6 times a year
- Have input into many R&D projects at various stages

RPIC

Research Public Involvement Committee

Research Paramedics

March 2025

June 2025

Completed Projects

CDM TBI Study

48 responses
4th out of all UK ambulance services

Pre-Feed Real Diary Study

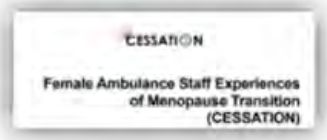
28 NIAS staff recruited
2nd place in UK ambulance services

NIAS Qualitative Pathways Study

Ready for publication in BPJ

Cessation

100 NIAS staff responded to this study



CATNAPS Study

NIHR Portfolio Study
Co-producing an ambulance trust national fatigue risk management system for improved staff and patient safety

CATNAPS: Fighting fatigue in the NHS ambulance workforce

Stroke Covid Study with Edel Burton, UCC

UCC
University College Cork, Ireland
Coláiste na hOllscoile Corcaigh

Complex Case Team

Potential Frequent Callers project
Published in JPP

Ongoing Projects

AMBOFALL

Ambulance response to older adults who have fallen

Keele University / WMAS

Cancer Registry

Data linkage study examining NIAS' role in cancer patient care in last year of life

NIAS / QUB / NI Cancer Registry

QUB PhD CAST Award

First PhD student looking at demand and capacity modelling

NIAS / QUB

Palliative Care

Palliative / End of Life care

NIAS / UU / Marie Curie

RESCUERS Study

Factors influencing healthcare workers decisions to wear PPE

University of Hertfordshire

RCCT Study

Ambulance Research Capacity building and culture national study

NIAS

EAC / NEAC Wellbeing

Impact of Shared Reading model on wellbeing of control room staff

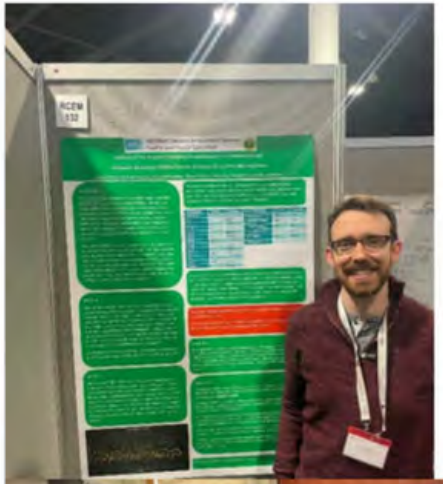
NIAS / Verbal

PEACE 3

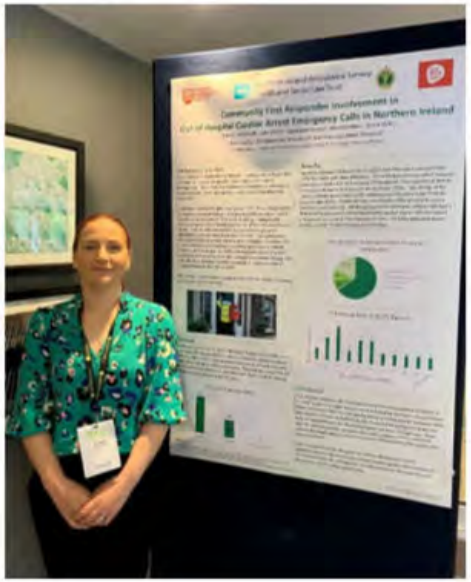
Violence and Aggression towards EMS staff

4 Nations Approach / WAST

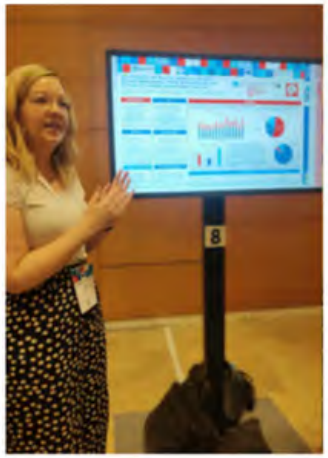
Research Impact

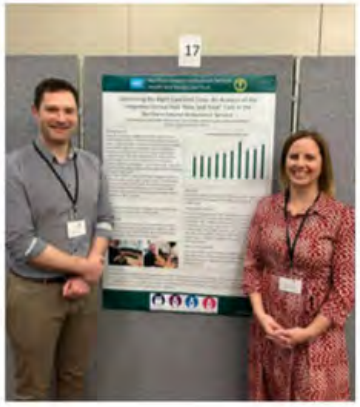


Research Impact



Research Impact





Research Output

Paramedicine

Paramedicine
OnlineFirst
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Sage Journals

Primary research (any research design)

Exploring undergraduate paramedic students' understanding and experiences of person-centred care while on practice placement

Lorraine McAteer[1] and Donna Brown[2]

Objective To explore paramedic students' understanding and experience of the perceived facilitators and barriers to implementing person-centred care in urgent and emergency practice-based placement situations.

Aim To explore paramedic students' understanding of this concept and how it may be applied to clinical practice.

Methods A non-probability convenience sample of participants was drawn from a second-year undergraduate Bachelor of Science (Hons) programme in Paramedic Science, at a United Kingdom university. The programme was underpinned by the Person-centred Practice Framework. Undergraduate paramedic students participated in face-to-face, audio-recorded, semi-structured interviews. A qualitative reflexive thematic analysis was then conducted to identify themes arising from the data.

Results Ten participants were interviewed. Four key themes emerged from the data: (1) realising person-centred prerequisites which have two sub-themes – curriculum and reality of practice, (2) challenge of high-acuity calls, (3) developing a rapport with vulnerable people and, (4) factors in the macro environment.

Conclusion Paramedic students witnessed moments of person-centred practice and were enabled to reflect on their learning experiences in positive ways, by working with paramedics/practice educators. However, their person-centred ideals were constantly challenged as students negotiated to work in complex, dynamic situations and in a health system under pressure.

Keywords
paramedic students, person-centred care, practice-based placement, curriculum, qualitative research

PARAMEDIC PRACTICE

Research

Prehospital anaesthesia by a helicopter emergency medicine service: a review

Abstract

PARAMEDIC PRACTICE

Research

A mass distribution letter as an early intervention for potential frequent callers

Abstract

Health Expectations

WILEY

ORIGINAL ARTICLE

'If It Was Easy Somebody Would Have Fixed It': An Exploration of Loneliness and Social Isolation Amongst People Who Frequently Call Ambulance Services

ABSTRACT

ORIGINAL RESEARCH

International Comparison of Ambulance Times Terminology and Definitions: A Benchmarking Study

Burton E, Willis D, Boseley E, Deasy C, Franklin M, Garrison D, Henderson C, Hutchinson H, Kearney PM, Krammel M, Lloyd A, Loudon W, Quinn R, Masterson S, McCarthy VJC, Merwick A, O'Donnell C, Overton J, Van de Pas H, Wolfe JH, Zavadsky M, Crosbie-Staunton K, Buckley CM

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5. Niagara Emergency Medical Services, Niagara-on-the-Lake, Canada.
6. Richmond Ambulance Authority, Richmond, VA, USA.
7. Scottish Ambulance Service, Edinburgh, United Kingdom.
8. Hato Hone St John Ambulance Service, Aotearoa, New Zealand.
9. Emergency Medical Services Vienna, Vienna, Austria.
10. University of Galway, Galway, Ireland.
11. International Academies of Emergency Dispatch, Salt Lake City, Utah, USA.

INTRODUCTION

Ambulance times are internationally recognised Key Performance Indicators (KPIs) for prehospital care. However, the terminology and definitions surrounding ambulance times and time intervals are not standardised across countries. This can pose challenges for clinicians and researchers when synthesising international evidence or comparing countries/regions in this context. Standardisation or alignment of terminology and definitions would accommodate more accurate international comparison.

International benchmarking, by comparing ambulance times between countries is a valuable method to help to identify strengths and weaknesses across healthcare systems. Benchmarking has a long history of being used in the healthcare sector to compare outcomes across organisations. It also facilitates shared learning and application of best practice. If applied correctly, benchmarking can highlight unnecessary variation and work to reduce its occurrence.

This study aims to compare terminolog... time intervals from the ambulance serv... international benchmarking.

Annals of Emergency Dispatch & Response

Education

Influence of simulation fidelity on student learning in a prehospital setting

Abstract

The Future

- Research Paramedics
- Research Assistants / Fellows
- Research Administrators

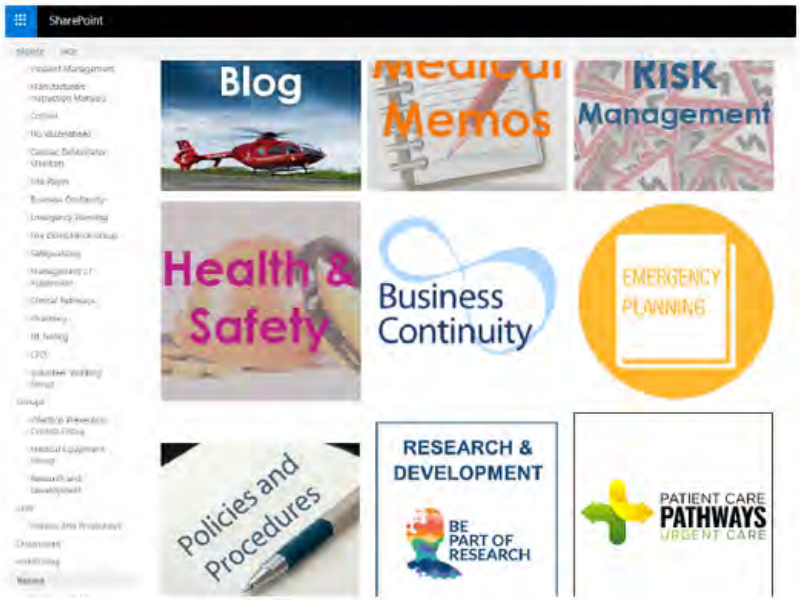
- Temp / Permanent
- Full time / Part time / Secondments

- CARC – Clinical Academic Research Careers
- PhD opportunities

- Clinical Audit function

- Clinical / Commercial studies

- Portfolio studies / Research income



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BE PART OF RESEARCH

Northern Ireland Ambulance Service
Health and Social Care Trust

PEOPLE, FINANCE & ORGANISATIONAL DEVELOPMENT COMMITTEE

Thursday 26 September 2024 at 9.30am in the Boardroom, NIAS HQ

MINUTES

			Paper enclosed	Presented by
1.	Attendees and Apologies			

Present:

- Jim Dennison Committee Chair
- Paul Corrigan Non-Executive Director
- Phelim Quinn Non-Executive Director

In Attendance:

- Maxine Paterson Deputy CEx & Director of Planning, Performance and Corporate Services
- Ciaran McKenna Assistant Director of Operations
- Laura Turley Senior HR Business Partner & Change Manager
- Michelle Lemon Director of Human Resources
- Simon Christie Interim Director of Finance
- Christopher Young Management Trainee- Observing

Apologies:

- Rosie Byrne Director of Operations
- Lorraine Gardner Assistant Director of Human Resources

2.	Procedure			
	2.1	Declaration of Potential Conflicts of Interest		
No conflicts of interest were declared.				
	2.2	Quorum		
The meeting was confirmed as quorate.				
	2.3	Confidentiality of Information		
Attendees were reminded of the confidentiality of the meeting.				
3.	Previous Minutes: - 3 July 2024 - 15 August 2024 **For Approval**		PC26/09/24/01	Chair
The minutes for previous meetings were approved.				
4.	Matters Arising		PC26/09/24/02	

	Operations Management Restructure – Implementation Plan Update – Assistant Director of Operations Ill Health Retirement Update – Director of HROD Updates were provided as follows:		

- **Update Provided by Ciaran:** The project team is meeting weekly, and a structured approach is in place, including Terms of Reference, a Gantt chart, and a risk register with reporting lines.
- **Equality Screening:** Completed and assessed as minimal impact, requiring no full equality impact assessment. The screening results will be discussed at the DVP meeting on 2 October.
- **Communication Efforts:**
  - Updates were shared via a daily bulletin on 14 August.
  - Meetings held with Area Managers on 20 August, Station Officers, Supervisors, and HALOs on 21 August, and Trade Unions on 22 August.
  - Face-to-face meetings took place across regions between 16–20 September, with two virtual sessions planned to ensure all PCS staff are informed.
- **Staffing:** Job descriptions for scheduled care service lead, sector lead, and team lead positions are under evaluation, with results expected on 8 October 2024. A workforce assessment identified 74 staff needing 1:1 meetings.
- **Risks:** The risk register includes 10 risks, with one notable risk around project team capacity, as they are also managing other major initiatives.
- **Budget:** A year 2024/25 spend profile is almost complete, with further work needed for years 2025/26 and 2026/27 due to uncertainties in fleet and estates.
- **Concerns Raised:**
  - Jim raised concerns about staff resistance to change, noting issues of "change fatigue" and employment security. Michelle acknowledged this and emphasised ongoing efforts to reassure staff.
  - Phelim noted the importance of maintaining quality patient services during the transition.
- **Action:** Laura will issue a high-level summary of the implementation plan to PFOD members.

Ill Health Retirement

- **Update from Michelle:** Processes are being streamlined to improve employee support throughout retirement procedures. This includes clearer communication lines and HR Advisor involvement.
- **Recognition for Retirees:** A letter from the Senior Executive will mark retirements from 1 October 2024 as a formal acknowledgment of employee contributions.
- **Action:** Review the retirement process in a year, as recommended by Jim, to ensure improvements are sustained.

5.	Finance Report (Month 4) **For Noting**	PC26/09/24/03	Interim Director of Finance

Report presented by Simon

- The Trust continues to report a break-even position year to date.
- Underspend in pay budgets due to vacancies are being offset by overspends in non-pay budgets.
- The level of vacancies is being partly managed by additional planned overtime and use of the IAS.
- Two new slides have been developed to report overtime and IAS against budgeted

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levels in order to further support Directors and management.

- The Trust also continues to forecast a full year break-even position. This is based on planned recruitment and the filling of vacancies in the 2nd half of the year.
- Detail profiling of budgets continues to be developed and is due to be completed in October. This will further help inform and strengthen the ongoing financial reporting.

Committee Feedback:

- Paul praised the finance team for their efforts and suggested regular reviews of savings plans to improve financial oversight.
- Simon mentioned that upcoming reports would include a deeper analysis of savings, with details on the £1 million savings target.
- Phelim and Jim expressed appreciation for the clarity and detail of Simon's presentation.

Action: Simon to present a detailed breakdown of savings and the £1 million savings plan at the next PFOD meeting.

6.	Independent Review of Financial Process Progress Report **For Noting**	PC26/09/24/04	Interim Director of Finance

Independent Review of Financial Process

- **Overview by Simon:** Of the nine original recommendations, three remain open:
  1. **Stable Structure:** Recruitment of permanent finance staff is ongoing to build a more sustainable structure.
  2. **Enhanced Reporting:** Finance reports are being developed to include more detail.
  3. **Relationship with SPPG:** Routine meetings are helping to strengthen the relationship with SPPG will continue.
- **Sustainability Discussion:** Paul highlighted the importance of embedding these improvements into team structures to ensure continuity regardless of senior management changes.

7.	HR & OD Balance Scorecard **For Noting**	PC26/09/24/05	Director of HR&OD

HR & OD Balance Scorecard

- **Report by Michelle:** Absences slightly increased over the summer but have since improved, though not to the desired levels.
- **Legacy Cases:** Laura provided an update on 81 active cases, 27 of which are complex, with strategy meetings and interventions underway to address them. Workshops and early intervention strategies have been implemented.
- **HR Structure:** Six permanent HR roles have been established, with five currently filled; one interim agency staff member may be brought on until a permanent hire is made.
- **Additional Discussion Points:**
  - Jim emphasised the importance of ensuring HR staff possess strong people management skills.
  - Phelim praised the early intervention focus, which aims to prevent issues from escalating.

Action: Laura to provide a breakdown of the 81 cases to the committee.

8.	Maximising Attendance: - Progress Report **For Noting**	PC26/09/24/06	Director of HR&OD

Maximising Attendance

- **Report by Michelle:** Notable progress on attendance; the focus remains on hotspots and sustained absence cases. Mental health-related absences are a particular area of concern, with new support options under review.
- **Medical Redeployment:** Processes and tracking for redeployment have improved, with fewer staff now entering the redeployment register.

- **Occupational Health (OH) Issues:** Challenges include limited OH practitioner availability and budget constraints.
- **Committee Feedback:**
  - Phelim inquired about manual handling compliance; Laura responded that improvements are underway.
  - Paul asked about the summer absence spike, attributed to family and carer responsibilities and shift scheduling issues.
  - Laura noted that new shift patterns have been introduced to improve work-life balance.
- **Action:** Explore OH service alternatives, potentially through private providers, subject to budget constraints.

9.	Organisational Culture 9.1 Proposal for organisational culture & improvement verbal update 9.2 Sexual Safety National Work stream **For Noting**	 No paper PC26/09/24/07	Director of HR&OD

Organisational Culture & Improvement Plan

- **Update from Michelle:** Developing a cohesive, three-year cultural improvement plan, with funding and procurement options under review. This initiative will focus on behaviour, engagement, and creating a restorative, trust-based culture.
- **Committee Feedback:** Phelim stressed the need for NIAS's approach to be value-led, with a commitment from Non-Executive Directors (NEDs) to support this work.
  Action: Present a tangible culture improvement plan at the next PFOD meeting.

Sexual Safety Workstream

- **Overview by Michelle and Laura:** A focus on zero tolerance for misconduct, especially in protecting female staff. Discussions included accountability and the importance of a safe workplace for all employees, particularly new recruits who are often women.
- **Committee Feedback:** Emphasis on clear messaging about acceptable behaviours and a zero-tolerance stance toward harassment.
- **Ongoing Action:** Ciaran confirmed that new staff are briefed on behavioural expectations during induction sessions with ADs.

10.	Update on addressing recommendations in HR Audit **For Noting**	PC26/09/24/8	Director of HR&OD

Update on HR Audit Recommendations

- **Progress:** Majority of audit recommendations closed; improvements in governance are noted. Two items remain, with work ongoing.
- **Audit Feedback:** Internal Audit expressed satisfaction with the current position and signed off on improvements.

	Date of next meeting: **28 November 2024 at 9.30am in the Boardroom, NIAS HQ**		
11.	Any Other Business		

HROD Directorate Restructure

- **Restructuring Update by Michelle:** Two new Deputy Director roles created to enhance HR

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leadership, with the aim of making regional posts more attractive for potential hires.

Board Effectiveness Discussion

- Members discussed improving meeting efficiency, reducing information duplication, and prioritising agenda items. A previous survey on meeting effectiveness was referenced to guide potential changes.

SIGNED: _____

DATE: _____4 December 2024_____

Northern Ireland Ambulance Service
Health and Social Care Trust

MINUTES OF THE SAFETY, QUALITY, PATIENT EXPERIENCE AND PERFORMANCE COMMITTEE HELD AT 9:30AM ON THURSDAY 12 SEPTEMBER 2024 IN THE BOARDROOM, NIAS HQ

PRESENT:	Mr D Ashford -	Committee Chair
	Mr P Quinn -	Non-Executive Director
	Mr P Graham -	Non-Executive Director
IN ATTENDANCE:	Ms L Charlton -	Director of Quality, Safety & Improvement
	Mr N Sinclair -	Chief Paramedic Officer
	Mr R Sowney -	Senior Clinical Advisor
	Dr N Ruddell -	Medical Director (for agenda Item 6 and 7 only)
	Ms C Hanna -	Pharmacy Lead (for agenda item 6 only)
	Ms H Maxwell -	Continuous Development Manager (for agenda item 7 only)
	Ms H Sharpe -	Assistant Director Emergency Preparedness, Resilience (EPRR) (for agenda item 8 only)
	Ms R Finn -	Assistant Director of Quality, Safety & Improvement (for agenda item 9 only)
	Mr C Young	General Management Trainee (for observation)
	Mr S Maguire	Quality & Service Improvement Lead (for observation)
	Ms M Smith -	Notetaker
APOLOGIES:	Ms M Paterson -	Director of Planning, Performance & Corporate Services
	Ms R Byrne -	Director of Operations
	Ms M Lemon -	Director of HR & OD
	Mr S Christie -	Director of Finance
	Mrs C Mooney -	Board Secretary

1. Apologies & Opening Remarks

The apologies were noted.

The Chair welcomed members to today's meeting.

The Chair welcomed and noted the attendance of Mr Christopher Young and Mr Sean Maguire for observation only.

2. Procedure

2.1 Declaration of Potential Conflict of Interest

No declarations were made.

2.2 Quorum

The Chair confirmed that the Committee was quorate.

2.3 Confidentiality of Information

The Chair confirmed emphasised the confidentiality of information.

3. Previous Minutes (SC12/09/24/01)

The minutes of the previous meeting on 13 June 2024 were **APPROVED** by the Committee.

4. Matters Arising (SC12/09/24/02)

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

Ms Charlton discussed actions arising at the Safety Committee Meeting held on 12 June 2024 as follows:

- Action 1 - Cat 2 response to be included in Corporate Risk Register, Ms Charlton provided background information, noting issues around Category 2 response times as a result of system wide pressures, ASOS arrangements and internal actions related to oncoming crews relieving crews at end of shifts. She advised that SMT gave consideration as to whether this issue should be added to Corporate Risk Register as a separate risk. SMT agreed that this would be put forward for consideration at the next ARAC meeting.
- Action 2 – it was noted that this action was now closed.
- Action 3 – Mr Sinclair noted that work in relation to CSO's can be seasonal and related to educational calendars. It was noted that this action remains ongoing.
- Action 4 – Mr Sinclair provided an update in relation to Cardiac Arrest outcome data, data review highlights to date show improvement up to 2023 with slight decline in 2024 further data is required for review and this matter is now expected to be discussed at the next Safety Committee in November. This action remains ongoing.
- Action 5 – Action remains ongoing.

5. Standing Items

(i) Identification of Risk

There was no risk identified at this juncture.

6. Controlled Drugs Update (SC12/09/24/03)

The Chair welcomed Catherine Hanna, Pharmacy Lead for discussion on Controlled Drugs Update. Dr Ruddell commended Ms Hanna for the progress she has made in this area of work to date.

Ms Hanna provided an overview of the update paper, highlights included an update on progression of implementation of recommendations made by the Department of Health Regulatory Group; of 131 recommendations made, 128 have now been implemented and remaining 3 are expected to complete before the end of December.

Mr Ashford enquired about progress on the recommendation regarding securing storage and tracking of Entonox cylinders. A discussion followed in relation to issues arising with storage of Entonox cylinders at hospital emergency departments as these facilities are shared with Independent Ambulance Services (IAS). Mr Sowney noted that some NIAS staff also work for IAS companies, Ms Hanna advised NIAS they are attempting to resolve these issues currently through a series of regular communications with operational staff and expect to resolve matters with plans to arrange face to face training and education sessions. Ms Hanna noted that the majority of Ambulance stations had now resolved the matter of securing storage of gas cylinders, work continue to progress and this task is expected to complete soon for all stations.

Mr Quinn commented on work carried out to significantly reduce Medicine's Regulatory Risk. Dr Ruddell noted that future plans for electronic tracking of controlled drug packs would reduce risks further.

The Chair thanked Ms Hanna and the update report was noted.

7. Clinical Governance and Safety in EOC (SC12/09/24/04

The Chair welcomed Ms Hanna Maxwell, Continuous Development Manager and invited her to present an update in respect of clinical governance and safety compliance with the Emergency Operational Control Centre (EOC). Presentation highlights included:

- NIAS EOC, EMD 12 week training course is now accredited, this includes MPDS certification, mentoring and clinical understanding.

- Areas of focus for the presentation, included a review of call coding for the period April 2023 to March 2024.
- Of the 253 calls reviewed 98.8% of correctly coded and received and appropriate response.
- The Chair enquired about the percentage of calls reviewed over total amount of calls received during the period referred to. Ms Hanna advised that the review looked at 3% of calls received during the period, she noted that they aspired to check a high percentage if funding was available.
- Ms Hanna discussed the Quality Improvement Cycle; she noted continuous support of staff individually.
- EOC awards ceremony planned for October 2024.
- NIAS are represented on the Clinical Focus Group with IAED, the aim is to proactively participate in proposals for change, learning form other services and continuity between services.
- Mr Quinn discussed changes in EOC call handling and how this linked with SAIs. Ms Charlton advised that Ms Maxwell is now part of the RRG meeting due to her expertise and knowledge of emergency call handling.
- Ms Maxwell noted that EOC received a lot of compliments regarding EMD call takers, particularly during cardiac arrest incidents.
- There was a discussion re working towards training to increase EMD's clinical knowledge, Mr Sinclair noted the MPDS system is developed with a clinical background and follows a protocol driven scripted process. It was acknowledged that there is an element of clinical awareness in MPDS training for EMDs.

The Chair thanked Ms Maxwell for her comprehensive presentation and update.

8. Emergency Preparedness, Resilience and Response (EPRR) Update (SC12/09/24/05)

Ms Sharpe provided an overview of the EPRR update paper, she advised that the EPRR team had undergone significant changes since the last update. An Assistant Director has recently been appointed to the team and recruitment is underway for two further substantive EPRR Managers (Band 8) to lead on Specialist Operations and Civil Contingencies. Long-standing capacity issues are expected to be addressed upon completion of these recruitments.

Work has commenced with the NIAS Transformation Team to streamline a number of areas of transformation in relation to AACE, Manchester Arena Inquiry (MAI) and Internal Audit. Ms Sharpe advised that recommendations emanating from the MAI are expected to be implemented as business as usual for EPRR teams nationally and will now form part of core education for teams going forward.

The Team are also looking into plans to expand HART to include collaborative work with NIAS counterparts in the Republic of Ireland. T

There was a discussion re use of Independent Ambulance Services (IAS) at upcoming and future large events. Ms Sharpe advised that an exercise was underway to collect and collate data regarding use of IAS at large events and potential impacts this may have in relation to business as usual for NIAS.

Ms Sharpe advised that NIAS have been asked to provided on site emergency medical cover at the International Golf Open competition next summer in Portrush, this work is being costed.

It was noted that Commander training remains ongoing, it is expected that changes will be made to the on-call rota going forward, ensuring that all those on-call are suitably trained.

Mr Quinn enquired about future funding in relation to the recommended expansion of HART capacity and operational hours which will require 24/7 operational cover. Ms Sharpe noted that a paper is being prepared in regard to this, which will provide an overview of the future structure and capacity of HART in Northern Ireland. Work in relation to proposed business cases etc is in the early stages but is underway. Proposals will include funding for additional operational capacity and associated related equipment, fleet and estate. The Chair suggested it would be good to have a discussion with the Department of Health at this early stage, he also suggested that interim meetings on this subject are to be continued and that this subject is added as a standard agenda item to this Committee going forward.

The Chair discussed options in relation to Commander Training in light of NARU being unable to provide this training in Northern Ireland at present. Ms Sharpe advised that NIAS are not funded for this training in the same way that national ambulance services are funded in the UK; ideally NIAS would prefer NARU to come to Northern Ireland to provide this training. It was noted that EPRR team are currently in the early stages of considering bespoke or unique Commander training in Northern Ireland to include "Blue Light" training across all emergency services.

Action: Continue Interim Meetings in relation to EPRR and consider adding HART Expansion Update as standard agenda item to this committee going forward.

9. Service User Feedback (SC12/09/24/06)

(i) Complaints Annual Report 2023-24

Ms Charlton apologised that the paper included in meeting pack was not the final edited version of the paper, although the changes were minor, it was noted that the latest version would be circulated following this meeting.

(ii) Complaints / Compliments Update

Ms Charlton provided an overview of the Complaints / Compliments Update, points of note included:

- There was a significant increase in complaints in the last quarter in relation to increase in waits for emergency response.
- There were also complaints about non-emergency response times largely in relation to patients requiring transport for Dialysis services.
- It was noted that a significant number of complaints in relation to non-emergency response times were largely received from 3 individuals who regrettably had a poor experience resulting in complaints multiple times.
- NIAS have been unable to meet complaint response time KPI targets of response withing 20 days, with average KPI of 44% of complaints being responded to in the correct timeframe. Ms Charlton noted this is an issue for all HSC Trusts at present.
- Ms Charlton highlighted the increase in regarding staff attitude and behaviour. Mr Sowney requested more detail regarding staff complaints. Ms Charlton described the nature of the complaints and also noted the challenge in the absence of objective evidence in determining the outcome of the investigation such as a complaint regarding a statement a staff member made which was denied by staff member. Ms Charlton described assurance processes into determine the history of complaints and compliments for individual staff members. Mr Sowney suggested engaging with these staff directly to fully understand the nature of the complaints. Ms Charlton advised that where concerns were identified they were considered in terms of required nest steps which could include additional support to staff, professional standard consideration etc.. He suggested it may be worthwhile for station officers to be on site at EDs when they are particularly busy to offer support.
- There were less compliments received this quarter. Ms Charlton drew attention to 3 compliments included at end of the report from the family of a patient with cardiac arrest which the crew responding were able to achieve flow back.

There was further discussion regarding the staff complaints issue and potential resolutions such as delegating staff to a vehicle not a partner when they come on shift. Mr Quinn discussed the need to embed more positive working cultures and that this work could perhaps be looked at as part of the Operational Structure Review project.

The Chair thanked Ms Charlton and the update was noted.

10. Independent Ambulance Service Assurance and Governance Update (SC12/09/24/07)

Ms Charlton provided overview of the Independent Ambulance service (IAS) update. The Committee noted the paper as read.

The Committee discussed key areas of the update which included:

- The most recent non-emergency service provider framework includes 17 providers.
- IAS provide approx. 40k journeys per year, a significant amount of journeys.
- Providers are not currently regulated, this has been discussed with RQIA, and at ground clearing meeting with Department of Health
- Mr Graham suggested that NIAS to correspond with the RQIA on this subject. Ms Charlton referred to the current governance and assurance arrangements in place and noted that IAS providers have worked collaboratively with NIAS in this context. She acknowledged that these arrangements could be strengthened with a 3rd level of defence and alluded to the lack of dedicated resources within the organisation to undertake unannounced inspections and follow up with actions arising..
- It was noted that all HSC Trusts are clients on the BSO Non-Emergency Framework, a discussion ensued regarding the need to send a formal letter from RQIA in the first instance in relation to regulation of IAS. Mr Quinn advised that the formal communication should go to DoH as they would be required to consider the current legislation and would be responsible for making any changes. Mr Sowney suggested that as all 6 Trusts are clients on the framework that consideration should be given to a communication on behalf of all Trusts. Ms Charlton advised that she would discuss with NIAS CEx. The Committee agreed and this was noted as an action to take forward.

Action: LC to discuss formal letter regarding regulation of IAS with NIAS CEx.

11. Infection Prevention Control Key Performance Indicators (SC12/09/24/08)

(i) Environmental and Vehicle Cleanliness Update: 1 April – 31 July 2024

Ms Ruth Finn, Assistant Director of Quality, Safety and Improvement, provided an overview of the Environmental and Vehicle Cleanliness Update for the period 1 April to 31 July 2024. The update was noted as read.

(ii) IPC – 1 April – 31 July 2024

Ms Finn provided and overview of the Infection Prevention Control (IPC) update for the period 1 April to 31 July 2024. Point of note from the update included:

- Hand Hygiene Audits – achieving target KPI of 90% remains challenging to meet. Common issues included non-compliance with "bare below the elbows" policy and overuse of gloves. The Committee discussed the issue of overuse of gloves, the discussion focused on historical training around glove use, which lead to an longstanding culture developing with NIAS on this issue. Ms Charlton advised that further educational pieces of work on this subject will be required commencing with operational line managers. Mr Sowney agreed with Ms Charlton noting the support and encouragement of best practice could not lie solely with the IPC Team and suggested that Station Officers could be more involved.
- Environmental Auditing – IPC has increased frequency of environmental cleanliness Audits and are using a tool based on RQIA inspection tool.
- Management of Alert Organisms and Outbreaks – Ms Finn noted NIAS are awaiting guidance from the National Ambulance Resilience Unit and will move to the next step of preparedness once this has been received.

The Committee noted the update.

12. Date of next meeting

The next Committee meeting will take place on Thursday 21 November 2024 at 9:30am in the Boardroom, NIAS HQ.

13. Any Other Business

The following item was noted:

Ms Charlton discussed cumulation of risk in relation to operational vacancy level and level of sick absence within PCS workforce and the subsequent dependency on IAS. For the Committee's awareness, she noted this had been previously discussed at SMT and it was agreed this should be added to the Corporate Risk Register. The Committee noted the update.

THIS BEING ALL THE BUSINESS, THE CHAIR DECLARED THE MEETING CLOSED AT 12:30PM

SIGNED: _____

DATE: 21 November 2024