Northern Ireland Ambulance Service
Health and Social Care Trust

MINUTES OF THE SAFETY, QUALITY, PATIENT EXPERIENCE AND PERFORMANCE COMMITTEE HELD AT 9.30AM ON THURSDAY 25 JANUARY 2024 IN THE BOARDROOM, NIAS HQ

PRESENT:	Mr D Ashford	-	Committee Chair
	Mr P Quinn	-	Non-Executive Director
	Dr P Graham	-	Non-Executive Director
IN ATTENDANCE:	Mr M Bloomfield	-	Chief Executive
	Ms R Byrne	-	Director of Operations
	Ms L Charlton	-	Director of Quality, Safety & Improvement
	Mr P Nicholson	-	Director of Finance, Procurement, Fleet & Estates
	Ms M Paterson	-	Director of Planning, Performance & Corporate Services
	Mr N Sinclair	-	Chief Paramedic Officer
	Mr R Sowney	-	Senior Clinical Adviser
	Mrs C Mooney	-	Board Secretary
	Ms R Finn	-	Assistant Director QSI
	Mr P Corns	-	Consultant Paramedic (for agenda item 6 only)
	Mr T O'Neill	-	Education Team (for agenda item 6 only)
APOLOGIES:	Dr N Ruddell	-	Medical Director
	Ms M Lemon	-	Director of HR & OD

1 **Apologies & Opening Remarks**

The apologies were noted.

The Chair welcomed members to today's meeting, particularly the new Non-Executive Director members of the Committee, Mr Quinn and Dr Graham.

2 Procedure

2.1 Declaration of Potential Conflicts of Interest

There were no declaration of conflicts of interest.

2.2 Quorum

The Chair confirmed that the Committee was quorate.

2.3 Confidentiality of Information

The Chair emphasised the confidentiality of information.

3 Previous Minutes (SC25/01/24/01)

The minutes of the previous meeting on 17 November 2023 were **APPROVED** on a proposal from the Committee Chair and seconded by Mr Bloomfield.

4 Matters Arising (SC25/01/24/02)

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

(i) Hand Hygiene Standards

Ms Finn updated the feedback to Committee on engagement with national IPC colleagues around Hand Hygiene standards and explained that the Trust had wished to consider if the hand hygiene target was too ambitious at 90%. However, she said, having engaged nationally in this regard, the team had concluded that the target of 90% was reasonable and Ms Finn highlighted that NIAS was not currently achieving this compliance despite a number of actions within the Trust to improve.

The Chair stressed the need for the Trust to renew its efforts to encourage staff to adhere to the guidelines.

(ii) FIT Testing

Ms Paterson reminded members of the discussion at the previous Committee meeting in November when she had advised that 1,186 staff were required to be FIT tested. She explained that all staff had

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been FIT tested at the start of the pandemic, with all testing expiring at the same time. She advised that a plan on how this would be addressed by the end of March was currently in development but acknowledged that it would be important for the Trust to put more robust and resilient arrangements in place moving forward.

Mr Nicholson explained that there were two elements to this issue. Firstly, the testing exercise itself and secondly the release of staff to be tested for the different types of masks that were available.

(iii) Body Worn Video (BWV)

Ms Paterson alluded to discussion at the November meeting on the 2022-23 Annual Health, Safety and Fire Safety Annual Report and the queries over whether there had been a reduction in the number of assaults against staff through the use of Body Worn Video (BWV). She advised that, since the full introduction of BWV in April 2023, the Trust had not seen a decrease in the number of incidents of violence and aggression reported by staff. She pointed out that, while there had been a slight decrease in the number of reports for 2022-23, there had been an increase in reports in quarter three.

Ms Paterson reported that the project had been fully rolled out to operational staff, with 420 cameras available across 34 sites. She advised that camera use was gradually increasing with an average of 55 cameras being carried per shift. However, she said, this only represented approximately 25% compliance. Ms Paterson indicated that there still appeared to be a reluctance by staff to use cameras and added that anecdotal feedback showed that staff were apprehensive that the BWV would be used to oversee clinical practice.

Mr Bloomfield pointed out that the use of BWV by staff was voluntary. He commented that, at the time of introducing the BWV, it had been hoped that seeing the positive benefits would encourage staff to use BWV. Mr Bloomfield noted that there was some national consultation ongoing around the use of BWV and he queried whether there was any learning for the Trust from the consultation with a view to increasing uptake amongst staff.

Ms Paterson advised that NIAS was hosting the National Violence and Aggression Team in Belfast on 6-7 February and said the team

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would liaise with the Team to ensure the Trust was establishing best practice and exploring every option to do so.

Responding to a question from the Chair on whether there was any potential for BWV to be used to oversee clinical practice, Mr Bloomfield explained that the incidences in which BWV could be used were very tightly controlled, ie only for use in potential incidences of violence or aggression against staff.

Ms Paterson alluded to the detailed discussion which had taken place at ARAC in the context of the information governance aspects of the Policy. She said the Policy made it very clear that the use of BWV was for the protection of NIAS staff.

Mr Quinn referred to the anecdotal feedback and suggested the use of questionnaires to collate feedback might be beneficial.

Ms Paterson said that the fact the Trust was now seeing a reduction in the use of BWV would signal that it needed to undertake further engagement with staff to determine, for example, if further training was required. She said it would be important to capture such issues in a qualitative way to inform the next steps. Ms Paterson reminded colleagues of the significant investment in the procurement of BWV equipment and said the Trust was able to demonstrate that the use of BWV reduced the escalation in certain situations when it was made clear that the equipment was being used. She said it was fair to say that the majority of staff who reported assaults/acts of aggression had not been wearing BWV at the time of the incident and that few of the reported assaults had been recorded. Ms Paterson said that the Trust had forwarded footage to the PSNI to support prosecutions but unfortunately the Trust was not yet notified by the PSNI of successful prosecutions.

The Chair thanked Ms Paterson for her update and suggested that the Committee should receive a further update in six months' time. Ms Paterson agreed to take forward as appropriate.

(iv) Emergency Preparedness, Resilience and Response

The Chair noted the continuing progress in relation to EPRR and said he looked forward to further updates.

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5 **Standing Items:**

(i) **Identification of Risk**

The Chair explained the background to this particular agenda item.

Mr Quinn said he would find it useful to have sight of the existing risks for the Committee in order to create a baseline. Ms Charlton said she would be happy to look at this and circulate as appropriate.

In terms of identifying risk for the Committee, Ms Charlton alluded to the low uptake of the flu and Covid-19 vaccinations amongst staff. She explained that, over the last couple of years, the Trust had not been able to administer the vaccines within the Trust due to storage requirements. She added that the PHA had worked with the Trust to deliver a vaccination programme and ensure access for staff to receive their vaccinations at other Trust vaccination centres.

Ms Charlton reported that the flu vaccination uptake was 21% regionally with NIAS at 12%, while the Covid-19 vaccination uptake was at 16% regionally, with NIAS at 9%. She acknowledged that there had been a much lower uptake rate across the region than in previous years and the PHA had expressed some concern at this.

Continuing, Ms Charlton said it had originally been thought that the vaccination programmes would end in December. However, the Trust had been advised that these would now continue until the end of March. She said the Trust had engaged with PHA colleagues and were exploring internally how the Trust might make a more concerted effort and revert to a peer delivered vaccination programme until the end of March. Ms Charlton said the Trust had also engaged with national colleagues to determine if this was a risk reflected on corporate risk registers and feedback to date indicated that it was not. She added that feedback through IPC colleagues had also shown that the low uptake rate had not been reflected as a risk on HSC registers. Ms Charlton said she was of the view that the low level of uptake should be identified as a risk on the Corporate Risk Register and wanted to bring this to the Committee's attention. She pointed out that, regardless of the concerted efforts made over the next number of weeks, regrettably the Trust would not achieve its previous vaccination levels.

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Mr Sowney sought further detail on the proposed arrangements.

Responding, Ms Charlton advised that she and the IPC team were engaging with Mr Sinclair's team around the pharmacy input required. She explained that the vaccination programme would require two paramedics and work was underway to explore the potential of using paramedics currently on light duties. Ms Charlton said that the Senior Management Team (SMT) had felt it was important to make every effort to increase the uptake levels amongst staff.

Ms Byrne commented that the reduction in the vaccination levels reflected the downturn seen by primary care colleagues in the public not receiving both vaccinations.

Mr Sowney commented on the pharmaceutical input required and alluded to the pressures within the small team and asked whether the Trust's plans to have its own vaccination programme were realistic.

Ms Charlton said that SMT had discussed how much pharmaceutical input would be required and whether this would be detrimental to their workplan. She advised that the time requirement would be two weeks and said that, given the workplan and the risk to the delivery of that workplan, SMT had collectively agreed that the Trust should proceed to have an internal vaccination programme until the end of March.

Ms Charlton pointed out that NIAS did not have a 'flu team' as such and had not been funded by the PHA for its administration of the vaccine through internal arrangements. She referred to the operational pressures which had existed recently and said these had also contributed to the low uptake levels amongst staff. Ms Charlton said that the PHA was now considering a funding stream for the Trust for future programmes and added that it would be important that the Trust would consider putting more robust arrangements in place for future vaccination programmes should the necessary funding be made available.

Mr Bloomfield believed that the low uptake rates were more of a societal issue. He said that, for a number of years, NIAS had achieved the highest uptake rates across the HSC and had been lauded by the Chief Medical Officer on many occasions.

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Mr Quinn said that he was shocked at the low uptake rates across the HSC and agreed that it would be important for the Trust to act. He believed that it was as much testing the impact now so as to gauge future impact. Mr Quinn alluded to the mixed messaging and cited the example of 60-65 year olds not being eligible to receive the flu vaccination while individuals who were 50+ years were eligible to receive the Covid-19 vaccination.

Mr Sowney agreed that there was an element of mixed messaging.

6 **Occupational Road Risk & Fleet Safety Policy v1.0 Driving and Care of Vehicles when driving on behalf of the Trust v11.4 (SC25/01/24/03)**

The Chair welcomed Mr Corns and Mr O'Neill to the meeting and asked them to present the 'Occupational Road Risk & Fleet Safety Policy v1.0' and the 'Driving and Care of Vehicles when driving on behalf of the Trust Standard Operating Procedure (SOP)'.

The Chair welcomed the development of the Policy and said it was not dissimilar to other emergency services road operational policies.

Mr Bloomfield explained that the Trust had developed this Policy in the knowledge that it would be introduced at risk. He acknowledged that he was uncomfortable with seeking Committee approval to a Policy which he knew the Trust would experience challenges in implementing. However, he stressed that the Senior Management Team's strong view had been that having the Policy was the right thing to do and that the Trust could focus on working towards full implementation of the Policy. Mr Bloomfield indicated that, if it were not possible to provide the capacity from within the Trust's own training team, assistance would be sourced from external providers. However, he added that he was of the view that, over time, having internal capacity would be important.

The Chair commented that the Trust was now committing to paper what should be done in relation to these areas of work.

Agreeing, Mr Bloomfield reiterated that the development of the Policy was the right thing to do. He clarified that it not only concerned NIAS staff but also the Voluntary Car Service and anyone who drove on behalf of the Trust.

Ms Paterson pointed out that the benefits of having the Policy outweighed the risk carried by the Trust and clarified that the assessment element of the Policy was where the risk lay. She said the Trust would work to implement the Policy in the knowledge that there would be elements within it which would not be implemented satisfactorily.

Mr Corns pointed out that, although the Trust would be unable to carry out the 250 assessments required, it would be able to process approximately 100 assessments per year. He drew the Committee's attention to the risk assessment tool at the back of the Policy which would be used to prioritise staff for assessment.

Responding to a query from the Chair, Mr Corns confirmed that the 250 assessments would include assessments in respect of voluntary car drivers. He clarified that the Trust had approximately 1,100 operational staff and around 80-100 'grey fleet' which, for example, were voluntary care drivers and Community First Responders.

The Chair questioned the timeframe for assessment of competency being between every three to five years.

Mr Corns explained that five years was the legal requirement and explained that the Policy had been developed in conjunction with the National Driver Training Advisory Group. He acknowledged that other services had opted for assessment every three years and said that it was accepted that assessment between every three to five years was in order.

Mr O'Neill pointed out that five years would be the maximum timeframe. He acknowledged that some staff had been in the service for a number of years and would be viewed as priority for assessment. However, those Associate Ambulance Practitioners (AAPs) due to qualify in April would not be due for assessment until 2029. Mr O'Neill referred to the rolling process of assessment.

The Chair welcomed the prioritisation approach. He referred to red traffic light signals and said that his understanding was that the legislation allowed this to be treated as give way in an emergency situation.

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Mr O'Neill noted that, in driver training, a red traffic light signal was either a stop or give way signal.

The Chair asked whether consideration had ever been given to 'black box' technology for routine calls.

Mr O'Neill explained that, if ambulances exceeded the speed limit on non-emergency calls, a voice warning sounded in the cab. However, this ceased when lights and sirens were activated. He added that there was technology on the vehicles which recorded the vehicle speed throughout each call.

Mr Sinclair added that the technology also recorded the times at which blue lights were deployed and the volume etc.

Mr Corns alluded to the table on page 15 of the SOP which set out the statutory speed limit and the NIAS guidance limit and stressed that the speeds were not targets or expectations. He emphasised the importance of taking account of road conditions.

Mr Sowney referred to the need to undertake basic roadworthiness checks and asked how realistic it was to expect staff to undertake these even when being dispatched to a Cat 1 call. He acknowledged that a basic inspection would take a couple of minutes approximately and alluded to the impact on the response time of 8 minutes for a Cat 1 call.

Mr Corns acknowledged the negative impact on such calls but said it was important that the Trust provided the appropriate guidance to staff. He referred to the constant dispatching of vehicles and said it was unlikely that full Vehicle Daily Inspections (VDI) were carried out. However, he said, this did not mean that the Trust should not recommend it and support staff to do so. Mr Corns added that some staff came on shift early to carry out a VDI, however he added that this was an individual's choice.

Mr O'Neill commented that it was practice to advice Control if unable to conduct a VDI.

Mr Sowney pointed to para 1.13.3 re the use of the MDT screen and the fact that it '… must not be used by the driver whilst the vehicle is in motion ….'. He said that the Trust had been encouraging its use and now appeared to be reversing on this approach.

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Mr Corns acknowledged that the vast majority of MDT usage would be by the attendant as would usage of a mobile phone. He cited the example of being a single-handed practitioner in a RRV vehicle and said that using a MDT whilst responding to an emergency call was extremely challenging.

Ms Paterson agreed that staff should only be using the MDT screen when it was safe to do so.

Mr Sowney referred to para 4.9 of the Policy around 'Fatigue' and questioned how this impacted on staff given the challenges around missed meal breaks. He also queried whether there was provision within the guidance to encourage staff to report fatigue and to be stood down for a period of time if deemed appropriate. Mr Sowney accepted the importance of acknowledging fatigue and felt it would be important for staff to report fatigue. He said he was of the view that it would be difficult for consideration to be taken of this given the current pressures.

Mr O'Neill said the Trust would encourage rotational driving and alluded to the setting up of welfare hubs at EDs. However, he acknowledged that the Trust attempted to encourage staff to self-report fatigue.

Mr Sowney alluded to those circumstances where staff experienced fatigue not only on shift but on driving back to station. He said the Trust had a duty of care to staff and acknowledged the complexity of such issues.

Ms Byrne referred to the work being taken forward by the Trust in relation to late finishes and missed meal breaks and acknowledged that, whilst not dramatic, there had been a slight improvement in the position.

Ms Charlton said that, over the last number of months, the Trust had made concerted efforts to relieve crews at EDs at the first possible opportunity in order to avoid protracted shifts of 15-16 hours.

Mr Sowney was of the view that the Trust should not be using these staff as an additional resource when they finished their shift.

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Mr Nicholson highlighted the two elements to driver training. The first element was around having the necessary infrastructure and vehicles to deliver the training and the second related to the ability of the Trust to release staff to undertake the training.

The Chair acknowledged his nervousness in the Committee approving a Policy which the Trust clearly would struggle to implement fully. He expressed concern at the potential for the 100 assessments which could currently be undertaken to become the norm as opposed to striving to deliver 250 assessments per year.

Mr Sinclair advised that there was a business case developed to support the Trust requirements to implement the Policy.

Mr Bloomfield said he understood the Chair's concerns and believed that having a Policy highlighted the gaps within the Trust and the need for a plan to address such gaps. He suggested that the Committee might wish to approve the Policy and SOP reflecting the Committee's clear concerns around the Trust's ability to implement the Policy and SOP and that it wished to review the position in six months' time.

Mr Quinn agreed with the suggestion put forward by Mr Bloomfield and believed that the Trust could not countenance the continuation of not having a Policy and SOP in place. He acknowledged the challenges associated with implementation. Mr Quinn proposed that the implementation plan should set out incremental interim projections of performance against the Policy to ensure the Trust continued to strive to meet its targeted assessments.

Mr Bloomfield clarified that the Trust provided driver training to the Ulster University graduates and that emergency driving was not part of the degree course.

Ms Paterson suggested that a phased implementation plan should be scrutinised by the Committee.

Mr Quinn commented on the length of the Policy and believed that there were elements of a SOP within it. He suggested that, on occasions, policies were more accessible if brief and concise.

Ms Paterson alluded to the extant framework in place and said there would be an opportunity to look at this moving forward.

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Following discussion, Mr Quinn proposed that the Committee approve the Policy and SOP. This proposal was seconded by Dr Graham and **APPROVED** by the Committee with the caveat that the position would be reviewed in six months' time and that a phased implementation Plan would be presented to the Committee showing a clear trajectory to achieve the target of 250 assessments per year.

The Chair thanked Mr Corns and Mr O'Neill for their attendance and they withdrew from the meeting.

7 **NIAS Annual Pharmacy Update (SC25/01/24/04)**

The Chair welcomed Ms Catherine Hanna to the meeting and invited her to present her update.

Following Ms Hanna's presentation, the Chair commended her for her leadership and the significant progress which had been made since she had joined the Trust. He reminded the Committee that the Trust had previously not had any pharmacy oversight.

However, he alluded to the current arrangements whereby pharmacy teams members had been seconded to NIAS and expressed concern at the potential cessation of this arrangement.

Mr Bloomfield acknowledged the significant progress which had been made and noted that, of the 131 actions recommended by the Medicines Regulator, the Trust had completed 123 with only eight outstanding. However, he noted the significant risks associated with the outstanding actions.

Continuing, Mr Bloomfield referred to the seconded posts within the pharmacy team and said the Trust was trying to assess the scale of the pharmacy requirement within the Trust as work to address the Medicine Regulator actions progressed. He acknowledged that it was an area where the Trust had to assess the level of risk against the financial risk.

Mr Sowney alluded to the level of work yet to be completed in terms of policies, procedures and legal documentation. Ms Hanna acknowledged the challenges associated with the timeframe for completion of the actions and said the focus was now on completion by the end of March.

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She acknowledged that further work was required to improve Patient Group Directive (PGD) record keeping and said she had engaged with the education team with a view to disseminating learning through learning letters and speaking to staff.

Mr Sowney noted that over one third of inspections undertaken by the Medicines Regulator had been within NIAS.

Ms Hanna confirmed that this was the case and indicated that the Trust had not been fully inspected since 2012 despite requests from the Medical Director to the Medicines Regulator. However, she acknowledged that, should the Trust not be in a position to complete the actions and demonstrate improvement in relation to the management of controlled drugs, there was potential for the Regulator to undertake a full inspection. She pointed out that inspections were undertaken on an annual basis within the English model.

Ms Hanna said that the Trust's Medical Gas Group had not yet been established and explained that the Group would consider the risks associated with medical gases and the need for more robust governance procedures.

Mr Nicholson pointed out that the Trust had a Medical Equipment Group which would consider medical gases and accepted that the Regulator's actions provided an opportunity to reconsider how this was managed.

Ms Hanna acknowledged this but advised that there was no specific group meeting on a monthly basis to manage this equipment.

Mr Sinclair explained that, through the work completed by Ms Hanna and her team, the Trust had been able to identify a number of issues to be examined in further detail.

Mr Sowney welcomed the fact that issues were being identified for further consideration.

Ms Hanna advised that work was ongoing to develop a pharmacy dashboard which would show, for example, usages of morphine by staff and allow the Trust to identify above normal levels of drug usage.

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The Chair referred to a time when the Trust did not have a Pharmacy Lead and he commended Ms Hanna on the progress she had made to date. He acknowledged the importance of completing work over the next few months.

Mr Quinn said that Ms Hanna's presentation highlighted the risks associated with medicines management within the Trust.

Ms Charlton agreed and believed it also assisted in clarifying the risks from the Committee's perspective.

Ms Paterson clarified that, while the Trust's Audit and Risk Assurance Committee had a number of risks which fell within its remit, it was ultimately responsible for the governance of risks with individual Committees overseeing the mitigation and actions taken to reduce the level of risk.

Mr Sowney asked for the inspection reports to be shared with members. Ms Hanna undertook to forward these to Mrs Mooney for onward circulation to the Committee.

Mr Quinn said he had found it interesting, coming from a regulatory background, that the regulator had undertaken 33 inspections within one organisation.

Ms Charlton reminded the meeting that the Trust had not been fully inspected since 2012 and said that a large proportion of the issues had been historic to the Trust in the context of not having similar inspection programmes or a similar infrastructure to other Trusts. She welcomed the attention given by the Regulator as the Trust strived to improve its governance in this area.

Mr Bloomfield explained that the Trust had decided to recruit at risk in areas such as pharmacy, safeguarding, Public and Personal Involvement (PPI) and Infection Prevention Control (IPC) for example and he acknowledged that current size of the pharmacy team was inadequate for the Trust. However, he said it had been made clear to the Trust that if it believed there were areas of such significant risk, the Trust would have to identify funding from within its existing resources to address the gap.

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The Chair said it was incumbent upon the Trust's Non-Executive Directors to highlight these challenges at every opportunity.

He thanked Ms Hanna for her annual pharmacy update which was **NOTED** by the Committee and Ms Hanna withdrew from the meeting.

8 Emergency Preparedness, Resilience & Response – Update

The Chair updated the Committee on his meeting with Ms Byrne, Ms Sharpe and Mr McArthur held on 4 January to discuss progress against the Improvement Plan.

Ms Byrne advised that Foundation Commander Training continued with two courses remaining for this year to April. She confirmed that the EPRR department staffing had been enhanced with the Assistant Directors of EPRR due to take up post on 29 January 2024.

Continuing, she advised of engagement with DoH colleagues around HART capacity enhancement and said that, with the appointment to the Assistant Director posts, there would be more capacity to commence work on business cases.

Ms Byrne advised that there had been a positive response to the recruitment exercise for administrative support and it was hoped that a postholder would be in post by mid-March. She added that work had also commenced around the development of a job description and personnel specification for an EPRR Training Officer and it was intended that this work would be completed by mid-February.

Ms Byrne reported that, of the 13 Priority 1 recommendations, two had been completed and 11 were in progress and on track. She alluded to the development of the dashboard which showed progress at a glance and allowed the necessary monitoring to take place to provide assurance.

Ms Byrne added that the Trust had undertaken a recruitment exercise for two additional HART officers.

Mr Bloomfield added that the Trust was only able to recruit to its funded establishment.

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The Chair took this opportunity to describe the current HART model in NI and said it was important to highlight the need for discussion with the DoH on this issue.

Mr Sowney acknowledged the position of the Trade Unions (TU) in the context of ASOS around derogation and asked that, given Trade Unions were not in dispute with NIAS, whether there was any potential to discuss derogation around posts in terms of allowing TU representatives to participate in job matching panels given the criticality of the posts and the associated risks carried by the Trust.

Ms Byrne confirmed that Ms Lemon had been engaging closely with TU colleagues.

However, Mr Bloomfield clarified that discussions on derogation were focussed on the day of strike. He advised that he had indicated his intention to discuss EPRR at the Accountability Review meeting with the Permanent Secretary in February.

The Chair expressed his view that he did not believe EPRR was yet in a position whereby it could be considered as normal Committee business and asked for a further briefing meeting to be arranged. He added that an invitation should be extended to the Trust's three new Non-Executive Directors to attend should they wish to do so.

The Chair said it was clear that progress had been made and he commended those involved. However, he said it was important also to recognise the inherent risks involved with the work being taken forward.

The Committee **NOTED** the update.

9 **Strategic Review of Clinical Education – final report (SC25/01/24/05)**

The Chair explained that, while the final report had initially been discussed at the November meeting, he had asked for the report to come back to this meeting so members could have a further opportunity for discussion.

Mr Sinclair explained that the strategic review of clinical education had been commissioned by the Trust's Chief Executive in February

2021 with the aim of modernising and enhancing the development of staff at all levels within the Trust and he highlighted the main findings of the review.

Mr Bloomfield acknowledged that, while there were issues around the content of the course material, the main motivating factor to commission the review focussed heavily on the cultural element. He said that, for many staff coming into the organisation, their first exposure to the Trust was the training team for a number of weeks. Mr Bloomfield emphasised the importance of this being a positive experience and believed it very much set the tone and culture for the workforce. He said that he believed the transformation of the training team led by Mr Sinclair had been positive.

Mr Quinn said that, as a new Non-Executive Director to the Trust, he had found the Strategic Review report to be extremely helpful and interesting. He noted that one of the key issues had been the continuing professionalisation of the organisation and its staff and he believed that the current structure of the education team now reflected that. However, Mr Quinn said he had assumed that clinical supervision would be in place within the Trust and he queried whether clinical supervision performance metrics should be more outcome rather than activity based. He indicated that the overriding point for him was that it was focussed on a particular cohort of staff as opposed to the organisation as a whole.

Continuing, Mr Quinn alluded to a competency framework for the Trust and said that he had had experience of this in a previous organisation. He suggested that a competeny framework would allow the Trust to explore the various capacities such as care, technical or clinical with a view to determining whether the model moving forward could reflect these. Mr Quinn added that proficiencies could also be examined within the remit of a competency framework.

Mr Quinn commended the review and believed it provided a sound background to education within the Trust.

Mr Sinclair explained that the exercise had initially commenced as a review of the Trust's education programme but had subsequently expanded as he had assumed responsibility for the department. He welcomed the opportunity to explore a capacity framework in more detail and believed that, as the Trust was now capturing electronic

data via the REACH tablets, that would allow the Trust to develop a digital dashboard to look at Key Performance Indicators (KPIs) or clinical outcomes and drill down to individual level.

Mr Quinn was of the view that this would be an outcome and suggested that a further outcome related to the staff experience of their education experience.

Mr Sinclair said the Trust had been very fortunate to have the Clinical Support Officer (CSO) tier of staff and explained that, during the pandemic, these officers had been diverted to frontline duties. He explained that Ms Emma Boylan, Consultant Paramedic Clinical Education and Standards, had led a review on CSOs with a view to aligning the guidance, support, policies and education used by the CSOs so they recognise that the Trust has refreshed its education model. He added that the new structure had been aligned to the Association of Ambulance Chief Executives (AACE) and the Allied Health Professions Northern Ireland supervision policies.

Dr Graham described the review as 'impressive' and 'detailed' and was of the view that education was inextricably linked to cultural and organisational change. He commended all involved in the review.

Mr Sowney emphasised the importance of the culture change within the team and said this was clearly evident moving forward. He noted that the paramedics at the Ulster University were now in their third year of study. He said the Trust would be hoping to recruit these students following a recruitment exercise and said they would be instrumental in driving forward change. Mr Sowney said he hoped the work being taken forward by Mr Sinclair and the education team would transcend amongst Station Officers and Clinical Support Officers with a view to creating a supportive environment which would be critical to the Trust's success.

Mr Quinn believed that, from a Continuing Professional Development (CPD) perspective, there was an organic drive which would take place.

Ms Charlton indicated that there was a need to recognise the importance of expertise by experience and believed that when it worked best, it was symbiotic.

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Mr Nicholson noted that funding had been prioritised both in terms of the numbers of students and the infrastructure described within the paper. He said that the Trust was exploring the potential to further augment this with driver training mentioned earlier in the meeting.

The Chair congratulated all involved and said that, while the report was presented to the Committee for noting, he would appreciate an update on a biannual basis.

The Committee **NOTED** the Strategic Review of Clinical Education as presented by Mr Sinclair.

10 **Serious Adverse Incidents (SAIs) Update (SC25/01/24/06)**

Ms Charlton drew the Committee's attention to the SAI update and said she wished to highlight a number of points. She said it would be important to note that the context of SAIs in NI would change in the near future and noted that the extant procedure had been in place since 2016. Ms Charlton explained that, following a review by the Regulation and Quality Improvement Authority (RQIA) there was a recognition that the procedure needed to be refreshed. She advised that, in order to progress this, the DoH established a SAI Redesign Group and said that representatives from the Group had met with the Trust Board in October 2023.

Ms Charlton said it was likely the current process would change significantly and acknowledged that there were some elements of the current process which could be improved upon. She said she was of the view that viewing SAIs as figures alone was not helpful and reminded members that behind every complaint, SAI and compliment were patients, families, carers and service users.

Alluding to the paper, Ms Charlton said it was not surprising, given the context of current HSC-wide pressures, the Trust had seen an increase in the number of SAI notifications. She advised that, from August to December 2023, there had been a 22% increase in reporting compared to the same period within the 2022-23 reporting year. She pointed out that the majority of SAIs had been related to a delayed response outwith standard and also took account of the potential impact on the patient.

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Ms Charlton explained that the determination as to whether a delayed ambulance response was a direct causal factor to a patient outcome of death was complex and required consideration of a number of factors. She said that, in some cases, NIAS had already identified that the delayed ambulance response had not been a causal factor in the patient's outcome of death. However, she added, several cases were awaiting a determination from the coroner as to whether the delay was a causal factor in the patient's death.

Continuing, Ms Charlton outlined the membership of the Rapid Review Group (RRG) which met on a weekly basis to discuss each incident report recorded on Datix and said that the RRG discussed more incidents than those notified as SAIs. She acknowledged that a challenge for the Trust was the harm not being reported in that it may have been reported to another Trust. She said she, Mr Sinclair and Dr Ruddell were considering other methodology to better understand the pattern of harm.

Ms Charlton drew the Committee's attention to section 4 of the report which highlighted that there had been seven reported incidents in December 2023 within a 10-day period. She indicated that the Trust reported this increase internally through Trust Board and externally through the Early Alert process to the DoH/SPPG. She noted that a similar increase had also been recorded in December 2022.

Ms Charlton highlighted the need to be transparent and said the Trust had invited SPPG colleagues to meet to discuss the increased mortality being seen by the Trust and noted that other Trusts were in a position to report adjusted mortality data. Ms Charlton said that the Trust was exploring themes and benchmarking against other national ambulance services as well as undertaking some sub-group analysis to better understand the specifics in the Trust, for example with whom would learning best be shared.

Ms Charlton highlighted the importance of learning and said the Trust was significant efforts to follow up recommendations and ensure there were robust processes in place to ensure learning was disseminated and steps put in place to ensure improvements. She acknowledged that a significant proportion of SAIs related to delayed response and said the Trust was not seeing an improvement in this area.

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Continuing, Ms Charlton said that effective family and staff engagement was important to the Trust as well as the culture of the organisation. She indicated that SAI investigations continued to be viewed on occasions as a punitive process and said that efforts were being made to make it feel different. She said that work was being taken forward through the Professional Standards Lead in Mr Sinclair's Directorate and Clinical Support Officer support around staff reflections. Ms Charlton said it would be important at the Committee to share the human side of the SAIs.

Mr Quinn commended the SAI update report and felt it was very open and transparent. He said he had been interested to note that there would be revisions to the SAI approach and indicated that he would be keen to know the outcomes and how they are continually monitored. He acknowledged that several SAIs were linked to system pressures.

Ms Charlton explained that the report had been drafted by Ms Audrey Murdoch, SAI Lead, and said that there was potential for a number of contributory factors to a delayed response. She cited the example that some learning may focus on how the Trust triaged calls.

Mr Quinn commented on the potential re-traumatisation of the particular family who had not been aware that a delayed response had featured in the incident.

Ms Charlton agreed that it was very challenging and traumatic having to contact a family dealing with a family bereavement to explain that the Trust was not in a position to confirm whether it had contributed to the patient outcome and she acknowledged that this, on occasions, left families having to seek further clarification.

The Committee **NOTED** the report as presented by Ms Charlton.

11 **Service User Feedback, Complaints and Compliments Update (SC25/01/24/07)**

Ms Charlton drew the Committee's attention to the update paper which had been written by Ms McVeigh and Ms Hamilton and reported that, during the period 1 April – 31 December 2023, the Trust had received 175 complaints compared to 166 complaints

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during the same period in the previous year. She expressed her surprise at this given the increase in delayed handovers.

Ms Charlton reminded members that they had previously indicated their wish to have sight of the narrative from a complaint and she pointed out that, under the current Complaints Procedure, there was a 20-day timeframe to respond to the complaint.

Continuing, Ms Charlton advised that most complaints fell within EAC and explained that this was not necessarily due to practice but because of the impact of delayed response. She described the current system in place in terms of how the Trust monitored its performance in responding to complaints, ensuring actions were progressed, learning implemented and those complaints yet to be responded to.

She indicated that the average response time for the Trust to a complaint was 35 days. She emphasised that the Trust approach was to ensure a bespoke response to each complaint and said this was signed off by the Chief Executive. Ms Charlton explained that the bespoke response provided a more qualitative response. She advised that the NI Public Services Ombudsman was currently undertaking a review of complaints in the public sector and said that she and Ms McVeigh would participate in the review. Ms Charlton said she hoped that she would be able to influence the timeframe for response to ensure responses were of a more qualitative nature as opposed to the focus being on meeting the timeframe for response.

Ms Charlton reminded members that, upon receipt of compliments, the Trust wrote to the member of staff concerned to share the compliment with them and she pointed out that the Trust received many more compliments than complaints.

Mr Quinn referred to the value of compliments and highlighted the importance of the Trust ensuring bespoke responses to complaints. He believed that this fed back into the organisational culture.

Ms Charlton pointed out that, as NIAS crews conveyed patients to EDs, they often were not aware of the patient outcome. She advised that 0.06% of calls resulted in complaints and indicated that a complaint theme emerging related to patients being asked to walk to the ambulance.

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Mr Sowney sought further detail around informal resolution to complaints.

Responding, Ms Charlton explained that, upon receipt of a complaint, the complainant would be asked what they would like to see in terms of outcome. She cited the example of a complaint around crew attitude where the complainant had indicated their wish to receive an apology.

Ms Charlton explained that, when receiving a complaint relating to a member of staff, the Trust had a process in place whereby checks were undertaken to determine if previous complaints had been received regarding that staff member. She advised that, when discussing the complaint at the Rapid Review Group, it was helpful to know whether there was a trend emerging in relation to an individual member of staff and a determination could made on whether the staff member needed additional support with their practice or onward referral to the Trust's Professional Standards Team.

Mr Sowney said he would encourage staff to respond to complaints as early as possible.

Ms Charlton clarified that, if the complaint was linked to clinical practice, an investigation report would be sought. She highlighted the importance of having robust records and engagement with families.

Mr Bloomfield acknowledged that the Trust's performance in terms of responding to complaints within the required 20-day timeframe had not been good. However, he noted that 163 complaints had been closed in nine months which equated to an average of four complaints closed each week and said that, given each complaint required investigation, he commended this outturn. Mr Bloomfield acknowledged that, while it was important for the complainant to receive a response to their complaint quickly, it was more important for that response to respond to the issues raised. He pointed out that very few complainants expressed dissatisfaction with the response received or consulted the NI Public Services Ombudsman on their response.

Ms Charlton said it was her intention to carry out some qualitative work around the experience of those involved in the complaints process. She welcomed the Internal Audit report on complaints which had recently received a satisfactory level of assurance.

Ms Paterson pointed out that Internal Audit had previously given a limited level of assurance in relation to complaints and she commended all involved in the improvements made to the complaints process in terms of framework, governance and structure.

Ms Byrne commented that the thoroughness of the investigation did not lend itself to responding within the 20-day timeframe.

The Committee **NOTED** the update as presented by Ms Charlton.

12 **Independent Ambulance Service Update (SC25/01/24/08)**

Ms Charlton noted the Trust's reliance on independent providers over the last few years and the fact that the service was not regulated in Northern Ireland. She said, as commissioner, there was a recognition that, as part of the Non-Emergency Framework of which all Trusts were clients, there was a need to strengthen governance and assurance around the arrangements provided on behalf of Trusts. Ms Charlton said that, following a cross-Directorate approach within NIAS in terms of health and safety, Infection Prevention Control (IPC), a process was put in place whereby NIAS undertook its own unannounced inspections.

Ms Charlton noted that approximately 58,000 journeys had been undertaken on behalf of NIAS in 2022-23 and said the Trust was striving to reduce its reliance on independent ambulance services. She explained that there had previously been seven independent ambulance service contractors and advised that there were now 16 contractors who had joined the Framework.

Ms Charlton highlighted the increased administrative challenges associated with the increased number of providers on the Framework and said that Ms Paterson intended to liaise with her Director of Planning colleagues with a view to adopting a collective approach to this work.

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Ms Charlton referred to the arrangements within NIAS in respect of unannounced inspections, the online audit system and actions plans shared with providers who had been very engaged in the process.

Continuing, Ms Charlton advised that the Trust had engaged with the Regulation Quality and Improvement Authority (RQIA) in the context of the regulatory gap and how this might be considered. She said that the Trust had shared with RQIA colleagues some documentation which had been produced by the Care Quality Commission (CQC) in England. She commended the work which had been done to date and acknowledged that further refinements were needed.

Responding to a question from Mr Quinn, Ms Charlton clarified that the specification and scoping documentation described the level requirements to deliver on the Framework. She indicated that the Trust sought assurance at their quarterly review meetings with providers and asked providers to confirm they met the specification. Ms Charlton acknowledged that the Trust did not have all its own staff trained to the required standards and said that the feedback from independent providers was that having a Framework in place which clearly sets out what was expected of them strengthened their governance and assurance processes. She said she was conscious that some of the providers had small workforces and said NIAS had undertaken to provide Subject Matter Experts to undertake some awareness sessions around complaints, IPC, sharing learning etc.

Mr Quinn noted that the purpose of the regulation through the NI Order was to protect the public and sought clarification on whether there would be a vicarious responsibility on the HSC in the event of an untoward incident, for example, in the area of safeguarding. He said that the level of regulatory risk did not decrease.

Responding, Ms Charlton explained that this issue was currently being explored and said the Trust was attempting to mitigate what it perceived to be the risk. She indicated that, whilst the Trust sought assurances at the quarterly review meetings with providers, the only way it could assure itself from a second level of defence perspective was through unannounced inspections. Ms Charlton said there was now an opportunity to look at this on a regional basis with a view to protecting all organisations.

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Mr Bloomfield commended the processes put in place and said that, although these had resulted in improvements, it did not negate the need for regulation.

Mr Nicholson explained that independent ambulance services comprised private and voluntary ambulance services and expenditure was in the region of £7 million per year. He clarified that it did not include taxis and Voluntary Car Services, totalling approximately £600,000 per year.

Responding to a question from Mr Sowney, Ms Charlton explained that there were clauses within the contract which allowed the Trust to stand down a provider until an investigation/review was completed. She added that the Trust could also ask a provider to remove a vehicle from the road if significant risks had been identified.

Mr Sowney asked for confirmation regarding providers using Patient Record Forms (PRFs).

Ms Charlton advised that this was the case and said that the Trust would seek PRFs and crew reflection in any investigations to be undertaken. She added that providers were largely compliant with any requests from the Trust.

Ms Paterson noted the significant expenditure and effort on independent ambulance services and said it would be the Trust's preference to focus on using its own staff to deliver these services.

The Chair thanked Ms Charlton for her update which was **NOTED** by the Committee.

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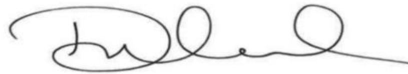
13 Date of next meeting

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

14 Any Other Business

There were no items of Any Other Business.

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



SIGNED: ______________________

DATE: 25 April 2024

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