Northern Ireland Ambulance Service Health and Social Care Trust

Minutes of NIAS Trust Board held on Thursday 22 February 2024 at 10am in the Boardroom, NIAS HQ, Knockbracken Healthcare Park, Saintfield Road, Belfast BT8 8SG

Present:	Mrs M Larmour	Chair
	Mr D Ashford	Non-Executive Director
	Mr P Corrigan	Non-Executive Director
	Dr P Graham	Non-Executive Director
	Mr P Quinn	Non-Executive Director
	Mr M Bloomfield	Chief Executive
	Ms R Byrne	Director of Operations
	Ms M Lemon	Director of Human Resources & Organisational Development (HR & OD)
	Mr P Nicholson	Director of Finance, Procurement, Fleet & Estates
	Dr N Ruddell	Medical Director (joined the meeting at 11am)
Apologies:	Mr J Dennison	Non-Executive Director
	Ms L Charlton	Director of Quality, Safety & Improvement (QSI)
In Attendance:	Ms M Paterson	Director of Planning, Performance & Corporate Services
	Mr N Sinclair	Chief Paramedic Officer
	Mrs C Mooney	Board Secretary
	Ms R Finn	Assistant Director QSI (obo Ms Charlton)
	Mr K Bloomer	Consultant Paramedic Urgent Care (for agenda item 6 only)

1 **Welcome, Introduction & Apologies**

Welcoming those present to the meeting, the Chair noted the apologies. She said she was delighted to welcome the three new Non-Executive Directors to the meeting - Mr Phelim Quinn, Mr Paul Corrigan and Dr Philip Graham – who alongside Mr Dale Ashford

and Mr Jim Dennison would ensure a full complement of Non-Executive Directors.

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

The meeting was declared as quorate.

2 **Previous Minutes (TB22/02/2024/01)**

The minutes of the previous meeting held on 14 December 2023 were **APPROVED** on a proposal from Mr Ashford. This proposal was seconded by Mr Quinn.

3 **Matters Arising (TB22/02/20234/02)**

Members **NOTED** the Matters Arising.

Mr Ashford noted that, with the exception of one Trust, written responses had now been received to his correspondence expressing concern at the potential risks to patient safety as a result of delayed ambulance handovers.

The Chair asked whether it had been possible from the responses provided to glean a set of agreed actions to be taken forward.

In Ms Charlton's absence, Mr Bloomfield advised that Trusts had acknowledged the issue and had given assurances they were taking it seriously, however few additional actions had been identified. He advised of the introduction by one Trust of a nurse with an enhanced focus on observations of patients waiting in the back of ambulances monitoring hydration, toileting, pain relief etc which had been positively received by NIAS crews.

Mr Quinn said several issues had occurred to him upon reviewing the minutes of the December meeting. The first related to the RCC and its initial impact in terms of addressing ambulance waits outside EDs. He alluded to Ms Charlton's work around the age profile of patients waiting in the back of ambulances and the associated issue of their human rights. Mr Quinn referred to Mr Bloomfield's attendance at the Assembly's Health Committee later that afternoon and said that, while he appreciated the importance of addressing issues on a HSC-wide basis, if NIAS was not seeing any tangible

improvement, the Trust should highlight this. He stressed that the issue of delayed ambulance handovers should not be focussed on numbers of ambulances waiting or for how long but on the fact that those patients waiting in the back of ambulances tended to be elderly vulnerable patients.

Mr Bloomfield said that when he and the Chair had attended the Belfast Trust Board meeting, they had taken the opportunity to share such detail with members. He said that this was much more powerful than merely highlighting statistics of NIAS losing capacity of 25%.

With regard to the RCC, Mr Bloomfield explained that the intention had been to evaluate its work during February to inform whether the RCC should continue beyond the end of March. However, he advised that the six Chief Executives had agreed that it was too early to carry out an evaluation as the RCC had only been in operation for two months. Mr Bloomfield said it had been agreed that the RCC would continue for a further six months to allow a full and proper evaluation to be undertaken. He was of the view that the RCC had brought a sense of improved co-ordination and order across Trusts and Trusts had a better appreciation of pressures being faced by other Trusts. He added that it was not possible to say what the position would have been had the RCC arrangements not been put in place.

Ms Byrne referred to the regular meetings NIAS had with the SET and SHSCT and said that, in addition to these, she and her Assistant Directors would join the three daily escalation meetings with the RCC.

Ms Lemon was of the view that waiting in the back of ambulance was becoming a normal part of the culture. She added that related to this were the rights of staff and their right to work their contracted hours and get home on time. She reminded the meeting that, on occasions, NIAS crews were working shifts of between 15-18 hours and said that, while unacceptable, the practice continued.

The Chair pointed out that responses had now been received to Mr Ashford correspondence and she sought clarification on the next steps.

Mr Ashford believed that the Trust should continue to highlight this as an issue.

The Chair suggested that the responses should be reviewed to determine if there were any apparent trends across the Trusts and to ascertain if work being taken forward in one Trust had the potential to be replicated in another. She said she would be happy to raise the issues at a meeting with her Chair colleagues and Chief Executives with a view to reaching an agreed position.

Mr Corrigan pointed out that all Trusts were involved in the discussions around the GIRFT report.

The Chair agreed and suggested that it would be important to thread together the information received through the written responses from Trusts.

Mr Bloomfield agreed the importance of continuing to raise this issue at the highest levels and advised that it had been the main topic of discussion at the Accountability Review meeting with the Permanent Secretary.

Mr Quinn highlighted the wealth and value of the information held by NIAS and asked what the Trust's communications strategy was around this issue, particularly with politicians. He suggested that there was a need to be more proactive in terms of communications with the general public.

Mr Bloomfield acknowledged that the Trust's communications with the public tended to be reactive. He explained that the Trust regularly received correspondence from MLAs regarding ambulance waits and would issue social media messages periodically in relation to the service being under pressure. He agreed that further consideration needed to be given to communications.

Mr Quinn suggested it would be important to change the narrative through a proactive communications strategy in terms of the ambulance service being viewed by the public as a means of conveyance to EDs. He referred to discussions at the Strategic Planning workshop around the importance of communications with the public as well as staff around the work being taken forward by the Trust.

The Chair advised of work ongoing regionally to look at the narrative across the HSC. However, she stressed there was the need to engage the public to take more responsibility for their own health.

Referring to action point 3 re the GIRFT report, Mr Bloomfield advised that the Trust had now received the first draft of the action plan. He said that the Trust's Senior Management Team had been of the view that the plan had not specifically addressed what GIRFT had described as being the '… *the biggest single risk to patients in the emergency care system of Northern Ireland..'* but focussed on the overall need to improve the flow of patients through a hospital setting.

Ms Byrne advised the meeting that Trusts were scheduled to meet individually with GIRFT representatives on 12 March and said that NIAS would have the first slot in the schedule which would provide an opportunity to highlight the delayed handover issue for the subsequent meetings with other Trusts. She added that a workshop had then been scheduled for 13 March at which Trusts would have a 10-minute slot to present on their service improvement work.

Mr Bloomfield said that NIAS intended to make clear that it expected a stronger response in relation to the need to address ambulance handovers.

The Chair said that, at the end of the meetings with GIRFT, the Board would expect some clarity around the GIRFT statement and how that would be managed and mitigated. She asked that the Board would be kept updated.

The Chair reminded the meeting that the report had documented delayed ambulance handovers as the biggest single risk but yet NIAS could not address this risk on its own and needed the interdependent actions to be addressed by other Trusts.

4 **Chair's Update**

The Chair advised that she had attended a meeting with Ernst and Young in relation to Artificial Intelligence where the Trust had been commended on the wealth of business intelligence that it produced and developments in this area.

Ms Paterson commented that the Trust had discussed its journey in terms of business intelligence and had received some positive feedback as to the progress made to date. She said the meeting had provided the opportunity to benchmark with other organisations and added that it was clear that the Trust was on the correct path in terms of business intelligence.

Continuing, the Chair reported that she had attended a meeting with other Trust Chairs on 19 December and had taken the opportunity to discuss the GIRFT report with them in advance of a meeting with Trust Chairs and Chief Executives in mid-January. She said the focus of this meeting had been collaborative working and it had been agreed that Mr Bloomfield and Ms Welsh would work together to identify some work which could be progressed on a pilot basis.

The Chair said that she perceived more interest in how NIAS could assist in terms of non-conveyance to ED through the use of See & Treat, Hear & Treat and the use of alternative pathways.

The Chair advised that she had attended a commissioning approach workshop which had been facilitated by Mr Farrar and attended by the Permanent Secretary, Trust and Public Health Agency (PHA) representatives on 20 December. The meeting had identified three priorities, namely commissioning, performance accountability and strategic narrative, which would be progressed through Task and Finish Groups. She indicated that she had been invited to participate in the strategic narrative group to explore a HSC-wide strategic narrative for staff, partners and primarily the public. The Chair said she had requested that the Chairs of the PHA and the Patient Client Council (PCC) would also join the group to add benefit. She noted that an initial meeting had already been held and it was intended others would occur before feedback would be provided to the wider group at the end of March.

Continuing her report, the Chair advised that an initial induction session had been held for the new Non-Executive Directors on 16 January 2024 and she shared a number of actions which had been agreed at the session. She expressed her delight at now having a full complement of Non-Executive Directors to provide support and expertise across the various Trust Committees.

The Chair advised that, on 29 January, the wider HSC Chairs met with the Permanent Secretary. On raising the GIRFT report with the

Permanent Secretary, a presentation was given by Mr Wilkinson and Mr Toogood around the service reconfiguration work and work around adult social care. She said that, while she had found the meeting very informative, she was not yet seeing evidence of the impact of this work on the ambulance risks raised within the GIRFT report. The Chair said she hoped to invite Mr Toogood to a future Board meeting to discuss and further understand the challenge around adult social care and the correlation between hospital flow and discharge.

The Chair advised that Dr Ciaran Mulgrew, the Chair of the Belfast HSC Trust had invited her and the Chief Executive to attend a Trust Board meeting to discuss the role of NIAS. She welcomed the fact that NIAS was now being seen, not just as an emergency service, but a key enabler to regional transformation. The Chair said that both Chief Executives would engage with regard to actions to be progressed.

The Chair advised that her attendance at the NHS Chairs' Confederation provided her with the opportunity to present the challenges facing NIAS. She said she had expressed an interest in visiting and learning from other areas of good practice.

Continuing, the Chair reported that she had been appointed as Vice-Chair of the NI Public Sector Chairs' Forum at its meeting on 6 February and said that Mr Coffey, Chair of the PHA, had assumed the position of Chair following the end of Ms Lappin's term as Chair.

The Chair advised that she and the Chief Executive had attended the mid-year Accountability Review with the Permanent Secretary on 7 February. She said that she had already alluded to a number of issues discussed at the meeting, in particular the deteriorating position in handover delays from quarter one to quarter three. The Chair indicated that the Permanent Secretary had been concerned at the potential harm caused to those patients in the community waiting for a response and understood that the ability to address this was outwith NIAS control. The Chair said she had commented that she would be one year in post in April and acknowledged that there had not been any progress in terms of an improvement around handover delays and in fact the position had deteriorated.

The Chair indicated that the Permanent Secretary had been inquisitive regarding the Trust's sickness levels and said she and

the Chief Executive had explained the approach being taken by the Trust in this regard. She advised that she also took the opportunity at the Accountability Review meeting to raise the issue of Emergency Preparedness, Resilience and Response (EPRR).

The Chair advised that, after attending the Remuneration Committee on the morning of 8 February, she had been delighted to welcome Minister Swann, along with Dame Fionnuala Jay-O'Boyle, Lord Lieutenant for Belfast, to the Long-Service Award Ceremony which provided a great opportunity to showcase the difference NIAS staff made on a daily basis.

Concluding her report, the Chair thanked members for their contribution at the Strategic Planning workshop on 15 February. She noted that Mr Farrar had forwarded his report from the day and would share this with members once she had had an opportunity to consider it.

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

5 **Chief Executive's Update**

The Chief Executive said it was good to address a full complement of Board members. He acknowledged that the Chair had already mentioned a number of important points but he felt it was appropriate to reflect on the significant service pressures experienced by the Trust through the winter period. He added that it had been an extremely challenging couple of months since the Board had last met with pressures across the HSC impacting significantly on NIAS.

Mr Bloomfield said that he and the Chair had shared the level of deterioration at the Accountability Review meeting and also with the Belfast Trust Board. He reminded the meeting that Trusts had agreed to a two-hour backstop for ambulance handovers in March 2023 against what should be a 15-minute standard. Mr Bloomfield reported that, in quarter one, 8.8% of all handovers were over two hours. However, this had increased to nearly 20% in quarter three and a further increase to 24% was evident in January.

Mr Bloomfield noted that the DoH published fortnightly figures and had identified two priorities in its Winter Plan which would receive

more intense monitoring. The first related to ambulance handover times and the second was hospital discharges.

He commented that ambulance handover delays were the longest they had been in the last two years and said that, in December 2023, 90 minutes was the average handover delay against a 15-minute standard. He said that of particular concern, as a direct result of the increasing handover delays, ambulance response times had also increased, with Cat 2 calls having peaked at a mean response time of 74 minutes in December which was an increase from 34 minutes in quarter one against an 18-minute standard for emergency and potentially extremely urgent calls. Mr Bloomfield expressed concern at the impact on patients and noted that this had been an area covered in discussion at the Accountability Review. He pointed out that the level of lost capacity was now running at 23% which resulted in the Trust being unable to respond in a timely manner to patients waiting in the community for an emergency response.

Mr Bloomfield indicated that this was despite the Trust's staffing levels and cover remaining relatively strong. He acknowledged the issue relating to staff absence and said the Trust was covering this through overtime and independent ambulance providers. He said that, when the January performance figures became available, he expected these to show a further deterioration from the December position.

Mr Bloomfield noted that the Chair had raised the GIRFT report at the meeting with Trust Chairs and Chief Executives and had alluded to the potential to do some pilot work with Trusts. He pointed out that the root cause of the problem was the delayed discharge of patients; the issue of capacity in the community and the challenges experienced by Trusts in terms of recruiting and retaining domiciliary care staff. Mr Bloomfield explained that the pilot suggested was to ascertain if Trusts could contract with domiciliary care providers differently in order to increase capacity. However, he pointed out that approval would be needed from the DoH to progress this work and undertook to keep members apprised of progress.

Mr Bloomfield noted that a further day of industrial action had taken place in January and said he hoped that the return of the NI Executive and commencement of negotiations about pay with Trade

Unions would resolve the dispute quickly. However, he pointed out that Action Short of Strike (ASOS) would continue to have a significant impact on the Trust, particularly in the last hour of shift when crews only responded to Cat 1 calls.

Continuing, Mr Bloomfield said that, while some issues were outside the Trust's control, the Trust continued to focus on actions being taken to improve services for patients. He welcomed the expansion of the Integrated Clinical Hub which aimed to increase the number of calls to be resolved without having to dispatch an emergency response.

Mr Bloomfield reported that he had recently attended the first meeting of the new Road Safety Strategy Forum which had been established following a marked increase in road fatalities over the last year. He advised that the Forum was led by the Department of Infrastructure with representation from the PSNI, NIFRS and other partners to identify further actions to be taken to increase road safety and reduce deaths.

Mr Bloomfield said that the Chair had already alluded to their attendance at the Board meeting of the Belfast HSC Trust and said this was the first time he could recall an invitation being extended by another Trust for a Chair and Chief Executive to attend a meeting. He said it had been a positive meeting and, like other Trusts, a number of new Non-Executive Directors had been appointed to the the Belfast Trust. Mr Bloomfield said it had been clear that the safety risks posed to patients as a result of delayed ambulance handovers, including those waiting in the community for response, had been of particular interest to the members. He said that, as well as highlighting the impact on patients, he and the Chair also took the opportunity to stress the impact on staff. He welcomed the Belfast Trust's willingness to focus on areas of collaboration, particularly how the Trusts could maximise access to alternative care pathways and improve referrals to Hospital @ Home schemes. Mr Bloomfield said both Trusts had undertaken to consider the potential for other innovative practices and the possibility of operating these on a pilot basis to determine if they avoided attendance and admission to hospital. He said that it was agreed that a further meeting would be held in three months' time to review progress.

Moving to discuss the Accountability Review, the Chief Executive advised that the main issue of discussion related to ambulance handover delays and the deterioration which had been highlighted earlier.

Mr Bloomfield said he expected to see improvement in absence figures over the next three months and added he was confident that the level of senior focus on a consistent basis as well as the arrangements in place were building momentum. He added that further detail would be provided in the Trust Performance Report later in the meeting.

Mr Bloomfield said he had been delighted to attend the Long Service Awards Ceremony which had been postponed due to the pandemic. He explained that further ceremonies would be held during the course of the year to ensure all eligible staff received the recognition they deserved. Mr Bloomfield said that the comments from the Minister and the Lord Lieutenant of Belfast were greatly appreciated. He added that the Minister had an awareness of the issue of delayed handovers and acknowledged how significant the issue was for the service, for patients and staff. Mr Bloomfield conveyed his thanks to those Board members who had attended the ceremony.

Continuing, Mr Bloomfield reminded the meeting that he and the Chair had welcomed the first cohort of the Prince of Wales Royal College of Nursing Cadet Scheme in NIAS back in October. He pointed out that, as well as clinical roles, the scheme also highlighted a wide range of support functions essential to deliver Trust services. He said he had met up again recently with the cadets when they returned on placement to NIAS and had discussed their experience to date and to welcome a second cohort of cadets.

Mr Bloomfield said he had been delighted recently to attend the inaugural meeting of the newly formed Association of Retired NIAS Personnel. He indicated that the idea had first been suggested three years previously through a presentation to the Trust's Senior Management Team who had been keen to support the establishment of the Association. Mr Bloomfield said he welcomed hearing positive reports of the service from staff who had retired, for example peer support, which had not existed when they had served.

He said the Trust was keen to explore how it might tap into the expertise of retirees.

Mr Corrigan commended the newly formed Association of Retired Personnel and highlighted the importance of the relationship and interface with retired colleagues. He believed that it conveyed a strong message to current employees at a time when staff morale was impacted by delayed handovers, late finishes and ongoing industrial action.

Mr Quinn welcomed the establishment of the Road Safety Strategy Forum and said that, while there had been increases in road deaths across the UK, he had been struck by the young age profile of those killed on the roads throughout Ireland. He said he would be interested in hearing more about the causes as well as the strategy to address the increase in road fatalities.

Mr Bloomfield said that he would be happy to provide an update to members. He noted that Ms Paterson's team was considering the information available within NIAS and the Forum would also tap into international research with a view to undertake a public education role in terms of presenting intelligence in the context of road traffic collision hotspots as well as highlighting how NIAS respond to such incidents.

Mr Bloomfield noted that the budget for public campaigns on road safety had decreased significantly a number of years previously. However, there was now a renewed focus on an education role in schools.

Dr Graham commented that there had been a conscious decision to remove the road safety advertisements from TV but, due to the marked increase in road fatalities, this decision had since been reversed.

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

6 Integrated Clinical Hub (TB22/02/2024/03)

The Chair welcomed Mr Karl Bloomer, Consultant Paramedic Urgent Care, to the meeting and invited him to give his presentation on the Integrated Clinical Hub.

The Chair commented on the exciting nature of the initiative and welcomed the fact that NIAS had been able to support the work through investment in resources.

Mr Quinn commended Mr Bloomer on his presentation and asked if there was a model which could be used to shift resources.

Responding, Mr Sinclair explained that the mental health aspect would be sited in the Emergency Ambulance Control (EAC). He said that Mr Seamus Mullen, Head of Planning, had been instrumental in arranging for mental health practitioners to be present in the EAC through a bank arrangement with supervision and governance remaining with their employing Trust.

Mr Corrigan noted that the Trust focus was on improving its Hear & Treat (H&T) rates and acknowledged that further work was needed to bring NIAS up to the level of its UK counterparts. He said that one tended to consider See & Treat (S&T) and H&T together as both worked to keep patients and ambulances from attending EDs but that this was only possible through significant increase in resources and more senior clinical staff supporting the teams However, Mr Corrigan asked if the Trust was satisfied that the activity and overall increase of both S&T and H&T was worth the significant investment being made.

Mr Bloomer explained that the first cohort of six clinicians had completed their training early and were now practising independently. He pointed out that the Trust had made the decision to implement the Integrated Clinical Hub model as a 'business as usual' model during the day with the Duty Clinical Support Manager leading the team. Mr Bloomer advised that, by operating the optimum sized team with two clinical support managers, the Trust demonstrated the potential on one day in February where the team achieved a 11.14% performance in H&T while 12.15% performance in S&T led to conveyance to hospital reducing to 76%. He indicated that, with a team of approximately eight clinicians, there had been a real exponential increase in performance with 40% of every 999 call received being examined by a clinician, enabling an increase from 20% to 40% of the team's oversight of received 999 calls. He noted that the Trust had been able to increase its 2023 H&T baseline.

Mr Ashford commended Mr Bloomer's presentation and said it was a very exciting approach. He alluded to Mr Bloomer's reference to the fact that it had been difficult to recruit to the posts and sought further clarification on this.

Responding, Mr Bloomer explained that traditionally the workforce was made up of individuals from the greater Belfast area and believed that it was likely that delayed ambulance handovers had played a role in terms of staff not wishing to spend protracted periods of time waiting to handover patients. He indicated that a cohort of applicants had expressed a wish not to lose clinical skills and the creation of the clinical posts in the Hub had allowed the Trust to introduce rotation through clinical duties, thereby making the posts more attractive to candidates.

Mr Nicholson confirmed that the Trust would evaluate the outcomes of the Integrated Clinical Hub and that this evaluation would also include financial aspects.

Dr Graham was of the view that the data presented by Mr Bloomer underpinned the strategic thinking discussed at the workshop on 15 February in the context of approaching issues in an innovative manner. He commended the approach.

Ms Finn suggested that, in terms of building an evidence base to support the continuation and resourcing of the Hub, it would be important to triangulate the data in Mr Bloomer's presentation with other quality indicators such as information gleaned from Serious Adverse Incidents (SAIs), complaints and Care Opinion, for example.

Mr Ashford pointed out that one of the biggest contributing factors to complaints was that of delayed handovers.

Dr Ruddell said he would be keen to tie in the clinical outcomes for those patients treated through the Hub and explore how the Trust might consider obtaining this clinical data into the future. He explained that the initial triaging of patients in EAC was conducted through AMPDS which was a triage tool designed for use by non-clinicians with an over-emphasis on safety. Dr Ruddell pointed out the significant risks associated with remote triage undertaken by clinical support managers and said that the mitigation was to ensure well experienced and well trained clinicians undertook this role and

were able to consider different outcomes and balance the risks accordingly. He said that if the Trust invested appropriately in the Hub and ensured the appropriate level of experienced clinicians, patient outcomes would be positive.

Mr Bloomfield explained that arrangements for this approach had initially been put in place to address a period of industrial action and the DoH/SPPG had taken a keen interest in the results. He said that, with a small amount of non-recurrent funding, the Trust had been able to expand the staffing complement to continue this approach. Mr Bloomfield indicated that the Permanent Secretary was interested in exploring alternative care pathways and seeing an increase in H&T performance.

Mr Bloomfield acknowledged the significant pressures on EAC staff in managing a stack of sometimes up to 100 calls waiting and unable to dispatch an emergency response. He said there was an element of reassurance to these staff when they knew that senior clinicians were managing the risk associated with the calls waiting. Mr Bloomfield said that the previously seen call stacks of regularly 100+ calls did appear to have reduced to a more manageable number in recent weeks and suggested there may be a link to the introduction of the Hub approach.

The Chair thanked Mr Bloomer for his attendance and said the Board looked forward to receiving further updates in due course.

The Board **NOTED** the presentation on the Integrated Clinical Hub and Mr Bloomer withdrew from the meeting.

7 **Appointment to Trust Committees (TB22/02/2024/04)**

The Chair explained that, as per the Trust's Standing Orders, paragraph 4.6 'Approval of Appointments to Committees', '*The Board shall approve the appointments to each of the Committees which it has formally constituted…'* and she sought Board approval to the following appointments:

AUDIT & RISK ASSURANCE
Philip Graham – Chair
Dale Ashford
Paul Corrigan

SAFETY, QUALITY, PATIENT EXPERIENCE & PERFORMANCE
Dale Ashford – Chair
Phelim Quinn
Philip Graham

PEOPLE, FINANCE & ORGANISATIONAL DEVELOPMENT
Jim Dennison – Co-Chair (HR)
Phelim Quinn – Co-Chair (HR)
Paul Corrigan – Co-Chair (Finance)

REMUNERATION COMMITTEE
Michele Larmour – Chair
Phelim Quinn
Jim Dennison

These appointments were **APPROVED** by the Board on a proposal from Mr Ashford and seconded by the Chair.

The Chair explained that she had held an initial induction session with Non-Executive Directors in mid-January when they had discussed a number of issues. She advised that she intended to meet with Non-Executive Directors on a quarterly basis and encouraged those around the table to take every opportunity to meet and engage with staff. She said she would share dates of planned visits to facilities, for example, HEMS and HART, with Non-Executive Director colleagues.

The Chair advised that the Non-Executive Directors had agreed to retain the current Committee structure with a view to reviewing the position after six months. However, she indicated that concern had been raised in relation to the level of business transacted by the People, Finance and Organisational Development Committee and she would monitor how this progressed over the coming months.

The Chair said she would be keen for Non-Executive Director colleagues to avail of training opportunities and advised that she intended to carry out brief mid-year appraisals in preparation for the end of year appraisals.

8 **Corporate Risk Register (TB22/02/2024/05)**

Ms Paterson explained that the Corporate Risk Register had been presented to the ARAC on 1 February. She believed that it would

now be timely to review the Trust's approach to the Register with Dr Graham having taken up his role as the new Chair of ARAC and said they were planning to meet to discuss further.

Ms Paterson said she would welcome the opportunity to maximise the benefits of using the Register and the purpose for which it is intended. By way of background and assurance, she advised that Internal Audit had given a satisfactory audit opinion in terms of risk registers, governance and processes used by the Trust to consider risk.

Dr Graham said that, while he had been encouraged by the fact that the Trust had identified only four risks which had been categorised as extreme, there were several old risks which had not been addressed. He alluded to the discussion at the ARAC meeting and his further discussions with Ms Paterson at the Strategic Planning workshop and said he and Ms Paterson would review the Register.

Dr Graham said he would like to see the Register more focussed and aligned with the Trust's strategic planning, its vision and its strategic direction. He acknowledged that there were several elements of the Register which were outwith the Trust's control but was of the view that this did not mean the Trust could not attempt to address them.

Mr Quinn highlighted the manner in which Non-Executive Directors were exposed to the Register and acknowledged that there was a clear alignment with the various Trust Committees. He alluded in particular to the risk narrative around EDs waiting times and suggested expanding the narrative in the context of harm, human rights and the right to life. Mr Quinn also questioned why cyber security had been categorised as an extreme risk.

Ms Paterson clarified that ARAC was responsible for governance and ensuring other Committees were managing risks effectively, with individual risks aligned to Committees. She acknowledged that several risks fell within the remit of ARAC and said that these were in the ICT sphere.

Mr Quinn alluded to Dr Graham's reference to old risks and asked if there would be an opportunity for Committees to discuss the risks relevant to them and determine whether the mitigations were appropriate.

Ms Paterson explained it would be important that the actions accurately described the treatments of the risks within the Register and said it was about triangulating governance and assurance. She noted that the majority of the risks formed Committee agendas and specific areas of work were discussed by Committees on a cyclical basis. Ms Paterson stressed the importance of the assurance element so when it came to Trust Board, members were assured that all the necessary actions had been expedited.

Mr Ashford explained that the Safety Committee had developed a matrix of agenda items and said that he and Ms Charlton had recently revised the matrix which would be presented to the April meeting for consideration. He advised that there was a specific standing agenda item round the identification of risk which could then be highlighted to the ARAC. Mr Ashford welcomed the intention to refresh the Corporate Risk Register.

Ms Byrne believed that the fact that the Trust now had its full complement of Non-Executive Directors provided an opportunity to review the Risk Register and challenge Directors.

The Chair noted that the approval of the Register was until the end of the financial year at which time it was intended to refresh the Risk Register, reflecting on discussions at the Strategic Planning workshop. She suggested it would be helpful to organise a workshop which would inform baseline planning, identifying the strategic issues, priorities and risks.

The Corporate Risk Register was **APPROVED** on a proposal from Dr Graham which was seconded by Mr Ashford.

Dr Graham advised that the DoH had re-established the ALB Audit Chairs' Forum and had e-mailed Audit Committee Chairs to seek potential agenda items. He said that he welcomed such fora as they provided an opportunity to share good practice.

The Chair agreed and said the Forum would provide an opportunity also to build relationships.

Mr Corrigan acknowledged that the DoH audit agenda would differ from that of Trusts and agreed there would be benefit in meeting other Trust Audit Chairs.

The Chair reminded members of their role in the context of providing assurance and governance around the DoH's strategic priorities. She suggested it would be helpful at the next Non-Executive Director meeting for each lead Director to share the function of their respective Committee so there was a shared understanding of Committee remits.

9 **Trust Performance Corporate Scorecard (January 2024) (TB22/02/2024/06)**

Ms Paterson drew the Board's attention to the Executive Summary and noted that the Performance Report would continue to evolve to highlight where performance was good and where improvements were required through the use of RAG rating.

Ms Paterson indicated that the Trust continued to operate at REAP level 4 which had impacted on most performance metrics. She reported that call answer demand in the Control Room and call responses had decreased by 2% and 1% respectively compared to previous years. She added that patients conveyed to hospital had also decreased by 1% compared to previous years.

Ms Paterson advised that response times in December were challenging across all categories. However, of particular concern was the Cat 2 response times which had deteriorated by 23 mins from quarter 1 to quarter 3 during 2023. Ms Paterson said that there was a direct correlation to increases in delayed handovers which impacted on those patients waiting in the community for a response.

She pointed out that the Trust continued to manage ASOS with crews only responding to Cat 1 calls on the last hour of shift.

Ms Paterson advised that the Trust's clinical H&T rate for December was 4.3% which was an increase from December while the clinical S&T rate remained static at 13.8%.

The Chair said she had found the Executive Summary helpful in setting the context.

Ms Lemon alluded to the absence management section of the report and highlighted several important points. She explained that

the Trust approach had been to focus, in the first instance, on progressing the top 50 longest-term absences to conclusion, supported by HR. Ms Lemon said that this focussed approach had supported a reduction in long-term absence which was reflected in the January 2024 figures, highlighting the lowest in-month level of absence for 2023-24.

However, she stressed that the Trust's focus on long-term absence could not be at the detriment of short-term absence and said she was confident that short-term absence was an area where there would be good traction and progress.

Ms Lemon referred to the reasons for absence and highlighted the fact that sickness absence due to mental health reasons represented 30% of sickness absence in 2023-24, with stress and work-related stress accounting for 15.01% and 7.38% respectively. She explained that, when a member of staff was absent from work due to work-related stress, there were specific processes to be followed around the Health and Safety Executive Risk Management Tool which aimed to provide a very focussed plan to enable the individual to return to work in a supportive and managed way. She added that Occupational Health Service (OHS) was also involved in this process.

Responding to a question from the Chair as to the OHS capacity to undertake this work, Ms Lemon acknowledged that there were limitations to the OHS capacity. She advised that the Trust had engaged with other providers to supplement the OHS and had held a workshop with the Belfast Trust who provided the OHS to agree a more proactive process in terms of managing referrals where NIAS would prioritise those staff to be seen by the OHS.

The Chair enquired as to the progress which had been made in relation to the redeployment process which had been protracted.

Ms Lemon advised that a detailed report would be presented to the PFOD Committee and noted that approximately twenty staff remained on the redeployment list. She pointed out that the Trust did not allow staff to remain on the redeployment list for indefinite periods of time. She explained that, in agreement with Trade Unions, the Trust had established an eight-week trajectory which aimed to resolve the redeployment issue at the end of the eight weeks. If this was not possible, other HR procedures would be

considered. Ms Lemon reminded members that, at one point, the Trust had had three times as many individuals on the redeployment list as it would have had previously and she believed that this had been a legacy from the pandemic.

Ms Lemon reported that the overall impact on the in-month figures from December to January had been a reduction from 15.56% to 13.6%. She acknowledged that it would take longer to reduce the cumulative figure. She pointed out that, in December, there were 230 members of staff off on long-term sickness absence and that this figure had reduced to 201 in January.

Mr Bloomfield said it was notable that the Trust had seen a reduction in its in-month absence figures in January and noted that 13.6% was the lowest monthly absence figure in the 2023-24 year. He pointed out that January was traditionally not a month when the Trust would see low absence figures.

Mr Bloomfield said he was confident that Directors around the table had a detailed knowledge of the top absences within their respective Directorates. He explained that, as she had recently assumed responsibility for PCS, Ms Charlton now joined his monthly meetings with Ms Byrne and Ms Lemon. Mr Bloomfield pointed out that the Trust was now commencing its examination of the next top 50 long-term absences and believed that this focussed approach had been fruitful.

The Chair said it would be remiss of her not to recognise the significant efforts which had been made to reach this point and acknowledged the major impact absence had on service delivery. She said she had made this point to the Permanent Secretary in terms of the 25% capacity lost at EDs which was then compounded by the Trust's high absence figures. The Chair said she was keen to see the cultural shift continue.

Mr Corrigan referred to the 20-day timescale for responding to complaints and noted that, in December 2023, only 23 were closed within the required timescale, with 39 remaining open and an average response time being 29 days. He sought further detail as to why the Trust found it challenging to respond within the 20-day timescale.

Responding, Ms Finn explained that continued service pressures was one of the factors which contributed to the Trust's inability to respond to complaints within the 20-day timescale. However, she explained that the Trust took the view that it was more important to provide a quality tailored response to each complaint which was signed by the Chief Executive. Ms Finn alluded to ongoing regional work to bring the complaints process into line with the process followed by local Councils which required responses to be sent within 20-days. However, she reiterated the importance of providing a quality response to complainants.

Mr Quinn said that, as a new Non-Executive Director, he had found the Performance Report very reassuring and accessible in terms of the information provided.

Mr Ashford echoed Mr Quinn's comments about the quality of the report and said he had noted the iterative process to reach this point. He commented that the SET was a significant outlier in terms of handover times.

The Chair agreed and said this had been highlighted in the Accountability Review meeting by the Permanent Secretary who had met with SET representatives the following day.

Mr Ashford asked whether the Key Performance Indicators (KPIs) in respect of the PCS were realistic and if they needed to be revisited. He acknowledged the challenge in reporting on performance where there were no indicators, for example, patient journeys per shift and asked if four was reasonable.

Ms Finn agreed and explained that the journeys per shift were difficult to baseline due to the geography and advised that the national metric was between 2.2 - 2.4 patients per journey. However, the Trust had significant work to do to reach this point. Ms Finn described some of the work underway in terms of improvements and said there had been agreement in principle from the Senior Management Team to consider introducing a supervisory tier for this service. She acknowledged that 95% was an ambitious target in terms of inward and outward journeys and said the Trust needed to revisit this to determine if it was realistic.

Continuing, Ms Finn said that meetings had been scheduled with other Trusts to discuss PCS and how NIAS could improve the

service. She indicated that cancelled journeys had not been reflected in this report and it would be important to review this with a view to having this information available for the next Trust Board meeting.

Ms Paterson referred to the Internal Audit report on PCS and said that Ms Finn and her team were taking forward some focussed work on quality improvement as well as significant work around governance and processes.

The Chair suggested that it would be helpful for members to receive a general update on PCS along with details of the revised improvement plan at a future Trust Board meeting. Members agreed that this would be helpful.

Following this discussion, the Board **NOTED** the Trust Performance Corporate Scorecard (January 2024).

10 **Finance Report (December – Month 9) (TB22/02/2024/07)**

At the Chair's invitation, Mr Nicholson advised that the Trust was reporting a breakeven position at 31 December 2023 and was forecasting a breakeven position for the year ending 31 March 2024.

He advised that the only significant outstanding allocation related to the Integrated Clinical Hub and said that, while the Trust had been assured of this allocation, it remained subject to business case processes.

Mr Nicholson referred to page 5 of the report which focussed on expenditure against voluntary and private ambulance services which he said remained significant. He noted that expenditure could vary on a month-to-month basis.

Mr Nicholson alluded to the Trust's Capital Resource Limit allocation of £6.381 million which included allocations for Fleet & Estate, ICT, Leases and Backlog Maintenance. He indicated that there was a significant amount of expenditure to be incurred between now and the end of the financial year. Mr Nicholson said that this would make for a busy end of year as vehicles were commissioned into service. He noted that, while funding had been identified in-year for increased fleet costs and replacement

defibrillators, it was subject to formal allocations and business case approval, procurement timelines and supplier capacity. Mr Nicholson commended those involved in the complex business case process.

Concluding his report, Mr Nicholson confirmed that the Trust continued to achieve its prompt payment targets.

The Chair referred to the extremely challenging financial position and said that, for the Trust to forecast a breakeven position at year end, had required significant effort from all staff. She said that she did not underestimate the challenges ahead in the 2024-25 year.

Dr Graham noted that similar comments in relation to the Trust's forecast breakeven position had been made at the recent ARAC meeting and it had been noted that this would not be replicated across the HSC.

The Chair thanked Mr Nicholson for the Finance Report (December – Month 9) which was **NOTED** by the Board.

11 **NIAS Policies:**

- **Operational Road Risk, Fleet Safety Policy v1.0**
- **Driving and Care of Vehicles on behalf of the Trust – Standard Operating Procedure (SOP) (TB22/02/2024/08)**

The Board **NOTED** the above policy and SOP which had been approved by the Safety Committee.

Mr Ashford pointed out that the Committee had approved the policy at risk and acknowledged that there were aspects of the policy which were necessary. He said the Committee had been assured that there would be a prioritised approach to its implementation and it was on this basis that the Committee approved it with the caveat that a phased implementation plan would be brought back to the Committee for consideration.

Mr Bloomfield advised that similar concerns had been expressed by the Trust's Senior Management Team when it had considered the policy. However, he indicated that it had been the view that it would present a more significant risk for the Trust not to have a policy.

Mr Quinn alluded to the pharmacy update provided by Ms Hanna to the Safety Committee and noted the secondments of two team members.

Mr Sinclair confirmed that the Trust had been able to reprofile funding to make the pharmacy technician post permanent and said discussions were ongoing as to the part-time pharmacist post within the team.

12 **Committee Business:**

- **Safety Committee – minutes of meeting on 17 November & report of meeting on 25 January 2024;**
- **Audit & Risk Assurance Committee – minutes of meeting on 5 October 2023 & report of meeting on 1 February 2024; (TB22/02/2024/09)**

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

13 **Date of Next Meeting**

The next NIAS Trust Board will be held on Thursday 28 March 2024 at 10am in the Boardroom, NIAS HQ.

14 **Any Other Business**

(i) Cyber Security Awareness Training

Ms Paterson said she planned to arrange cyber security awareness training for Non-Executive Directors before the end of the financial year and hoped to schedule this to coincide with the March Board meeting.

THIS BEING ALL THE BUSINESS, THE CHAIR CLOSED THE PUBLIC MEETING AT 1.05PM.

M. Lavmour

SIGNED: _____

DATE: 28 March 2024