Northern Ireland Ambulance Service Health and Social Care Trust

Minutes of NIAS Trust Board held on Thursday 22 August 2024 at 10.50am in the Boardroom, NIAS HQ, Site 30, Knockbracken Healthcare Park, Saintfield Road, Belfast BT8 8SG

Present:	Mrs M Larmour	Chair
	Mr P Corrigan	Non-Executive Director (left the meeting at 1.15pm)
	Mr J Dennison	Non-Executive Director
	Dr P Graham	Non-Executive Director
	Mr P Quinn	Non-Executive Director
	Mr M Bloomfield	Chief Executive
	Ms R Byrne	Director of Operations
	Dr N Ruddell	Medical Director
In Attendance:	Ms L Charlton	Director of Quality, Safety & Improvement (QSI)
	Ms M Paterson	Director of Planning, Performance & Corporate Services/Deputy Chief Executive
	Mr S Christie	Interim Director of Finance
	Mrs C Mooney	Board Secretary
	Mr M Strong	Internal Auditor, BSO
	Ms R Finn	Asst Director QSI (for agenda item 6 only)
	Mr K Bloomer	Consultant Paramedic Urgent Care (for agenda item 7 only)
Apologies:	Mr D Ashford	Non-Executive Director
	Ms M Lemon	Director of Human Resources & Organisational Development (HR & OD)
	Mr N Sinclair	Chief Paramedic Officer

1 **Welcome, Apologies & Declarations of Conflict**

The Chair noted the apologies.

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 27 June 2024 were **APPROVED** on a proposal from Mr Corrigan and seconded by Mr Quinn.

3 Matters Arising (TB22/08/2024/02)

Members **NOTED** the Matters Arising.

The Chair advised that the NEDs had met on 15 August to discuss a number of issues, in particular the need to consider the format of the People, Finance and Organisational Development Committee with a view to ensuring further scrutiny and accountability around finance and performance.

The Chair alluded to discussion at the June Trust Board around the Corporate Plan and asked Ms Paterson to explain how the comments put forward by members would be taken into account.

Ms Paterson said that, at the October Trust Board meeting, members would receive a progress report against delivery of the Corporate Plan.

Mr Bloomfield asked that the final version of the Corporate Plan would be shared with members.

The Chair noted that the Corporate Plan had been developed based on discussions at the Strategic Planning workshop held in February 2024. She said it would be helpful for members to have a progress update on the key themes and how these would be fed into the governance structure.

Ms Paterson explained that the implementation plan would be written in such a way that would identify the governance thread and the oversight by the various Committees. She added that the Assistant Director Forum was currently working on finalising the implementation plan with a view to bringing together the various

plans to show delivery against objectives and the associated timescales.

The Chair acknowledged the variation in timescales for several plans and said it would be helpful to have clarity as to how each was linked to the implementation plan.

4 **Chair's Update**

The Chair reported that, at the start of July, she had attended a workshop to discuss the concept of Provider Collaborative Boards (PCB) and had the opportunity to hear from individuals about their experience in establishing PCBs in England.

She advised that the Task & Finish Group which had been set up to consider DoH strategic narrative had completed its work which would now be submitted to the Minister for his consideration and support for the direction of travel around HSC priorities and identification of challenges.

The Chair briefed the meeting on her and Mr Corrigan's visit to Omagh station. She said that staff very much appreciated Non-Executive Directors (NEDs) taking the time to engage, listen and share discussion from around the Board table. The Chair said that several issues had been raised by the staff during the visit and she had asked Mr Bloomfield to respond directly while she was on leave.

Mr Bloomfield explained that one issue raised by staff was the increasing time spent in transferring patients from the South West Acute Hospital (SWAH) to Altnagelvin. He pointed out that this was not only as a result of the changes in the services provided at SWAH but the cumulative impact was that staff feel they were spending considerable amounts of time driving. Mr Bloomfield said that this in turn was discouraging them from working overtime.

However, Mr Bloomfield clarified that the most significant issue raised by staff related to the number of paramedic vacancies in Enniskillen and the need for staff to cover shifts. He noted that there were approximately six paramedic vacancies and acknowledged the challenges associated with recruiting to Ennskillen station. Mr Bloomfield also noted that the Transfer Panel

which met on a monthly basis had no requests from staff to transfer to that location.

Continuing, Mr Bloomfield pointed out that there were several staff from Enniskillen seconded to other roles and he said work is ongoing to address the vacancies.

Mr Bloomfield reminded the meeting that 48 paramedics would be joining the Trust over the coming weeks and said that work was ongoing to target these new recruits towards the West Division, in particular towards Enniskillen. He noted that only a small number of qualified paramedics remained on the waiting list and action was being taken to recruit these individuals, following which the waiting list would be exhausted.

The Chair thanked Mr Bloomfield for updating members. She said she tried to meet staff on a monthly basis and encouraged other Non-Executive Directors to join her on these visits. The Chair said that there was an opportunity, when meeting staff, to discuss the challenges facing the service but also the significant progress which had been made over recent years.

Mr Corrigan said it was clear that staff appreciated the visit and added that he had found it to be a positive experience.

Continuing her report, the Chair advised that, in her capacity as vice-Chair of the Public Sector Chairs' Forum, she and Mr Coffey, Chair of the Public Health Agency (PHA) and also Chair of the Public Sector Chairs' Forum, had agreed to meet every 6-8 weeks to discuss issues relating to the Forum but also to engage around the PHA and its direction of travel as well as its work around prevention and how NIAS, as a regional service, could help support this. The Chair noted that she and Mr Coffey had invited Ms Ruth Sutherland, Chair of the Patient Client Council, to join several of these meetings.

The Chair reported that she had attended both Association of Ambulance Chief Executives (AACE) Chair and Council meetings in mid-July and believed it was helpful to maintain such contacts. She said it was clear that ambulance services across the UK were experiencing similar challenges and acknowledged that there were also examples of good practice and the potential to explore opportunities for collaboration with other services.

The Chair referred to the article on Sky News in relation to sexual safety and expressed her deep concern at the content. She reminded the meeting that Ms Bron Biddle would be attending the October Trust Board to brief members on her work around sexual safety in the Ambulance Sector.

The Chair advised that Trust Chairs had agreed to meet on a monthly basis to continue to build on the rapport and relationships formed on their appointments to their respective Chair roles in 2023.

The Chair reported that she had met with Mr Wilkinson on 24 July 2024 to discuss her appraisal and she and Mr Bloomfield had taken the opportunity to discuss several issues with him. She said that Mr Wilkinson had been pleased at the progress made by the Trust in relation to Hear and Treat, the investment in the Integrated Clinical Hub (ICH) and particularly the attention to absence management. The Chair noted that she had also discussed Senior Executive Pay and the issues pertaining to the Trust in terms of attracting senior staff. She added that the Board was keen to explore the potential for succession planning and she undertook to keep members apprised.

Continuing, the Chair said that, on her return from leave, she had visited the NHSCT and met with its Chair and Chief Executive. She added that she had also visited the ED and had been impressed by the Trust's efforts around the innovative practices in ambulatory care. The Chair said she had discussed these with the lead Consultant and the ED Consultant.

Mr Corrigan referred to the 'same day emergency care model' and asked if that operated on a seven day a week basis.

The Chair clarified that it did not currently and highlighted the importance of building evidence bases for such innovative practices. The Chair said she took the opportunity to raise the concerns expressed by NIAS staff around the variation in pathways in the NHSCT compared to other Trusts, in particular the absence of a Hospital at Home Service. She acknowledged the frustration felt by NIAS staff.

The Chair concluded her report by referring to her meeting with Non-Executive Director colleagues on 15 August and said that the

main topic discussed related to the Committee structure and the need for appropriate levels of scrutiny around people and culture.

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

5 Chief Executive's Update

Mr Bloomfield commenced his update by acknowledging that summer was traditionally a challenging period for the Trust in terms of striking a balance between staff taking annual leave but also ensuring the Trust maintained the required level of staffing to deliver the service.

Mr Bloomfield said it would be important to reflect on the appalling attacks and threats made against people from ethnic minorities in recent weeks. He alluded to reports in the media saying that health care workers from overseas felt threatened and unable to go to work and indeed, some were considering leaving NI. Mr Bloomfield said that this behaviour was rightly being condemned by all quarters. He acknowledged the number of overseas staff working in health and social care and highlighted the hugely valuable contribution they make to the delivery of health and social care services in NI. Mr Bloomfield said that, without their contribution, quite simply, health and social care in NI could not function. He said he was not aware of any specific incidents concerning NIAS staff but added that the Trust had issued a staff bulletin condemning what had taken place and reassured them of the valuable role all staff played and to contact the Trust should they have any concerns.

Continuing, Mr Bloomfield referred to the widespread outage of IT systems across the world in mid-July. He explained that initially it had been thought that the outage was the result of a cyber attack and the Trust had activated its Cyber Group. However, it transpired that the outage had come about because of patches applied to systems simultaneously. Mr Bloomfield said that, through early monitoring, the Trust had been able to establish that there had not been any impact on the Trust systems or on the suppliers who provided systems to the Trust. However, he acknowledged that there were impacts on other areas of the health and social care system.

Mr Bloomfield said he had been very impressed and reassured by the rapid response of the various teams across the Trust in terms of establishing the position and being ready to activate business continuity arrangements. He advised that a full debrief took place earlier in the week to identify any lessons to be learned.

Ms Byrne acknowledged that several minor issues had been identified, for example access to trained loggists, and said that the benefits of staff having undertaken commander level training had been clear.

The Chair said she very much appreciated the early read-out from the Chief Executive as to what had taken place and the arrangements put in place by the Trust.

Mr Bloomfield conveyed his appreciation to those involved, in particular, Mr McKenna, Assistant Director of Operations, who had assumed the role of Tactical Commander. He added that Ms Sharpe provided excellent advice ensuring that the Trust took all necessary actions and Mr Marcus, who had recently taken up post as Assistant Director of IT, had also made a significant contribution.

Mr Bloomfield said that he had previously advised the Board of the Northern Ireland Audit Office's (NIAO) intention to undertake a full study on the impact of delayed ambulance handovers. He advised that several Directors met with colleagues from the NIAO at the start of the study and had taken the opportunity to describe the background to the issue of delayed ambulance handovers which had not existed prior to the Covid-19 pandemic.

Mr Bloomfield said that the Trust had also described the impact on patients waiting in the back of ambulances outside EDs and the impact on those in the community waiting for a response. The Trust had also advised of the actions it had taken to mitigate the risks to both patients and staff and had acknowledged that not all had been successful. Mr Bloomfield believed that NIAO colleagues had gained a good understanding of the issues and added the Trust was engaging further with the NIAO in terms of any information. He said that it was hoped that initial findings would be available in the early autumn and a final report in the New Year.

Responding to a question from Mr Corrigan, Mr Bloomfield confirmed that the field work undertaken by the NIAO had included visits to EDs.

Ms Charlton added that the NIAO had also been in contact with AACE particularly around the impact on patients.

Mr Corrigan asked about the status of the report.

Mr Bloomfield highlighted the significant nature of the report following a full study undertaken by the NIAO and said it was likely that the issue of the report would be accompanied by a press statement and would attract media coverage. He said it was his understanding that the NIAO was undertaking twelve full studies and added that it would be a matter for the Public Accounts Committee (PAC) should it decide to look at the issue of delayed ambulance handovers more closely.

Mr Bloomfield advised the meeting that the NI Assembly Health Committee was due to visit NIAS HQ on 3 October. He added that the Chair had suggested it would be helpful for those NEDs available also to attend. Mr Bloomfield explained that the Health Committee was keen to meet with staff and a visit to the EOC had been scheduled. He said it was his understanding the Health Committee was coming to listen and observe.

Continuing his update, Mr Bloomfield reported that he and Dr Ruddell had attended a celebration event on 22 July 2024 to mark the 7th anniversary of HEMS and he added that the service had responded to 4,500 taskings over that time.

He advised that, on 24 July 2024, the Permanent Secretary, Mr Peter May, and Mr Jim Wilkinson, visited the Regional Co-ordination Centre as well as the Integrated Care Hub where they heard of the benefits the ICH had brought to patients.

Mr Bloomfield alluded to the Matters Arising discussed earlier in the meeting and noted the action in relation to keeping the Board apprised of developments with NIFRS around use of the Cookstown learning and development training facility. He said that several Directors had recently visited the facility and received a presentation from NI Fire & Rescue Service (NIFRS) colleagues on initial costs. Mr Bloomfield advised that the Trust would now examine these

costs in detail to better understand what elements the Trust might require. He indicated that Mr Christie was engaging with the NIFRS finance team around the detail.

Mr Bloomfield advised that members of the Senior Management Team had met with SPPG colleagues to discuss the potential development of paramedicine in primary care and added that this was often referred to as 'community paramedicine'. He explained that the model originally commenced through the Co-operation And Working Together (CAWT) group which had been set up to look at areas of mutual interest along the border areas. However, no funding had been made available in NI to continue the model at that time although it had continued in other parts of the UK. Mr Bloomfield explained that, at that time, the Trust had a large number of vacancies and was not in a position to support paramedicine in other settings and added that this position had now changed.

Continuing, he advised that the Trust now had a strong workforce supply and had commenced discussions with SPPG colleagues around the general principle of paramedics working in primary care. Mr Bloomfield stressed that the paramedics would continue to be employed by NIAS and would be rotated through other settings, including primary care. He said the Trust would continue its discussions with the SPPG and noted that several Directors were due to attend the Performance and Transformation Executive Board (PTEB) in October and the proposal would form part of the discussions at that meeting.

Mr Quinn said that he would be keen to hear further detail in relation to the model through the appropriate Committee.

Mr Bloomfield noted that the practice was commonplace in England and said it was important to see how the role of the paramedic could potentially be extended to other settings. However, he stressed the need to ensure the appropriate arrangements were put in place and alluded to the benefits both for staff in terms of learning from rotating in different settings and also to the organisation.

The Chair noted that she had been party to some discussions on this and believed that it was quite often the GP/primary care element that was missing because primary care was so diverse.

Dr Ruddell reminded the meeting that each GP practice was an independent business which sub-contracted with the DoH/SPPG. He acknowledged the difficulties in identifying a representative body but said a link had been established with the GP Council (GPC) which was led by Dr Alan Stout. Dr Ruddell said that agreement had been reached that the Trust would have regular meetings with GPs to discuss areas of mutual interest. He noted that rural GP practices were calling for support and he hoped that the concept of community paramedics would be very much welcomed.

Mr Bloomfield noted that the model would require additional funding and further noted that this aspect had not been included in the Trust's Workforce Plan currently being finalised.

Ms Paterson noted that it formed part of the Strategic Plan.

Mr Bloomfield alluded to Care Opinion which was in operation across NI and which sought patient stories on their experiences in the HSC and then published them. He said Care Opinion, in conjunction with the PHA, had arranged schedule of visits across NI to meet with service users and teams. Mr Bloomfield said that the Care Opinion team had visited Ballymena where it had met with representatives from the NIAS Service User Group with a view to gathering views on how it might be possible to collate more stories from patients. He acknowledged the difficulties with asking patients for stories on their experiences while in an ambulance setting. Mr Bloomfield commended the event.

Concluding his report, Mr Bloomfield said he had attended the Badge Ceremony organised by the Ulster University for the first cohort of BSc Paramedicine Science students. He noted the graduation had been planned for December 2024. Mr Bloomfield said he had been delighted to meet with the students again and welcome the majority of them to the Trust as paramedics. He noted that every student who graduated and wanted to work in NIAS had secured a post following a recruitment exercise.

The Chair welcomed this and noted that the degree course had been funded and supported by the DoH. She reiterated that a recruitment process had been in place and those successful students had secured a post with NIAS.

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

6 Patient Care Service Improvement (TB22/08/2024/03)

Ms Charlton explained that her presentation on the PCS improvement work would provide an overview of the PCS non-emergency service and would outline the improvement journey to date.

Ms Charlton acknowledged that, while she had provided an update recently to the Safety Committee, she was conscious other NEDs had requested an update on this important part of our service. She said welcomed Ms Finn who joined the meeting for this agenda item as she was leading on a number of aspects within the presentation.

Through her presentation, Ms Charlton provided a detailed update on the background to the improvement work within Patient Care Services. She outlined the number of non-emergency journeys undertaken prior to the Covid-19 pandemic compared to now and said that, in 2019-20, approximately 182,000 journeys had been undertaken and, in 2023-24, approximately 153,000 journeys.

Responding to a question from Mr Corrigan, Ms Charlton confirmed that the reduced activity was in relation to patient discharges and transfers.

Ms Charlton highlighted the variation between arrangements for NIAS non-emergency transport compared to English services.

Ms Charlton advised that the Trust had lost a significant amount of Voluntary Car Services (VCS) provider capacity as the service had been stood down during the pandemic. She indicated that Mr Carson, Assistant Director of Operations, had recently undertaken a recruitment drive to encourage volunteers to sign up for the VCS and to highlight to them how valued the service was by the Trust and patients.

In terms of PCS, Ms Charlton advised that the service undertook approximately 500 journeys per day. She said that she was currently engaging with other Trusts to discuss the current service delivery. She added that there had been a reduction in services to

Trusts and she was keen to discuss how NIAS and other Trusts could better work together collaboratively to deliver more.

Mr Corrigan pointed out that, while NIAS clearly managed its own PCS, other Trusts also engaged the independent sector.

Responding, Ms Charlton explained that Trusts presented such demand that it had become necessary for them to fund an element themselves. She said that the focus of current discussions with Trust colleagues was around better collaborative working. She acknowledged that there was variance in terms of reduction in PCS activity across Divisions.

Ms Charlton alluded to the PCS workforce and advised that, of the total 269 staff, 57 Whole Time Equivalents (WTEs) support A&E staff in lower acuity calls while the remaining 212 WTEs carried out planned and scheduled PCS duties. Ms Charlton noted that the Transport Strategy which originated in 2007 was due for review and advised that the Trust had its own strategy in which a number of aspects alluded to PCS. She highlighted the need for timely discharges, aligned with patient flow.

Ms Charlton said that the Trust had the Delivering Value Programme in place where aspects of PCS were mapped to the Trust's Corporate Plan. She highlighted the need to learn from others and noted that significant work was underway in England to improve patient transport services.

Ms Charlton acknowledged the work undertaken by the Business Intelligence (BI) team around the development of dashboards so managers could avail of accurate positions on a daily basis. She noted that absence amongst PCS staff was on a downwards trajectory. Ms Charlton said that, in a recent PCS recruitment drive, there had been 622 applicants and she advised that a course was commencing in mid-November for 24 Ambulance Care Assistants (ACAs).

Ms Charlton commented that PCS undertook a significant level of renal dialysis conveyance and said the service never cancelled appointments for renal dialysis patients. She said she was also keen to ensure that a similar approach was in place for oncology patients.

Continuing, Ms Charlton said that, in 2020, 10,000 More Voices undertook a survey around patients' experiences of PCS. She advised that, while a very positive survey, it would be important to ensure there was learning.

Ms Charlton said that members would be aware from recent performance reports of the increase in complaints received by the Trust around delays. She noted that in a recent report from Kidney Care UK, one of the most important factors for patients was transport to renal dialysis. Ms Charlton highlighted the need for better and more effective communication with patients as to why changes had been introduced. She referred to the Trust's Patient User Forum and said its membership had been drawn from individuals with varied backgrounds and different experiences. Ms Charlton said that Mr Gillen, Co-Production Manager, and his team were engaging with the Trust's Communications Department with a view to improving communications.

Ms Charlton said that, as well as listening to patient experiences, it would also be important to take on board staff views. She acknowledged that there were points from the survey to be taken forward and said a series of workshops with staff had been scheduled to take place over the coming months. Ms Charlton said the Trust would make arrangements to pay overtime to those staff not on shift and to ensure Independent Ambulance Services (IAS) were brought in to allow staff to attend with a view to ensuring their full involvement.

Ms Charlton advised that significant work was ongoing in relation to PCS support to A&E tier. She acknowledged the associated challenges with Trade Unions and said there was not yet a consensus view around this aspect of service. Ms Charlton indicated that a consultation exercise had been undertaken with staff asking them to declare their preference, ie either remain within PCS or provide A&E support. She confirmed that 57 staff had expressed their wish to remain within the A&E support tier with the remainder staying within PCS. Ms Charlton pointed out that Mr Sinclair would undertake a clinical review of the model.

Ms Charlton alluded to the need to explore the potential for changes in rotas and said that the Trust had asked extant staff if they would wish to avail of any new shift patterns before they were offered to new staff.

She referred to the existence of the IAS Non-Emergency Framework and noted the absence of governance arrangements. Ms Charlton pointed out that this service was not regulated and the Trust was carrying out its own unannounced inspections and assurance meetings with independent providers. She acknowledged that further work was required in this space.

The Chair thanked Ms Charlton for her detailed and informative presentation. She acknowledged the fact that Ms Charlton had assumed temporary responsibility for this service area and said she had been reassured by the presentation that the improvement work was impacting. She conveyed her thanks to Ms Charlton and her team for their efforts.

Mr Quinn agreed that the information presented had been informative and reassuring.

Mr Corrigan alluded to the eligibility criteria for PCS and acknowledged the urgent need to review this. He believed that the service was regarded by the system as 'free issue' and that it was very much demand led.

Ms Charlton agreed that the eligibility criteria were ambiguous. She advised that a new Reconfiguration Framework had been issued by the DoH in advance of consultation action to review the eligibility criteria within the Transport Strategy. However, she acknowledged that any change would not be implemented overnight. Ms Charlton commented that GPs did not believe it was their role to determine whether a patient met the criteria to receive non-emergency services and she added that it was not incumbent upon NIAS either to determine a patient's eligibility. She noted that the eligibility criteria was so encompassing that it was difficult to exclude any individuals.

Ms Charlton highlighted the need to have an efficient service which focussed on patients and delivered value for money.

The Chair thanked Ms Charlton for her detailed presentation and said that Board would appreciate being kept apprised of work. She commended the huge amount of work done to review the service and the efforts made to ensure staff were kept informed.

7 **Mental Health Practitioners in the Integrated Clinical Hub (TB22/08/2024/04)**

At the Chair's invitation, Mr Karl Bloomer presented his update on the involvement of Mental Health Practitioners in the Integrated Clinical Hub (ICH). He described the strategic drivers such as the HSC Locality Plan, the Mental Health and Protect Life Strategies which supported the integration of practitioners in the ICH. Mr Bloomer explained that the intention was to carry out a pilot in the first instance in the SEHSCT area from April 2024 to March 2026 with mental health professionals being located in the Emergency Operating Centre (EOC) and responding to calls from the SEHSCT area on a Friday, Saturday and Sunday evenings between 6pm – 2am. He added that training for the WHSCT staff was not yet completed.

Mr Bloomer advised that initial data was positive with a 36% Hear and Treat rate by the mental health professionals as well as a de-escalation of callers and reduced attendance to ED for callers meeting inclusion criteria. Mr Bloomer pointed out that there had been a reduction in conveyance of 25% and an increase of 26% in referrals to HSC Trusts' alternative pathways.

Continuing, Mr Bloomer reported that data from the SEHSCT in relation to the operation of the pilot between 15 March until 22 June had shown that 84 calls had been completed to date; 30 patients had been de-escalated by the service and had not required conveyance to ED; 32 ambulances had been dispatched and there was an unknown outcome in 22 cases. However, six of the 22 cases had been discussed with the Clinical Support Desk and/or the paramedic on site.

Mr Bloomer explained that the mental health professionals in the ICH were now responding to callers not just from the SEHSCT geographical area. He advised that, by having mental health professionals integrated in the ICH, these colleagues had provided informal education days to the ICH clinicians on the Mental Capacity Act, Deprivation of Liberty and general mental health assessment. Mr Bloomer said that this had improved the confidence of ICH clinicians to undertake mental health assessments when required and he added that there were plans to further develop and expand these sessions.

Mr Bloomer advised that the mental health professionals had also been able to provide peer support to ICH clinicians and EOC staff who had dealt with traumatic calls while on shift relating to mental health.

In terms of the next steps, Mr Bloomer advised that work would be progressed to complete the training in the WHSCT and make the necessary arrangements in EOC to operationalise this. He said he would be keen for an independent evaluation to be undertaken by PHA Health Intelligence as well as to ensure consistency of data through synchronising and streamlining data collection. Mr Bloomer said he would be keen to explore the potential to have this service available on a regional basis and utilise the voluntary sector and lifeline pathways. He suggested it might also be helpful to explore using a model similar to a provider collaborative to consolidate practice.

Mr Bloomfield referred to the fact that the mental health professionals had handled 36% of the cohort of mental health calls without the need to send an ambulance.

Mr Bloomer was of the view that these figures clearly demonstrated that having experts in a certain specialty deal with calls was extremely beneficial.

The Chair agreed that it certainly assisted in building the evidence base. She indicated that it was not always appropriate to dispatch an ambulance response to patients and alternative pathways could be more appropriate.

Mr Bloomer acknowledged the majority of patients treated by the mental health professionals had been from the SEHSCT area. However, he explained that, with the rollout of the Encompass system to the BHSCT area, the practitioners had been able to access patient records through Encompass and manage those patients safely. Mr Bloomer said that the SEHSCT was keen to explore formalising the management of other patients outside the SEHSCT geography. He pointed out that the BHSCT was unable to link into as many referral pathways as the SEHSCT practitioners and he said he was hopeful that this could act as the catalyst for discussions on how to overcome such barriers.

Mr Corrigan referred to the need to complete training with the WHSCT and the need for the mental health professionals to work out of the ICH. He alluded to the NIAS facility at Ballymena and asked if it was possible to locate staff there but continue to have linkages with the ICH.

Mr Bloomer said that work was currently ongoing to explore several NIAS facilities as potential locations.

Mr Quinn acknowledged that being located in the ICH was a different way of working for the mental health professionals and he welcomed Mr Bloomer's earlier reference to the fact that the practitioners' confidence had increased. He queried whether there had been any adverse incidents.

Responding, Mr Bloomer confirmed that none had been reported.

Mr Quinn referred to the clinical supervision provided by the host Trust and the opportunity provided to increase skills. He suggested that this assist in helping the SEHSCT to encourage other Trusts to participate.

Mr Bloomer explained that the Memorandum of Understanding signed by the SEHSCT had focused on the fact that governance, assurance and maintaining professional registration would remain with the host Trust. He advised that the host Trust would record notes on their system for governance purposes and added that the SEHSCT would subsequently audit the notes and provide feedback to NIAS. Mr Bloomer said that he and the ICH Manager would attend monthly meetings with SEHSCT colleagues as well as meetings with the SEHSCT team to audit calls. He said that this practice provided an additional layer of scrutiny.

Ms Paterson advised that the Trust had secured funding for a further two years with the potential for mainstreaming following evaluation by PHA Health Intelligence.

The Chair thanked Mr Bloomer for his attendance and congratulated all involved in this innovative work.

Mr Bloomer withdrew from the meeting.

8 **Board Governance Self-Assessment Tool (BGSAT) (TB22/08/2024/05)**

Ms Paterson advised that the Board Governance Self-Assessment Tool had considered by the ARAC at its meeting on 27 June and the Committee had recommended the document to the Board for approval.

Dr Graham commented on the cumbersome nature of the Self-Assessment and said he was unsure as to its worth.

Ms Paterson advised that an action plan had been developed to address the issues identified through the self-assessment and added that progress would be reported to the ARAC.

The Chair noted that the Self-Assessment accurately reflected the previous year and said that several developments had taken place since then.

The Board Governance Self-Assessment Tool was **APPROVED** by the Board on a proposal from Dr Graham. This proposal was seconded by Mr Quinn.

9 **Finance Report (Month 3) (TB22/08/2024/06)**

Mr Christie drew members' attention to the new format of Finance Report and believed it was in line with the finance reports being presented by Directors of Finance at other Trust Boards.

Mr Christie advised that the Trust's total income was £125 million for the 2024-25 year.

He advised that the Trust was reporting a breakeven position in the year to date and was forecasting a breakeven position at year end. However, he reminded the meeting that this breakeven position was predicated on the consistent achievement of the 2-hour backstop at Emergency Departments (EDs).

Mr Christie pointed out that the breakeven forecast was also based on several assumptions, ie that all indicative and assumed funding was released to the Trust by the SPPG; that all assumed further income would be realised and that all savings would be achieved.

Continuing, Mr Christie drew members' attention to the summary of Directorate positions. He said that significant work had been undertaken to confirm opening allocation budgets for respective Directorates and that all expenditure would be closely monitored as the year progressed.

With regard to overtime expenditure, Mr Christie indicated that the Trust relied on the use of overtime for the provision of services for several reasons including vacancies, planned and unplanned absences, additional cover or programmes of work.

In relation to Independent Ambulance Service (IAS) providers, Mr Christie advised that the Trust continued to benefit from the support of IAS providers and noted that the total IAS expenditure to 30 June 2024 was £2.089 million.

Mr Christie noted that the Trust would utilise all its Capital Revenue Limit (CRL) in the current year and reported continuing positive performance in relation to the prompt payment of invoices.

Mr Corrigan advised that the finance report had been presented at the PFOD Committee on 15 August and had been welcomed by members. He believed that it signalled a new way of working in terms of information and transparency. He acknowledged that the report was evolving and continued to develop and believed there was a need to tease out the formats of the finance reports to be presented to the Trust Board and the Finance & Performance Committee. Mr Corrigan commented that the Committee may provide the opportunity to drill down into certain areas of expenditure in more detail. He said he recognised that further work was required but welcomed the direction of travel.

The Chair agreed with the points made by Mr Corrigan and welcomed the progress which had been made over the last number of months.

She highlighted the fact that, despite the significant challenges facing it, the Trust had achieved a breakeven position in both 2022-23 and 2023-24. She alluded to the additional savings which would be required and said that members very much recognised the challenges associated with achieving such savings in the knowledge that the Trust's ability to breakeven was predicated on improvements against the 2-hour handover backstop.

The Chair said that there would be a high expectation that the Trust would continue to achieve breakeven despite the continued request for efficiency savings.

Dr Graham commended the presentation of the financial data and said it was easy to read and follow. He believed there were elements within the finance report which could be replicated in other reports and suggested there was potential to consider a corporate style of reporting, for example a page limit.

The Chair alluded to the discussion at the NED workshop around the importance of ensuring an Executive Summary was included in papers coming to the Committees/Trust Board for consideration. She said it would be important that the Board received succinct papers.

Ms Charlton highlighted the importance of taking account of the variation in subject content.

Mr Bloomfield acknowledged the difficulty of a standard approach given the wide range of subjects to be considered by the Committees and Trust Board. However, he agreed that an Executive Summary would be helpful.

The Board **NOTED** the Finance Report (Month 3) as presented by Mr Christie.

10 **Trust Performance Corporate Scorecard (July 2024) (TB22/08/2024/07)**

Ms Paterson presented the Trust Performance Report for July 2024 and explained that it provided a comprehensive overview of operational and clinical metrics from June 2024. She indicated that the report identified several improvements and challenges in service delivery, notably in response times, patient conveyance, and handover delays.

In terms of Demand and Service Delivery, Ms Paterson alluded to Emergency Call Volume and advised that there had been a 10% increase in call answer demand in June 2024 compared to the previous year. She advised that this had understandably impacted response times and service delivery.

Ms Paterson reported that, conversely, incident demand had decreased by 10% in the same period with a 2% decrease in patients conveyed to hospitals.
In relation to response times, Ms Paterson pointed out that the Trust continued to experience challenges with Cat 2 response times having significantly increased to an average of 52 minutes. This was an increase from 37 minutes in June 2023. Ms Paterson said that the delays had been attributed to hospital handover delays and operational policies linked to Action Short of Strike (ASOS).

Ms Paterson advised that positive trends were noted in clinical Hear & Treat rates which had increased to over 6% in June 2024. She said that efforts to improve these metrics continued with targeted training and process optimisation.

Continuing, Ms Paterson highlighted that over 9,775 hours had been lost due to handover delays over 15 minutes in June 2024. This, she said, represented a 5% increase from May 2024. She explained that such delays were a critical concern for operational efficiency and patient care quality.

Ms Paterson acknowledged that the Trust also continued to experience challenges in non-emergency services. She advised that performance metrics for non-emergency services like PCS showed a need for improvement, with significant percentages of journeys failing to meet targeted timeframes. Ms Paterson said that this had prompted a review of operational practices and patient handling procedures.

Ms Paterson reported that initiatives were underway under the Delivering Value Programme for 2024-25, with the aim of identifying and implementing service improvements throughout the year.

In relation to staffing and training, Ms Paterson advised the meeting that recruitment and training for Integrated Clinical Hub clinicians had been completed, with a focus on aligning staff levels with service demand.

Ms Paterson indicated that the Trust had received 31 compliments and 22 complaints in June 2024. She advised that a robust process for handling and learning from complaints was in place, ensuring continuous improvement

Ms Byrne advised that the work in relation to improvements around Cat 2 responses was ongoing. She drew members' attention to Slide 5 which showed a significant increase in duplicate calls and noted the direct correlation to response times with duplicate calls being made to ask estimated time of arrival (ETA). Ms Byrne advised that work was ongoing to triage the call volume with delayed responses and using that data to support the impact of the Integrated Clinical Hub (ICH).

Ms Byrne drew the Board's attention to the slide setting out the process recently introduced to reduce the number of duplicate calls. She explained that the process had been reviewed, action cards introduced as well as SMS messaging and said that these actions were linked to the work of the mental health professionals in the ICH but also the Complex Case Team. Ms Byrne said she and Mr Sinclair had discussed how further linkages with the Complex Case Team could be forged.

Ms Byrne alluded to the 2-hour handover backstop and said that, while a process was in place, there were no signs of improvement. Ms Byrne also referred to the Operations Management Structure review and said that members would be aware of communications issued to staff in mid-August providing an update on the actions taken to date and the plans moving forward in respect of an implementation plan.

Mr Corrigan referred to the Performance Scorecard, in particular complaints, and said that the Trust response times to complaints were showing a deteriorating trend with only 43% of complaints being responded to within the required timeframe, ie 20 days. He believed that such delays would only exasperate patients' experiences with Trust service and asked for some focus on this area.

Mr Corrigan also alluded to absence management and said there had been an improvement on last year's position. However, he noted an increase to 11% in June and asked if the Board should be concerned at this increase.

Ms Charlton acknowledged the need for improvement in the timeliness of responses to complaints. She said the Trust had been engaging with the NI Public Service Ombudsman (NIPSO) around

response times and added that the NIPSO was undertaking a review of complaints on behalf of the DoH. She advised that a significant percentage of delayed responses focussed on emergency response delays and, while small in number, these complaints were about life-changing events. Ms Charlton stressed the importance of ensuring the response was fulsome and addressed every aspect of the patient/service user's concerns. She indicated that the Trust had decided not issue a generic response to complainants but was keen to ensure that complainants received a personalised response, responding to every point made in the complaint.

Ms Charlton advised that a call audit was carried out for each complaint received in relation to a delay in response. She advised that the Trust's approach had been discussed with NIPSO and NIPSO had been informed that the Trust ensured there was regular contact with those complainants for whom a response had been outside the required timescale of twenty days to explain the reasons for the delay.

Ms Charlton explained that, if there was no clinical aspect to the complaint, the Trust's Service User Feedback Team contacted the complainant to enquire how they would like the Trust to deal with their complaint. She advised that, on occasions, the complainant wished the member of staff to be spoken to. However, Ms Charlton advised that each complaint and response was recorded for governance purposes and trend analysis.

Ms Charlton advised that the Trust had received several complex clinical complaints and she and Dr Ruddell had met with the families involved. She explained that this in itself took time and understandably, on occasions, families did not wish to engage.

Ms Charlton cautioned that, while time was easy to measure, the quality of response was not. She stressed the importance placed by the Trust on ensuring each complainant received a bespoke and individual response. She advised that the Trust had only had three complaints reopened. Ms Charlton advised that she and the Chief Executive met on a weekly basis with the Service User Feedback Team to discuss each response and acknowledged that, while the Trust process took longer, it was more important to ensure a quality response.

Mr Bloomfield indicated that the NIPSO had agreed with the Trust around the importance of the quality of response as opposed to the timescale for response.

With regard to Mr Corrigan's point re absence management and the fact that there had been an increase in June, Mr Bloomfield said he too shared Mr Corrigan's concern at the increase. He pointed out that there had been a month on month reduction in absence since November 2023. Mr Bloomfield said that the pace of reduction since March 2024 had been faster than he had anticipated, however, he expressed disappointment that the absence figure had increased to 11% in June and to 11.07% in July. Mr Bloomfield noted that the August 2023 absence figure was 16.04%, and he was confident that the ongoing work would ensure that these would not return to that level of absence. He said that, while not overly concerned at this stage, he believed there were seasonal issues at play which would take some time to address.

Mr Bloomfield reminded members that the Trust had looked at those staff who had been absent from work the longest and 57% of these staff had returned to work; 20% of staff had left the organisation and the remaining 23% of staff were at various stages of process. He said that, with this in mind, he was confident that the issues were being addressed and members would see a return to the previous improved position.

The Chair welcomed this. She noted the exceptional governance arrangements in place since November 2023 and highlighted the need for focus on this area to continue. She reminded the meeting that Mr Dennison, as co-Chair of the PFOD Committee, would continue to oversee managing absence.

Mr Bloomfield explained that slide 20 onwards focussed on the SPPG delivery plan and set out the ten metrics against which the SPPG assessed the Trust. He said that the Trust had reviewed the SPPG assessment of quarter one which would be discussed at the next PTEB meeting. Mr Bloomfield said that the Trust was of the view that there was room for improvement around performance, particularly Trust response times. He reminded the meeting that the SPPG assessed the Trust against trajectories and had assessed that the Trust had achieved green in eight areas and amber in two areas. Mr Bloomfield noted that NIAS was the only Trust assessed by the SPPG as having no red assessments.

He acknowledged that, while this was a factual position, the Trust's senior team was of the opinion that performance needed to improve.

The Chair indicated that there were still significant challenges for NIAS across the system and welcomed the fact that the trajectories were moving in the right direction. However, she acknowledged the need for balance and said she intended to raise the fact that the Trust's performance needed to be qualified at the forthcoming accountability review meeting.

Ms Byrne said she recognised the impact of seasonal absence and noted that a workshop was scheduled for September involving HR and Divisional representatives. She advised that the workshop would have a strong focus on performance over the summer months, particularly July which had also proved challenging for the Trust.

The Chair thanked everyone for their comments and the Performance Report was **NOTED** by the Board.

11 **DoH letter re: Strategic Priorities 2024-25 (TB22/08/2024/08)**

Mr Bloomfield drew members' attention to the Ministerial correspondence which set out the Strategic Outcomes Framework and System Oversight Measures which replaced the previous commissioning plan.

The Chair advised that she had discussed this correspondence with the Chief Executive prior to going on leave and said she had several reservations in terms of its content. She said Trust Chairs had discussed the correspondence and had agreed that Ms O'Reilly, Chair of the NHSCT, would work with Ms Moorehead, NI Confederation (NICON), to draft a paper around the concerns held by the Chairs. The Chair added that further discussion would take place at the forthcoming Trust Chairs' meeting.

Ms Paterson explained that the Minister's correspondence and its intention would be socialised more widely within the Integrated Care Structure and APBs. She advised that Trusts had been asked to respond to the correspondence.

She advised that there were seven domains to which Trusts had to respond by 30 September 2024. Ms Paterson indicated that Trusts' initial responses would be reviewed by the SPPG and PHA with a view to them issuing responses by 4 October 2024. Bilateral meetings, involving finance colleagues, would then be scheduled to take place on 7 October. Ms Paterson noted that, as yet, no governance mechanism had been established as to how Trusts would be held accountable. However, she acknowledged that this was the start of the process to develop a more focussed and accountable approach from a system perspective with measures which would align to that.

The Chair believed that it would be important to understand the strategic business planning process and align that to the Trust's own process. She highlighted the need for the Board to understand the Departmental and Ministerial approaches to inform NIAS' strategic planning.

Ms Paterson explained that each geographical Trust would receive intelligence from the PHA on their respective health needs. This, in turn, would align with the Area Integrated Partnership Board (AIPB) workplan on Ministerial priorities and dovetail with the Trust's own strategic planning and how it would support the overall regional delivery.

Mr Dennison was of the view that this would prove challenging to the Trust and asked how it was intended to overlay this expectation with the commitments already made by the Trust. He sought clarification around those elements which the Trust believed would be difficult to deliver.

Responding, Ms Paterson assured the Board that the Trust was already working on many aspects of the plan and said she had interpreted this as meaning that the DoH intended to place an 'outcome lens' on the work being progressed by the Trust and determine how this would feed into the overall system. She acknowledged the challenges involved for other Trusts which were not commissioned to take forward the work in the manner in which the outcomes had been framed.

The Chair thanked Mr Bloomfield for bringing this correspondence to members' attention and asked that the Board would be kept apprised of developments.

12 **Committee Business:**

- **Audit & Risk Assurance Committee – minutes of meeting on 16 May 2024;**
- **People, Finance & Organisational Development Committee – minutes of meeting on 18 April 2024 & report of meeting on 3 July 2024 (TB22/08/2024/09)**

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

- **ARAC**

Dr Graham noted the previous discussions around the annual report and the agreement by the DoH Finance Department to share with ARAC Chairs suggested guidelines/requirements for annual reports. He suggested it would be helpful for NEDs to oversee this as he believed there was room for improvement.

With regard to the risk register, Dr Graham said that members would be aware of the ongoing work around revising the risk register to make it more focussed and the need to de-escalate some risks to Directorate risk registers. He said that he would be meeting with Ms Paterson to discuss progress.

Dr Graham also advised that he intended to use the October ARAC meeting to consider progress on outstanding Internal Audit recommendations. He further advised of the potential to convene additional targeted meetings to look at progress. Dr Graham added that, linked to this, work would also be progressed in parallel to look at Directorate registers.

The Chair welcomed the focus of the ARAC on revising the risk register. She said it was on record at the June Trust Board meeting that the Trust had received a limited audit opinion and encouraged all necessary work to address this.

- **PFOD Committee**

Mr Quinn referred to the presentation at the July PFOD Committee on peer support. He said that he had been assured from the presentation on how the Trust was managing this important function and its important contribution to staff welfare.

Mr Quinn alluded to the forthcoming meeting he would be attending involving the Chief Executive and Head of HR to discuss the capacity framework and said he looked forward to discussions. Mr Quinn advised that he, Mr Sinclair and Ms Charlton had also met with Ms McAteer who had undertaken her Masters dissertation in Person Centred approach and some of the behavioural competencies which would be associated with this approach.

Ms Charlton said that she was delighted to advise that Ms McAteer had been accepted for her PhD.

The Chair thanked all involved in the PFOD Committee and noted that the Committee was also overseeing the implementation of recommendations from the independent review of financial process.

- **Safety Committee**

Ms Byrne advised that the additional assurance meetings in relation to EPRR continued with the next one scheduled to take place on 29 August in advance of the Safety Committee meeting on 12 September.

13 **Date of Next Meeting**

The next NIAS Trust Board will be held on Thursday 24 October 2024 at 10.30am in the Boardroom, NIAS HQ.

14 **Any Other Business**

(i) Trust Board Seal

The Chair advised that the Board Seal had been affixed to a lease renewal Roe Valley Ambulance Station and to the Memorandum of Understanding between NIAS and SEHSCT for premises at Ulster Hospital Dundonald.

(ii) Covid-19 Inquiry

Mr Bloomfield reminded the Board that the Trust had submitted evidence to the Covid-19 Inquiry some time ago. He advised that the Covid-19 Inquiry Hearings (module 3) would commence on 9 September and that evidence from a number

of Directors would be read during the hearings or published on the Inquiry's website. However, he said, the Trust had received correspondence from the Inquiry confirming that no-one would be called to give evidence.

(iii) **Mpox**

Ms Charlton informed the Board that the Trust had been advised by the Public Health Agency (PHA) of an emerging outbreak of Mpox which had been declared as a world health emergency. She explained that the Mpox was a highly infectious disease and strict guidance had been issued on how how to manage cases.

She advised that the Trust's Hazardous Area Response Team (HART) and Dr Ruddell were benchmarking practices across the UK around surveillance tools. Ms Charlton added that there were requirements for staff in terms of level 3 PPE and guidance as to how best to transport patients to hospital.

She agreed to keep the Board updated.

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

SIGNED: _____

DATE: ____**24/10/24**_____