NORTHERN IRELAND AMBULANCE SERVICE TRUST

TRUST BOARD - THURSDAY 20 FEBRUARY 2025 AT 09.00AM

Boardroom, NIAS HQ

Site 30, Knockbracken Healthcare Park

Saintfield Road

Belfast

BT8 8SG

Agenda

1 Welcome, Apologies & Declarations of Conflict of Interest

For Information

2 Minutes of the previous meeting held on 12 December 2024

For Approval

3 Matters Arising

For Noting

4 Chair's Update

For Noting

5 Chief Executive's Update

For Noting

6 Ambulance Handover Delays Update - Verbal Update

For Noting

7 Performance Report (December 2024)

For Noting

8 Finance Report (Month 9)

For Noting

9 Draft Financial Plan 2025-26

For Approval

10 Corporate Risk Register

For Noting

11 Updated Risk Management Policy including Risk Appetite Statement

For Approval

12 Revised Committee Terms of Reference

For Approval

13 NIAS Standing Orders Review February 2025 and Standing Financial Instructions (SFIs)

For Approval

The revisions to the Standing Orders were reviewed and approved in principle at ARAC on 6 February 2025.

The Standing Financial Instructions were approved by ARAC on 6 February 2025.

14 NIAS CCNI Registration

For Approval

15 Committee Business - see below

For Information

Committee Business:

- PFOD Cttee – mins of meeting on 28 Nov 2024.

- ARAC Cttee – mins of meeting on 10 October 2024

  - Adverse Incident Policy – reviewed and approved at ARAC on 6 February 2025

16 Date & venue of next meeting:

26 March 2025 at 09.00am in the Boardroom, NIAS HQ

17 Any Other Business

Invitees

Mr. Dale Ashford

Stacey Beggs

Mr. Michael Bloomfield

Mrs. Rosie Byrne

Ms. Lynne Charlton

Mr. Simon Christie

Mr. Jim Dennison

Dr. Philip Graham

Ms. Michele Larmour

Ms. Michelle Lemon

Mr. John McPoland

Carol Mooney

Ms. Maxine Paterson

Mr. Phelim Quinn

Dr. Nigel Ruddell

Mr. Neil Sinclair

Northern Ireland Ambulance Service Health and Social Care Trust

Minutes of Trust Board held at 10.30am on
Thursday 12 December 2024 in the Boardroom, NIAS HQ, Knockbracken Healthcare Park, Saintfield Road, Belfast BT8 8SG

Minutes

1	Welcome, Apologies & Declarations of Conflict of Interest	

Present:

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

In Attendance:

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

Apologies:
Jim Dennison Non Executive Director

Conflicts of Interest:
No conflicts of interest were declared.

2	Minutes of the previous meeting of the Trust Board held on 24 October 2024 **For Approval**	TB12/12/2024/01
The minutes were proposed and seconded.		
3	Matters Arising	TB12/12/2024/02

Ms Paterson confirmed that the accountability meetings held with Directors did not reduce assurance around ability to deliver expected plans by the end of the year.

The Chair highlighted the importance of the NEDs to complete their mandatory training. Due to the interim secretarial support, the Chair has asked the NEDs to take on the responsibility to contact the office and ensure they are booked into and complete any outstanding training.

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

The Chair provided an update on her recent engagement activities, including visits to frontline staff out on the road and situated within Emergency Departments. She noted that staff were appreciative of her presence and the opportunity to share their experiences directly was welcomed.
As part of this, the Chair acknowledged that frontline staff generally have good ideas on how to make improvements and to that end the Chair sought to understand how staff surface ideas and contribute to organisational improvements. In response, Ms. Charlton outlined the staff engagement initiatives led by the QSI department. These include informal lunches and curry nights, which provide opportunities for open discussions on innovation and service improvements. To supplement that Ms. Charlton also introduced the concept of GRATIX, an initiative designed to capture and implement innovative ideas from staff. She noted that similar systems have been successfully implemented elsewhere, and the team has been exploring how this could be adapted for NIAS. The Chair welcomed the initiative and emphasised the importance of encouraging staff to take the lead in driving innovation.

To enhance transparency and engagement, the Chair proposed inviting some NIAS staff to attend and shadow certain Board meetings. This initiative aims to build confidence and awareness among staff regarding Board-level decision-making. Mr. Graham confirmed his support for the proposal, and the Chair requested that a formal procedure or structure be developed, leveraging Mr. Graham's expertise.

The Chair followed by expressing significant praise for the service she had observed on her visits, commending staff for their compassion and dedication in delivering patient care. However, she acknowledged the ongoing challenges associated with late handovers and provided assurance to those she talked with in regard to the many discussions had taken place to address these issues.

The Chair advised that the Mid-Year Reviews for Directors had concluded, and the Board noted and accepted the outcome from the exercise. Additionally, the Chair updated members on discussions she had with the HR Director and the Permanent Secretary regarding senior executive pay and the expected process and timeline for the same.

The Board acknowledged these updates and supported the next steps outlined.

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

Mr Bloomfield provided an update on the following key issues and activities since the last meeting:

- Following discussion with the Permanent Secretary and Trust Chief Executives in relation to the need to release NIAS staff at the end of their shifts to avoid late finishes, there has been considerable work facilitated by the RCC to develop plans to introduce a targeted approach from 19 November 2024. An update on this is provided later on the agenda.
- Mr Bloomfield welcomed 41 newly qualified paramedics to NIAS at the end of October, including those who graduated from the first BSc in Paramedic Practice at UU. They are currently undergoing training and will start operational duties before Christmas. He will be attending their graduation ceremony on 17 December 2024.
- He was also pleased to report that 24 EMTs also completed their training in November 2024 and would provide further operational resilience for the Winter period.
- In addition, 24 new ACAs will complete their training next week.

- Mr Bloomfield reported that he attended the monthly PTEB meeting accompanied by Ms Paterson and Mr Sinclair to present the NIAS Clinical Strategy. A presentation highlighted progress with alternatives to ED, including the mental health pilot in the Control Room, and outlined the further potential of the ambulance service to support transformation. He advised that the presentation was positively received by PTEB members and there was agreement to extend alternative care pathways, to roll out the Mental Health pilot (subject to funding) and to explore the potential for paramedics to support GP practices. It was agreed that all Paramedics who work in the HSC system will be employed by NIAS.
- Mr Bloomfield represented NIAS at the Festival of Remembrance on 2 November at which NIAS staff participated for the second year in the muster. He advised that he hoped by next year staff will have a dress uniform to attend such events.
- Mr Bloomfield advised that he attended the Health Committee on 21 November along with the other Trust Chief Executives. The meeting focused on winter planning, Children's Services and the financial position. Mr Bloomfield outlined the range of areas Committee members asked about in relation to NIAS.
- He attended a reception at Hillsborough Castle on 28 November 2024 for the NI Honorary Consul to Ukraine attended by the Secretary of State. He advised that NIAS is due to donate a second decommissioned ambulance to the Ukrainians in NI Charity.
- Mr Bloomfield reported on a successful go-live of the new CAD system on 26 November and commended everyone involved for the excellent planning and implementation.
- Mr Bloomfield and Ms Paterson had a first meeting with SPPG under the new Support and Intervention arrangements. He explained the five levels of escalation and advised that SPPG has assessed NIAS as level 2 for two areas of performance. Further meetings are planned every 6 weeks, also to be attended by the Chair or another non-executive Director The Chair advised that she will attend the first meeting to understand the process and consider future representation thereafter.
- Mr Bloomfield advised that he had met with the NIAO in relation to their study on delayed ambulance handovers. He expects to receive a final draft in the next week to provide any further comments. He understands the report is due to be published in February.
- The Minister had visited the RCC the previous day and observed the daily call with Trusts on what was a particularly busy day with considerable delays. He indicated that he was impressed by the role of RCC and saw it as a good example of the system working together. He also visited NIAS Control Room and heard about the pressures facing the service.
- Finally, Mr Bloomfield reported that he had represented NIAS at a number of Carol Services, including the first one organised by AANI which was attended by patients and families who have used the service.

6	Trust Corporate Scorecard & Performance Report (October 2024) **For Noting**	TB12/12/2024/03

Ms Paterson took members through the NIAS Trust Performance Report for November 2024 indicating that the report continues to evolve to enhance transparency and drive improvement efforts across the organisation.

Ms Paterson spoke to some key highlights and started with operational performance in which demand saw a year-on-year decrease in call and incident demand (reducing -5% and -13%, respectively).

In regards to response times: Category 2 response times remain critically high at 58 minutes, which is an increase in51 minutes from last year, driven by hospital handover delays, ASOS, and shift management protocols.

In regards to Clinical Performance, Ms Paterson spoke to a number of metrics including Hear & Treat rates which decreased to 5.4%, and See & Treat which fell to 13.5% and reminded members, this performance can be influenced by demand and the opportunity of calls to be triaged.

There are notable improvements in Out-of-Hospital Cardiac Arrest (OHCA) survival rates, with ROSC for shockable rhythms improving from 34.7% to 50% and 30-day survival increasing from 5% to 6.8%.

Ms Paterson then spoke to system Performance & Handover Delays, which saw over 11,600 hours lost in October due to delays exceeding 15 minutes, reflecting a 2% month-on-month increase, furthermore 20% of patients waited over 2 hours at EDs despite NIAS conveying fewer patients than in previous years.

Ms Paterson emphasized we have seen a quarter-on-quarter deterioration in long handover times, impacting service capacity.

In respect of Non-Emergency & Independent Ambulance Performance, we have seen Non-emergency activity has reaching its highest level since COVID and the service is on track to meet its 10% improvement target in Patient Care Services (PCS) journeys, with over 5,100 additional patient journeys completed year-to-date.

Ms Paterson then touched on service Quality & Workforce Considerations, focusing on Serious Adverse Incidents – citing 14 reviewed, with 4 formally reported. Timeliness for complaints remains an issue, with an average response time of 55 days, and the reasons for this have been rehearsed.

There has and remains a marked improvement in sickness absence rates from 14.65% in October 2023 to 10.05% in October 2024, though mental health-related absences remain the predominant issue and finally there has been a 28% increase in safeguarding referrals which correlates with enhanced Level 3 safeguarding training for frontline staff.

While progress is evident in some areas, significant challenges persist in response times, handover delays, and staff well-being.

Strategic interventions around workforce planning, operational efficiency, and system-wide collaboration will be critical in achieving improvement.

Ms Paterson then welcomed direct questions and invited fellow Directors to comment on areas pertaining to their responsibility.

Ms Lemon referred members to the improved position of sickness absence and 10.68% which represented a significant improvement on the same period the previous year. She advised that mental health related absence remained the highest contributor to absence levels and described associated work to support staff through the Critical Incident Stress Management (CISM) tool and newly established Health and Wellbeing Team.

Mrs Larmour indicated that it was important for the board to recognised that significant

improvement had been achieved however remarked that the level sickness absence remained comparably high. Ms Lemon acknowledged this and advised that Maximising Attendance remained in a project context. She explained that this involved continuing escalated performance management arrangements and dedicated focus on continuing to embed improvements achieved and to seek to continue to progress these.

7	Finance Report (Month 7) **For Noting**	TB12/12/2024/04

Mr Christie presented the finance report for month 7 to 31 October 2025.

- The Trust is reporting year-to-date (YTD) expenditure of £68.7m with an underspend of £1m against reprofiled budgets.
- Easements in pay budgets are expected to continue to the end of the year. This is due to the recruitment of staff not happening as quickly as originally anticipated.
- Plans are being made to utilise these funds fully, in consultation with SPPG.
- A savings plan to deliver the full £2.475m has been developed and is included in the report. This plan will not impact on service delivery.
- In summary, the Trust continues to forecast a break-even position at year end.
- The capital budget is under significant pressure with a forecast pressure of £1m. The Trust has bid to the DoH for additional funding.
- In the absence of additional funding the Trust has made plans to with within its current Capital Resource Limit (CRL).

8	Update on Late Finishes **For Noting**	TB12/12/2024/05

The Chair welcomed Dean Sullivan, Programme Director of RCC to the meeting to provide an update on the work to address Late Finishes, in particular the recent focus on processes at shift end / start times to assist in addressing the impact late finishes were having on staff welfare.
Background and context provided in this regard, including the potential for Trade Unions to escalate existing ASOS in the absence of demonstrable improvement also noted, and that TUs had agreed to pause additional actions pending measures to be introduced to reduce late finishes.
Following engagement with all Trusts and DoH it was agreed that RCC would develop a new approach with particular focus on shift end times in the first instance.

Following preparatory meetings which included x3 specific asks of NIAS :

- Action to address hospital destination for HCP patients and other 'patient / family choice' decisions to be determined by NIAS
- HALO capacity at larger EDs to be reviewed and enhanced where possible
- Ambulance support for discharges to be enhanced

The above 3 actions for NIAS delivered, and RCC had also asked other geographical Trusts to put in place a range of measures to support this process.

New arrangements were introduced on Monday 18 November (soft launch) with go-live from Tuesday 19 November 2024. Ongoing sharing of daily monitoring data introduced as well as weekly regional review meetings.

Analysis of consideration of impact included ambulance handover delays over time shift completion delays over time and compensatory rest over time.

Whilst it was noted general USC performance had been particularly challenged in recent weeks at the time of Trust Board RCC noted that it was very early following establishment of new arrangements to reach a firm view on their effectiveness and impact. Further analysis would be required of data.
DS advised that there were some 'green shoots' of impact and changes to / escalation of the existing arrangements will need to be considered in the future.

P Corrigan gave an example of his personal experience whilst out on a 'ride along' in the Northern Division, and his view of the engagement with and understanding of the process by some ED staff.

Discussion continued with TB members seeking to better understand some of the limiting factors in realising significant impact.

Next Steps: It was agreed that given that the project was in the early stages, further monitoring would be required and brought back to the relevant meetings and committees, to determine effectiveness, next steps and potential for further escalation if no improvement made.

9	Incident Response Plan **For Noting**	TB12/12/2024/06
Incident Response Plan was noted.		
10	Presentation on Research and Development at NIAS **For Noting**	TB12/12/2024/07

Ms. Julia Wolfe, Research & Development Lead, presented an overview of NIAS's R&D strategy, highlighting its importance in improving patient outcomes, organisational performance, and staff satisfaction. She outlined key milestones, including governance structures, the establishment of the R&D Oversight Group, and the introduction of Research Paramedics. Ms. Wolfe also discussed future plans to expand research capacity through Research Assistants, Fellows, and Clinical Academic Research Careers (CARC), alongside opportunities for PhD-level research and clinical/commercial studies. Mr. Graham expressed strong support for the R&D work, emphasing the importance of academic recognition and how this should be reflected in career progression and salary structures for research-active staff. Mr. Corrigan praised the progress made and sought clarity on the next steps, particularly around implementation and securing funding. He stressed the need for funding to be prioritised from the outset rather than as a secondary consideration. Mr. Sinclair commended Ms. Wolfe's dedication, stating that her determination has been instrumental in advancing the R&D agenda. He acknowledged that further discussions would be necessary to maintain momentum. Mr. Quinn reinforced the importance of sustaining research capacity and capability within NIAS. He highlighted the potential for collaboration with the Shared Island initiative potentially, stressing that it would be a significant loss if the organisation could not continue building on its achievements in this area. The Chair inquired whether NIAS had ever needed to turn away research opportunities due to capacity constraints. Ms. Wolfe responded that they work hard to avoid saying no, keeping doors open with potential stakeholders. She noted that research prioritisation is an ongoing, self-assessed exercise and emphasised the desire to continue expanding NIAS's research scope. The Chair also questioned whether NIAS's research priorities were effectively aligned with the broader Planning and Performance Strategy. Ms. Paterson acknowledged that research integration within the organisation was still maturing

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and that ongoing resource development would be required to enhance both short- and long-term research capacity. The Chair suggested exploring the feasibility of an Innovation Hub to support NIAS's research ambitions, providing a structured environment for research and innovation. Mr. Graham and Mr. Quinn offered their support in developing this concept further.

Board members reaffirmed their support for Ms. Wolfe and the R&D team in progressing these initiatives.

11	Committee Business:	TB12/12/2024/09

Safety Committee

Mr Ashford provided a brief synopsis of the committee as articulated in the minutes presented within the papers. Mr Ashford noted progress in controlled drugs management, with nearly all recommendations implemented. In regards to EOC, training accreditation had been a positive development and recruitment efforts are ongoing to strengthen the EPRR team, with a focus on HART expansion and cross-border collaboration.

Independent Ambulance Services governance remains a concern, and discussions are underway with the Department of Health regarding potential regulatory oversight although a number of subsequent conversations on who can take ownership of this will determine next steps.

Members noted the update.

PFOD Committee

Mr Corrigan and Mr Quinn spoke to some of the focus of the committee, the Ops Management Restructure review noted recruitment for key roles is progressing, and a high-level implementation summary will be shared and has been at a subsequent committee in November.

Discussions at PFOD also focused on the Trust maintaining its break-even position, with a £1 million savings plan still under review.

Furthermore, a welcome update on HR on maximising attendance, and addressing long-standing absence cases. A cultural improvement plan is in development, and the committee reinforced its focus on sexual safety. The committee welcomed that HR audit recommendations are mostly complete, with internal audit satisfaction noted.

Members noted its update.

12	Date and venue of next meeting: **20 February 2025 at 09.30am in the Boardroom, NIAS HQ**	
13	Any Other Business	

Ms Paterson advised they have been involved and supporting the DoH consultation process on the reconfiguration of hospital services. This is a DoH consultation and it was important that NIAS attend as an opportunity to hear feedback from patients and especially the challenges for the rural community. Ultimately NIAS support the approach as it involves 'planning' rather than the reactive situation NIAS has found themselves in from other unplanned changes. Ms Paterson will embark on visits on each Trust locations. Ms Paterson and Ms Byrne will attend the first visit next week in Omagh.

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The Chair shared she will meet with Save our Acute Services. Representatives. A number of invitations had been sent and the Chair advised that she is aware the group have met with Mr Bloomfield and Dr Ruddell. Mr Bloomfield conveyed to the Board the intention behind the group and outcomes of the meetings he had undertaken. had met with them. However, a second invitation has now been received for a meeting with the Chair however details of the request they have sent is yet to be considered.

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TRUST BOARD – 24 October 2024

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

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TRUST BOARD

PRESENTATION OF PAPER

Date of Trust Board:	20 February 2024
Title of paper:	Trust Performance Report
Brief summary:	This paper sets out NIAS's performance framework as of January 2025 for noting by Trustboard. The Trust performance report outlines the key performance metrics up to and including the 31 December 2024. This paper is presented to Trustboard for noting.
Recommendation:	**For Approval** ☐ **For Noting** ☒
Previous forum:	If applicable
Prepared and presented by:	Neil Walker (Head of Performance) Maxine Paterson (Director PPCS)
Date:	7 February 2025

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TRUST CORPORATE SCORECARD

NORTHERN IRELAND AMBULANCE SERVICE

January 2025

for December 2024 Data and Performance

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Executive Summary

The Trust Performance report continues to evolve, and you will notice changes over the coming months to the report to help everyone in the organisation understand where performance is good and where we need to drive improvements.

Operational Performance:

Demand:

- Call answer demand in EAC for December 2024 increased by 8% when compared to December 2023
- Incident demand in December 2024 has decreased by 6% when compared to December 2023
- Patients conveyed to Hospital during December 2024 has also decreased by 12% when compared to December 2023
- December 2024 saw an average number of patients conveyed to Hospital per day of 291 patients.

Response Times:

- Response times In December remain a significant challenge across all categories, when comparing to the national standards.
- Category 2 response times are extremely concerning remaining significantly high at 1 hour 50 mins for December 2024. This is compared with December 2023 where category 2 performance was 1 hour 13 mins.
- This is linked to the following:
    - Increasing delays in Hospital Handovers
    - Action Short of Strike (ASOS). Category 1 calls are the only calls being responded to in the last hour of shift.
    - Changes to the working arrangements of relief staff at the start of shift.
    - The end of shift protocol continues to be implemented across the trust:
        - Sending oncoming crews to ED to relieve late finished crews;
        - Holding calls at the end of shift until the relieving crew(s) is released from ED;
        - Providing compensatory rest to any crew finished later than 1hr

Clinical Performance:

Clinical Hear & Treat and See & Treat

- The Clinical H&T rate increased in December with an outturn position of 10.4%, which was an increase from November 24. Clinical See & Treat also increased in December 2024 to 15.2% from 14.7% in November 2024.

Complex Cases

- Complex Cases demand remains high with 9% of all calls answered in control being from a known complex case. Financial Year 2024.25 has saw a 14% increase in activity from complex cases compared with Financial Year 2023.24.

Out of Hospital Cardiac Arrest

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

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

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System Performance:

Handover:

- December 24 saw the trust lose >14k hrs with handover delays >15mins this is an increase of 22.3% from the hours lost in November 24, were the trust lost >11.5K.
- The patients waiting longer than 2hrs to handover at Emergency departments are deteriorating quarter on quarter for Financial Year 2023.24 from Q1 14.9%, Q2 16.1% to Q3 21.8%
- 20% of all arrivals at ED in November 2024 (1,953 patients) waited over 2hrs to be handed over. This is despite NIAS conveying the least number of patients to EDs in the past 24 months.

Non-Emergency Performance:

- Despite an approx. 20% vacancy rate the Service is on target to meet the Improvement target of 10% (6000) in PCS journeys, year to date comparison shows 5,500 more patient journeys than 23/24
- Significant progress continues with the improvement target of reducing staff absence through sickness currently meeting the improvement target
- The needs led additional IAS deployments are significantly reducing the number of "Cancellations by NIAS", Dec '24 figure was down by 85% in comparison to Dec '23
- Service Demand, Total Activity and PCS Share of Activity measurements were all lower than recent months (seasonal variation) but all show increases in comparison to Dec '23
- Loading Factor remains plateaued at around 1.4. Further improvement will be dependent on progressing issues such as, better matching staff rotas to service need and significantly reducing the vacancy rate of ACA posts. In addition, future consideration is required in respect of understanding loading factor as a measure of efficiency in planned versus unplanned activity (outpatient / scheduled treatments versus discharge/ transfers,) where responsiveness and agility may be more deterministic of same.
- Performance against Patient Experience KPIs remains low. A review with patient representatives of how we should be assessing patient experience is required and planned before the end of 2024.

Independent Ambulance Performance:

Patient Experience

- KPI 1 Inward journeys – Year to date average of 47% compliance an increase from 41% in same period 23/24. Of the non-compliant journeys 61% are within 30 minutes of the target.
- KPI 2 Outward Journeys – Year to date average of 57% compliance a decrease from 66% in same period 23/24. Of the non-compliant Journeys 45% are within 30 minutes of the target.

Productivity

- To date in 24/25 IAS activity accounts for 26% of non-emergency activity compared to 28% for the same period in 23/24.
- Increased use of IAS is due to ongoing vacancies within the tier and a targeting of reducing cancellation rates. Cancellations by NIAS in Dec were 85% below Dec '23 figure

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Executive Summary

Service Quality and Our People:

Serious Adverse Incidents, Complaints, Compliments and Care Opinion:

- There have been 23 potential SAIs reviewed, with the Trust notifying 10 during December 24. The 8-week timeframe for submission of SAI reports to SPPG remains challenging and the current average time for completion remains unchanged from the 23/24 average of 98 days (14 weeks).
- During December 2024, the Trust received 32 complaints, no new complaints were accepted by NIPSO for investigation, 35 compliments were received, and 13stories submitted via care opinion. 24/25 performance against the 2-day acknowledgement KPI has been strong at 100%, however several factors have impacted on the response within 20-day timeframe, which as of the end of December 2024 was averaging at 44% compared to YTD average of 53%.
- Safeguarding referrals have increased by 28% in FY 2024.25 when compared with the same period in 2023.24. Nearly 400 staff have completed their training with a plan in place to achieve 600 trained staff by March 2025.

Absence Management:

- The Financial Year Sickness absence rate is 10.44% for the trust. December 2024, monthly for sickness absence rate has increased to 10.05% from 8.63% in November 2024, a decrease in the monthly position from the summer months. There has been a marked improvement in comparing the December Year on Year positions, where December 2023 was 14.90%.
- 60% of the Trusts sickness absence is contained within the following categories (Mental Health, Injury | Fracture, Miscellaneous, Influenza and Untoward accident).
- The largest category for sickness absence within the trust is for mental health reasons, with stress being the prevalent reason.

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

Indicator	Measure	SDP Target 2024.25 (Q2)	Outturn 2023.24	Latest Reported Period		
				This Month	12 Month Trend	This Month (RAG)
Our Patients will be professionally cared for: Always with compassion and respect						
1.01	Category 1 Mean Response Time (mins)	11 mins	11	13		R
1.02	Category 1 90th Centile Response Time (mins)	22 mins	22	25		R
1.03	Category 1T Mean Response Time (mins)	19 mins	15	18		R
1.04	Category 1T 90th Centile Response Time (mins)	30 mins	30	35		R
1.05	Category 2 Mean Response Time (mins)	44 mins	48	110		R
1.06	Category 2 90th Centile Response Time (mins)	94 mins	107	255		R
1.07	Category 3 90th Centile Response Time (mins)	270 mins	338	772		R
1.08	Call Answering Performance	90%	85.0%	85.9%		A
1.09	No. of Calls Answered within Emergency Ambulance Control	N/A	19,209	24,264		
Our Staff will feel positive and proud to work for NIAS						
2.01	Monthly Percentage of Hours Lost	N/A	11%	10%		G
2.02	Cumulative % Hours lost from Sickness	11%	12%	10%		G
2.03	Cumulative % Hours lost from Short Term Sickness	N/A	3%	2%		G
2.04	Cumulative % Hours lost from Long Term Sickness	N/A	9%	8%		G

RAG status key

Green = On or exceeding target | Amber = within 5% of target

Red = outwith 5% of target | No Target Agreed

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Corporate Scorecard | Dashboard | Key Metrics December 2024

Indicator	Measure	SDP Target	Outturn 2023.24	Latest Reported Period		
Our Stakeholders and partners will have confidence in us as a reliable provider at the centre of USC						
3.01	Average Handover Time at Type 1 ED (mins)	15 mins	64	113		R
3.02	Lost Hours from Handover delays >15mins (hrs)	N/A	8,967	14,088		R
3.03	Number of Patients >2hrs for Handover	0	16,286	2,252		R
3.04	Hear & Treat Rate	8.5%	4%	10.4%		G
3.05	See and Treat Rate	14.7%	14%	15.1%		G
3.06	Conveyance Rate	N/A	82%	75%		
3.07	Number of Scheduled journeys made	N/A	12,798	13,136		
Our Communities will continue to value and trust us						
4.01	Number of potential SAIs reviewed	N/A	135	23		
4.02	Number of SAIs notified	N/A	42	10		
4.03	Number of Complaints	N/A	148	32		
4.04	Number of Compliments	N/A	272	35		
4.05	Nmber of patient stories received	N/A	128	13		
4.06	Forecast Revenue Expenditure	£ -	£ -	£ -		G

RAG Status Key

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

Northern Ireland Ambulance Service
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Operational Performance

Northern Ireland Ambulance Service
Health and Social Care Trust

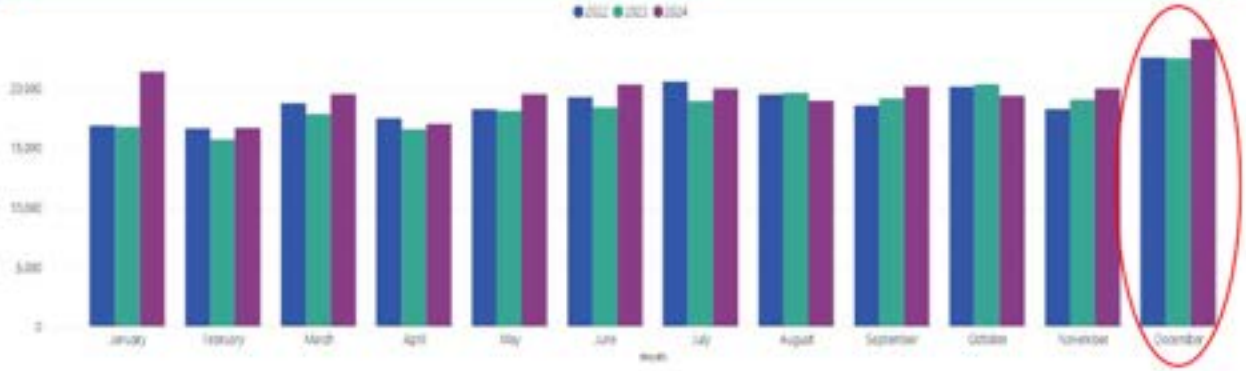
Our Patients | Emergency Demand Performance | Operational Demand

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

The analysis below describes: Calls Answered and Call Answering Performance

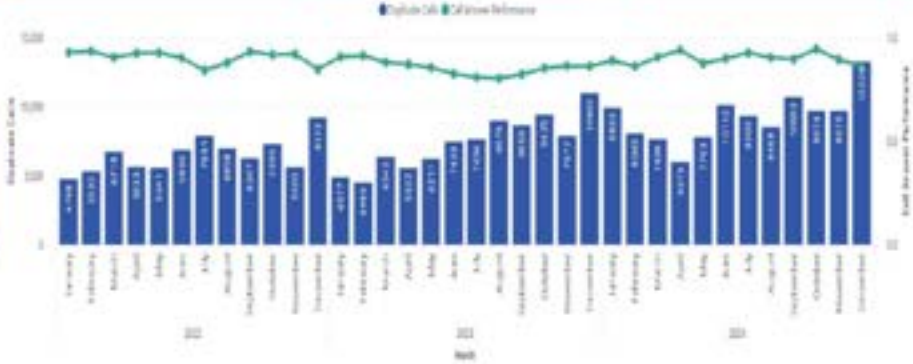
999 Calls Answered

Monthly Demand



Call Answering Performance and Duplicate Calls

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



- **December 24** has seen an increase in demand levels of 8% when compared with December 2023. The call demand into EAC for 2024.25 Financial Year to date has saw an increase of 4% than the Financial Year 2023.24.
- **December 2024** saw an average of 783, 999 calls per day being answered by EAC which is an increase from 667 calls per day in November 2023.
- **Call Answering performance** despite missing target remained strong given the challenges in December 24. The **December 2024 call answering performance was 86% which was just below the standard** for the month.
- **Duplicate Calls** were exceptionally high during **December 2024** at 13,223 which is an increase of 37% when compared with **November 2023**.

Northern Ireland Ambulance Service
Health and Social Care Trust

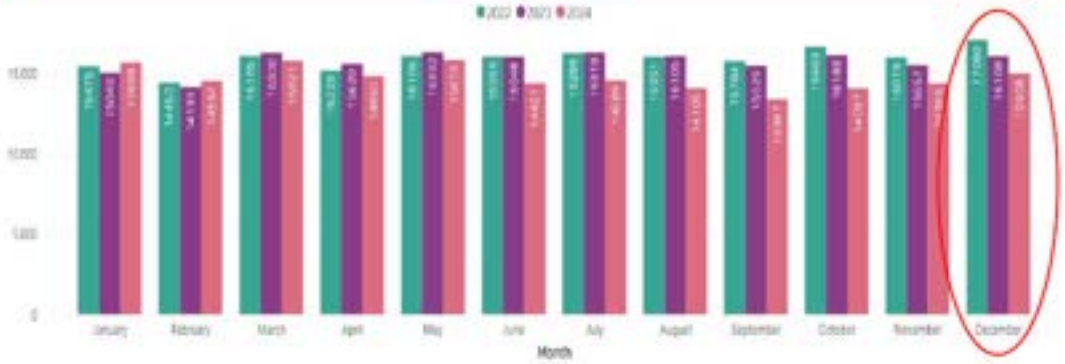
Our Patients | Emergency Demand Performance | Operational Demand

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

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

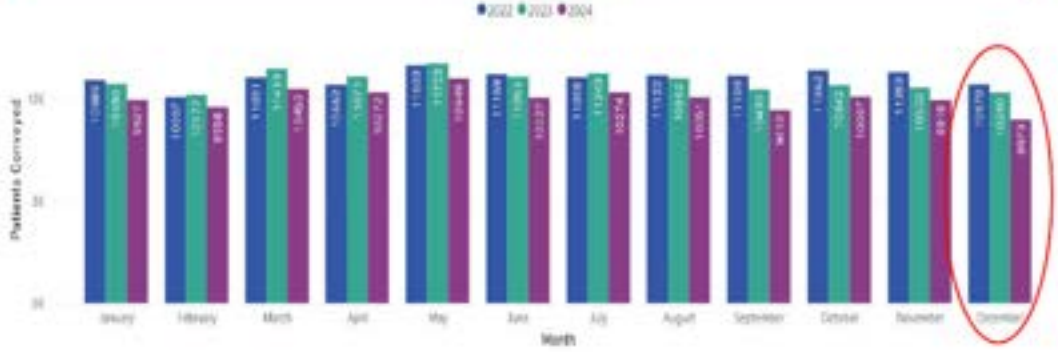
Response Demand

Monthly Incidents (A7)



Conveyances to Hospital

Patients Conveyed per Month



- **December 2024** has seen a decrease in Incident levels of 6% when compared with December 2023. The incident demand for 2024.25 Financial Year to date has also decreased by 9% compared with Financial Year 2023.24.
- **December 2024** saw an average of 486 incidents per day requiring an ambulance response.
- **December 2024** conveyances decreased by 12% when compared with December 2023. The numbers of patients conveyed to hospital 2024.25 Financial Year to date has also decreased by 8% compared with Financial Year 2023.24.
- **December 2024,** saw an average of 290 patients conveyed to hospital per day.

Northern Ireland Ambulance Service
Health and Social Care Trust

Our Patients | 999 Response Time Performance | Response Times Scorecard

Latest Month	Dec-24

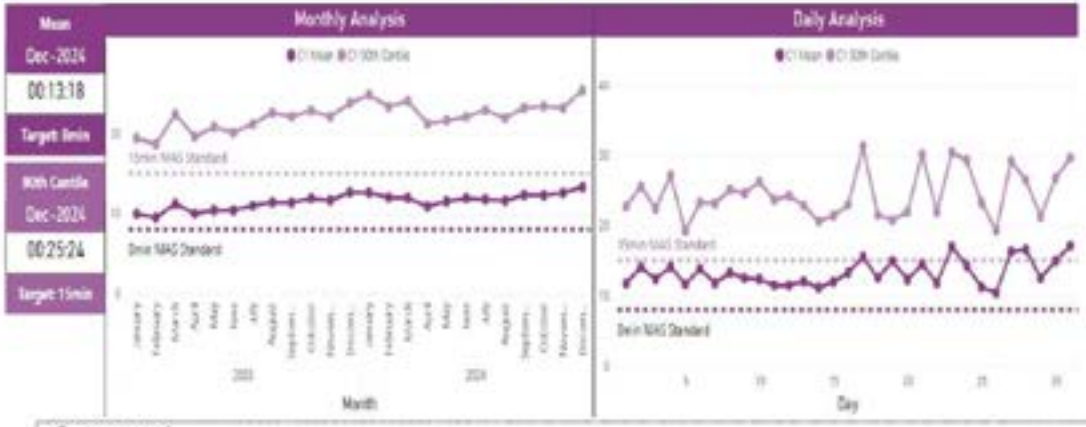
	Target	Current Performance: Latest Month	Current Performance: YTD (from April)	Current Performance: Rolling 12 Month	Benchmarking (Latest Month): National Data	Benchmarking (Latest Month): Best in Class	Benchmarking (Latest Month): Ranking (out of 12)
Category 1 response - Mean	8 Minutes	00:13:20	00:12:03	00:12:05	00:08:40	00:06:55	12
Category 1 response - 90th Centile	15 Minutes	00:25:27	00:22:59	00:23:13	00:15:25	00:11:45	12
Category 1T response - Mean	19 Minutes	00:18:04	00:16:10	00:16:07	00:10:50	00:07:56	12
Category 1T response - 90th Centile	30 Minutes	00:35:20	00:30:55	00:30:55	00:19:39	00:13:48	12
Category 2 response - Mean	18 Minutes	01:50:02	00:58:20	00:58:47	00:47:26	00:27:35	12
Category 2 response - 90th Centile	40 Minutes	04:15:03	02:09:05	02:10:21	01:41:40	00:59:36	12
Category 3 response - Mean	Not a target	04:09:03	02:24:05	02:26:26	03:02:00	01:14:29	11
Category 3 response - 90th Centile	2 Hours	12:50:09	06:19:27	06:23:21	07:21:03	02:44:38	12
Category 4 response - Mean	Not a target	01:43:34	02:52:39	02:57:30	03:21:37	01:33:15	2
Category 4 response - 90th Centile	3 Hours	02:55:47	07:24:18	07:34:33	08:15:44	03:31:13	1

Northern Ireland Ambulance Service
Health and Social Care Trust

Our Patients | 999 Response Time Performance | Response Times

CATEGORY 1 and CATEGORY 2 Response Times are measured based on the mean and the 90th centile of the response time provided.
The target for a CATEGORY 1 call response time is 8 minutes (15 minutes for the 90th centile).
The target for a CATEGORY 2 call response time is 18 minutes (40 minutes for the 90th centile).

CATEGORY 1 Performance



CATEGORY 2 Performance

Category 1

- December 24 Category 1 mean response time was 13 minutes 18 seconds; while the Category 1 90th centile was 25 minutes 24 seconds.
- December 24 continues to see a challenging Category 1 mean response position for the Trust. This is replicated on the Category 1 90th centile performance.

Category 2

- December 2024 Category 2 mean response time was 1hour 50 minutes 15 seconds; while the Category 2 90th centile was 4 hours 15 minutes 7 seconds.
- Both the Category 2 mean and 90th centile response times remain a challenge in December 24. There are a number of actions that have been particularly impactful on performance:-
  - Persistence in handover delays >2hr, outlined in slides further in this paper.
  - Action short of Strike (ASOS) is impacting our category 2 response times.
  - Changes to the working arrangements of relief staff at the start of shift.
  - Realising crews at ED at the end of shift with oncoming crews.
  - Providing staff with compensatory rest for those late finishes over 1hr.
- The delay in this category 2 response time is having a significant impact on patient safety

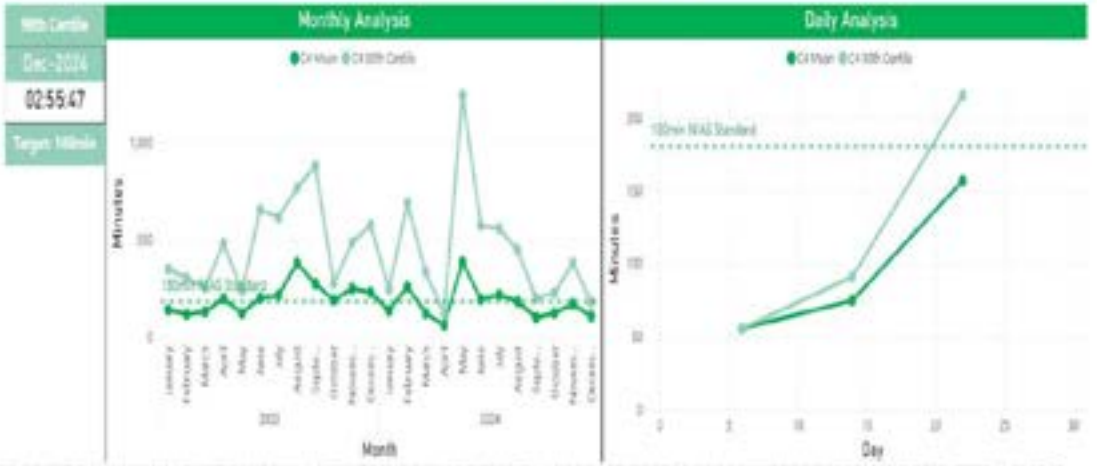
Northern Ireland Ambulance Service
Health and Social Care Trust

Our Patients | 999 Response Time Performance | Response Times

CATEGORY 3 and CATEGORY 4 Response Times are measured based on the 90th centile of the response time provided.

CATEGORY 3 Performance

CATEGORY 4 Performance



Category 3

- December 24 Category 3 mean response time was 4 hours 09mins; while the Category 3 90th centile was 13 hours 05 minutes, **over 11 hours above target.**
- As outlined in the previous slide, category 3 response times are impacted by the same root causes.

Category 4

- December 24 Category 4 mean response time was 1 hours 43 minutes; while the Category 4 90th centile was 2 hours 55 minutes. It must be noted that the volume of Category 4 calls received by NIAS is very low and response times can be impacted significantly on a daily basis.

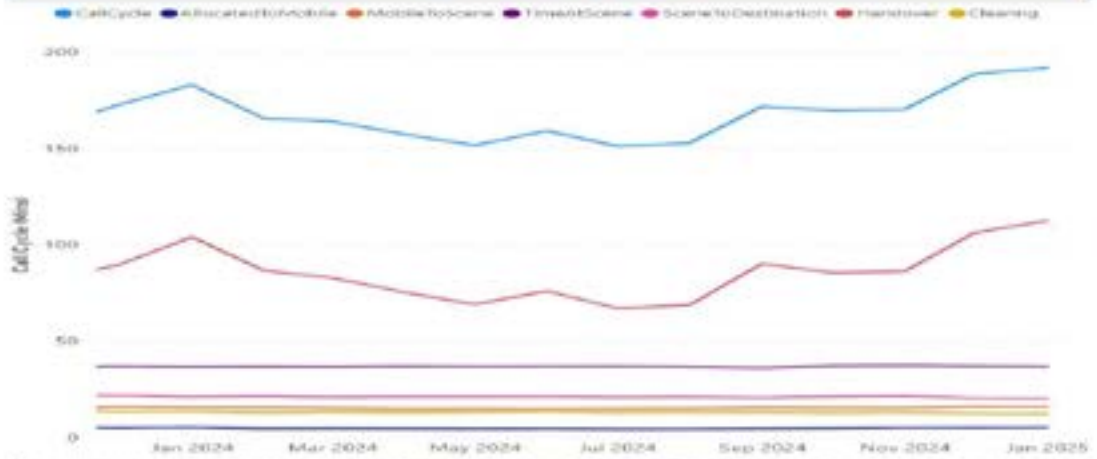
Northern Ireland Ambulance Service
Health and Social Care Trust

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

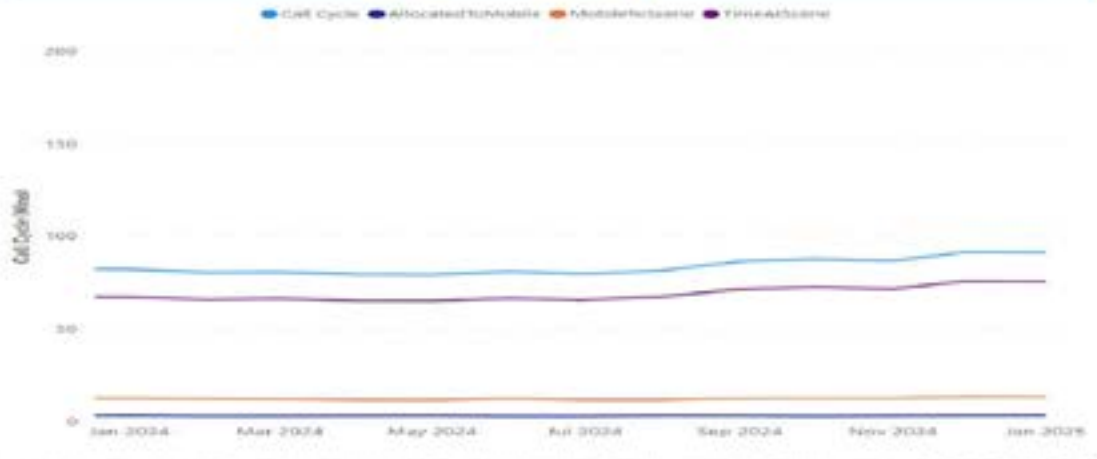
Efficient Job cycle times are critical to our response to patients across the region.

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

Conveyed Job Cycle Times



Non-Conveyed Job Cycle Times



Conveyed Average Job Cycle Times

- December 2024 Conveyed average job cycle time was 3 hours 08 mins (188mins), when compared with December 2023 the average job cycle time was 2 hours 52 mins (172mins).
- The 2024.25 YTD conveyed average job cycle time is 2 hours 43mins , whilst in 2023.24 the average job cycle time was 2 hours 31mins. This is an increase of 12mins between the two periods.

Non-Conveyed Average Job Cycle Times

- December 2024 Non-Conveyed average job cycle time was 1 hour 31mins (91mins), when compared with December 2023 the average job cycle time was similar at 1 hours 22mins (82mins).
- The 2024.25 YTD Non-Conveyed average job cycle time is 1 hour 23mins, whilst in 2023.24 the average job cycle time was 1 hours 15mins. This is an increase of 8 mins between the two periods.

Northern Ireland Ambulance Service
Health and Social Care Trust

Our Patients | Operational Performance | Actions to Improve Performance

- Planning has commenced to identify the key projects for the delivering value programme for 2024.25, service improvements will be identified and implemented through the programme and regular updates will be provided to Trustboard throughout the year.

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

- Additional mitigation has been employed at the end and start of shifts to reduce the impact of late finishes on staff. The Trust is currently using its own staff to relieve crews at ED. This essentially means that these crews coming on shift are tasked to make their way to Emergency Departments to allow those crews finishing to get away as close to their finish time as possible.
- The Emergency efficiencies improvement group has been established, targeting improvements with Category 1 response times.
- SOP for Category 1 release policy endorsed by AD forum and for sign off by SMT W/C 14th October.
- Emergency Annual Leave SOP complete and endorsed by AD forum for SMT sign off W/C 14th October.
- Work is being prioritised to develop principles and approaches to introducing enhanced rotas to support staff health and wellbeing, along with delivering operational cover during times patients require the Trusts services. It is planned that South-East division will go live January 2025.

- Challenges with Duplicate Call continue to persist at a high levels within EOC as outlined earlier in this report. EOC has reviewed the process and how it can be address, with the review of the delay scripts within EOC to deal with these callers, whilst ensuring patient safety. Alongside this, SMS messaging continues to be sent to 999 callers (with exception of Category 1 and HCP calls) from mobile phones informing the caller to only call back if there is a change in the patient's condition.
- NIAS have committed to work with GIRFT colleagues to develop a full understanding of the regional Directory of Services (DOS) and actions to deliver this recommendations will be taken forward with support from our RCC affiliates.

Northern Ireland Ambulance Service
Health and Social Care Trust

Clinical Performance

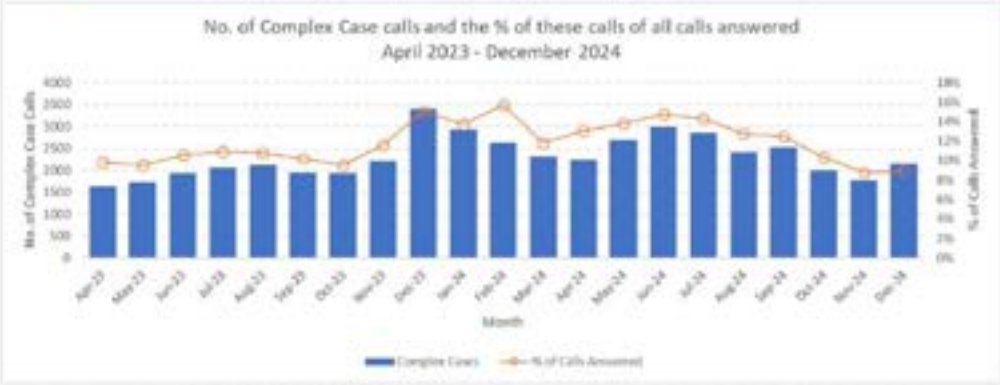
Northern Ireland Ambulance Service
Health and Social Care Trust

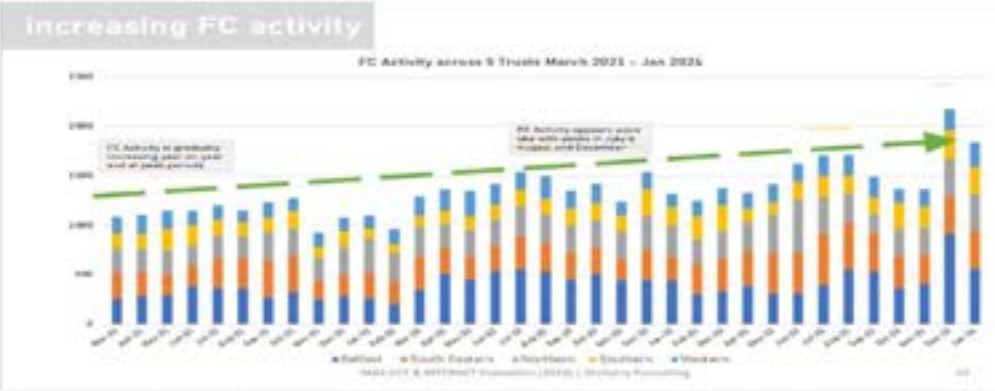
Our Patients | Emergency Demand Performance | Prevention

The level of demand from Complex Cases has a direct relationship to demand in our Control Room. Ensuring we manage these patients effectively is critical to managing demand effectively and therefore making the most of our resources and capacity to respond to our most critical patients.

The analysis below describes: Complex Case activity and volumes within the Trust

Complex Cases





December 2024 saw Complex Case calls at **9%** of all the calls answered within the control room, a total of 2,157 calls were made by complex cases.

When comparing **December 2024**, there was a **36% decrease** in activity from these service users than the activity in **December 2023.**

Financial Year 2024.25 has saw a **14% increase** in Complex case activity compared to the same period in **Financial Year 2023.24.**

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

Northern Ireland Ambulance Service
Health and Social Care Trust

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

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

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

Clinical Hear & Treat

Monthly Hear and Treat %

December 2024 saw the Hear and Treat rate exceed the target at 10.4%, The number of calls being dealt with in the room was over 1,200 patients for the month. The largest number of patients ever dealt with by clinicians in our control room.

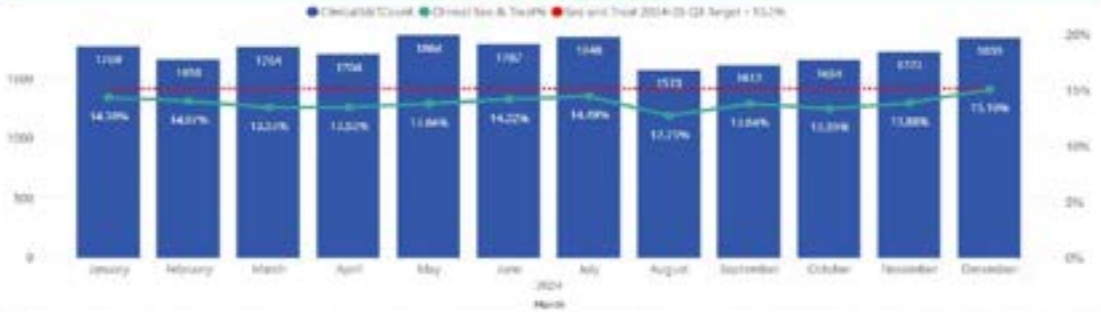
Work continues to train and develop the Clinical hub staff to realise a continued improvement in the Trust's Hear & Treat rate as we move through 2024.25.

The new clinical approach within the team with a revised DCR table has commenced and is now Business as usual.

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

Clinical See & Treat

Monthly See & Treat %



December 2024 See & Treat rate was 15.1% which is a steady state. Work is ongoing to work with Trusts to improve performance with See & Treat.

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

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

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

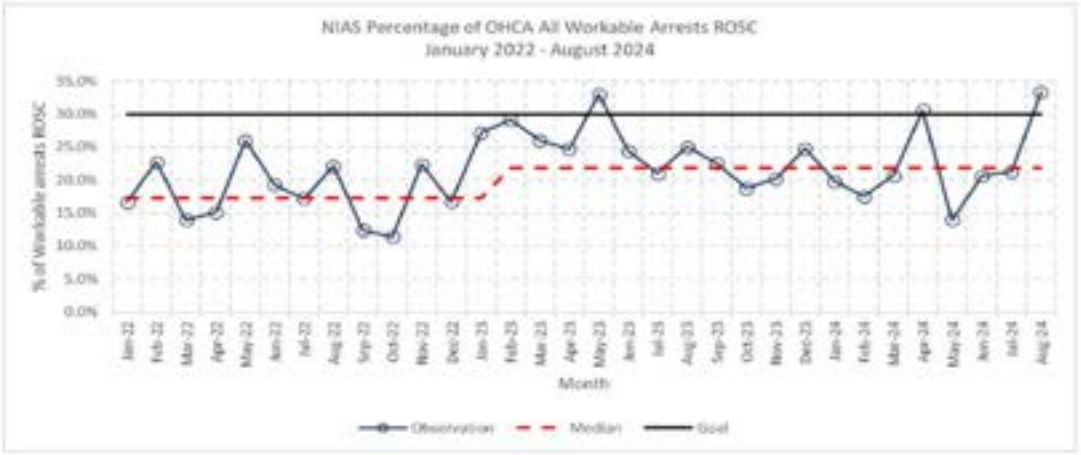
Northern Ireland Ambulance Service
Health and Social Care Trust

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

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

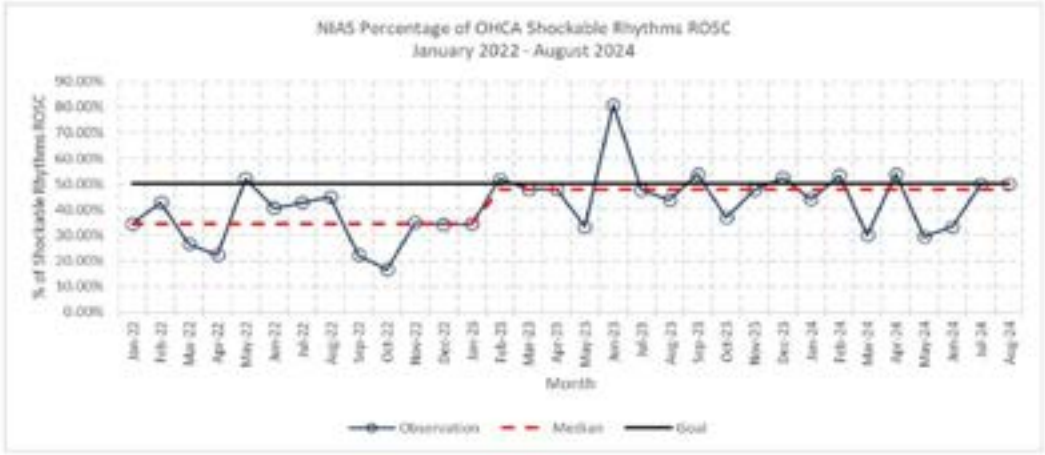
The analysis below describes: NIAS Return of Spontaneous Circulation (ROSC) Rates for Workable Arrests and Shockable Rhythms

ROSC Percentage of OHCA for all Workable Arrests



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

ROSC Percentage of OHCA for Shockable Rhythms



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

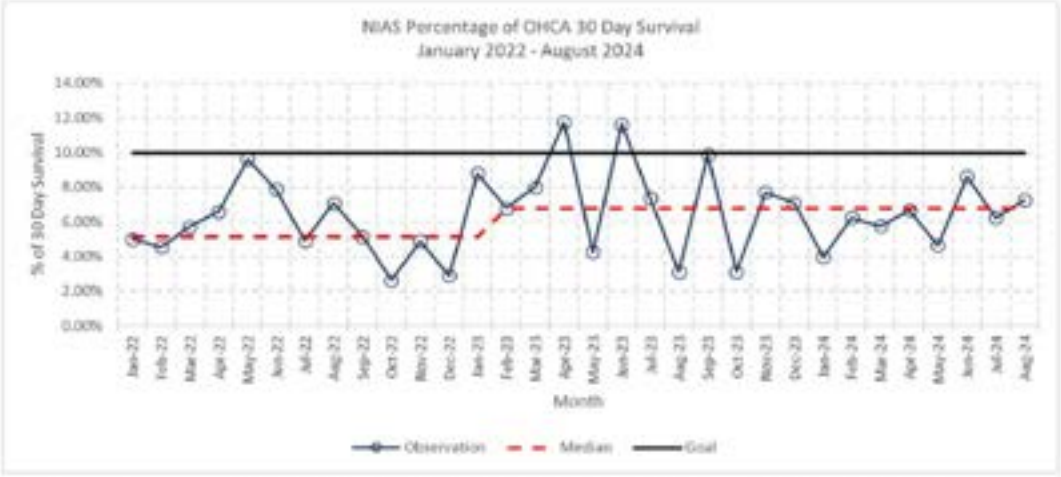
Northern Ireland Ambulance Service
Health and Social Care Trust

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

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

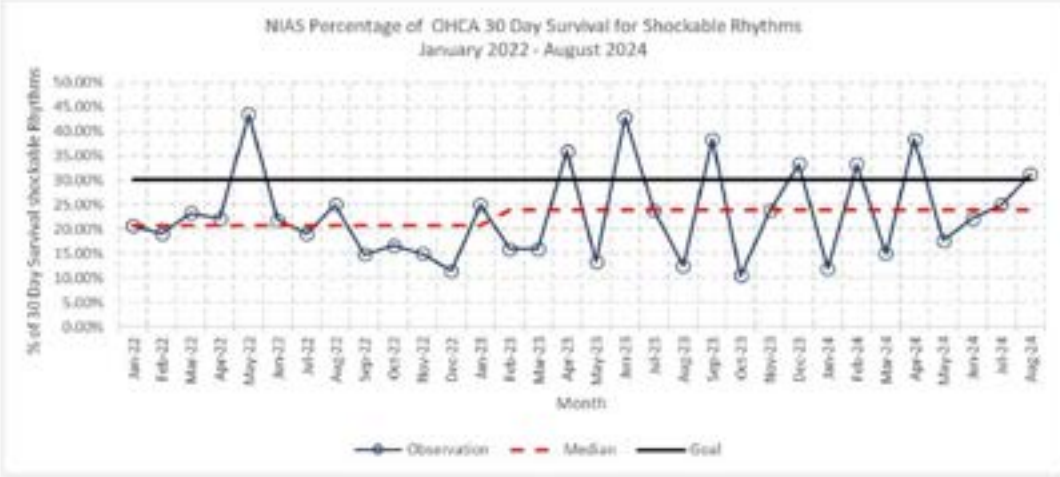
The analysis below describes: NIAS OHCA 30-day Survival and 30-day Survival Shockable Rhythms

OHCA 30-day Survival



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

OCHA 30-day Survival Shockable Rhythms



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

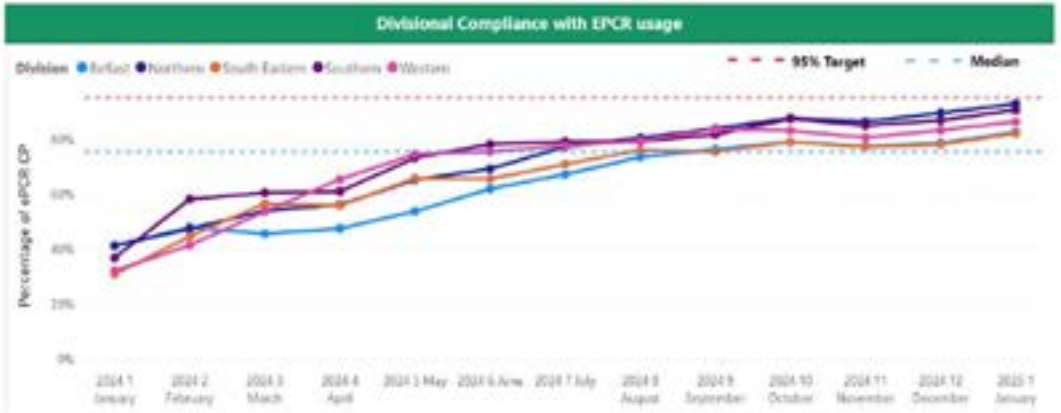
Northern Ireland Ambulance Service
Health and Social Care Trust

Our Patients | Emergency Demand Performance | ePCR Compliance

The usage of electronic patient record is a key enabler of the trust to understand clinical outcomes for patients. This will ensue we make the most appropriate response to patients making the most of our resources and capacity to respond to our most critical patients.

The analysis below describes: NIAS ePCR Compliance

ePCR Compliance



The chart demonstrates the progress made across the organisation with the uptake of ePCR usage across the Trust.

December 2024 compliance across the trust is **87%** against an internal trust standard of 95%. During Q3 of 24.25 all divisions have made great progress with uptake of the ePCR and have exceeded 80% compliance with ePCR usage.

Financial Year 2024.25 compliance within the Trust is **78%** against the internal standard of 95%.

Work continues across the trust both within the Clinical directorate and Operations directorate to maximise the usage of the ePCR and utilise the data generated to drive improvements across the Trust.

Northern Ireland Ambulance Service
Health and Social Care Trust

Our Patients | Clinical Performance | Actions to Improve Performance

- Work is ongoing within the complex case team to review the impact of the team to support complex cases within the community to prevent unnecessary contact with the service. Currently the team are evaluating the interventions made with patients to ascertain the areas where investment of time and effort would benefit the service and reduce demand to the control room.
- Recruitment of additional Pathway Leads within the organisation has concluded and successful candidates are in post to support the organisation in improving its See and Treat rates. These posts will work within division as champions for alternative pathways and work closely with the CSO tier to develop decision making within the clinical tiers of the organisation.
- Newly appointed Integrated clinical hub clinicians are now in post following their training, with the new rota now implemented from March 2024. This Rota is based on call demand for the service, with a focus on ensuring staffing levels meet the call demand as it commences within the trust. Performance management and clinical audit mechanisms have been strategically implemented to quantify and understand the hub's impact, aiming to optimise its full potential.
- The Urgent Care Liaison Desk within Control in now implemented to support crews with clinical decision making and alterative pathways for suitable patients.
- Key focus pathways to support the wider HSC system for 2024.25 are:
    - Hospital at Home
    - Falls
    - Mandatory Referrals
- Urgent Care Oversight Group (UCOG) is now fully established within the organisation and will govern all the improvement work to progress clinical developments within the organisation. The improvements required to increase the use of the Focus Pathways for 2024.25 will be managed and assessed through the UCOG.
- Hospital at Home:
    - Work is ongoing within the Southern Trust to develop a pilot for all patients >75 to be referred directly to the Hospital at Home team.
    - The trust are supporting Belfast in the expansion of their hospital at home team along with service hours available.
    - The trust is actively engaged with the South-Eastern Trust in the expansion of the Hospital at Home team.
- Falls:
    - Trust is working with the PHA to support the developments within the Safer Mobility Group
    - NIAS are establishing a Safer Mobility Group internally to review and develop our response to patients that fall
    - Alignment of clinical practice within the trust to the PHA post fall guidance
- Mandatory Referrals:
    - Target the relevant calls via the Urgent Care Liaison desk within EAC to ensure mandatory referrals are made by staff.

Northern Ireland Ambulance Service
Health and Social Care Trust

System Performance

Northern Ireland Ambulance Service
Health and Social Care Trust

Our Patients | Emergency Performance | Hospital Handover Performance

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

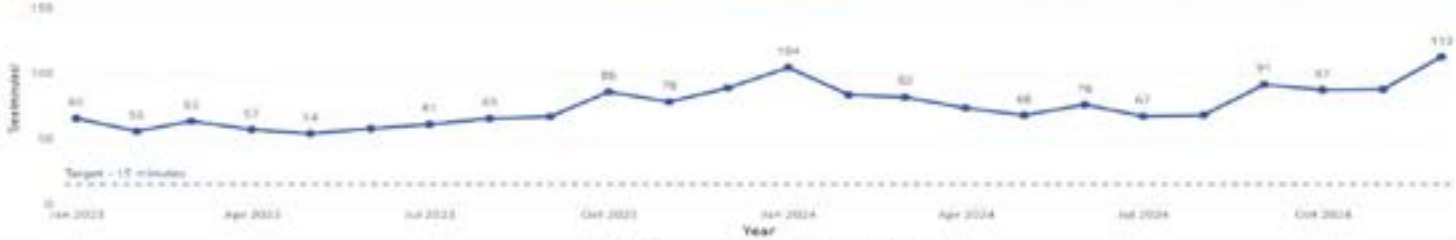
Arrival at Hospital to Patient Handover

Hospital Attended	Total Attendances	Total Handovers	Total Handovers Over 15mins	% Over 15mins	Total Handovers over 60mins	% Over 60mins	Total Time Lost (Hours)	Average Handover Time (Minutes)
ULSTER	1121	1121	1057	94.29%	627	55.92%	2,988.54	160.11
CAUSEWAY	490	490	479	96.37%	318	64.11%	1,169.11	136.24
ANTRIM AREA	1349	1349	1298	96.07%	660	48.91%	2,830.38	140.30
CRAIGAVON AREA	1126	1126	1036	92.01%	503	44.83%	2,177.59	130.67
ROYAL GROUP	1797	1797	1693	94.21%	914	50.86%	3,142.21	99.30
MATER	371	371	334	90.03%	119	32.08%	346.37	70.86
ALTNAGELVIN	1174	1174	1126	95.91%	474	40.37%	1,562.66	65.10
DAISYHILL	489	489	464	94.89%	138	28.22%	284.62	62.22
SOUTH WEST	623	623	589	94.54%	206	33.06%	487.73	39.33
BELFAST CITY	31	31	25	80.65%	3	9.68%	10.04	53.22
LAGAN VALLEY	75	75	53	70.67%	5	6.67%	20.57	50.20
RBSC	90	90	60	66.67%	3	3.33%	14.70	23.20
DOWNE	22	22	13	59.18%	0	0.00%	2.20	20.08
Total	**8766**	**8766**	**8227**	**93.85%**	**3987**	**45.48%**	**14,088.96**	**111.16**

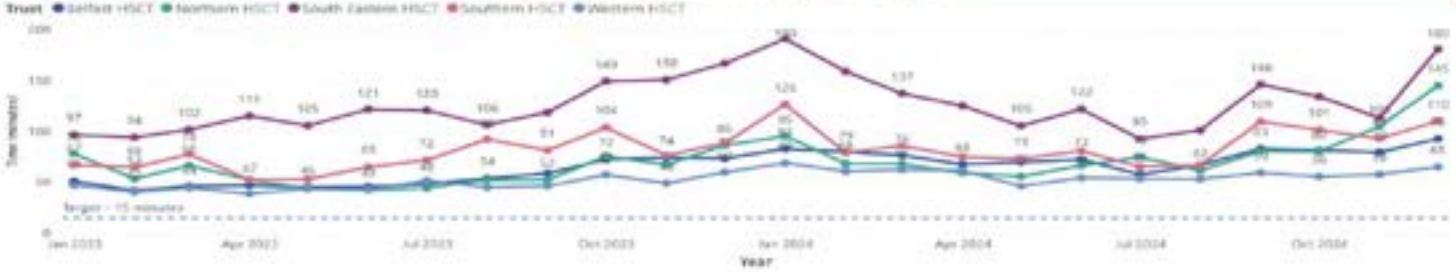
Total Time Lost (Hours) - Last 12 months

130,515.24

Monthly Handover Times



Monthly Handover Times for Type 1 EDs, by Trust



In December 2024, NIAS experienced a total of 14,088 lost hours. This is the equivalent of 38 shifts per day where crews are waiting with patients outside EDs; 35% of our planned capacity. These lost hours were experienced from 8,766 instances where our crews waited longer than 15mins to handover their patient at ED. 3,987 handovers took longer than an hour in December 2024

In December 24, >75% of the 14,088 lost hours occurred at the four ED sites listed below in order of hours lost:

- *Ulster Hospital (3.0k hours; 94% > 15min; 56% > 1hr)*
- *Antrim Area (2.8k hours; 96% > 15min; 49% > 1hr)*
- *Royal Victoria (2.5k hours; 94% > 15min; 50% > 1hr)*
- *Craigavon Hospital (2.1k hours; 92% > 15min; 45% > 1hr)*

In the last 12 months, >94% of the handovers exceeded the 15min target at our acute EDs, resulting in circa 130k hours lost. The lost hours experienced in December 24 is an increase of 2,565 hrs or 22% from November 24, whilst the number of instance of delayed handovers also decreased by 9% in the same period.

The 14,088 operational hours being lost are equivalent to 1,174 12-hours shifts per month, or 38 12-hour shifts per day.

Northern Ireland Ambulance Service
Health and Social Care Trust

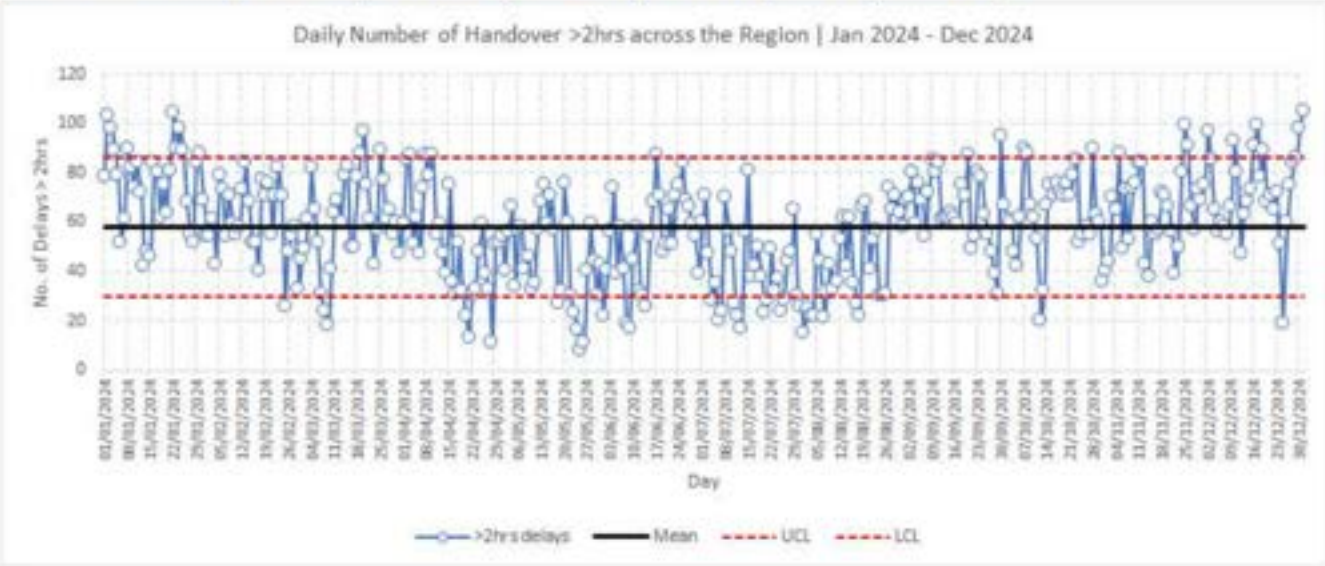
Our Patients | Emergency Performance | 2hr Back Stop Regional Performance

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

Area	Q1 23.24	Q2 23.24	Q3 23.24	Q1 24.25	Q2 24.25	Q3 24.25
South Eastern	21.1%	23.5%	32.8%	29.6%	28.7%	33.8%
Northern	5.4%	7.2%	17.2%	11.1%	16.6%	25.5%
Southern	9.5%	18.8%	20.2%	17.5%	17.8%	23.9%
Belfast	6.6%	9.8%	18.9%	14.6%	14.0%	20.7%
Western	2.8%	5.3%	8.1%	5.7%	6.5%	8.2%
Region	8.8%	12.2%	19.2%	14.9%	16.1%	21.8%

The table shows the deterioration in >2hr delays by trust from March 2023.
Q3 24.25 2hr handover **increased by 2%** compared to **Q3 23.24. December 24** is a 2% increase from **December 2023**

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



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

The trust is now experiencing an average 56 patients per day being delayed >2hrs before being admitted into Emergency departments across the region.

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

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

Northern Ireland Ambulance Service
Health and Social Care Trust

Non-Emergency Performance

Northern Ireland Ambulance Service
Health and Social Care Trust

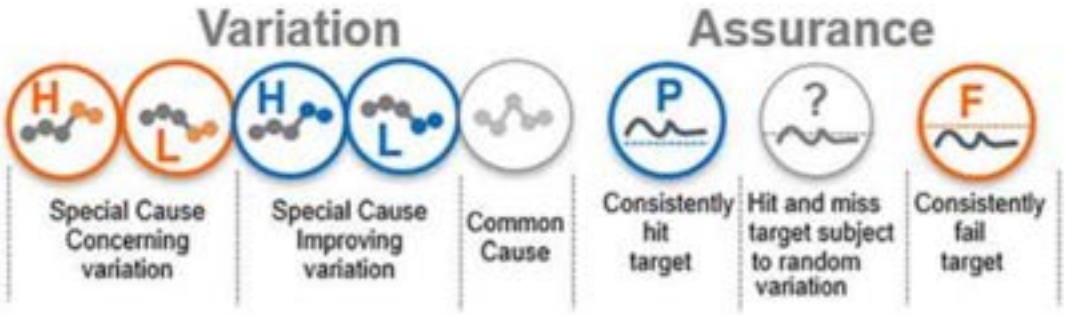
Our Patients | Non - Emergency Performance | Actions to improve Performance

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

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

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

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



Northern Ireland Ambulance Service
Health and Social Care Trust

Our Patients | Non - Emergency Performance | Summary Sheet

Improvement Summary/Actions

Positive variations are identified in 5 of the 9 measures this month.

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

Non-Emergency Services

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
KPI 1 Arrivals	Dec 24	38.01%	95.00%			37.30%	32.63%	41.97%
KPI 2 Departures	Dec 24	69.00%	95.00%			66.76%	62.37%	71.15%
PCS Journey's	Dec 24	4928	5500			5208	4126	6289
Cancellations	Dec 24	274	438			781	294	1267
Loading factor Outpatients	Dec 24	1.48	1.80			1.39	1.30	1.48
PCS complaints	Dec 24	4	0			7	-1	16
Loading factor total	Dec 24	1.36	1.80			1.33	1.26	1.41
PCS sickness absence	Dec 24	22	24			35	22	48
PCS WTE	Nov 24	204	265			219	209	229

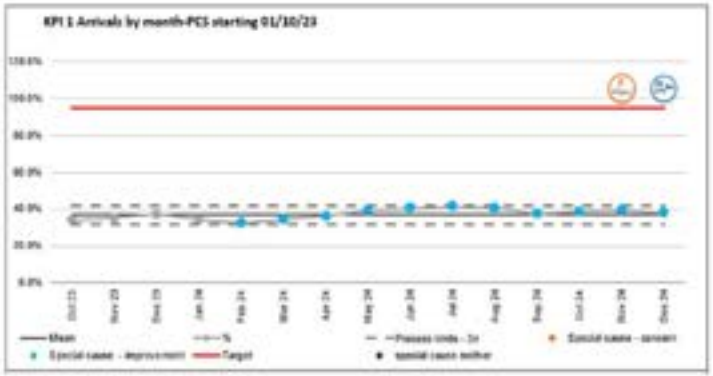
Northern Ireland Ambulance Service
Health and Social Care Trust

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

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

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

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

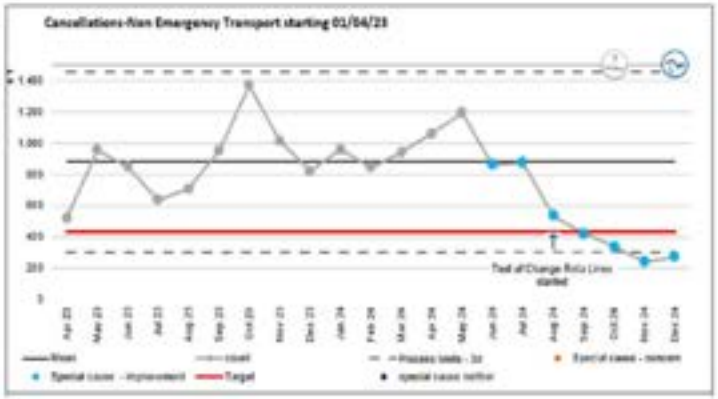


KPI 2 - That 95% of outward journeys will start within 60 minutes of the patient being booked as ready by the clinic/hospital.

Compliance at 70% remains below the required level with minimal variance. Interrogation of the data shows the majority of non-compliant journeys are collected within 30 mins of the target.

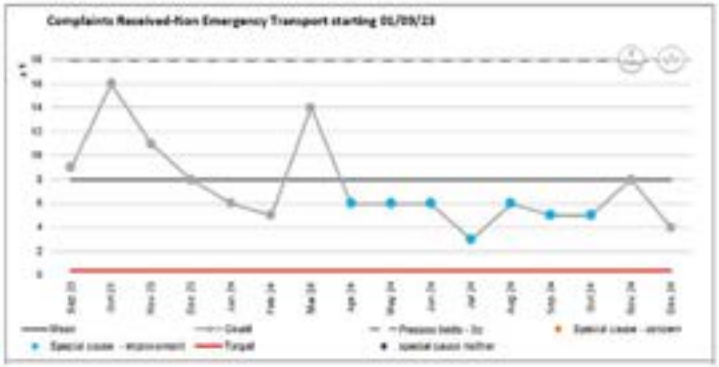
Cancellations by NIAS

- Additional processes to avoid cancellations in particular for journeys such as Renal Dialysis and Cancer treatments are now in place with triggers for additional resources when necessary to prevent these.
- Targeted action to reduce cancellations was instigated in Aug '24 with "Test of Change" Rota lines added to service provision.
- In 2023/4 monthly cancellations averaged 6.4% of service demand, therefore an initial improvement goal for 2024/25 is to reduce cancellations by 50% therefore improvement trajectory is 3.2% of 20/25 service demand.
- Dec '24 cancellation by NIAS figure continues the trend of significant reduction in comparison to 23/24.



Complaints

- In December, 4 complaints were received relating to Non emergency services for a few different reasons including challenges with Renal appointments.
- 2 of the 4 complaints were resolved locally at the time of reporting.
- Whilst the service has an aim of no complaints the 24/25 levels ranging between 3-8 per month are in the context of the service providing approx. 13,000 patient journeys per month.



Northern Ireland Ambulance Service
Health and Social Care Trust

Variation

Assurance

Special Cause Concerning variation | Special Cause Improving variation | Common Cause | Consistently hit target | Hit and miss target subject to random variation | Consistently fail target

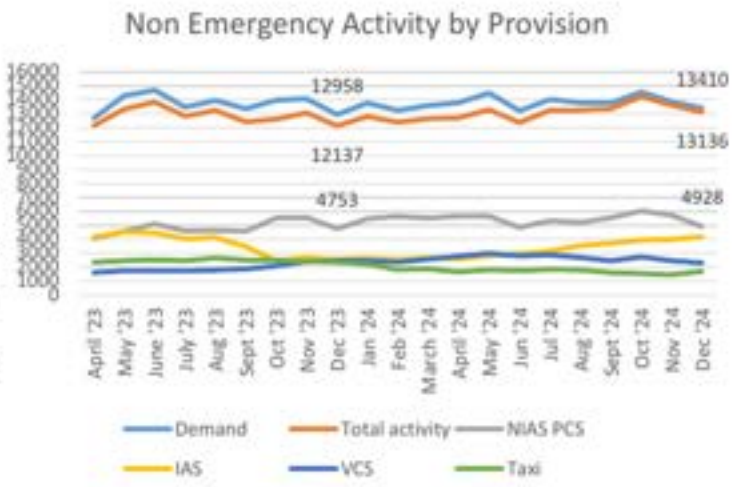
Our Patients

Non-Emergency Performance

Non-emergency transport journeys in Total and by Provision

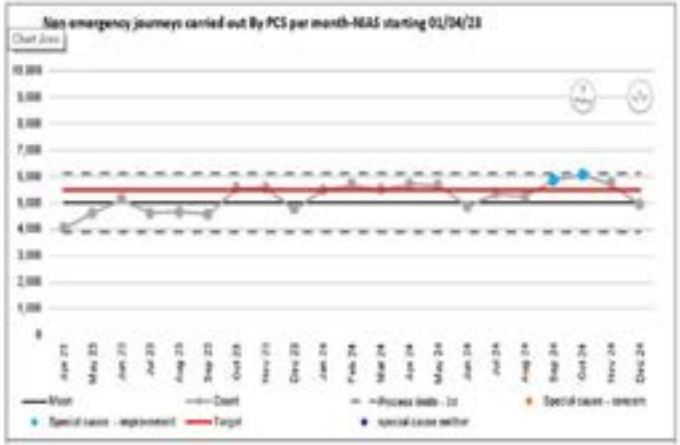
- This comparative graphic is included to illustrate the share of non-emergency activity undertaken via each of the delivery options.
- The underlying objectives are to maximise the activity share completed by NIAS resources either PCS or where suitable the Volunteer Car Service and to meet service demand within contract limits.
- In Dec 23 Activity was 94% of demand in Dec 24 this has risen to 98% of demand
- The increase in the use of IAS resources in recent months is as a result of a number of factors including increased ACA vacancy levels, improvement aim to reduce cancellations & efforts to provide a responsive discharge service and hence flow through hospitals.

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



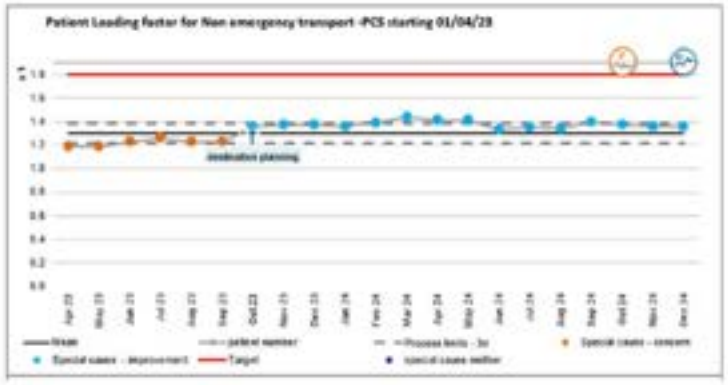
Non emergency transport Journeys completed by PCS

- The Improvement Objective is that PCS activity will increase in 24/25 by 10% from 23/24 this requires approx. 6,000 additional journeys.
- A year to date comparison indicates that at end of Month 9 in 24/25 an additional 5,500 patient journeys have been completed by PCS crews. Therefore well on target to meet the Improvement Objective.
- This improvement measure is being met despite a current staff vacancy rate in PCS of over 20%.



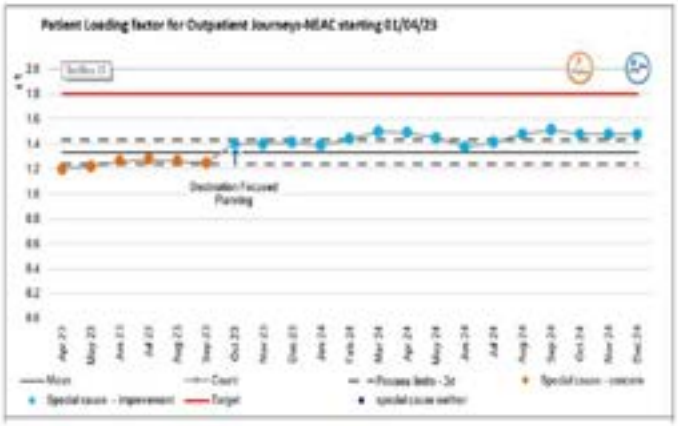
Patient Loading Total

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



Patient Loading Outpatients

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

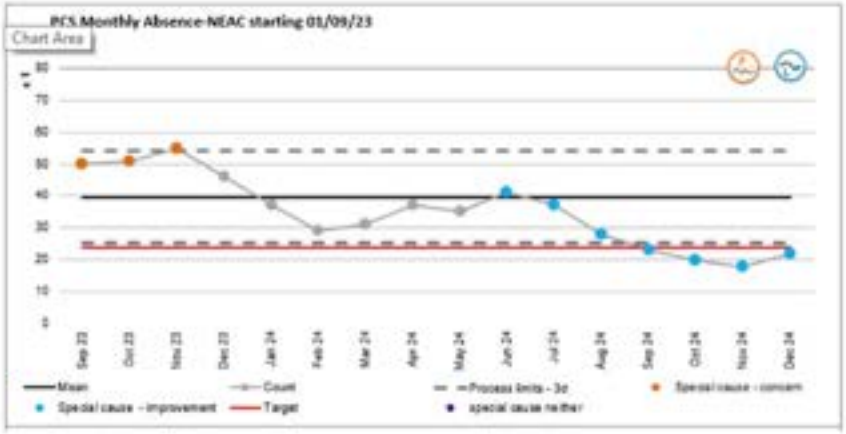


Northern Ireland Ambulance Service
Health and Social Care Trust

Our People | Non-Emergency Performance | Productivity Performance

Our People

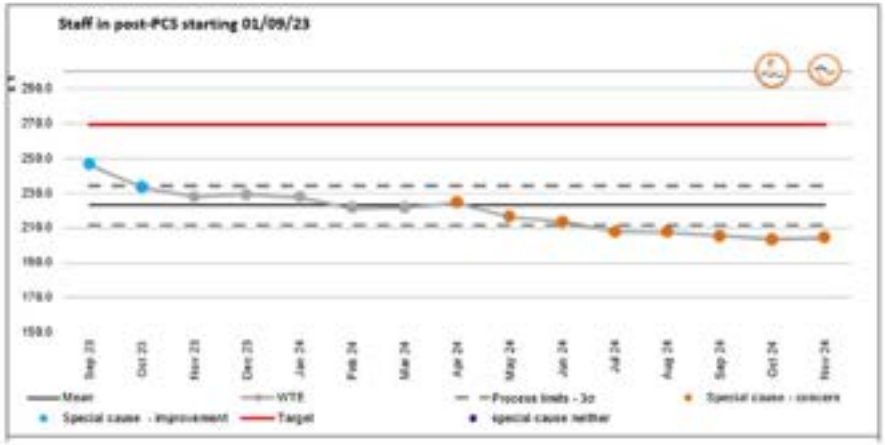
This section currently reflects the DVP Improvement Measures of Reducing the sickness absence level in line with Trust wide targets and recruiting ACAs up to the funded WTE level.
Additional Our People improvement Measures should be set in the areas of training and personal development



Sickness Absence

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

October in month ACA absence is reported through HRPTS as 9.45% a marked reduction from April 24 in month percentage of 14.97.
NB the information in this graph currently relates to ACA staff working both in non-emergency PCS and A&E support roles



Staff in post WTE

- A steady decline of PCS staff in post over the past 12 months is currently being addressed with a cohort of 22 new staff who finished ACA training at the end of Dec '24. These new staff will be reflect in the "staff in post" numbers when they are added to the rosters.
- A further intake of 24 ACA recruits will commence training in Feb '25 and join the rotas by the end of March '25
- An evaluation will take place at the beginning of 2025/26 to define any further recruitment targets and strategies.
- **NB** the information in this graph currently relates to ACA staff working both in non-emergency PCS and A&E support roles

Northern Ireland Ambulance Service
Health and Social Care Trust

Independent Ambulance Performance

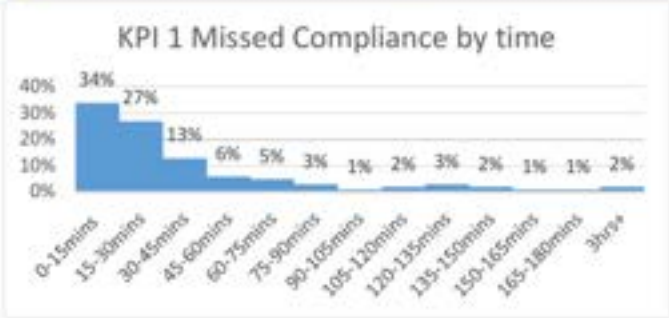
Directorate of Planning, Performance & Corporate Services

Northern Ireland Ambulance Service
Health and Social Care Trust

Our Patients | Non-Emergency IAS Performance | Patient Experience

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

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



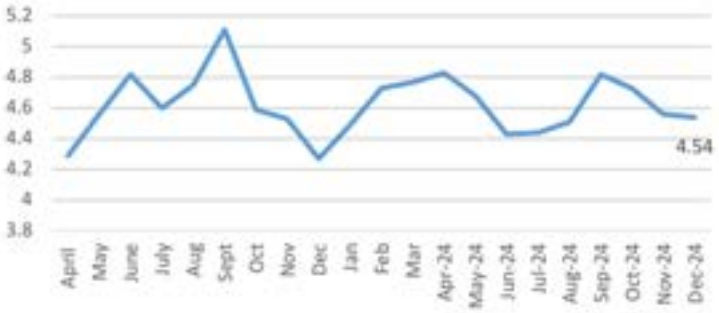
Analysis

- An analysis of the journeys that missed compliance shows that 34% of these journeys missed the target by 15 minutes or less, 80% missed the target by 60 minutes or less
- Similarly, for KPI 2, relating to outward journeys 26% of journeys that missed the target were no more than 15 minutes over this and 73% missed the target by 60 minutes or less
- In the case of KPI 1 where a patient is going to be significantly late for an appointment, NIAS Non-Emergency Control will be in contact with the service that the patient is attending to advise of a delay in order that patients do not miss their appointment.

Northern Ireland Ambulance Service
Health and Social Care Trust

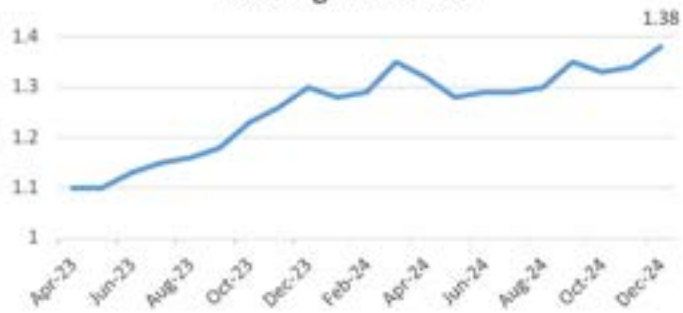
Our Patients | Non-Emergency IAS Performance | Productivity Performance

Average no of Patient Journeys Per Shift - IAS



Non-Emergency Patient Journeys by IAS

Loading Factor IAS



Activity and IAS Share
The proportion of non-emergency activity completed by Independent Ambulances has generally been increasing since May '24, to counter significant staff vacancies in PCS and in a targeted response to reduce cancellations due to no available resources, this initiative has been quite successful to date.

On the 19th Nov 5 additional IAS "Discharge Vehicles" 1 in each division on a daily 12 hour shift were deployed as a Winter Pressure initiative to assist hospital flow.

To date in 24/25 IAS activity accounts for 26% of non emergency activity compared to 28% for the same period in 23/24

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

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

Northern Ireland Ambulance Service
Health and Social Care Trust

Service Quality and Our People

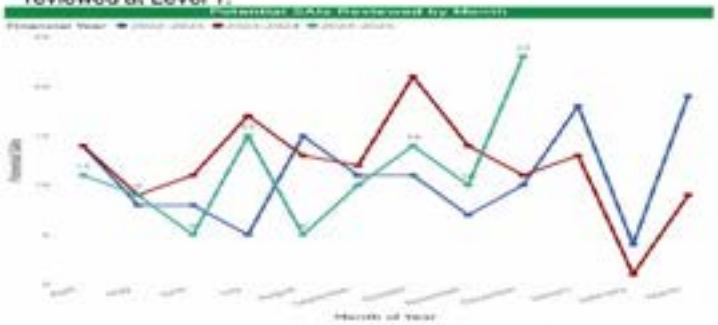
Northern Ireland Ambulance Service
Health and Social Care Trust

Our Patients

SAIs & Complaints

Serious Adverse Incidents

During December 2024, the Trust reviewed 23 potential SAI's resulting in 10 notifications to SPPG.
There are currently 16 ongoing SAI's which are all being reviewed at Level 1.



Themes

Early review of the 10 SAI's notified in December has identified the following themes:

- Delayed response out with standard
- C-spine immobilisatrion
- ECG recognition
- Incorrect application of patient information marker

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

Timeliness of process

2 SAI's were completed and closed within December 2024.
Both reviews were completed at Level 1 with a required completion time of 8 weeks.
The average completion time was 28 weeks due to competing demands within the team completing the review. Input from NHSCT was also required for 1 review.

Recommendations & Learning

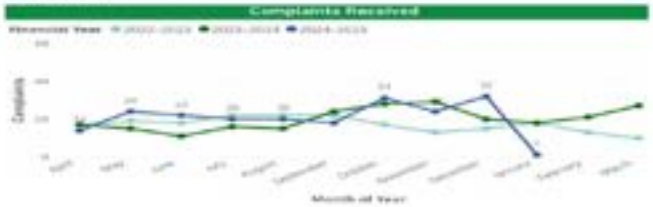
During December 2024, 2 SAI's were closed with the following learning identified:

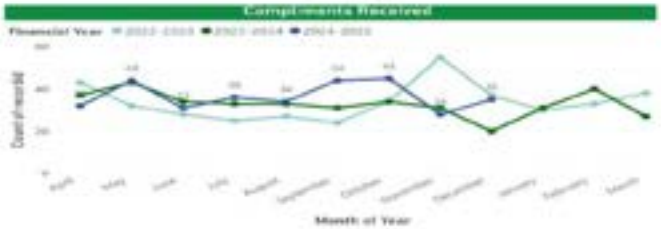
- Moving & handling techniques employed were not completed in accordance with current guidelines
- Importance of accurate completion of clinical documentation
- Northern Ireland Health and Social Care (NI HSC) system wide pressures are impacting the ability of NIAS to respond to patients in the community as delays at emergency departments are significantly longer than government recommended standard handover times.
- Impact of ASOS rest period guidance on IFT2 response

Implementation and evidencing of SAI recommendations remains an area of focus and to date we have completed and evidenced 94% of the outstanding SAI recommendations. Of the remaining 6%, 1% have not yet reached there due date and therefore remain active.

Complaints, Compliments & Care Opinion

During December 2024, **35 compliments** & **32 complaints** were received.





Timeliness of Process

19 complaints were closed during December 2024.

At the end of December 2024, 56 complaints remained opened with the average number of days opened being 37 working days.

Trends & Learning: Of the 19 complaints closed, 74% were upheld/ partially upheld with some of the following learning outcomes identified: Customer service, duplicate call procedures; non-convey decision making, staff attitude; professional practice & learning & disability training.

Service Improvement Plans

- Regional roll out of feedback leaflet for frontline staff to issue to service users
- Development of a new NIAS Complaints policy; systems developments; and operational training requirements to support the new NIPSO Model Complaints Handling Procedure for Trusts (planned publication extended from 01/04/24 to 01/07/24 due to other HSC providers now being included in change process).

Care Opinion

During December 2024, 13 stories were submitted via Care Opinion.
By 31st of December these stories were viewed 1,130 times.
The main areas of feedback were:
What's good – Staff/ Care/ Compassion
Improvements – Ambulance wait/ Dignity
Feelings – Thankful/ Concerned/ Reassured/ vulnerable

Northern Ireland Ambulance Service
Health and Social Care Trust

Our Patients

Safeguarding Education, Training and Referrals

Safeguarding Education

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

Safeguarding & Welfare Referrals

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

Northern Ireland Ambulance Service
Health and Social Care Trust

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

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

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

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

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

Top 5 Sickness Categories 2024/25*	
Mental Health	30.00%
Injury, Fracture	8.66%
Accident/Untoward Incident	9.20%
Miscellaneous	6.82%
Back Problems	6.31%

* Accounts for 60.99% of absence

Miscellaneous includes General Debility (2.55%); Hospital Investigations (2.04%); Post Surgical Debility (1.75%); Post Viral Fatigue (0.49%); Chronic Fatigue (0%)

Mental Health Reasons	
Stress	41.03%
Stress-Work Related	30.20%
Grief/Bereavement	12.54%
Anxiety	7.24%
Other Mental Health	3.61%
Depression	2.38%
Panic Attacks	1.51%
Behavioural Disorder	0.79%
Insomnia	0.70%

2024/25 Cumulative Sickness Absence by Month including Comparison with Previous Reporting Year

	Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
1.	Absence Target (2024/25)	%[1]											
2.	Current Status against Target	10.44% ↓											
3.	Cumulative % hours lost (23/24)	14.25%	14.19%	14.25%	14.27%	14.64%	14.60%	14.65%	14.82%	14.90%	14.76%	14.53%	14.23%
4.	Cumulative % hours lost (24/25) (Total)	10.24%	9.64%	10.06%	10.49%	10.70%	10.79%	10.68%	10.43%	10.38%			
4.1	Cumulative % hours lost (24/25) (Non-Covid)	9.94%	9.28%	9.66%	10.03%	10.24%	10.36%	10.27%	10.06%	10.05%			
4.2	Cumulative % hours lost (24/25) (Covid)	0.30%	0.36%	0.40%	0.46%	0.45%	0.43%	0.41%	0.37%	0.33%			
4.3	Cumulative % hours lost (24/25) Short-Term	1.94%	1.89%	2.03%	2.17%	2.10%	2.13%	2.17%	2.13%	2.19%			
4.4	Cumulative % hours lost (24/25) Long-Term	8.30%	7.75%	8.03%	8.32%	8.60%	8.67%	8.51%	8.29%	8.20%			
5.	Monthly % hours lost (24/25) Total	10.24%	9.07%	11.00%	11.71%	11.55%	11.28%	10.05%	8.63%	10.05%			
6.	Average standard working days lost/employee/month	2.19	2.02	2.14	2.62	2.46	2.30	2.19	1.75	2.15			
7.	Average estimated cost per month (£'000)	£527	£481	£644	£688	£727	£690	£615	£534	£630			

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

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

Northern Ireland Ambulance Service
Health and Social Care Trust

Appendix

Northern Ireland Ambulance Service
Health and Social Care Trust

Our Patients | SPPG Service Delivery Plan | Trajectories and Performance

The information below sets out the Trajectories agreed with SPPG for 2023-24 and our performance against these trajectories

Call Answer Performance:

	April 24	May 24	June 24	July 24	August 24	September 24	October 24	November 24	December 24	January 25	February 25	March 25
Call Answer Outturn	93.7%	87.4%	89.8%	92.5%	90.2%	89.4%	94.3%	89.2%	85.9%			
Trajectory	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%

Hear and Treat and See & Treat

	April 24	May 24	June 24	July 24	August 24	September 24	October 24	November 24	December 24	January 25	February 25	March 25
Hear & Treat Outturn	5.2%	5.3%	6.2%	5.5%	6.1%	5.8%	5.4%	6.6%	10.4%			
Hear & Treat Trajectory	5.0%	5.2%	5.5%	6.0%	6.6%	7.5%	7.8%	8.2%	8.5%	8.8%	9.2%	10%
See & Treat Outturn	13.6%	13.9%	14.3%	14.5%	12.8%	13.9%	13.5%	13.9%	15.2%			
See & Treat Trajectory	13.8%	14.0%	14.3%	14.4%	14.6%	14.7%	14.9%	15.0%	15.2%	15.2%	15.3%	15.5%

Northern Ireland Ambulance Service
Health and Social Care Trust

Our Patients | SPPG Service Delivery Plan | Trajectories and Performance

The information below sets out the Trajectories agreed with SPPG for 2023-24 and our performance against these trajectories

Response Times

	April 24	May 24	June 24	July 24	August 24	September 24	October 24	November 24	December 24	January 25	February 25	March 25
Category 1 Mean	11mins	12mins	12mins	12mins	12mins	12mins	12mins	13mins	13mins			
Cat 1 Mean Trajectory	11mins	11mins	11mins	11mins	11mins	11mins	10mins	10mins	10mins	10mins	10mins	10mins
Category 1 90th Centile	21mins	22mins	22mins	23mins	22mins	23mins	23mins	23mins	25mins			
Cat 1 90th Centile Trajectory	22mins	22mins	22mins	22mins	22mins	22mins	21mins	21mins	21mins	21mins	21mins	21mins
Category 1T Mean	14mins	15mins	15mins	16mins	15mins	18mins	17mins	17mins	18mins			
Cat 1T Mean Trajectory	19mins	19mins	19mins	19mins	19mins	19mins	19mins	19mins	19mins	19mins	19mins	19mins
Category 1T 90th Centile	28mins	28mins	29mins	30mins	26mins	35mins	32mins	34mins	35mins			
Cat 1T 90th Centile Trajectory	30mins	30mins	30mins	30mins	30mins	30mins	30mins	30mins	30mins	30mins	30mins	30mins

Northern Ireland Ambulance Service
Health and Social Care Trust

Our Patients | SPPG Service Delivery Plan | Trajectories and Performance

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Response Times

	April 24	May 24	June 24	July 24	August 24	September 24	October 24	November 24	December 24	January 25	February 25	March 25
Category 2 Mean	39mins	41mins	52mins	51mins	49mins	66mins	59mins	64mins	110mins			
Cat 2 Mean Trajectory	48mins	48mins	48mins	46mins	45mins	44mins	44mins	42mins	40mins	40mins	38mins	36mins
Category 2 90th Centile	88mins	93mins	115mins	114mins	110mins	145mins	132mins	139mins	255mins			
Cat 2 90th Centile Trajectory	100mins	100mins	100mins	98mins	96mins	94mins	92mins	90mins	88mins	86mins	83mins	80mins
Category 3 90th Centile	208mins	263mins	381mins	360mins	312mins	489mins	460mins	338mins	772mins			
Cat 3 90th Centile Trajectory	300mins	300mins	300mins	290mins	280mins	270mins	260mins	255mins	250mins	243mins	238mins	233mins

Northern Ireland Ambulance Service
Health and Social Care Trust

Our Patients | SPPG Service Delivery Plan | Trajectories and Performance

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Handover Performance

	April 24	May 24	June 24	July 24	August 24	September 24	October 24	November 24	December 24	January 25	February 25	March 25
<=15mins	7.5%	7.8%	7.6%	7.7%	7.6%	6.4%	6.3%	6.3%	6.1%			
<=15mins Trajectory	7.1%	10%	12%	13%	14%	15%	17%	19%	20%	22%	24%	25%
<=30mins	30.2%	31.8%	29.6%	29.7%	30.3%	25.7%	26.7%	25.9%	25%			
<=30min Trajectory	27%	30%	32%	23%	34%	36%	38%	39%	40%	43%	44%	45%
<=60mins	65.8%	68.5%	63.4%	66.5%	66.1%	58.8%	60.7%	59.3%	54.4%			
<=60mins Trajectory	59%	62%	64%	66%	68%	70%	73%	74%	76%	80%	82%	85%
>2hrs	15.4%	13.2%	16.2%	12.7%	14.1%	21.9%	20%	20.2%	25.7%			
>2hrs Trajectory	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
No of Patients >2hrs	1,545	1,412	1,585	1,267	1,376	2,003	1,974	1,953	2,252			
No of Patients >2hrs Trajectory	0	0	0	0	0	0	0	0	0	0	0	0

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

PRESENTATION OF PAPER

Date of Committee:	20 February 2025
Title of paper:	Finance Report – December 2024 (Month 9)
Brief summary:	• Attached is the finance report for month 9 to 31 December 2024. • The Trust is reporting year-to-date (YTD) expenditure of £89.5m with an underspend of £1.3m against profiled budgets. • Easements in pay budgets are expected to continue to the end of the year. This is due to the recruitment of staff not happening as quickly as originally anticipated. • Contingency support of £1m retained by NIAS to implement new protocols for end of shift handovers will not be utilised in 2024/25. Expenditure has been returned to SPPG. • £10.3m of expenditure has been incurred in December. If this run rate continues, the Trust is on course to deliver a break-even position at year-end. • The savings plan to deliver the full £2.475m is on track to be achieved. • Additional finding of £1.1m to support the Trusts capital pressures has been provided by the DoH. Forecast to break even in relation to capital expenditure.
Recommendation:	**For Approval** ☐ **For Noting** ☒ *Click the appropriate box*
Previous forum:	SMT 4 February 2025, PFOD 13 February 2025
Prepared and presented by: **Date:**	Leahann Donnelly and presented by Simon Christie 4 February 2025

Northern Ireland Ambulance Service
Health and Social Care Trust

PEOPLE, FINANCE & ORGANISATIONAL DEVELOPMENT COMMITTEE
PRESENTATION OF PAPER

Date of Committee:	13 February 2025
Title of paper:	Draft Financial Plan (Officer Draft) 2025-26
Brief summary:	This paper provides an update to PFOD on the officer draft of the 2025-26 financial plan. PFOD are asked to note the report, that it has been shared with SPPG on the 5 February 2025 and that will be presented to Trust Board on 20 February 2025. Trust Board will be asked to formally agree for the draft to be sent to SPPG in order to aid further discussions.
Recommendation:	**For Approval** ☒ **For Noting** ☐
Previous forum:	SMT on 4 February 2025
Prepared and presented by: **Date:**	Leahann Donnelly Simon Christie 5 February 2025

NIAS DRAFT FINANCIAL PLAN 2025-26

Introduction

About the Northern Ireland Ambulance Service HSC Trust

The Northern Ireland Ambulance Service (NIAS) was established by the Northern Ireland Ambulance Service Health and Social Services Trust (Establishment) Order (Northern Ireland) 1995 as amended by the Health and Social Services Trusts (Establishment) (Amendment) Order (Northern Ireland) 2008 and Section 1 of the Health and Social Care (Reform) Act (Northern Ireland) 2009.

The principal ambulance services we provide are:

- Emergency response to patients with sudden illness and injury;
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- Specialised health transport services; and
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The NIAS Control Room answers circa 230k calls per annum generating approximately 190k incidents with 173k crews deployed to scene. This equates 470 deployments every day.

NIAS continues to be severely impacted by delayed hospital turnaround times during 2024-25. In 2023-24 NIAS lost circa 119k hours of capacity due to ambulances waiting at hospitals for longer than 30 minutes. This translated to a productivity loss of £13m. Due to a further deterioration in 2024-25 this is now estimated to be £16m.

This is the single most contributory factor by far for the NIAS poor response time performance.

NIAS also delivers circa 155k journeys per annum to support patients with their transportation to non-emergency routine admissions, discharges, outpatient appointments and transfers. This equates to over 400 journeys every day.

NIAS continues to make good progress in implementing its ambitious transformation strategy to move to a more sustainable and clinically effective and efficient service delivery model. This will see significant benefits to the delivery of emergency care right across the health sector in Northern Ireland. The continued support from the Strategic Planning and Performance Group (SPPG) and the Department of Health (DoH) is a critical component in this journey.

2025-26 Indicative Budgetary Allocations

The Acting Director of Finance - SPPG wrote to NIAS on 15 January 2025 providing NIAS with an indicative budgetary envelope of £ 122.5m for the 2025-26 financial year. The breakdown of this allocations is detailed below.

	CYE £	FYE £	Comments / Dependencies
Opening FYE Commitments - SPPG	107,672,546	107,672,546	
Service Pressures - NIAS	2,000,000	2,000,000	
22/23 Growth - Associated backfill	1,336,000	1,336,000	
Service Delivery	4,000,000	4,000,000	
Growth in Demand - NIAS Paramedic Graduate Posts(NIAS)	1,300,000	1,300,000	
Growth in Demand - NIAS workforce	5,700,000	5,700,000	
Subtotal - indicatives	**14,336,000**	**14,336,000**	
PPE	500,000		
2025/26 Non Pay	0		TBC
NIC	0		TBC
2025/26 Pay	0		TBC
GRAND TOTAL	**122,508,546**	**122,008,546**	

Within this letter NIAS was directed to develop a plan, with Board approval, to deliver a breakeven position for the 2025-26 financial year whilst maintaining existing services. Subsequent clarity from the Chief Operating Officer (Interim) – SPPG indicated that NIAS should submit a Board approved, or officer draft if the Board meeting is later by the 7 February 2025 (with an outline draft by 4 February 2025 if possible).

Whilst NIAS has not been in receipt of deficit funding (as with the other Trusts) and has managed to deliver a break-even position year on year, NIAS remains very concerned about the indirect impact that the total 2025-26 HSC draft budget will have. This could result in a further deterioration in service delivery from all Trusts. If this occurs, it will lead to a further deterioration beyond NIAS control in both handover and subsequently poor response times.

NIAS 2025-26 Draft Financial Plan

This draft plan below outlines the deployment of the indicative budgetary envelope of £122.5m and the response to the requirement to breakeven in the financial year 2025-26 across the following areas:

- Opening Allocation
- Summary Assumptions
- Savings Plans
- Workforce Plan
- 5 Year recovery plan

- Emerging financial pressures beyond 2025-26
- Governance Arrangements
- Conclusions
- Recommendation

Opening Allocation

SPPG have provided NIAS with an indicative budgetary envelope of £122.5m for 2025-26. This includes the opening baseline allocation of £107.673m (net of £2.475m of recurrent savings) and includes additional allocations as outlined.

The indicative allocation provided is in effect a 'roll forward' of the funding provided in the 2024-25 financial year. This means that it is expected that NIAS will continue to live within its current funding received in 2024-25 for the 2025-26 year. Once the final allocation is received, and Trust Board approve the final financial plan, NIAS will set its budgets accordingly (subject to Trust Board approval) in line with funding and established budgetary protocols.

There are however a number of areas of essential funding which SPPG has not indicatively allocated thus far. Some of these have been highlighted in their letter and are included in the above table. However, the indicative budget also does not include any funding for the recurrent impact of the 2024-25 pay award settlements.

This plan assumes that all these financial pressures will be fully funded by SPPG and are summarised below.

Summary Assumptions

In summary it is assumed:

1. that all indicative funding is released to NIAS by SPPG.
2. that the following expenditure will be fully funded by SPPG and will be additional to the £122.5m opening allocation:
    - the recurrent impact of the 2024-25 pay award.
    - the 2025-26 pay award.
    - uplifts to include Non-Pay, National Living Wage, and National Insurance contributions.
3. that all savings will be achieved.

Savings Plan

During the last 2 financial years SPPG has recurrently reduced NIAS allocation by £2.475m (£1,975m in 2023-24 and a further £0.5m 2024-25) expecting NIAS to deliver this amount as efficiency without materially impacting service delivery.

Due to the extreme pressure that NIAS has been under, predominantly due to the significantly poor performance at HSC Trust EDs (resulting in unacceptable handover delays at an estimated £16m of lost productivity), NIAS to date has been unable to convert the recurrent saving requirement into a recurrent plan. Subsequently NIAS has delivered this saving through non-recurrent contingency measures. NIAS will continue to adopt this approach for 2025-26 and until the handover times at EDs return to acceptable levels.

Details of the 2025-26 non-recurrent savings proposals for NIAS are summarised in the table below. This is very much a repeat of the strategy adopted for savings in the past 2 years, necessitated by the handover issues at EDs.

Description	£m
Non-Frontline Vacancy Management	1.055
Defer Minor Schemes Backlog Maintenance	0.100
Income	0.100
Sale of End-of-Life Vehicles	0.100
Clinical training	0.100
Defer Medical Equipment Replacement	0.050
Uniforms	0.050
Other Low Impact Schemes TBC	0.920
Total	**2.475**

The delivery of savings of this magnitude will continue to be a challenge for NIAS and will require specific action and monitoring during the year. A number of schemes have yet to be identified to deliver the full savings required in 2025-26. These can be assessed and established as the year progresses.

Workforce Plan

As noted above, SPPG have provided NIAS with an indicative budgetary envelope of £122.5m for 2025-26. This includes funding of £13m for 2025-26 for the NIAS Workforce to support NIAS in continuing to deliver its ambitions transformation strategy. This strategy is gathering pace and the funding is a critical component for successful outcomes. NIAS continue work closely with SPPG on these projects and it is expected the draft business cases for all initiatives will be finalised in the coming months.

NIAS has experienced slower than expected implementation of these initiatives mainly due to recruitment timelines. This has and will necessitate a higher than anticipated expenditure on overtime and the use of the Independent Ambulance Service (IAS) to offset the vacant roles. However this will steadily reduce during the year as the implementation and associated recruitment progresses.

The plan to utilise the £13m workforce funding in 2025-26 and recurrently is provided in the table below.

Benefit to be realised	Initiative	2025/26 £m	Recurrent £m
Increased Production Hours	Increased Paramedic Provision (NQPs)	5.5	7.0
Increased Production Hours/Reduced Conveyance Rates	Introduction of Advanced Practice	1.0	1.7
Reduced Conveyance Rates	Integrated Clinical Hub	1.5	1.5
Organisational Resilience & Leadership	Operational Resilience and Leadership	1.5	2.2
Emergency Preparedness (EPRR)	EPRR Resilience	0.35	0.35
Improved EOC Resilience	Improved 24/7 Cover	0.25	0.25
Continued Service Provision in Transition	Overtime	1.5	0.0
Continued Service Provision in Transition	IAS	1.4	0.0
	TOTAL	**13.0**	**13.0**

Having considered the current retirement and attrition rates at NIAS, the paramedic workforce supply in Northen Ireland and the headcount required to deliver the new Service Delivery Model in line with the Strategic Plan, NIAS will require additional paramedics. It is anticipated that this may not be fully achieved until the next cohort of newly qualified paramedics join NIAS halfway through the 2025-26 financial year. This is reflected in the updated plan above. NIAS will continue to incur additional overtime and IAS until the funded establishment staff numbers are fully embedded.

NIAS will continue to refine its workforce plan in the short term and the expenditure mix may change during the course of the year in order to maintain service delivery.

The recurrent funding to support the Operational Resilience and Enhanced Leadership initiative of £2.2m will only fund phase 1 of this initiative. Future growth funding of circa £3m will be required in order to fully implement phase 2. This was highlighted in the NIAS 5 year recovery plan submitted to SPPG in September 2024 as an emerging cost pressure.

5 Year Recovery Plan and Emerging Financial Pressures

NIAS attended a recovery plan workshop hosted by SPPG with all HSC Trusts in August 2024. Subsequent to this all Trusts (including NIAS) were asked to submit a 5 year recovery plan to reduce their deficits and return to financial balance. As NIAS is not operating with deficit funding, this plan was a 5 year 'look ahead', identifying growth pressures that will likely emerge in the future. Whilst there is limited growth funding available regionally for HSC, it is important that future provision is made by SPPG to support NIAS pressures.

NIAS submitted a 5 year draft recovery plan to SPPG on the 27 September 2024. A further future financial pressure has arisen since the plan was submitted to recognise the need to expand the NIAS Emergency Preparedness and Response (EPRR) team.

It is recommended at a small amount of recurrent growth funding of circa of £0.5m (final amount to be agreed) is earmarked by SPPG for NIAS in the 2025-26 financial year to bolster the EPRR team in the short-term pending the completion of the business case. Further details of the pressure is articulated below.

EPRR Pressure

The NIAS EPRR team is responsible for Civil Contingency Preparedness and the planning and delivery of Specialist Ambulance Response.

The team continue to take forward implementation of recommendations from the peer reviews commissioned from the Association of Ambulance Chief Executives (AACE) by NIAS as well as relevant Manchester Arena recommendations.

Capacity in the specialist response Hazardous Area Response Team (HART) remains a challenge, and a considerable difference between commissioned staffing numbers compared with the national standards to deliver 24/7 sufficient cover.

NIAS continues to engage with DoH Director of Emergency Resilience and Protecting Health Directorate to agree the extent of difference between HART staff numbers in NIAS (x9 paramedics) vs HART Team staff in GB teams (x52 paramedics) at a cost of circa £4.9m per annum.

Within current staffing numbers this presents a substantial risk. NIAS HART delivery model has been outside recognised National Ambulance Resilience Unit (NARU) standards. A position paper is being finalised which articulates the difference between the current NI model and GB recognised standards, gaps, associated risks, and potential options to address including on a phased approach and recognises current NI position is somewhat different to GB given the interoperability with NIFRS.

It will not be possible to implement a service in line with national standards unless funding is provided.

Governance Arrangements

Given the prevailing financial climate, it is essential that the Trust ensures that strong financial controls are in place throughout the organisation. Governance and accountability arrangements will continue unchanged and NIAS Finance will continue provide monthly Finance Reports to SMT, PFOD, Trust Board and SPPG in line with existing protocols.

Summary Conclusions

- SPPG wrote to NIAS on the 15 and 24 January 2025 providing an indicative allocation for 2025-26.
- SPPG requested a Board approved (or officer draft) draft financial plan be submitted by the 7 February 2025.
- Whilst the indicative allocation is incomplete the plan will remain in draft and will work on the assumption that funding not included in the allocation letter will be provided in full.
- The Trust budget setting processes for 2025-26 cannot commence until a final allocation is provided which includes all funding elements.
- The Trust remains very concerned about the wider HSC budget for 2025-26 and the impact it will have on ED handover delays and subsequent NIAS response performance.
- NIAS plans to deliver a breakeven position for 2025-26 (subject to assumed funding being provided).
- Efficiency savings of £2.475m will continue to be delivered non-recurrently for 2025-26. This approach will be adopted until the handover performance at ED significantly improves.
- NIAS is requesting that an initial amount of ear-marked funding of £0.5m is recurrently provided to bolster the Trusts EPRR team in the short term whilst a business case is developed.

Recommendation

It is recommended that;

- SMT agree this officer draft to be shared with SPPG by 7 February 2025.
- The draft plan be presented to PFOD Committee to note on 13 February 2025.
- The draft plan be presented at Trust Board on 20 February 2025, to note and to agree submission to SPPG to support continuing discussions.

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD
PRESENTATION OF PAPER

Date of Committee:	20 February 2025
Title of paper:	Draft Financial Plan 2025-26
Brief summary:	Attached is a draft of the 2025-26 financial plan. Trust Board is asked to agree for the draft to be sent to SPPG in order to aid further discussions.
Recommendation:	**For Approval** ☒ **For Noting** ☐
Previous forum:	PFOD 13 February 2025, SMT on 4 February 2025
Prepared and presented by: **Date:**	Leahann Donnelly Simon Christie 5 February 2025

Northern Ireland Ambulance Service
Health and Social Care Trust

PEOPLE, FINANCE & ORGANISATIONAL DEVELOPMENT COMMITTEE
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- Emerging financial pressures beyond 2025-26
- Governance Arrangements
- Conclusions
- Recommendation

Opening Allocation

SPPG have provided NIAS with an indicative budgetary envelope of £122.5m for 2025-26. This includes the opening baseline allocation of £107.673m (net of £2.475m of recurrent savings) and includes additional allocations as outlined.

The indicative allocation provided is in effect a 'roll forward' of the funding provided in the 2024-25 financial year. This means that it is expected that NIAS will continue to live within its current funding received in 2024-25 for the 2025-26 year. Once the final allocation is received, and Trust Board approve the final financial plan, NIAS will set its budgets accordingly (subject to Trust Board approval) in line with funding and established budgetary protocols.

There are however a number of areas of essential funding which SPPG has not indicatively allocated thus far. Some of these have been highlighted in their letter and are included in the above table. However, the indicative budget also does not include any funding for the recurrent impact of the 2024-25 pay award settlements.

This plan assumes that all these financial pressures will be fully funded by SPPG and are summarised below.

Summary Assumptions

In summary it is assumed:

1. that all indicative funding is released to NIAS by SPPG.
2. that the following expenditure will be fully funded by SPPG and will be additional to the £122.5m opening allocation:
    - the recurrent impact of the 2024-25 pay award.
    - the 2025-26 pay award.
    - uplifts to include Non-Pay, National Living Wage, and National Insurance contributions.
3. that all savings will be achieved.

Savings Plan

During the last 2 financial years SPPG has recurrently reduced NIAS allocation by £2.475m (£1,975m in 2023-24 and a further £0.5m 2024-25) expecting NIAS to deliver this amount as efficiency without materially impacting service delivery.

Due to the extreme pressure that NIAS has been under, predominantly due to the significantly poor performance at HSC Trust EDs (resulting in unacceptable handover delays at an estimated £16m of lost productivity), NIAS to date has been unable to convert the recurrent saving requirement into a recurrent plan. Subsequently NIAS has delivered this saving through non-recurrent contingency measures. NIAS will continue to adopt this approach for 2025-26 and until the handover times at EDs return to acceptable levels.

Details of the 2025-26 non-recurrent savings proposals for NIAS are summarised in the table below. This is very much a repeat of the strategy adopted for savings in the past 2 years, necessitated by the handover issues at EDs.

Description	£m
Non-Frontline Vacancy Management	1.055
Defer Minor Schemes Backlog Maintenance	0.100
Income	0.100
Sale of End-of-Life Vehicles	0.100
Clinical training	0.100
Defer Medical Equipment Replacement	0.050
Uniforms	0.050
Other Low Impact Schemes TBC	0.920
Total	**2.475**

The delivery of savings of this magnitude will continue to be a challenge for NIAS and will require specific action and monitoring during the year. A number of schemes have yet to be identified to deliver the full savings required in 2025-26. These can be assessed and established as the year progresses.

Workforce Plan

As noted above, SPPG have provided NIAS with an indicative budgetary envelope of £122.5m for 2025-26. This includes funding of £13m for 2025-26 for the NIAS Workforce to support NIAS in continuing to deliver its ambitions transformation strategy. This strategy is gathering pace and the funding is a critical component for successful outcomes. NIAS continue work closely with SPPG on these projects and it is expected the draft business cases for all initiatives will be finalised in the coming months.

NIAS has experienced slower than expected implementation of these initiatives mainly due to recruitment timelines. This has and will necessitate a higher than anticipated expenditure on overtime and the use of the Independent Ambulance Service (IAS) to offset the vacant roles. However this will steadily reduce during the year as the implementation and associated recruitment progresses.

The plan to utilise the £13m workforce funding in 2025-26 and recurrently is provided in the table below.

Benefit to be realised	Initiative	2025/26 £m	Recurrent £m
Increased Production Hours	Increased Paramedic Provision (NQPs)	5.5	7.0
Increased Production Hours/Reduced Conveyance Rates	Introduction of Advanced Practice	1.0	1.7
Reduced Conveyance Rates	Integrated Clinical Hub	1.5	1.5
Organisational Resilience & Leadership	Operational Resilience and Leadership	1.5	2.2
Emergency Preparedness (EPRR)	EPRR Resilience	0.35	0.35
Improved EOC Resilience	Improved 24/7 Cover	0.25	0.25
Continued Service Provision in Transition	Overtime	1.5	0.0
Continued Service Provision in Transition	IAS	1.4	0.0
	TOTAL	**13.0**	**13.0**

Having considered the current retirement and attrition rates at NIAS, the paramedic workforce supply in Northen Ireland and the headcount required to deliver the new Service Delivery Model in line with the Strategic Plan, NIAS will require additional paramedics. It is anticipated that this may not be fully achieved until the next cohort of newly qualified paramedics join NIAS halfway through the 2025-26 financial year. This is reflected in the updated plan above. NIAS will continue to incur additional overtime and IAS until the funded establishment staff numbers are fully embedded.

NIAS will continue to refine its workforce plan in the short term and the expenditure mix may change during the course of the year in order to maintain service delivery.

The recurrent funding to support the Operational Resilience and Enhanced Leadership initiative of £2.2m will only fund phase 1 of this initiative. Future growth funding of circa £3m will be required in order to fully implement phase 2. This was highlighted in the NIAS 5 year recovery plan submitted to SPPG in September 2024 as an emerging cost pressure.

5 Year Recovery Plan and Emerging Financial Pressures

NIAS attended a recovery plan workshop hosted by SPPG with all HSC Trusts in August 2024. Subsequent to this all Trusts (including NIAS) were asked to submit a 5 year recovery plan to reduce their deficits and return to financial balance. As NIAS is not operating with deficit funding, this plan was a 5 year 'look ahead', identifying growth pressures that will likely emerge in the future. Whilst there is limited growth funding available regionally for HSC, it is important that future provision is made by SPPG to support NIAS pressures.

NIAS submitted a 5 year draft recovery plan to SPPG on the 27 September 2024. A further future financial pressure has arisen since the plan was submitted to recognise the need to expand the NIAS Emergency Preparedness and Response (EPRR) team.

It is recommended at a small amount of recurrent growth funding of circa of £0.5m (final amount to be agreed) is earmarked by SPPG for NIAS in the 2025-26 financial year to bolster the EPRR team in the short-term pending the completion of the business case. Further details of the pressure is articulated below.

EPRR Pressure

The NIAS EPRR team is responsible for Civil Contingency Preparedness and the planning and delivery of Specialist Ambulance Response.

The team continue to take forward implementation of recommendations from the peer reviews commissioned from the Association of Ambulance Chief Executives (AACE) by NIAS as well as relevant Manchester Arena recommendations.

Capacity in the specialist response Hazardous Area Response Team (HART) remains a challenge, and a considerable difference between commissioned staffing numbers compared with the national standards to deliver 24/7 sufficient cover.

NIAS continues to engage with DoH Director of Emergency Resilience and Protecting Health Directorate to agree the extent of difference between HART staff numbers in NIAS (x9 paramedics) vs HART Team staff in GB teams (x52 paramedics) at a cost of circa £4.9m per annum.

Within current staffing numbers this presents a substantial risk. NIAS HART delivery model has been outside recognised National Ambulance Resilience Unit (NARU) standards. A position paper is being finalised which articulates the difference between the current NI model and GB recognised standards, gaps, associated risks, and potential options to address including on a phased approach and recognises current NI position is somewhat different to GB given the interoperability with NIFRS.

It will not be possible to implement a service in line with national standards unless funding is provided.

Governance Arrangements

Given the prevailing financial climate, it is essential that the Trust ensures that strong financial controls are in place throughout the organisation. Governance and accountability arrangements will continue unchanged and NIAS Finance will continue provide monthly Finance Reports to SMT, PFOD, Trust Board and SPPG in line with existing protocols.

Summary Conclusions

- SPPG wrote to NIAS on the 15 and 24 January 2025 providing an indicative allocation for 2025-26.
- SPPG requested a Board approved (or officer draft) draft financial plan be submitted by the 7 February 2025.
- Whilst the indicative allocation is incomplete the plan will remain in draft and will work on the assumption that funding not included in the allocation letter will be provided in full.
- The Trust budget setting processes for 2025-26 cannot commence until a final allocation is provided which includes all funding elements.
- The Trust remains very concerned about the wider HSC budget for 2025-26 and the impact it will have on ED handover delays and subsequent NIAS response performance.
- NIAS plans to deliver a breakeven position for 2025-26 (subject to assumed funding being provided).
- Efficiency savings of £2.475m will continue to be delivered non-recurrently for 2025-26. This approach will be adopted until the handover performance at ED significantly improves.
- NIAS is requesting that an initial amount of ear-marked funding of £0.5m is recurrently provided to bolster the Trusts EPRR team in the short term whilst a business case is developed.

Recommendation

It is recommended that;

- SMT agree this officer draft to be shared with SPPG by 7 February 2025.
- The draft plan be presented to PFOD Committee to note on 13 February 2025.
- The draft plan be presented at Trust Board on 20 February 2025, to note and to agree submission to SPPG to support continuing discussions.

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

PRESENTATION OF PAPER

Date of Trust Board:	20 February 2025
Title of paper:	**Corporate Risk Register Summary Report February 2025**
Brief summary:	The updated Corporate Risk Register (CRR) is presented to Trust Board. The substantive changes since the last time the CRR was approved at Trust Board (October 2024) are: • Agreed at SQPPE in Nov 2024 that risks 417 and 790 could be de-escalated. • Risks 761 (HART Capacity) and 833 (Ability to respond to HCID) to be added to the CRR. • Proposal to de-escalate 712 (Medical Asset Management) and 760 (EPRR Capacity). • Risk 559 Organisation Culture Improvement consolidated with 301. • Updated controls and actions documented. There are currently 14 open corporate risks (following these changes). The CRR summary report was reviewed and approved at ARAC on 6 February 2025.
Recommendation:	**For Approval** ☐ **For Noting** ☒
Previous forum:	SMT – 28 January 2025 ARAC – 6 February 2025
Prepared and presented by:	Maxine Paterson, Director for Planning and Performance and Corporate Services
Date:	13 February 2025

Northern Ireland Ambulance Service
Health and Social Care Trust

Corporate Risk Register Summary
February 2025
Risk Management

CORPORATE RISK REGISTER (SUMMARY)		Date: 7 February 2025
	Risk	**Changes**
NEW risks for consideration:	Hazardous Area Response Team (HART) Capacity (761)	New to Corporate Risk Register – added December 24.
	Ability to respond to a High Consequence Infectious Disease (833)	New to Corporate Risk Register – added November 24.
Changes to risks	Oversight of Independent Sector Providers (531)	Risk Grading lowered and title/description amended.
	Organisational Culture Improvement (559)	Risk Grading lowered and description amended.
	Support For Staff Health & Wellbeing (301)	Consolidated with risk 559.
Risks to be de-escalated to Directorate risk registers / closed:	Medicines Asset Management & Governance (712)	Proposed de-escalation to Directorate Risk Register
	Capacity of the Emergency Preparedness, Resilience and Response (EPRR) Department (760)	Proposed de-escalation to Directorate Risk Register

Strategic Objectives	
1	**We will identify the most appropriate clinical response for our patients.**
2	**We will work collaboratively with our HSC partners to maximise the use of available care pathways for our patients.**
3	**We will promote a culture of compassionate leadership and respect for Equality and Human Rights that delivers excellent patient care through investment in the wellbeing of our workforce.**
4	**We will work with partners to ensure the appropriate resources are deployed to meet our patients/needs.**
5	**We will optimise organisational resilience to respond to patients' needs.**
6	**We will support regional initiatives that aim to drive improved health outcomes for the population of Northern Ireland.**

NIAS Corporate Risk Register Summary: January 25

						Initial		Current		Target		Current Risk Status					
Risk Type	**Risk ID**	**Lead Director**	**Risk Title**	**Risk Description**	**Link to Strategic Objective**	**Score**	**Grade**	**Score**	**Grade**	**Score**	**Grade**	**Months since score changed**	**Change in score since last review**	**Months since last updated**	**Action Plan Status**	**Risk Movement**	**Latest Update**
Corporate	816	Director of Operations	Failure to meet agreed regional standards in respect of ambulance turnaround at hospitals.	If ambulances cannot be released from hospital EDs more quickly, this will lead to increased incidence of breaching the agreed regional performance standard of 30-minute turnaround, impacting the organisation's capacity and ability to respond to calls. NIAS crews are experiencing lengthy waits at hospitals.	6	25	Extreme	25	Extreme	6	Low	11	Reviewed-9/1/25. No change.	0	Actions noted		Risk Grading reviewed – no changes – 9 January 2025. **Controls**: • Turnaround performance reported to all HSC Trusts on weekly basis. • Regional Control Centre (RCC) to monitor pressures across HSC system, manage demand and put in place escalation as required. • Escalation to HSC partners, SPPG and DOH in respect of pressures. • SOP developed for Cat 1 Call release at ED. • Measures in place to ensure patients over 75 do not wait more than 8 hours in an ED. Letter 4 December COO. • Escalation to NIAS Chief/ Chair for discussion at accountability meetings. • Clinical strategy – Hear & Treat, See & Treat to manage patients without conveyance to hospital where clinically appropriate. • Consideration of models to help improve turn around performance used by other ambulance services. **Key Actions**: • Further engagement with DOH and HSC partners to identify options to release pressure across the system and reduce turnaround times.
Corporate	761	Director of Operations	Hazardous Area Response Team (HART) Capacity	If NIAS's Hazardous Area Response Team (HART) is not resourced in line with NHS commissioning standards, its capability to respond to high-risk and complex emergency events, will be limited, leading to unsafe systems of work for staff and potential safety risks to patients. The NHS Core Standards for EPRR mandate that six operational HART staff must be on duty at any given time. NIAS does not have adequate resources and personnel to deliver this operating model.	4 & 5	20	Extreme	16	High	4	Low	0	Reviewed-9/1/25. No change.	0	Actions noted	**New to CRR**	New to Corporate Risk Register. Presented and agreed at SMT – December 24. **Controls**: • Director of Ops has engaged with DOH Emergency Resilience & Protected Health Policy Lead to communicate lack of capacity within NIAS to provide a specialist response (including ability to respond to a Chemical, Biological, Radiological or Nuclear/MTA event). 3rd meeting occurred on 16 January 25. • Specialist Response Capability report produced which articulates differences in GB HART & NI HART and sets out potential models for enhancing capacity at NIAS. **Key Actions**: • Continued engagement with DOH and development of Specialist Response Capability report with view to agree next steps/ business case.

Corporate	311	Director of PPCS	Cyber Security	Information security across the HSC is of critical importance to delivery of care, protection of information assets and many related business processes. If a Cyber incident should occur, without effective security and controls, HSC information, systems and infrastructure may become unreliable, not accessible when required (temporarily or permanently), or compromised by unauthorised 3rd parties including criminals. This could result in unparalleled HSC-wide disruption of services due to the lack of/unavailability of systems that facilitate HSC services (e.g. the ability to dispatch and monitor emergency ambulances, appointments, admissions to hospital, ED attendances) or data contained within. This may result in the need for HSC to cancel appointments and treatments or divert emergency/essential clinical or other services. The significant business disruption could also lead to increased waiting lists, delayed urgent clinical interventions and ambulance response, suboptimal clinical outcomes and potentially bring liabilities for the Service. It could also lead to unauthorized access to any of our systems or information (including clinical/medical systems), theft of information or finances, breach of statutory obligations, substantial fines and significant reputational damage.	6	20	Extreme	16	High	4	Low	3	Reviewed-16/12/24. No change	0	Actions noted		Risk Grading reviewed – no changes – 20 January 25. **Controls**: • HSC security hardware (e.g. firewalls) • HSC security software (threat detection, antivirus, email & web filtering) • Server / Client Patching • 3rd party Secure Remote Access • Data & System Backups. • Regional and Local ICT/Information Security Policies • Data Protection Policy • Change Control Processes • User Account Management processes • Disaster Recovery Plans • Emergency Planning/Business Continuity Plans • Regional Cyber Programme business case to fund improved cyber security for HSC has been approved. Expected Delivery lasts until 2028. • Work ongoing on 'Least Privilege' admin model access for 3rd party supplier accounts. • Met with internal audit January 25 to review and support implementation of recommendations. • Regional workshop on learning and implementing minimum standards for cyber security controls assurance framework. **Key Actions**: • Development of NIAS Digital Steering group • Enhance mandatory e-learning for staff. • Cyber Security best practices applied into the implementation of the new core CAD infrastructure. • 2x Band 5 Cyber posts being submitted to scrutiny with aim to appoint in Q4 24/25.
Corporate	403	Director of HR	Sickness Absence	If the management of sickness absence is not improved, this may impact on service delivery and improvement as well as resulting in an inability to achieve financial balance. This could further exacerbate the potential for detrimental impact upon service.	3	16	High	16	High	8	Medium	65	Reviewed-14/1/25 No change.	0	Actions noted		Risk Grading reviewed – no changes – 14 January 2025. **Controls**: • Programme of improvement to improve absenteeism via Delivering Value Programme. • Increased reporting on risk at PFOD. • Funding approved for 6 new Band 6 Senior HR Officers to support managers in the management of absence and wider people agenda. **Key Actions:** • Implementation of Culture Programme improvement plan.

Corporate	830	Director of QSI	Delayed call responses because of actions to mitigate late finishes.	If late finishes, largely caused by delayed hospital handovers, are not reduced or eliminated, actions (including Action Short of Strike (ASOS)) which have been put in place to mitigate impact on staff health/safety & wellbeing will continue and will impair NIAS' ability to respond to 999 calls particularly at shift handover times.	1.5	15	High	15	High	6	Low	4	Reviewed 10/12/24 No Change	1	Actions noted		Risk Grading reviewed December 2024– no change to current. **Controls:** • Dispatch to Category 1 calls prioritised at start/end of shift. • Range of risks associated with actions/ASOS quantified and presented to SMT. • Regular engagement and communication with partners across HSC to escalate issues around late finishes and options to mitigate impact. • Regional actions directed through SPPG to HSC geographical Trusts and NIAS implemented a series of measures to aim to ensure at times of ambulance shift changes, no ambulances would be waiting outside Emergency Departments. **Key Actions:** • Continuous monitoring by NIAS and RCC to measure impact of the changes put in place in December 2024. Data shared daily with SPPG and HSC Trusts. • SPPG communication from T McCaig 4 January regarding pending outcome of current arrangements potential consideration/adoption of ambulance handover system introduced by the London Ambulance Service alongside London Hospitals to ensure sustainable handover times. • NIAS CEx & Chair raised matter and associated performance with Perm Sec at Mid-Year accountability meeting (Jan 25).
Corporate	372	Director of Operations	Operational Management Structure	The current operational management arrangements (nine to five) present a risk to effective service delivery and the necessary support to staff.	3	15	High	15	High	9	Medium	75	Reviewed –9/1/25. No change	0	Actions noted		Risk Grading reviewed – no changes – 9 January 2025. **Controls:** • Project team established and meets weekly. • Equality screening complete. Assessed as minimal impact with no requirement for full equality impact assessment. • Job descriptions for scheduled care service lead, sector lead and team lead submitted for evaluation. • Structure review progression discussed at NIAS engagement meeting with all Trade Unions on 9 January 25. • Spend plan for year 0 complete. **Key Actions:** • Continue progress on recruitment of key posts. • Continue review of rotas for new management structure.

Corporate	820	Director of Finance	Financial Stability - Achieving Financial Balance 2024-25	The Trust may breach its statutory duty to break even if it overspends against core budget, experiences unfunded cost pressures and/or service changes or does not deliver levels of required cash releasing efficiency savings.	4	16	High	9	Medium	6	Low	5	Reviewed No change.	0	Actions noted		Risk Grading reviewed – no changes – 9 January 2025. **Controls:** • SMT and Trust Board have approved a 2024/25 financial plan, underpinned by targets and opening budget allocations. • Budget management and monitoring arrangements have been implemented with opening budget allocation meetings and CP training sessions occurring in August and September 2024. • A Month 3 Finance Report has been provided to SMT, PFOD and Trust Board. • Monthly Directorate finance update meetings from November 2024 onwards. **Key Actions:** • Monitoring to continue at Directorate Accountability meetings - held 3 times a year. • Monthly finance reports will be provided to SMT and to the Trust Board/Committees as appropriate.
Corporate	531	Director of QSI	Oversight of Independent Sector Providers	If NIAS does not implement effective governance and assurance in respect of Independent Ambulance Services (IAS) (in absence of RQIA) there is a risk that quality and performance issues may not be addressed efficiently.	1.4.5	16	High	9	Medium	4	Low	1	Reviewed-10/12/24. Lowered from High (16)	1	Actions noted		The title and description of this risk have been amended to focus on the risks associated with extant governance/assurance processes in respect of independent ambulance services locally. In the context of current NI legislation Independent Ambulance Services are not currently regulated by RQIA. Governance and assurance arrangements against the requirements of the regional non emergency framework have been implemented at NIAS. Risk grading reviewed and lowered on 10 December 2024. While the current controls have limitations, they have been effective in mitigating the risk partially, leading to a current grading of medium. **Controls:** • Framework contract in place with independent providers. • Quarterly assurance meetings between NIAS and independent providers. • Periodic audits of independent provider premises/activity. • Engagement with RQIA to highlight NIAS's desire to see the establishment of a regulated framework. • Approval at SMT to support Quality Assurance Manager and Admin Support. • Recruitment of 22 ACAs completed. **Key Actions:** • Further recruitment into ACA vacancies to reduce reliance on IAS - 24 ACA recruits to commence February 2024. • Recruitment for Quality Assurance Manager and Admin Support. • Progress PCS rota redesign and seek volunteers for new rota times which would lead to increased efficiency and a reduction in IAS usage.

Corporate	825	Director of QSI	Patient Care Service (PCS) Capacity	If adequate resources are not in place to deliver PCS demand (within funded levels) there is a risk to delivery of services, patients and system HSC flow in terms of discharge.	1	15	High	9	Medium	6	Low	4	Reviewed- 10/12/24. No change	0	Actions noted	Risk Grading reviewed – no change to current. Target grade lowered- 10 December 2025. **Controls**: • Ops team reviewing cancellations on daily basis to identify risks. • Recruitment of 22 ACA staff completed & course commenced October 2024. • BI dashboard developed to continuously review and manage absence in line with Trust Policy **Key Actions**: • Ongoing input from NIAS QSI Directorate into ACA absence management – DQSI, expected for whole of financial year 24/25. • Sickness absence target as per DoH target 23/24, 24/25 target awaited, when received will be utilised as target for improvement. • Program for configuration of NIAS fleet to support PCS operational service model to be completed - profile of 22 new vehicles to be submitted to fleet. • Further recruitment into ACA vacancies to reduce reliance on IAS - course of 24 ACA recruits to commence February 2024.
Corporate	559	Director of HR	Organisational Culture Improvement	If the Trust does not facilitate an organisational culture which makes staff feel safe and supported and enables delivery of compassionate care, there is a risk of adverse impacts to staff health and wellbeing, potentially leading to increased absence rates and recruitment and retention challenges. This would have a knock-on effect for delivery of core services and could also compromise the quality of patient care and service user experience.	3	15	High	6	Medium	4	Low	2	Reviewed 25/11/24. Score lowered from High (15)	2	Actions noted	In November 2024 it was agreed to consolidate this risk with 301 Support for Staff Health & Wellbeing given the close overlap in issues, and the progress made in respect of addressing these risks individually. Further, given the extent of controls which have been put in place in the last number of months the risk grading was lowered from High (15) to Medium (6) – 25 November 24. **Controls**: • Established Health & Wellbeing & Peer Support Teams • Focus on delivery of the Trust's Health and Wellbeing Strategy and improving the health and wellbeing of the workforce. • Presentation of progress delivered at PFOD. • Strategy to address workforce absence levels targeted on key reasons for absence with a particular focus on mental health and MSK issues. • Development of Culture Programme improvement plan and presentation to PFOD. **Key Actions**: • Implementation of Culture Programme improvement plan.

Corporate	455	Director of QSI	Trust Safeguarding Arrangements	If adequate corporate safeguarding arrangements are not in place, there is a risk that supports and effective protective interventions are not provided to service users.	2	15	High	12	Medium	6	Low	4	Reviewed -21/01/25.	0	Actions noted		Risk Grading reviewed – 21 January 2025. No change. **Controls:** • Weekly Rapid Review Safeguarding Meeting. • Regular position report to SQPPE to provide safeguarding assurance. • Safeguarding Policy, procedures and pathways in place, and training for staff. • Review of NIAS commissioned private ambulance providers to include safeguarding processes and staff training (twice yearly inspections). • Safeguarding pathway live on REACH. Dashboard has been created, with data pulled from Datix and Reach. • Bespoke Safeguarding training introduced for Vol Car Driver and Volunteer first responders. • Bespoke Safeguarding training introduced for Vol Car Driver and Volunteer first responders. ***Key Actions:*** • E-learning to be updated to include Level 1 and 2. • Continue to deliver training to frontline teams with aim of achieving approx. 50% of patient facing workforce trained to level 3 by April 2025.
Corporate	395	Director of PPCS	Violence & Aggression in the workplace	There is a risk that should the Trust not develop, implement and resource an holistic, detailed and fit-for-purpose response to acts of aggression towards NIAS employees, there is potential for such aggression to continue to rise. This will adversely affect the health and well-being of staff.	3	9	Medium	9	Medium	6	Low	5	Reviewed- No change	0	Actions noted		Risk Grading reviewed –no change- 20 January 2025. **Controls**: • Violence and Aggression Reduction Officer in post. • Violence reduction working group meets quarterly. • Information Markers placed on properties where service users have been violent and aggressive. • Policy and process in place for staff to report all incidents of violence and aggression which are investigated, and appropriate support provided. • Staff have access to Body Worn Cameras when out on shift. • Engagement and advocacy with partner organisations in respect of investigating and enforcing episodes of violence and aggression towards NIAS staff. ***Key Actions:*** • Progress options for delivering conflict resolution refresher training for staff. • Proposals for lightweight "body armour" pilot to be progressed. • Scope undertaking a NIAS staff survey on violence and aggression.

Corporate	276	Director of Finance	Corporate Wide Contract Management	There is a risk that ineffective monitoring and control of contracts could result in expenditure being inappropriately or inaccurately incurred. Internal Audit provided Limited assurance in 2019-20 in an audit of Procurement and Contract Management which focused on Estates. A previous audit recommendation was that a central record of contracts should be created and maintained. External Audit in 2019-20 also made recommendations regarding DACs and the record of contracts.	4	9	Medium	9	Medium	4	Low	5	Reviewed- 9/1/25. No change	0	Actions noted		Risk Grading reviewed – no changes – 9 January 2025. **Controls**: • A record of all NIAS contracts has been created. Suppliers and payments have been mapped against the contract record. • A Direct Award Contract Register has been created and is a standing agenda item at the Audit & Risk Assurance Committee. • Contract management and Procurement guidance updated and disseminated to managers including the use of DACs. • Contract Management included as part of Directorate Accountability meetings which commenced November 2024. • Review of all spend over £10k during 23/24 in progress to ensure that contracts are in place for spend. ***Key Actions:*** • Contract Management monitoring as part of Directorate Accountability meetings. • Explore Contract Management software options January 25.
Corporate	833	Director of Operations	Ability to respond to a High Consequence Infectious Disease	If NIAS is not able to provide a response to a High Consequence Infectious Disease (HCID), such as MPox, in line with recommended guidance because of capacity constraints, it could place patients and staff at clinical risk, and compromise service delivery. The National Ambulance Resilience Unit's (NARU) guidance recommends that HART services respond to all probable cases of Clade 1 MPox and that all operational staff complete HCID training and receive education on specific HCID PPE donning/doffing techniques. It is currently not possible to facilitate these aspects of the guidance at NIAS due to capacity constraints within the HART team and limited availability of the requisite training.	1,2,5	12	High	9	Medium	2	Low	0	Reviewed – 9/1/25. No change	0	Actions Noted	**New to CRR**	New to CRR- Risk Opened November 2024. Discussed at SMT- October 24. **Controls:** • Discussions with PHA and Regional IPC leads regarding the levels of PPE required for a HCID and the education required. • Development of an HCID guidance document in collaboration with IPC, HART, Operations and clinical team with information pertaining to HCIDs, PPE.. • Ongoing engagement with DoH, PHA, NASIPCG regarding potential need for deviations from guidance in the context of unique position in NI due to HART capacity at NIAS. • Completion of an internal risk assessment in respect of any NIAS deviations from the NARU guidance. • Circulation of a memo to staff (co-signed by TUs) emphasising the importance of Fit Testing in the context of MPox, and provision of updated Fit Testing at EDs across the region in October/November. • NIAS participated in Regional Tabletop Exercise – January 25. ***Key Actions:*** • MPox IMT to continue to meet and review NIAS response/contingencies. • Risk assessment to be completed documenting NIAS planned response in context of AACE guidelines. • Guidance document for NIAS staff to follow to be developed and disseminated.

Corporate	712	Medical Director	Medicines Asset Management & Governance	If arrangements for medicines asset management and governance are not improved, there is a risk of loss of packs and packs expiring and remaining in the system - risking expired medicines being administered to patients. This may lead to regulatory action / involvement of the Medicines Regulatory Group (statutory powers under the Medicines Act and subordinate legislation).	5	20	Extreme	9	Medium	1	Low	6	No change	0	Actions noted	Move to Directorate Risk Register	Risk to be De-escalated. Presented and agreed at SMT- December 24. A significant programme of work has been implemented since this risk was opened in 2022 to address concerns around medicines asset management and traceability across the service, including implementation of new policies and procedures and a programme of regular inspections. Given the controls which have been put in place, and the assurance provided by NIAS, the regulator has confirmed that its inspections of NIAS practice will revert to a routine schedule. This risk is currently graded as Medium, and it is considered that the remaining outstanding action, the introduction of an electronic tracking system, can be appropriately monitored and managed via the Directorate risk register.
Corporate	760	Director of Operations	Capacity of the Emergency Preparedness, Resilience and Response (EPRR) Department	The current structure and capacity of the Emergency Preparedness, Resilience and Response (EPRR) Department is not sufficient to achieve the full breadth of statutory and organisational responsibilities, this may result in a failure to access funding, adhere to legislative and nationally recognised standards resulting in the inability to respond to major incidents, provide a specialist response, support large events, manage risk to public safety at mass gatherings etc.	6	16	High	12	Medium	4	Low	2	Reviewed- No change.	0	Actions noted	Move to Directorate Risk Register	Risk to be De-escalated. Presented and agreed at SMT- December 24. Since this risk was added to the CRR in January 2023, there has been a significant improvement in the staffing position within EPRR and most of the required posts have been appointed, either substantively or through EOIs. This has markedly improved the capacity of the service to deliver the necessary planning and preparatory work to be able to respond to major and unexpected events. Following review, the current grading is Medium, and it is proposed that it should be de-escalated to the Operations Directorate Risk Register for ongoing management, including implementation of the EPRR Improvement and Transformation Plan and delivery of recommendations arising from the Manchester Arena Inquiry. The EPRR service will continue to provide updates about its capacity and activities through the Trust's assurance framework via the EPRR Group and the Safety, Quality, Performance and Patient Experience (SQPPE) Committee.

Time since last risk grades changed:

Time Since last risk grades changed		
<12 Months	1-3 years	> 3 Years
12	**0**	**2**

NIAS Corporate Risk Register Heat Map:

		Impact (Consequence) Levels - Current				
		Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Likelihood	Almost Certain (5)			372, 830		816
	Likely (4)			455	403, 311, 761	
	Possible (3)			276, 395,820, 531, 825, 833		
	Unlikely (2)			559		
	Rare (1)					

		Impact (Consequence) Levels - Target				
		Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Likelihood	Almost Certain (5)					
	Likely (4)		403			
	Possible (3)		816, 455, 395, 820, 825, 830	372		
	Unlikely (2)		311, 531, 559, 276, 761			
	Rare (1)		833			

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

PRESENTATION OF PAPER

Date of Trust Board:	20 February 2025
Title of paper:	**Updated Risk Management Policy including Risk Appetite Statement**
Brief summary:	The Trust's Risk Management Policy has been updated following Internal Audit recommendations. The substantive changes to the current policy/strategy are: • Synthesising the strategy and policy into a single document and streamlining content. • Directorates will be required to review risks on at least a quarterly basis (as opposed to monthly) – rationale is that most HSC Trusts require quarterly review and monthly review of risks is often too short a timeframe for meaningful update. • Defining in more detail the organisation's Risk Appetite Statement and explaining how this should be used to help manage risks (pages 10 to 12). • Training: change from making this mandatory for all staff to mandatory for Band 6 staff (and above) with line management responsibility. The policy was reviewed and approved at ARAC on 6 February 2025.
Recommendation:	**For Approval** ☐ **For Noting** ☒
Previous forum:	SMT – 28 January 2025 ARAC – 6 February 2025
Prepared and presented by: **Date:**	Maxine Paterson, Director for Planning and Performance and Corporate Services 13 February 2025

Northern Ireland Ambulance Service Health and Social Care Trust

Title:	**Risk Management Policy**		
Author(s):	Nick Henry, Assistant Director for Governance, Risk and Assurance		
Ownership:	Maxine Paterson, Director of Planning, Performance & Corporate Services		
Date of SMT Approval:	28 January 2025	**Date of Committee Approval:**	6 February 2025
Operational Date:	February 2025	**Review Date:**	February 2026
Version No:	4.0	**Supersedes:**	3.0
Key Words:	Risk Management, Governance, Assurance, Risk Matrix, Likelihood, Impact, Risk Appetite, Controls, Actions.		
Other Relevant Policies / Procedures:	Health and Safety Policy, Serious Adverse Incidents (SAI) procedure, Reporting and Management of Adverse Incidents Policy, Management of Medical Devices Policy.		

Version Control:			
Date:	**Version:**	**Author:**	**Comments:**
February 2025	4.0	AD Governance, Assurance and Risk	Scheduled Review
April 2022	3.0	Risk Manager	Scheduled review
April 2019	2.0	Risk Manager	Scheduled review
October 2016	1.0	Risk Manager	New

1.0 INTRODUCTION:

1.1 Background:

This policy outlines the Northern Ireland Ambulance Service Health and Social Care Trust's (NIAS) approach to the management of risk. It sets out a framework for the systematic management of risk across NIAS's activities, which is an integral aspect of the Trust's corporate governance framework, and will support effective decision-making, strategic planning and service delivery.

1.2 Purpose

The primary purpose of this policy is to support staff at all grades to understand and discharge their responsibilities in relation to risk management. It will also enable achievement of the Trust's strategic objectives and delivery of high-quality and safe patient care.

Specific objectives of the policy are to:

- Outline the Trust's processes for identifying, controlling and reviewing risks.
- Define the organisation's risk appetite and outline how this is to be used to manage risks in practice.
- Establish a clear structure of responsibility and accountability for risk management and risk assurance reporting.
- Ensure that existing and emerging risks to NIAS are managed and controlled to an acceptable level.
- Support a culture of proactive risk management where risks are regularly reviewed and actions are progressed to mitigate their impact.
- Form part of the Trust's internal control and corporate governance framework.

2.0 SCOPE:

This policy applies to all aspects the Trust's activities and is relevant to all staff.

3.0 DEFINITIONS

The following definitions apply throughout this policy:

- **Risk:** something that might occur which could impact the Trust's activities and goals.
- **Risk management:** the process of identifying risks and putting in place strategies to manage them to an acceptable level.
- **Risk register:** a log/database where the identification, assessment and actions taken in respect of risks is documented.

- **Likelihood:** how likely or frequently a risk is to occur.
- **Impact:** the potential consequences/effects a risk could have on the Trust's activities.
- **Controls:** processes or activities which have been put in place to reduce the likelihood and/or mitigate the impact of a risk.
- **Actions:** processes or activities which will be put in place to reduce the likelihood and/or mitigate the impact of a risk.
- **Risk appetite:** the acceptable level of risk to the organisation, as defined by Trust Board.
- **Risk owner:** the nominated staff member responsible for reviewing and managing a risk.

4.0 ROLES/RESPONSIBILITIES:

All staff have a responsibility to support effective risk management. Specific roles and responsibilities are set out below:

4.1 Trust Board is responsible for:

- Ensuring that an appropriate risk management framework is in place across the Trust.
- Agreeing the risk appetite statement and reviewing this regularly.
- Obtaining assurance about the risk management processes within the Trust through the corporate governance framework.
- Reviewing the Corporate Risk Register and Board Assurance Framework and progress of any action plans to manage associated risks at least twice a year.
- Supporting the Chief Executive and the Senior Management Team (SMT), as required, to manage significant risks.
- Ensuring that risk management is integrated into decision-making processes, development of organisational strategy and objective setting.

4.2 The Governance, Audit and Risk Assurance Committee is responsible for:

- Appraising and approving the Corporate Risk Register and Board Assurance Framework before it is reviewed by Trust Board.
- Obtaining assurance on all matters relating to risk management within the organisation.
- Obtaining assurance on the processes in place to manage and control the principal risks to the Trust.
- Approving this policy and any other key documents in respect of risk management.

4.3 The Chief Executive is responsible for:

- Ensuring that the risk management processes outlined in this policy are applied consistently throughout the organisation.
- Establishing clear processes to bring significant risk issues to the attention of SMT and Trust Board promptly.
- Providing leadership and continual commitment to risk management.
- Ensuring that SMT maintains regular oversight and review of the Corporate Risk Register.

4.4 **The Director for Planning, Performance and Corporate Services** is the lead Director for the strategic development and implementation of organisational risk management and is responsible for:

- Ensuring risk is effectively managed across NIAS through suitable policies, processes, and procedures and that appropriate mechanisms are in place to provide assurance to Trust Board.
- Deputising for the Chief Executive with regards to risk management.
- Leading on the implementation of this policy, ensuring that it is regularly reviewed and fit-for-purpose.
- Ensuring that the Corporate Risk Register, and other information in respect of risk management, is provided to Trust Board and delegated Committees.

4.5 **Directors and Assistant Directors** are responsible for:

- Ensuring that all activities within their area of responsibility are assessed for risk and that any identified risks are managed appropriately, in accordance with this policy.
- Regularly reviewing their Directorate Risk Register, ensuring that controls and actions are accurate and up to date – this should happen on at least a quarterly basis with the support of the Assistant Director for Governance, Risk and Assurance/Risk Manager.
- Increasing the frequency of risk register review and action planning, as required. For example, in response to internal audit recommendations and reviews by external agencies, such as RQIA.
- Implementing and monitoring action plans which are introduced to help address risks.
- Ensuring that risk management is embedded in strategic and operational planning and decision making.
- Identifying any new or emergent risks to their activities and documenting these on the Directorate Risk Register.
- Monitoring the effectiveness of Controls which have been put in place to manage risks in their area.
- Highlighting any risks on Directorate Risk Registers which may warrant escalation to the Corporate Risk Register.
- Liaising with the Assistant Director for Governance and Risk/Risk Manager for advice and support on the management of risks within their Directorate.
- Supporting their teams to manage and update identified risks in accordance with the guidance outlined in this policy.

4.6 **All staff** are responsible for:

- Maintaining a safe working environment that protects the safety of patients, colleagues and service user.
- Dynamically risk assessing the work environment and activities for any potential hazards.
- Notifying their line manager of any identified risk(s).
- Compliance with this policy and related risk management processes.
- Completing required training in relation to risk management.
- Supporting the delivery and implementation of actions to help address risks, where required.
- Reporting to senior management when serious risks are perceived to have not been addressed appropriately or in a timely manner.
- Being aware of existing risk assessments and any associated procedures or control measures within their team/department.

4.7 The Assistant Director for Governance, Risk and Assurance/Risk Manager are responsible for:

- Providing assurance to SMT regarding risk management systems and processes.
- Providing advice to teams and staff across the organisation in respect of risk management, ensuring that risks are managed consistently and in line with this policy and regional guidance.
- Supporting Directors and managers in the assessment and articulation of risks on risk registers.
- Highlighting to risk owners risks that need reviewing, or where there is insufficient evidence to demonstrate that a risk is being effectively managed.
- Ensuring that risks are being appropriately reviewed and updated in line with this policy and for escalating any issues to GARAC, through the Trust's Assurance Framework.
- Coordinating the regular review of Directorate and Corporate Risk Registers and supporting the development of actions to address risks.
- Ensuring that Datix, the Trust's risk register database, is maintained and accessible.
- Providing Trust Board and other groups with requested information in respect of organisational risk management.
- Providing and developing risk management training.

5.0 RISK MANAGEMENT PROCESS

There are four key steps in the risk management process:

1. Risk identification.
2. Risk analysis and evaluation.
3. Risk treatment.
4. Risk review.

The risk management process must be documented using available tools, primarily risk registers, to provide evidence of a systematic and consistent approach and to ensure there is a record of key decision-making and actions taken to mitigate risks to the Trust.

5.1 RISK IDENTIFICATION

Risks can be identified from a wide range of sources including review of adverse incidents and Serious Adverse Incidents, complaints, inspections, audit, performance analysis and via regulatory and legislative processes, as well as from the experience of other organisations.

What constitutes a risk will vary across Directorates and individual teams should regularly monitor evidence and information sources available to them to identify risks which may impact on their objectives and core operating activities.

Once a risk is identified it should be documented on the appropriate risk register via Datix. The risk title and description should clearly and precisely articulate how the risk may impact the Trust. The risk description should follow the "Cause, Effect, Event" model as illustrated below:

	What is it?	Worked Example Description
Cause	The source of the risk - the event/situation that gives rise to the risk	**IF** I leave the house after 8am, ….
Effect	The area of uncertainty - what will happen if the risk occurs	**THEN** I might be late for work…
Event	The impact the risk would have on organisational activity	…**RESULTING IN** my manager and colleagues being unhappy.

It is likely that Directorates will identify risks which may be partly, or entirely, outside of the Trust's control. For example, they may require action by a different HSC Trust(s), commissioners or another third-party to address them adequately. Where this occurs, the risk should be documented on a Trust risk register and appropriate steps taken insofar as possible to control the risk internally, with appropriate governance and/or contractual arrangements put in place to monitor the risk on an ongoing basis.

5.2 RISK ANALYSIS AND EVALUATION

Identified risks must be analysed by considering their potential likelihood and impact.

The criteria and guidance in the regionally agreed Risk Impact Assessment Table (Appendix 1) and Risk Matrix (Appendix 2) should be used to inform this analysis to ensure a consistent approach to the assessment of risks across the Trust.

Teams may also use available primary evidence or data to help inform this analysis.

By multiplying the likelihood and impact scores, taken from the Risk Matrix, an overall score for the risk is generated. The overall score determines the risk's grading as either Low, Medium, High or Extreme.

The grading helps classify risks in terms of their severity and significance and is a useful means of prioritising action and informing escalation of risks (where appropriate).

After a new risk has been added to a risk register, the allocated risk owner will be notified automatically via email to review it on Datix. The risk owner will be required to enter:

- An Initial grading, reflecting the risk's likelihood and impact if no controls whatsoever were in place.

- A Current grading, reflecting the likelihood and impact with controls that have been put in place. The Current grading should never be higher than the Initial grading and will be assessed and adjusted each time the risk is reviewed (see below section 5.4).

- A Target grading, reflecting the likelihood and impact which are acceptable to the organisation. The Target scores are derived from the Trust's risk appetite statement (see below section 8.0).

5.3 RISK TREATMENT

The primary purpose of risk treatment is to identify strategies to manage a risk to an acceptable level, i.e. to reach the Target score.

Broadly, there are four strategies available:

- Terminate: Eliminate or remove the source of the risk entirely. E.g., if risks are identified with use of a particular medical device, then removing it from service would terminate the associated risks. If a risk is terminated, it can be closed, i.e., removed from the relevant risk register.

- Treat: Introduce controls which will help to reduce the likelihood and/or impact of the risk, thereby lowering its grading and overall impact to the organisation. This might include, for example, new processes, policies, service delivery models, reporting or changes in resource allocation. In practice, most of the Trust's risks will be managed by treating them to some extent.

  As part of this process, it is important that mechanisms are established to verify that controls which have been implemented to manage a risk are working and are effective. For example, this could be through data reporting and trend analysis, auditing/spot checks or monitoring KPIs.

- Transfer the risk to a different entity/organisation. For example, by putting in place contractual arrangements with third parties to take responsibility/liability for certain activities.

- Tolerate: it will be impossible to terminate all risks to the organisation, given that risks are inherent to the Trust's activities. Once a risk has achieved its Target score, i.e., it has been managed to an acceptable level, it may be tolerated, with no additional interventions or actions to manage it further.

Risk owners should consider the range of options which might be available to manage risks within their remit and should develop and implement associated action plans, with the support of their staff and line manager as required.

5.4 RISK REVIEW

Risks must be reviewed on a regular basis (at least quarterly) and the risk register updated.

As part of the review, the risk owner should:

- Revise the current grading by assessing the likelihood and impact to ensure it reflects the up-to-date position.
- Update the controls which have been implemented for the risk (including evidence as to their effectiveness).
- Specify key priority actions which will be taken forward to help address the risk. The actions documented in the risk register should be precise and specific, with a designated lead and timeframe for delivery.

  If actions are overdue, revised timescales should be entered on the register with any additional contingency measures that may need to be put in place.

The Assistant Director for Governance, Risk and Assurance/Risk Manager will meet with Directorates on at least a quarterly basis to review their risk registers and will provide advice and assistance to managers in identifying appropriate controls and actions.

It is good practice for Directorates and management teams to discuss their risk registers and associated action plans regularly in their management meetings, by way of helping to identify new risks and determining whether additional actions or escalation of risks is required.

This will help to standardise practice and embed a culture of risk management across the organisation.

6.0 RISK REGISTERS

All identified risks should be populated on the appropriate risk register on Datix.

Each risk will have a unique identifier generated on entry. The risk's record must include the name of the risk owner, its title and description, a summary of the current controls, its Initial, Current and Target grading, the priority actions to be taken forward and the most recent review date.

The relevant Trust Strategic Objective(s) to which the risk relates should also be populated for risks on the Corporate and Directorate Risk Registers.

There are three types of risk register used at NIAS:

1. The Corporate Risk Register captures the principal risks to the organisation, i.e., those that present potentially the most serious threats to delivery of the Trust's objectives and key activities.

A risk should be considered for inclusion on the Corporate Register it if meets the following criteria:

- It has a Current grading of High or Extreme; and/or
- It would have a significant, adverse effect on delivery of the Trust's Strategic Objectives; and/or
- It cannot be adequately managed at Directorate level; and/or
- It requires escalation to another HSC organisation due to its significance and/or requires commissioner involvement; and/or
- It is considered in any other way to have significant implications for the Trust.

The Corporate Risk Register will be reviewed regularly by SMT (at least on a quarterly basis), and SMT will approve the content of the Corporate Risk Register before it is tabled at GARAC (and subsequently Trust Board).

Each corporate risk must have an allocated Director as the risk owner, who will be primarily responsible for its management. Where a risk is cross-cutting, i.e., it affects multiple Directorates, SMT will nominate the most appropriately placed Director as the risk owner.

The following amendments to the Corporate Risk Register must be considered and agreed by SMT:

- Addition of a new corporate risk.
- Change of responsibility, e.g., risk owner/Directorate.
- Any changes to the title or description.
- Changes to the Current or Target grading.
- Proposals for de-escalation or closure.

The Corporate Risk Register will be included for publication on the Trust's website as part of the pack of papers which is submitted to Trust Board.

2. Directorate Risk Registers capture the risks which are being managed within each Directorate, with the relevant Director being responsible for ensuring that the risk owner(s) within their team are regularly updating and reviewing their risks.

3. Project Risk Registers capture risks specific to ongoing Projects/Programmes. The relevant Project Manager and Senior Responsible Officer are responsible for managing the Project Risk Register.

7.0 RISK ESCALATION

The Assistant Director for Governance, Assurance and Risk and Risk Manager will provide specialist advice and support to teams across the Trust on the management of risk registers including whether risks are being handled at the appropriate level in the organisation and, relatedly, if they should be escalated or de-escalated.

There are a range of factors which may trigger escalation of a risk. Risks should be considered for escalation when:

- Controls are proving to be ineffective.
- The risk is not being reduced or managed as expected.
- Actions needed to manage the risk further cannot be delivered at the current level.

Conversely, where there is satisfactory evidence that the controls which have been put in place have been effective in reducing a risk, the risk has reached a Current grading close to, or at, its Target and/or it is considered that the risk can be adequately managed at a lower level, it should be de-escalated.

8.0 RISK APPETITE STATEMENT

Risk appetite is the amount of risk an organisation is willing to accept in the pursuit and delivery of its goals and objectives, i.e., it reflects the level of risk with which the organisation aims to operate.

NIAS's risk appetite statement reflects the expectations of Trust Board in terms of what level of risk is acceptable and the type of risks which should be identified and managed by the Trust.

NIAS recognises that, as a provider of health and social care, risks are inherent to delivery of its core activities and will inevitably occur when providing care and treatment to patients, employing staff, contracting with third parties, managing its estate and maintaining its finances.

The Trust also acknowledges that identifying and appropriately managing risks is necessary to achieve its Strategic Objectives and ensure delivery of high-quality and safe care to service users.

Trust Board is committed to ensuring an effective risk management system is in place to manage risks from operational to Board level and that robust mitigating action plans are put in place.

The Trust will take risks in a controlled and considered manner and exposure to risks will be kept to an acceptable level as determined by Trust Board, using the below framework derived from *The Orange Book*:

Risk Appetite Level	Description
Averse	Avoidance of risk and uncertainty altogether.
Minimal	Preference for safe options that have a low degree of risk and uncertainty.
Cautious	Prepared to accept some risk that can be easily controlled, with little chance of significant repercussions.
Open	Willing to consider all options and to choose one likely to support successful delivery of objectives.
Eager	Willing to be innovative and progress options with high degrees of potential risk and uncertainty.

Overall, NIAS's willingness to accept risk is low but its risk appetite varies across different types of risk. Broadly, the organisation is averse to risks that could negatively affect the safety of patient care and those that could result in non-compliance with professional standards and legal requirements. Conversely, it is willing to accept a higher level of considered risk in areas relating to finance and strategy development, for example.

The table below sets out NIAS's risk appetite for various categories of risk, along with the target score range, representing the acceptable level of risk. This should be used to inform decision-making internally in respect of risk identification and management.

Some risks which score above the desired acceptable level may nevertheless be tolerated by the Trust, because:

- The likelihood of them occurring is deemed to be sufficiently low; and/or
- They may be considered too costly to control given other priorities; and/or
- The cost of controlling them may be greater than the cost of the impact should they materialise; and/or
- There is likely to only be short-term exposure to them.

A decision to tolerate an increased level of risk above the risk appetite will be reviewed and authorised by Trust Board.

Risk Category	Description	Risk Appetite Level	Target Score Range
Safety of Care	Risks that impact on patient safety.	Averse	1 to 3
Quality	Risks that negatively affect service user experience, such as delays or long waiting times.	Minimal	1 to 5
People	Risks that impact on staff recruitment, retention, skills and capacity and well-being.	Minimal	1 to 5
Operational	Risks arising from agile internal processes/planning resulting in poor service performance and outcomes.	Minimal	1 to 5
Financial	Risks that impact on income, expenditure, procurement, and value for money.	Cautious	1 to 9
Regulation and Compliance	Risks that impact on legal/regulatory requirements for example compliance with professional standards and legislation and adherence with national guidance.	Averse	1 to 3
Reputational	Risks arising from, for example, adverse events, repeated failures/poor performance or a lack of innovation.	Cautious	1 to 9
Health and Safety	Risks related to the assessment and management of potential hazards under Health and Safety legislation.	Averse	1 to 3

Strategic	Risks arising from pursuing an inadequately designed strategy or one which fails to support delivery of commitments, plans and objectives.	Cautious	1 to 9
Environmental	Risks that adversely affect the organisation's impact on climate and environmental health.	Minimal	1 to 5
Information and Assets	Risks arising from inadequate management of physical assets (such as buildings and fleet) and data held by the organisation.	Minimal	1 to 5

9.0 BOARD ASSURANCE FRAMEWORK

The Board Assurance Framework (BAF) provides Trust Board with a comprehensive overview of the management of strategic risks facing the organisation.

The BAF differs from the Corporate Risk Register in that it provides a high-level summary of risk to the delivery of key priorities and provides an assessment of the control systems and assurances currently in place. This enables Trust Board to assess the extent and quality of existing assurance, to identify gaps and to make informed decisions about seeking further assurance on specific activities.

Conversely, the Corporate Risk Register is a dynamic record of the management of the principal operational risks facing the Trust. Risks on the Trust's Corporate Risk Registers and Directorate Risk Registers are reviewed and linked to strategic risks contained in the BAF where appropriate.

The BAF is reviewed by GARAC at least twice a year in advance of it being tabled and approved by Trust Board.

10.0 IMPLEMENTATION

10.1 Dissemination:

- This policy will be emailed to Assistant Directors and Directors for onward circulation to staff.
- It will be made available on the Trust's intranet.
- The Risk Department will maintain a copy of the policy and will be responsible for ensuring that it is reviewed in line with the review schedule.
- The policy should be made available to all staff as part of induction.

10.2 Training

A risk management e-learning package is available on the Regional Learning Management System (LMS) and is accessible by all staff.

All Band 6 staff and above with line management responsibility must complete this training package once every three years. Training compliance is monitored and reported through the Trust's assurance framework.

The Assistant Director for Governance, Assurance and Risk and the Risk Manager will facilitate additional, ad hoc training for teams and individual staff members on risk management as required and are available to provide advice and support.

11.0 MONITORING

This policy is owned by the Director for Planning, Performance and Corporate Services and will be reviewed and updated annually, following the yearly review of the Risk Appetite Statement by Trust Board.

12.0 EVIDENCE BASE/REFERENCES:

- The Orange Book – Management of Risk Principles & Concepts, HM Government (2023).
- Innovation and Risk Management: A good practice guide for the public sector, Northern Ireland Audit Office (2023).
- Board Guidance on Risk Appetite, Good Governance Institute (2020).
- Risk Appetite and Tolerance Guidance Paper, The Institute of Risk Management.
- Principles for assessing and managing risks across integrated care systems, NHS England (2024).

13.0 CONSULTATION PROCESS:

This policy was shared with Assistant Directors and Directors at NIAS to seek feedback before it was submitted to Senior Management Team for approval.

14.0 EQUALITY STATEMENT:

In line In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been carried out.

The outcome of the equality screening for this policy is:

Major impact	☐
Minor impact	☐
No impact.	✓

14.0 SIGNATORIES:

Lead Author Nick Henry	**Date**
AD for Governance, Risk and Assurance	13 February 2025
Lead Director Maxine Paterson	**Date** 13 February 2025
Deputy Chief Executive and Director of Planning, Performance and Corporate Services	

Appendix 1: HSC Regional Impact Table – with effect from April 2013 (updated)					
IMPACT (CONSEQUENCE) LEVELS [can be used for both actual and potential]					
DOMAIN	**INSIGNIFICANT (1)**	**MINOR (2)**	**MODERATE (3)**	**MAJOR (4)**	**CATASTROPHIC (5)**
PEOPLE *(Impact on the Health/Safety/Welfare of any person affected: e.g. Patient/Service User, Staff, Visitor, Contractor)*	• Near miss, no injury or harm.	• Short-term injury/minor harm requiring first aid/medical treatment. • Any patient safety incident that required extra observation or minor treatment e.g. first aid • Non-permanent harm lasting less than one month • Admission to hospital for observation or extended stay (1-4 days duration) • Emotional distress (recovery expected within days or weeks).	• Semi-permanent harm/disability (physical/emotional injuries/trauma) (Recovery expected within one year). • Admission/readmission to hospital or extended length of hospital stay/care provision (5-14 days). • Any patient safety incident that resulted in a moderate increase in treatment e.g. surgery required	• Long-term permanent harm/disability (physical/emotional injuries/trauma). • Increase in length of hospital stay/care provision by >14 days.	• Permanent harm/disability (physical/ emotional trauma) to more than one person. • Incident leading to death.
QUALITY & PROFESSIONAL STANDARDS/ GUIDELINES *(Meeting quality/ professional standards/ statutory functions/ responsibilities and Audit Inspections)*	• Minor non-compliance with internal standards professional standards, policy or protocol. • Audit / Inspection – small number of recommendations which focus on minor quality improvements issues.	• Single failure to meet internal professional standard or follow protocol. • Audit/Inspection – recommendations can be addressed by low level management action.	• Repeated failure to meet internal professional standards or follow protocols. • Audit / Inspection – challenging recommendations that can be addressed by action plan.	• Repeated failure to meet regional/ national standards. • Repeated failure to meet professional standards or failure to meet statutory functions/ responsibilities. • Audit / Inspection – Critical Report.	• Gross failure to meet external/national standards. • Gross failure to meet professional standards or statutory functions/ responsibilities. • Audit / Inspection – Severely Critical Report.
REPUTATION *(Adverse publicity, enquiries from public representatives/media Legal/Statutory Requirements)*	• Local public/political concern. • Local press < 1day coverage. • Informal contact / Potential intervention by Enforcing Authority (e.g. HSENI/NIFRS).	• Local public/political concern. • Extended local press < 7 day coverage with minor effect on public confidence. • Advisory letter from enforcing authority/increased inspection by regulatory authority.	• Regional public/political concern. • Regional/National press < 3 days coverage. Significant effect on public confidence. • Improvement notice/failure to comply notice.	• MLA concern (Questions in Assembly). • Regional / National Media interest >3 days < 7days. Public confidence in the organisation undermined. • Criminal Prosecution. • Prohibition Notice. • Executive Officer dismissed. • External Investigation or Independent Review (e.g., Ombudsman). • Major Public Enquiry.	• Full Public Enquiry/Critical PAC Hearing. • Regional and National adverse media publicity > 7 days. • Criminal prosecution – Corporate Manslaughter Act. • Executive Officer fined or imprisoned. • Judicial Review/Public Enquiry.
FINANCE, INFORMATION & ASSETS *(Protect assets of the organisation and avoid loss)*	• Commissioning costs (£) <1m. • Loss of assets due to damage to premises/property. • Loss – £1K to £10K. • Minor loss of non-personal information.	• Commissioning costs (£) 1m – 2m. • Loss of assets due to minor damage to premises/ property. • Loss – £10K to £100K. • Loss of information. • Impact to service immediately containable, medium financial loss	• Commissioning costs (£) 2m – 5m. • Loss of assets due to moderate damage to premises/ property. • Loss – £100K to £250K. • Loss of or unauthorised access to sensitive / business critical information • Impact on service contained with assistance, high financial loss	• Commissioning costs (£) 5m – 10m. • Loss of assets due to major damage to premises/property. • Loss – £250K to £2m. • Loss of or corruption of sensitive / business critical information. • Loss of ability to provide services, major financial loss	• Commissioning costs (£) > 10m. • Loss of assets due to severe organisation wide damage to property/premises. • Loss – > £2m. • Permanent loss of or corruption of sensitive/business critical information. • Collapse of service, huge financial loss
RESOURCES *(Service and Business interruption, problems with service provision, including staffing (number and competence), premises and equipment)*	• Loss/ interruption < 8 hour resulting in insignificant damage or loss/impact on service. • No impact on public health social care. • Insignificant unmet need. • Minimal disruption to routine activities of staff and organisation.	• Loss/interruption or access to systems denied 8 – 24 hours resulting in minor damage or loss/ impact on service. • Short term impact on public health social care. • Minor unmet need. • Minor impact on staff, service delivery and organisation, rapidly absorbed.	• Loss/ interruption 1-7 days resulting in moderate damage or loss/impact on service. • Moderate impact on public health and social care. • Moderate unmet need. • Moderate impact on staff, service delivery and organisation absorbed with significant level of intervention. • Access to systems denied and incident expected to last more than 1 day.	• Loss/ interruption 8-31 days resulting in major damage or loss/impact on service. • Major impact on public health and social care. • Major unmet need. • Major impact on staff, service delivery and organisation - absorbed with some formal intervention with other organisations.	• Loss/ interruption >31 days resulting in catastrophic damage or loss/impact on service. • Catastrophic impact on public health and social care. • Catastrophic unmet need. • Catastrophic impact on staff, service delivery and organisation - absorbed with significant formal intervention with other organisations.
ENVIRONMENTAL *(Air, Land, Water, Waste management)*	• Nuisance release.	• On site release contained by organisation.	• Moderate on site/ off site release contained by organisation.	• Major release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc.).	• Toxic release affecting off-site with detrimental effect requiring outside assistance.

Appendix 2: HSC REGIONAL RISK MATRIX – WITH EFFECT FROM APRIL 2013 (Updated)

Risk Likelihood Scoring Table			
Likelihood Scoring Descriptors	Score	**Frequency (How often might it/does it happen?)**	**Time framed Descriptions of Frequency**
Almost certain	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily
Likely	4	Will probably happen/recur, but it is not a persisting issue/circumstances	Expected to occur at least weekly
Possible	3	Might happen or recur occasionally	Expected to occur at least monthly
Unlikely	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually
Rare	1	This will probably never happen/recur	Not expected to occur for years

	Impact (Consequence) Levels				
Likelihood Scoring Descriptors	**Insignificant(1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
Almost Certain (5)	**Medium**	**Medium**	**High**	**Extreme**	**Extreme**
Likely (4)	**Low**	**Medium**	**Medium**	**High**	**Extreme**
Possible (3)	**Low**	**Low**	**Medium**	**High**	**Extreme**
Unlikely (2)	**Low**	**Low**	**Medium**	**High**	**High**
Rare (1)	**Low**	**Low**	**Medium**	**High**	**High**

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

PRESENTATION OF PAPER

Date of Trust Board:	20 February 2025
Title of paper:	**Revised Board Committee Terms of Reference**
Brief summary:	The revised terms of reference of assurance Committees constituted by Trust Board are tabled for review and approval. Draft terms of reference for the GARAC, PCOD, SPF and SQPE Committees were circulated to Non-Executive Directors for review and feedback in December 2024. The terms of reference for the Charitable Trust Funds Advisory Committee were reviewed at ARAC on 6 February 2025. ARAC approved the revised terms of reference for all of the Committees on 6 February 2025, subject to minor amendments being made to the terms of reference of GARAC and the Charitable Trust Funds Advisory Committee (which have been actioned).
Recommendation:	**For Approval** ☒ **For Noting** ☐
Previous forum:	SMT – 28 January 2025 ARAC – 6 February 2025
Prepared and presented by:	Maxine Paterson, Director for Planning and Performance and Corporate Services
Date:	13 February 2025

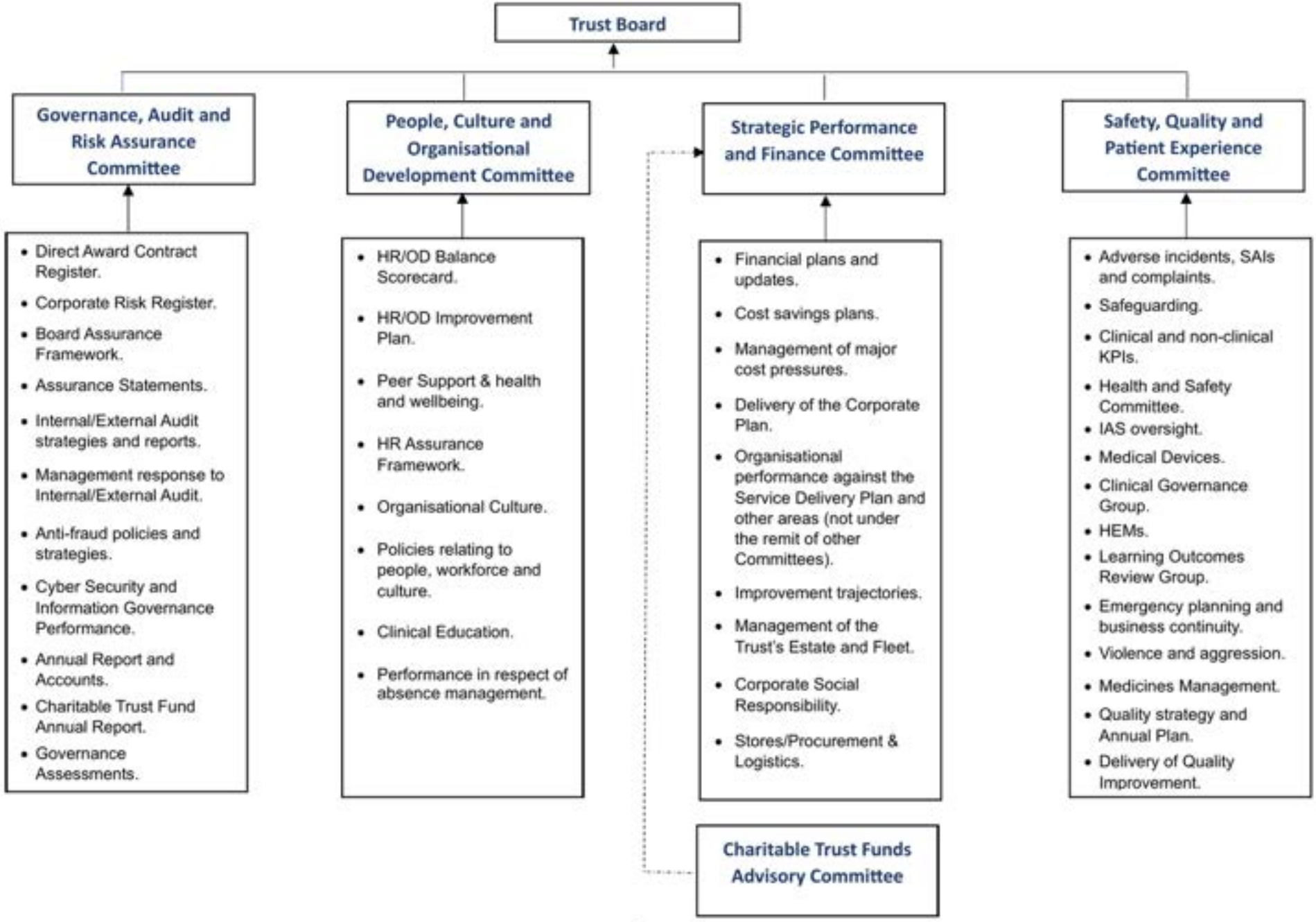
NIAS Board Committees: TOR Realignment Summary

The proposed amendments to the Terms of Reference of Committees constituted by NIAS Trust Board are summarised below:

- The role and remit of ARAC is largely unchanged, but it will be re-titled the Governance, Audit and Risk Assurance Committee (GARAC).
- The current PFOD Committee will be split into two:
    - The People, Culture and Organisational Development (PCOD) Committee will retain oversight of all activities and assurance relating to people, culture and human resources.
    - A new Strategic Performance and Finance (SPF) Committee will be established and will scrutinise financial management, as well as organisational performance and delivery against the Corporate Plan.
- The current SQPPE Committee will be retitled as the Safety, Quality and Patient Experience (SQPE) Committee.
- While the SPF Committee will have primary responsibility for scrutinising organisational performance, each of the other Committees will have oversight of performance in specific areas:
    - GARAC will review performance relating to Information Governance and Cyber Security.
    - PCOD will review performance in respect of absence management.
    - SQPE will review performance relating to adherence with timescales for reporting adverse incidents, SAIs and complaint responses.
- Realignment of some activities from existing Committee TORs to others, e.g. health and safety from ARAC to SQPE, and inclusion of new areas not currently reported on regularly, e.g. Corporate Social Responsibility to SPF.
- A Charitable Trust Funds Advisory Committee will be established as a sub-Committee of SPF. It will meet twice a year and will be responsible for providing independent oversight regarding the expenditure and management of the Trust's charitable funds.

The new Committee structure is set out overleaf along with a summarised list of areas that will be considered by Committee.

Should Trust Board ratify the revised Terms of Reference, they will take effect from 1 April 2025.


Trust Board
Governance, Audit and Risk Assurance Committee
Direct Award Contract Register.
Corporate Risk Register.
Board Assurance Framework.
Assurance Statements.
Internal/External Audit strategies and reports.
Management response to Internal/External Audit.
Anti-fraud policies and strategies.
Cyber Security and Information Governance Performance.
Annual Report and Accounts.
Charitable Trust Fund Annual Report.
Governance Assessments.
People, Culture and Organisational Development Committee
HR/OD Balance Scorecard.
HR/OD Improvement Plan.
Peer Support & health and wellbeing.
HR Assurance Framework.
Organisational Culture.
Policies relating to people, workforce and culture.
Clinical Education.
Performance in respect of absence management.
Strategic Performance and Finance Committee
Financial plans and updates.
Cost savings plans.
Management of major cost pressures.
Delivery of the Corporate Plan.
Organisational performance against the Service Delivery Plan and other areas (not under the remit of other Committees).
Improvement trajectories.
Management of the Trust's Estate and Fleet.
Corporate Social Responsibility.
Stores/Procurement & Logistics.
Charitable Trust Funds Advisory Committee
Safety, Quality and Patient Experience Committee
Adverse incidents, SAIs and complaints.
Safeguarding.
Clinical and non-clinical KPIs.
Health and Safety Committee.
IAS oversight.
Medical Devices.
Clinical Governance Group.
HEMs.
Learning Outcomes Review Group.
Emergency planning and business continuity.
Violence and aggression.
Medicines Management.
Quality strategy and Annual Plan.
Delivery of Quality Improvement.

Northern Ireland Ambulance Service
Health and Social Care Trust

Charitable Trust Funds Advisory Committee

TERMS OF REFERENCE

February 2025

CONTENTS

1.0 ESTABLISHMENT

The Board of the Northern Ireland Ambulance Service Health & Social Care Trust (the Trust) has established the Charitable Trust Funds Sub-Committee.

This is a sub-Committee of the Strategic Performance and Finance Committee.

The sub-Committee has no executive powers other than those specifically delegated by the Board and detailed within these Terms of Reference.

2.0 MEMBERSHIP

The membership of the sub-Committee shall be determined by Trust Board and appointments made from amongst its membership.

The Committee Chair shall be a member of the Strategic Performance and Finance Committee.

A quorum shall be two Non-Executive Directors including the sub-Committee Chair.

In the absence of the sub-Committee Chair, another Non-Executive Member may temporarily act as Chair for a meeting of the sub-Committee by agreement of the other Non-Executive Directors present.

3.0 ATTENDANCE

The Director of Finance and the Assistant Director of Financial Services will be in attendance at meetings of the sub-Committee. Other Trust Officers may be in attendance as required.

The Assistant Director for Governance, Risk and Assurance/Board Secretary (or nominee) may be in attendance at meetings of the sub-Committee (where required).

4.0 FREQUENCY OF MEETINGS

The sub-Committee shall meet at least twice per year.

5.0 AUTHORITY (including escalation to Trust Board)

The sub-Committee is authorised by the Strategic Performance and Finance Committee to undertake the activities stated within these Terms of Reference.

The sub-Committee Chair shall draw to the attention of the Strategic Performance and Finance Committee or Trust Board any issues that may require disclosure or may require executive action by the Chief Executive and/or wider Senior Management Team.

6.0 REMIT

The sub-Committee shall embed the Trust's vision and values in conducting its business.

The sub-Committee will oversee the administration, including banking arrangements, of charitable funds, their investment and disbursement. The responsibility for expending of the charitable funds remains with the Senior Management Team.

The sub-Committee will:

- Satisfy itself that charitable funds are managed in line with the Trust's Standing Financial Instructions, guidance issued by the Department of Health and legislation.

- Ratify the creation of a new fund where funds and/or other assets are received from donors in circumstances where the wishes of the donor cannot be accommodated within the scope of an existing fund.

- Make recommendations on the potential rationalisation and utilisation of funds within statutory guidelines.

- Ensure that assets in the ownership of, or used by, a charitable fund will be maintained with the Trust's general estate and inventory of assets.

- Ensure that funds are not unduly or unnecessarily accumulated.

- Review distribution of funds and ensure that expenditure is subject to due process including appropriate value for money considerations and proper procurement procedures (where applicable).

- Ensure that Annual Accounts are prepared in accordance with Department of Health guidelines and that these are submitted to the Governance, Audit and Risk Assurance Committee within agreed timescales.

- Ensure that a Governance Report and Trustees Report are produced as part of the annual accounts process for charitable funds.

7.0 OPERATIONAL ARRANGMENTS

Administrative Support to the Committee

The sub-Committee shall be supported administratively by the Board Secretary (or nominees) whose duties in this respect include:

- Preparation and issue of an agenda on behalf of the Chair;
- Collation and distribution of papers to Members in advance of each meeting;
- Taking minutes and keeping a record of matters arising;
- Maintaining a record of attendance at Committee meetings;
- Advising the sub-Committee on pertinent issues;
- Assisting the Chair in ensuring the effective operation of the sub-Committee;

- Arranging attendance of appropriate staff at meetings;
- Ensuring these Terms of Reference are reviewed and updated annually; and
- Developing and maintaining the sub-Committee's meeting schedule.

Conduct of Meetings

All procedural matters in respect of conduct of meetings of the sub-Committee shall be in accordance with the Trust's Standing Orders.

All questions arising will be decided by a simple majority of Members of the sub-Committee. In the case of equal votes, the Chair will have a casting vote.

Agenda Items and Papers for Meetings

The Board Secretary (or nominee) will issue the agenda and associated papers for each meeting no later than five days prior to the date of the scheduled meeting, to provide Members and those in attendance the opportunity to read information in advance.

Papers may be accepted and distributed within five days of the date of scheduled meeting at the discretion of the sub-Committee Chair.

Minutes of Meetings

The minutes of the sub-Committee shall be recorded by the Board Secretary (or nominee) and agreed with the sub-Committee Chair prior to issue in advance of the next meeting. Minutes will be circulated as soon as possible after the meeting.

Once approved by the sub-Committee at its subsequent meeting, the minutes will be submitted to the Strategic Performance and Finance Committee and Trust Board for noting.

8.0 DECLARATION OF INTEREST

The sub-Committee Chair shall ask Members to declare any actual or potential conflict of interest on any matter listed on the agenda for consideration at the outset of each meeting.

Where a conflict arises during the course of the meeting, the Member(s) with the conflict should declare their interest immediately and withdraw for the duration of the discussion on the relevant item(s) of business.

All stated declarations of interest made during each meeting shall be recorded in the minutes.

Northern Ireland Ambulance Service
Health and Social Care Trust

Strategic Performance and Finance (SPF) Committee

TERMS OF REFERENCE

February 2025

CONTENTS

1.0 ESTABLISHMENT

The Board of the Northern Ireland Ambulance Service Health & Social Care Trust (the Trust) has established the Strategic Performance and Finance Committee.

The Committee has no executive powers other than those specifically delegated by the Board and detailed within these Terms of Reference.

2.0 MEMBERSHIP

The membership of the Committee shall be determined by Trust Board and appointments made from amongst its membership.

A full list of Committee Members as of the date of these Terms of Reference can be found in Appendix 1.

The Committee Chair shall be a Non-Executive Director appointed by the Chair of Trust Board and will hold office for a term specified on appointment or until such time as the Chair of Trust Board determines otherwise.

The Committee Chair will cease to act as Chair if they are no longer a Non-Executive Director or if they notify the Chair of Trust Board in writing that they no longer wish to continue in the role as Committee Chair.

A quorum shall be two Non-Executive Directors including the Committee Chair.

In the absence of the Committee Chair, another Non-Executive Member may temporarily act as Chair for a meeting of the Committee by agreement of the other Non-Executive Directors present.

3.0 ATTENDANCE

All Executive Directors may be in attendance at meetings of the Committee (where required).

If an Executive Director who is required is unavailable to attend, he/she can nominate a senior manager to attend in their absence by recording an apology in advance with the Board Secretary and providing details of the proposed substitute no later than three working days prior to the date of the scheduled meeting.

The Assistant Director for Governance, Risk and Assurance/Board Secretary (or nominee) will be in attendance at meetings of the Committee (where required).

4.0 FREQUENCY OF MEETINGS

The Committee shall meet at least three times annually.

Members must attend a minimum of two meetings during the course of the year.

5.0 AUTHORITY (including escalation to Trust Board)

The Committee is authorised by Trust Board to undertake and investigate any activity stated within these Terms of Reference.

The Committee is further authorised to obtain legal or other independent professional advice and to secure the attendance of other relevant external parties if it considers this necessary in order to fulfil its remit.

The Committee Chair shall draw to the attention of Trust Board any issues that require disclosure to the full Board or may require executive action by the Chief Executive and/or wider Senior Management Team. In addition, the Committee has authority to formally escalate any issues Members determine require notification to, or further consideration by, Trust Board.

6.0 REMIT

The Committee shall embed the Trust's vision and values in conducting its business.

The Committee has delegated oversight responsibility to ensure Trust Board delivers its statutory responsibility to "break-even".

Performance reports will be considered by the Committee to seek assurance about Trust performance compared to the Service Delivery Plan and associated targets, key performance indicators and trajectories.

The Committee will:

- Review the Trust's financial strategy in detail to be able to confirm to Trust Board the basis of acceptance.
- Review financial monitoring information and provide Trust Board with an assessment of its confidence in respect of the financial performance of the Trust.
- Keep Trust Board up to date regarding the financial outlook, and to review the key financial assumptions used in estimating projected position(s).
- Review the progress of any cost saving measures in line with submitted plans.
- Ensure that actions and controls are put in place to ensure effective and sound financial management in the Trust.
- Consider and approve Capital Business Cases.
- Review activity and other monitoring information relevant to performance of the organisation.
- Review performance against delivery of the Trust's Corporate Plan and annual priorities.

- Seek assurance from other Committees of the Board about aspects of Trust performance within their remit.

- Monitor, assess and respond to the information presented to it in respect of the Trust's strategic objectives relating to finance and performance, including external factors and any potential impact on the organisation.

- Ensure that suitable plans are in place to monitor performance against agreed targets.

- Ensure that Trust Board is provided with a holistic view of Trust performance including any specific challenges, mitigating actions and recovery plans.

- Monitor progress against performance improvement plans.

7.0 OPERATIONAL ARRANGMENTS

Administrative Support to the Committee

The Committee shall be supported administratively by the Board Secretary (or nominees) whose duties in this respect include:

- Preparation and issue of an agenda on behalf of the Chair;
- Collation and distribution of papers to Members in advance of each meeting;
- Taking minutes and keeping a record of matters arising;
- Maintaining a record of attendance at Committee meetings;
- Advising the Committee on pertinent issues;
- Assisting the Chair in ensuring the effective operation of the Committee;
- Arranging attendance of appropriate staff at meetings;
- Ensuring these Terms of Reference are reviewed and updated annually; and
- Developing and maintaining the Committee's meeting schedule.

Conduct of Meetings

All procedural matters in respect of conduct of meetings of the Committee shall be in accordance with the Trust's Standing Orders.

All questions arising will be decided by a simple majority of Members of the Committee. In the case of equal votes, the Chair will have a casting vote.

Agenda Items and Papers for Meetings

The Board Secretary (or nominee) will issue the agenda and associated papers for each meeting no later than five days prior to the date of the scheduled meeting, to provide Members and those in attendance the opportunity to read information in advance.

Papers may be accepted and distributed within five days of the date of scheduled meeting at the discretion of the Committee Chair.

Minutes of Meetings

The minutes of the Committee shall be recorded by the Board Secretary (or nominee) and agreed with the Committee Chair prior to issue in advance of the next meeting. Minutes will be circulated as soon as possible after the meeting.

Once approved by the Committee at its subsequent meeting, the minutes will be submitted to Trust Board for noting.

8.0 DECLARATION OF INTEREST

The Committee Chair shall ask Members to declare any actual or potential conflict of interest on any matter listed on the agenda for consideration at the outset of each meeting.

Where a conflict arises during the course of the meeting, the Member(s) with the conflict should declare their interest immediately and withdraw for the duration of the discussion on the relevant item(s) of business.

All stated declarations of interest made during each meeting shall be recorded in the minutes.

Northern Ireland Ambulance Service
Health and Social Care Trust

People, Culture and Organisational Development Committee (PCOD)

TERMS OF REFERENCE

February 2025

CONTENTS

1.0 ESTABLISHMENT

The Board of the Northern Ireland Ambulance Service Health & Social Care Trust (the Trust) has established the People, Culture and Organisational Development Committee.

The Committee has no executive powers other than those specifically delegated by the Board and detailed within these Terms of Reference.

2.0 MEMBERSHIP

The membership of the Committee shall be determined by Trust Board and appointments made from amongst its membership.

A full list of Committee Members as of the date of these Terms of Reference can be found in Appendix 1.

The Committee Chair shall be a Non-Executive Director appointed by the Chair of Trust Board and will hold office for a term specified on appointment or until such time as the Chair of Trust Board determines otherwise.

The Committee Chair will cease to act as Chair if they are no longer a Non-Executive Director or if they notify the Chair of Trust Board in writing that they no longer wish to continue in the role as Committee Chair.

A quorum shall be two Non-Executive Directors including the Committee Chair.

In the absence of the Committee Chair, another Non-Executive Member may temporarily act as Chair for a meeting of the Committee by agreement of the other Non-Executive Directors present.

3.0 ATTENDANCE

All Executive Directors may be in attendance at meetings of the Committee (where required).

If an Executive Director who is required is unavailable to attend, he/she can nominate a senior manager to attend in their absence by recording an apology in advance with the Board Secretary and providing details of the proposed substitute no later than three working days prior to the date of the scheduled meeting.

The Assistant Director for Governance, Risk and Assurance/Board Secretary (or nominee) will be in attendance at meetings of the Committee (where required).

4.0 FREQUENCY OF MEETINGS

The Committee shall meet at least three times annually.

Members must attend a minimum of two meetings during the course of the year.

5.0 AUTHORITY (including escalation to Trust Board)

The Committee is authorised by Trust Board to undertake and investigate any activity stated within these Terms of Reference.

The Committee is further authorised to obtain legal or other independent professional advice and to secure the attendance of other relevant external parties if it considers this necessary in order to fulfil its remit.

The Committee Chair shall draw to the attention of Trust Board any issues that require disclosure to the full Board or may require executive action by the Chief Executive and/or wider Senior Management Team. In addition, the Committee has authority to formally escalate any issues Members determine require notification to, or further consideration by, Trust Board.

6.0 REMIT

The Committee shall embed the Trust's vision and values in conducting its business.

The Committee has responsibility for providing assurance to Trust Board regarding all strategic issues relating to Human Resources, workforce and organisational development to deliver the Trust's strategic objectives and other plans as determined by Trust Board.

The Committee will:

- Provide assurance to the Board on the effectiveness of the Trust's arrangements for managing people and culture and that all issues relating to Human Resources are regularly reviewed.

- Monitor, assess and respond to the information presented to it in respect of the Trust's strategic objectives relating to people and culture, including external factors and any potential impact on the organisation.

- Monitor the implementation of the Trust's programmes of work on people, culture and organisational development ensuring they are aligned to the Trust's Strategic Objectives and regional HSC workforce strategies and policies.

- Monitor and seek assurances on programmes of work put in place in respect of the Trust's culture, including workplans to develop the organisation's values, behaviours and attitudes.

- Give consideration to all items presented at the Committee and seek, and receive, regular reports on the activities within the scope of the Committee.

- Review and seek assurances on Trust performance in respect of people and culture, including absence management.

- Consider the implications for people and culture from other significant external and internal assurance functions such as relevant reviews by the Department of Health (DoH), other DoH ALB or commissioned bodies, the Regulation and Quality Improvement Authority (RQIA), the Equality Commission for NI, the NI Human Rights Commission or professional bodies with responsibility for the performance of staff or functions (e.g. Joint Royal Colleges Ambulance Liaison Committee and other accreditation bodies, etc.).

7.0 OPERATIONAL ARRANGMENTS

Administrative Support to the Committee

The Committee shall be supported administratively by the Board Secretary (or nominees) whose duties in this respect include:

- Preparation and issue of an agenda on behalf of the Chair;
- Collation and distribution of papers to Members in advance of each meeting;
- Taking minutes and keeping a record of matters arising;
- Maintaining a record of attendance at Committee meetings;
- Advising the Committee on pertinent issues;
- Assisting the Chair in ensuring the effective operation of the Committee;
- Arranging attendance of appropriate staff at meetings;
- Ensuring these Terms of Reference are reviewed and updated annually; and
- Developing and maintaining the Committee's meeting schedule.

Conduct of Meetings

All procedural matters in respect of conduct of meetings of the Committee shall be in accordance with the Trust's Standing Orders.

All questions arising will be decided by a simple majority of Members of the Committee. In the case of equal votes, the Chair will have a casting vote.

Agenda Items and Papers for Meetings

The Board Secretary (or nominee) will issue the agenda and associated papers for each meeting no later than five days prior to the date of the scheduled meeting, to provide Members and those in attendance the opportunity to read information in advance.

Papers may be accepted and distributed within five days of the date of scheduled meeting at the discretion of the Committee Chair.

Minutes of Meetings

The minutes of the Committee shall be recorded by the Board Secretary (or nominee) and agreed with the Committee Chair prior to issue in advance of the next meeting. Minutes will be circulated as soon as possible after the meeting.

Once approved by the Committee at its subsequent meeting, the minutes will be submitted to Trust Board for noting.

8.0 DECLARATION OF INTEREST

The Committee Chair shall ask Members to declare any actual or potential conflict of interest on any matter listed on the agenda for consideration at the outset of each meeting.

Where a conflict arises during the course of the meeting, the Member(s) with the conflict should declare their interest immediately and withdraw for the duration of the discussion on the relevant item(s) of business.

All stated declarations of interest made during each meeting shall be recorded in the minutes.

Northern Ireland Ambulance Service
Health and Social Care Trust

Governance, Audit and Risk Assurance Committee (GARAC)

TERMS OF REFERENCE

February 2025

CONTENTS

1.0 ESTABLISHMENT

The Board of the Northern Ireland Ambulance Service Health and Social Care Trust (the Trust) has established the Governance, Audit and Risk Assurance Committee.

The Committee has no executive powers other than those specifically delegated by the Board and detailed within these Terms of Reference.

2.0 MEMBERSHIP

The membership of the Committee shall be determined by Trust Board and appointments made from amongst its membership.

A full list of Committee Members as of the date of these Terms of Reference can be found in Appendix 1.

The Committee Chair shall be a Non-Executive Director appointed by the Chair of Trust Board and will hold office for a term specified on appointment or until such time as the Chair of Trust Board determines otherwise.

The Committee Chair will cease to act as Chair if they are no longer a Non-Executive Director or if they notify the Chair of Trust Board in writing that they no longer wish to continue in the role as Committee Chair.

A quorum shall be two Non-Executive Directors including the Committee Chair.

In the absence of the Committee Chair, another Non-Executive Member may temporarily act as Chair for a meeting of the Committee by agreement of the other Non-Executive Directors present.

3.0 ATTENDANCE

The Director of Finance and Director of Planning, Performance and Corporate Services will attend meetings of the Committee. Other Directors may be in attendance at meetings of the Committee (where required).

The Chief Executive will attend meetings of the Committee regularly.

If an Executive Director who is required is unavailable to attend, he/she can nominate a senior manager to attend in their absence by recording an apology in advance with the Board Secretary and providing details of the proposed substitute no later than three working days prior to the date of the scheduled meeting.

The Assistant Director for Financial Services and Assistant Director for Governance, Risk and Assurance/Board Secretary (or nominee) will be in attendance at meetings of the Committee (where required).

A representative(s) from External and Internal Audit will be in attendance at every meeting.

4.0 FREQUENCY OF MEETINGS

The Committee shall meet at least three times annually.

Members must attend a minimum of two meetings during the course of the year.

5.0 AUTHORITY (including escalation to Trust Board)

The Committee is authorised by Trust Board as an independent Committee to undertake and investigate any activity stated within these Terms of Reference.

The Committee is further authorised to obtain legal or other independent professional advice and to secure the attendance of other relevant external parties if it considers this necessary in order to fulfil its remit.

The Committee Chair shall draw to the attention of Trust Board any issues that require disclosure to the full Board or may require executive action by the Chief Executive and/or wider Senior Management Team. In addition, the Committee has authority to formally escalate any issues Members determine require notification to, or further consideration by, Trust Board.

6.0 REMIT

The Committee shall embed the Trust's vision and values in conducting its business.

The Committee will ensure that the system of integrated governance and internal control across the Trust's activities is effective in supporting achievement of its objectives.

The Committee shall ensure that there is an effective internal audit function established by management that meets the Government Internal Audit Standards and provides appropriate independent assurance to the Chief Executive and Board.

The Committee shall review the work and findings of the External Auditor appointed by the NI Audit Office and consider the implications of, and management's responses to, their work.

The Head of Internal Audit and the External Auditor will have free and confidential access to the Chair of the Committee as required.

The Committee will:

- Maintain and seek assurance from the Safety, Quality and Patient Experience Committee for all matters pertaining to safety, quality and improvement (including clinical and social care governance).

- Maintain and seek assurance on all matters pertaining to integrated governance including Corporate Governance, Risk Management & Organisational Controls.

- Maintain and seek assurance on the processes in place to manage and control the principal risks to the Trust and will review and approve the Corporate Risk Register, prior to it being considered by Trust Board.

- Give consideration to all items presented at the Committee and seek, and receive, regular reports on the activities within the scope of the Committee.

- Review the adequacy of assurance processes in the Trust and the effectiveness of the Board Assurance Framework.

- Review and seek assurances on Trust performance in respect of Information Governance and Cyber Security.

- Review and seek assurances on arrangements to reduce the risk of fraud.

- Review the adequacy of policies, Standing Orders and Standing Financial Instructions in terms of compliance with regulatory, legal and code of conduct requirements, including those related to fraud and corruption as required by the Counter Fraud Policy Unit.

- Review any decisions taken by Trust Board to suspend Standing Orders.

- Review and approve all governance, risk management and control related disclosure statements (including the Head of Internal Audit statement, external audit opinion or other appropriate independent assurances), prior to endorsement by the Board.

- Identify priority areas for internal audit and will approve the Internal Audit strategy, operational plan and detailed programme of work, ensuring they are consistent with the audit needs of the organisation, are effective and resourced appropriately."

- Consider the Chief Internal Auditor's annual report, major findings of internal audit work (and management's response) and ensure co-ordination between the Internal and External Auditors to optimise audit resources.

- Discuss with the External Auditor the audit strategy for the annual report and accounts including the key risks identified.

- Consider all External Audit reports and the appropriateness of management's response before submission to Trust Board.

- Review the Trust's Annual Report and Accounts and the Charitable Trust Funds Annual Report and Accounts before submission to the Board.

- Meet privately in the absence of Officers as part of each Committee meeting.

- Consider the implications for integrated governance arising from other significant external and internal assurance functions such as relevant reviews by the Department of Health (DoH), other DoH ALB or commissioned bodies, the Regulation and Quality Improvement Authority (RQIA) or professional bodies with responsibility for the performance of staff or functions (e.g., Joint Royal Colleges Ambulance Liaison Committee and other accreditation bodies, etc.).

7.0 OPERATIONAL ARRANGMENTS

Administrative Support to the Committee

The Committee shall be supported administratively by the Board Secretary (or nominees) whose duties in this respect include:

- Preparation and issue of an agenda on behalf of the Chair;
- Collation and distribution of papers to Members in advance of each meeting;
- Taking minutes and keeping a record of matters arising;

- Maintaining a record of attendance at Committee meetings;
- Advising the Committee on pertinent issues;
- Assisting the Chair in ensuring the effective operation of the Committee;
- Arranging attendance of appropriate staff at meetings;
- Ensuring these Terms of Reference are reviewed and updated annually; and
- Developing and maintaining the Committee's meeting schedule.

Conduct of Meetings

All procedural matters in respect of conduct of meetings of the Committee shall be in accordance with the Trust's Standing Orders.

All questions arising will be decided by a simple majority of Members of the Committee. In the case of equal votes, the Chair will have a casting vote.

Agenda Items and Papers for Meetings

The Board Secretary (or nominee) will issue the agenda and associated papers for each meeting no later than five days prior to the date of the scheduled meeting, to provide Members and those in attendance the opportunity to read information in advance.

Papers may be accepted and distributed within five days of the date of scheduled meeting at the discretion of the Committee Chair.

Minutes of Meetings

The minutes of the Committee shall be recorded by the Board Secretary (or nominee) and agreed with the Committee Chair prior to issue in advance of the next meeting. Minutes will be circulated as soon as possible after the meeting.

Once approved by the Committee at its subsequent meeting, the minutes will be submitted to Trust Board for noting.

8.0 DECLARATION OF INTEREST

The Committee Chair shall ask Members to declare any actual or potential conflict of interest on any matter listed on the agenda for consideration at the outset of each meeting.

Where a conflict arises during the course of the meeting, the Member(s) with the conflict should declare their interest immediately and withdraw for the duration of the discussion on the relevant item(s) of business.

All stated declarations of interest made during each meeting shall be recorded in the minutes.

Northern Ireland Ambulance Service
Health and Social Care Trust

Safety, Quality and Patient Experience (SQPE) Committee

TERMS OF REFERENCE

February 2025

CONTENTS

1.0 ESTABLISHMENT

The Board of the Northern Ireland Ambulance Service Health & Social Care Trust (the Trust) has established the Safety, Quality and Patient Experience Committee.

The Committee has no executive powers other than those specifically delegated by the Board and detailed within these Terms of Reference.

2.0 MEMBERSHIP

The membership of the Committee shall be determined by Trust Board and appointments made from amongst its membership.

A full list of Committee Members as of the date of these Terms of Reference can be found in Appendix 1.

The Committee Chair shall be a Non-Executive Director appointed by the Chair of Trust Board and will hold office for a term specified on appointment or until such time as the Chair of Trust Board determines otherwise.

The Committee Chair will cease to act as Chair if they are no longer a Non-Executive Director or if they notify the Chair of Trust Board in writing that they no longer wish to continue in the role as Committee Chair.

A quorum shall be two Non-Executive Directors including the Committee Chair.

In the absence of the Committee Chair, another Non-Executive Member may temporarily act as Chair for a meeting of the Committee by agreement of the other Non-Executive Directors present.

3.0 ATTENDANCE

All Executive Directors may be in attendance at meetings of the Committee (where required).

If an Executive Director who is required is unavailable to attend, he/she can nominate a senior manager to attend in their absence by recording an apology in advance with the Board Secretary and providing details of the proposed substitute no later than three working days prior to the date of the scheduled meeting.

The Assistant Director for Governance, Risk and Assurance/Board Secretary (or nominee) will be in attendance at meetings of the Committee (where required).

4.0 FREQUENCY OF MEETINGS

The Committee shall meet at least three times annually.

Members must attend a minimum of two meetings during the course of the year.

5.0 AUTHORITY (including escalation to Trust Board)

The Committee is authorised by Trust Board to undertake and investigate any activity stated within these Terms of Reference.

The Committee is further authorised to obtain legal or other independent professional advice and to secure the attendance of other relevant external parties if it considers this necessary in order to fulfil its remit.

The Committee Chair shall draw to the attention of Trust Board any issues that require disclosure to the full Board or may require executive action by the Chief Executive and/or wider Senior Management Team. In addition, the Committee has authority to formally escalate any issues Members determine require notification to, or further consideration by, Trust Board.

6.0 REMIT

The Committee shall embed the Trust's vision and values in conducting its business.

The Committee will be responsible for assuring Trust Board that effective clinical and non-clinical governance arrangements are in place and that processes to identify and manage risks are effective.

The Committee will:

- Ensure that the Trust's assurance processes in respect of clinical and non-clinical activities are adequate to meet the Trust's objectives, and that associated risks are identified and escalated, where necessary, to Trust Board.

- Seek assurance from Executive Directors covering all aspects of quality, safety and patient experience.

- Review and seek assurances on Trust performance in respect of the identification and management of clinical and non-clinical Adverse Incidents, Serious Adverse Incidents, Complaints and Compliments.

- Review and seek assurance on Trust delivery against clinical and safety key performance indicators.

- Provide assurance that adequate systems and processes are in place for the delivery of high-quality patient care that is safe, effective and patient focused.

- Monitor, assess and respond to the information presented to it in respect of the Trust's strategic objectives relating to safety and quality, including external factors and any potential impact on the organisation.

- Review implementation and continued compliance with quality/risk related standards e.g. NICE, NPSA.

- Support a learning culture across the Trust to ensure high quality service delivery and patient safety.

- Seek assurance that action plans developed as a result of external reviews/reports are being progressed and implemented.

- Monitor the implementation of the Trust's Quality Strategy and approve this Strategy before it being presented to Trust Board.

- Oversee development of quality improvement programmes and projects.

- Consider the implications for safety and quality from other significant external and internal assurance functions such as relevant reviews by the Department of Health (DoH), other DoH ALB or commissioned bodies, the Regulation and Quality Improvement Authority (RQIA) or professional bodies with responsibility for the performance of staff or functions (e.g. Joint Royal Colleges Ambulance Liaison Committee and other accreditation bodies, etc.).

7.0 OPERATIONAL ARRANGMENTS

Administrative Support to the Committee

The Committee shall be supported administratively by the Board Secretary (or nominees) whose duties in this respect include:

- Preparation and issue of an agenda on behalf of the Chair;
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- Taking minutes and keeping a record of matters arising;
- Maintaining a record of attendance at Committee meetings;
- Advising the Committee on pertinent issues;

- Assisting the Chair in ensuring the effective operation of the Committee;
- Arranging attendance of appropriate staff at meetings;
- Ensuring these Terms of Reference are reviewed and updated annually; and
- Developing and maintaining the Committee's meeting schedule.

Conduct of Meetings

All procedural matters in respect of conduct of meetings of the Committee shall be in accordance with the Trust's Standing Orders.

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Once approved by the Committee at its subsequent meeting, the minutes will be submitted to Trust Board for noting.

8.0 DECLARATION OF INTEREST

The Committee Chair shall ask Members to declare any actual or potential conflict of interest on any matter listed on the agenda for consideration at the outset of each meeting.

Where a conflict arises during the course of the meeting, the Member(s) with the conflict should declare their interest immediately and withdraw for the duration of the discussion on the relevant item(s) of business.

All stated declarations of interest made during each meeting shall be recorded in the minutes.

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

PRESENTATION OF PAPER

Date of Trust Board:	20 February 2025
Title of paper:	**Standing Orders Review**
Brief summary:	The Trust's Standing Orders have been reviewed (last review date was September 2023). Several amendments are suggested to reflect the updated Board Committee structure and to simplify wording and approach in some areas. The Belfast, Western and Southern HSC Trust Standing Orders were used to help inform the review. A summary outline of the key proposed changes is provided. The revisions to the Standing Orders were reviewed and approved in principle at ARAC on 6 February 2025.
Recommendation:	**For Approval** ☒ **For Noting** ☐
Previous forum:	SMT – 28 January 2025 ARAC – 6 February 2025
Prepared and presented by:	Maxine Paterson, Director for Planning and Performance and Corporate Services
Date:	13 February 2025

NIAS Standing Orders Review February 2025

Summary of Proposed Changes

The key changes proposed following a review of the Standing Orders are:

- Adjusting the names of Committees to reflect the proposed revisions to the Board Committee structure and terms of reference.

- Wording changes to reflect the new Committee structure, for example at paragraph 1.2.3 and in Section C – Scheme of Reservation and Delegation.

- Removing the Committee terms of reference from the Standing Order appendices and managing these as standalone documents, to assist with version control.

- Amending wording relating to the appointment of the Chair and Non-Executive Directors as follows: "[they are appointed] by the Minster for Health through the DoH Public Appointments Unit ~~in accordance with the relevant legislation~~" to reflect wording in other HSC Trust Standing Orders.

- Simplifying the wording at 3.2.5 in respect of publicising notice of Board meetings to "Members of the public and staff will be advised of the date and time of all meetings through a notice on the Trust website." (paragraph 3.2.5).

- Clarifying the arrangements should the Trust Board Chair be absent for any reason at section 3.9 as follows:

  "3.9.1 At any meeting of the Trust Board, the Chair shall preside. In the Chair's absence, a Non-Executive Member who has been predesignated by the Chair will deputise as Chair for the meeting.

  3.9.1 Alternatively, if a Non-Executive Member has not been predesignated, the Non-Executive members present may choose a member to act as Chair for the meeting."

- Suggested amendment to the quoracy of Trust Board at 3.11.1 as follows:

  "No decisions may be taken at a meeting unless at least two Non-Executive Director Members and two Executive Director Members who have voting rights) are present."

- Simplifying wording at paragraph 3.16.2 in respect of the tabling of Committee meeting minutes at Trust Board: "The approved minutes of meetings of Committees constituted by the Board will be presented at meetings of Trust Board for information, along with a written report from the Chair of the Committee."

- Removing the following from paragraph 3.17.4 "In order to avoid undue disruption to Board meetings, television crews/press photographers or other media representatives can have access for a maximum of ten minutes prior to the meeting commencing. This will be subject to agreement of the Chair."

- At paragraph 4.4.1 on Committee Terms of Reference, a line has been added: "Each Committee's Terms of Reference will be reviewed annually by the Committee and approved by the Board."

- Removal of the following from Section C – Scheme of Reservation and Delegation, as this does not seem to be a requirement in the Standing Orders of other Trusts and has not been facilitated in practice:

  "In addition, Trust Board will, once per year, be presented with a register detailing the policies, and including such information as review dates and monitoring information, including scrutiny at Committee level. In exceptional circumstances, the Committee Chair or the Trust's Senior Management Team may take a view that the significance of the policy and its impact on the organisation is such that it merits direct consideration by the Trust Board. The Chief Executive will agree this in consultation with the Chair. There may also be regional policies which the Trust Board is required to adopt and these will be considered at Trust Board."

  The Standing Orders still specify that policy approval must come through Committees and onwards to Trust Board.

Northern Ireland Ambulance Service
Health and Social Care Trust

STANDING ORDERS

And

SCHEME OF RESERVATION AND DELEGATION

~~September 2023~~February 2025

Title:	Standing Orders and Scheme of Reservation and Delegation		
Author:	Ms Stacey Beggs ~~rs Carol Mooney~~, Interim Board Secretary		
Ownership:	Ms Maxine Paterson, Director of Planning, Performance and Corporate Services		
Date of Audit Committee Approval:		**Date of Trust Board Approval:**	
Operational Date:	21 October 2021	**Review Date:**	March 2026~~5~~4
Version No:	V3.0	**Supercedes:**	TW/4/Fin (03) 2014
Key words:	Standing Orders, Scheme of Reservation and Delegation, Standing Financial Instructions		
Other Relevant Policies:	Standing Financial Instructions		

Date	Version	Author	Comments
17 June 2019	V0.1	Andrew Phillips	Standing Orders benchmarked with HSC Trusts
18 June 2019	V1.0	Andrew Phillips	Approved at Audit Committee and Trust Board
21 October 2021	V2.0	Carol Mooney	Approved at Audit Committee and Trust Board
9 February 2023	V3.0	Carol Mooney	Approved at ARAC (19/1/23) and Trust Board
24 August 2023	V4.0	Carol Mooney	Amendment approved at Trust Board (24/8/23)

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Commented [NH1]: Suggest deletion of these from Standing Orders and managing as standalone documents.

SECTION A

1. INTERPRETATION AND DEFINITIONS FOR STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS

1.1 Save as otherwise permitted by law, at any meeting, the Chair of the Trust shall be the final authority on the interpretation of Standing Orders (on which they should be advised by the Chief Executive).

1.2 Any expression to which a meaning is given in the HPSS (NI) Order 1991, the Health and Social Care (Reform) Act (Northern Ireland) 2009 and other Acts/Orders relating to the HSC shall have the same meaning in these Standing Orders and Standing Financial Instructions and in addition:

1.2.1 **"Accounting Officer"** means the HSC Officer responsible and accountable for funds entrusted to the Trust. The officer shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive.

1.2.2 **"Trust"** means the Northern Ireland Ambulance Service (NIAS) Health & Social Care Trust.

1.2.3 **"Board"** means the Chair, Executive and Non-Executive members of the Trust collectively as a body.

1.2.4 **"Budget"** means a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.

1.2.5 **"Budget holder"** means the Director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation.

1.2.6 **"Chair of the Board (or Trust)"** is the person appointed by the Minister for Health through the Departmental Public Appointments Unit ~~in accordance with the relevant legislation[1] to lead the Board and~~ to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression "the Chair of the Trust" shall be

Commented [NH2]: Suggested revision

[1] Regulation 3 of the Health and Social Services Trusts (Membership and Procedure) Regulations (Northern Ireland) 1994

deemed to include the member acting as Chair of the Trust if the Chair is absent from the meeting or is otherwise unavailable.

1.2.7 **"Chief Executive"** means the Chief Officer of the Trust. The Chief Executive is the Trust's Accounting Officer.

1.2.8 **"Commissioning"** means the process for determining the need for and for obtaining the supply of healthcare, social care and related services by the Trust within available resources.

1.2.9 **"Committee"** means a Committee or Sub-Committee created and appointed by the Trust.

1.2.10 **"Committee members"** means persons formally appointed by the Board to sit on or to chair specific Committees.

1.2.11 **"Contracting and procuring"** means the systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.

1.2.12 **"Director of Finance"** means the Chief Financial Officer of the Trust.

1.2.13 **"Funds held on trust"** shall mean those funds which the Trust holds on date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under Article 16 of the HPSS (NI) Order 1991. Such funds may or may not be charitable.

1.2.14 **"Member"** means Executive or Non-Executive member of the Board as the context permits. Member, in relation to the Board, includes its Chair.

1.2.15 **"Associate Member"** means a person appointed to perform specific statutory and non-statutory duties which have been delegated by the Trust Board for them to perform and these duties have been recorded in an appropriate Trust Board minute or other suitable record.

1.2.16 **"Membership, Procedure and Administration Arrangements Regulations"** means HSS Trusts (Membership and Procedure) Regulations (Northern Ireland) 1994.

1.2.17 **"Nominated officer"** means an officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.

1.2.18 **"Officer"** means employee of the Trust or any other person holding a paid appointment or office with the Trust.

1.2.19 ~~"**Audit and Risk Assurance Committee**" means a Committee whose primary role is to independently contribute to the Board's overall process for ensuring that an effective internal financial control system is maintained.~~

1.2.20 ~~**"People, Finance and Organisational Development Committee"** (People Committee) means a Committee whose functions are concerned with providing assurance in relation to strategic HR issues and the Trust Board's statutory responsibility to break even.~~

1.2.21 ~~"**Remuneration Committee & Terms of Service Committee**" means a Committee whose primary role is to advise the Board about appropriate remuneration and terms of service for the Chief Executive and all other direct reports to the Chief Executive.~~

1.2.22 ~~**"Safety, Quality, Patient Experience and Performance Committee"** (Safety Committee) means a Committee whose functions are concerned with the arrangements for the purpose of monitoring and improving the quality and safety of health and social care for which the Northern Ireland Ambulance Service Health and Social Care Trust has responsibility.~~

1.2.23 **"Secretary"** means a person appointed to act independently of the Board to provide advice on corporate governance issues to the Board and the Chair and monitor the Trust's compliance with the law, Standing Orders, and DoH guidance.

1.2.24 **"SFIs"** means Standing Financial Instructions.

1.2.25 **"SOs"** means Standing Orders.

1.2.26 **"Member acting as Chair"** means the Non-Executive member appointed by the Board to take on the Chair's duties if the Chair is absent for any reason.

Commented [NH3]: The Committee roles/remit are described in section 4.8

1.2.27 **"DoH"** means the Department of Health.

1.2.28 "**SPPG**" means Strategic Planning and Performance Group.

1.2.29 "**PHA**" means Public Health Agency.

SECTION B – STANDING ORDERS

1. INTRODUCTION

1.1 Statutory Framework

The Northern Ireland Ambulance Service (NIAS) HSC Trust (the Trust) is a statutory body which came into existence on 1 April 1995 under the Northern Ireland Ambulance Service Health and Social Services Trust (Establishment) Order (Northern Ireland) 1995.

1.1.1 The principal place of business of the Trust is Northern Ireland Ambulance Service, Headquarters, Site 30, Knockbracken Healthcare Park, Saintfield Road, Belfast, BT8 8SG.

1.1.2 HSC Trusts are provided for under Article 10(1) of the Health and Personal Social Services (NI) Order 1991 and subsequently amended under Health and Social Care (Reform) Act (Northern Ireland) 2009.

1.1.3 The functions of the Trust are conferred by this legislation.

1.1.4 As a statutory body, the Trust has specified powers to contract in its own name and to act as a corporate trustee.

1.1.5 Schedule 3 of the HPSS (NI) Order 1991 specifies the duties, powers and status of HSC Trusts.

1.1.6 The Codes of Conduct and Accountability (October 2022) require the Trust to adopt Standing Orders for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions (SFIs) as part of Standing Orders setting out the responsibilities of individuals.

1.1.7 The Trust will also be bound by such other statutes and legal provisions which govern the conduct of its affairs.

1.2 Health and Social Care Framework

1.2.1 In addition to the statutory requirements, the Minister for Health, through the DoH, issues further directions and guidance. These are normally issued under cover of a circular or letter.

1.2.2 The Codes of Conduct and Accountability require that, among other things, Boards draw up a schedule of decisions reserved to the Board, and ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives (a scheme of delegation). The Code also requires the establishment of Audit and Remuneration Committees with formally agreed terms of reference. The Standards of Business Conduct make various requirements concerning possible conflicts of interest of Board members.

1.2.3 The Trust will produce and publish an annual report for each financial year within the timescales set by the DoH. The Annual Report will identify the Chair, Chief Executive and Non-Executive Directors, as well as the Chair and members of the Governance, Audit, and Risk Assurance Committee, and the Chair and members of other committees constituted by the Trust Board. ~~Safety, People and Remuneration Committees.~~ It will also set out the numbers of meetings of the Board and ~~those~~ cCommittees and ~~individual~~ records of attendance by members.

Commented [NH4]: Changes to reflect revised TORs

1.2.4 The Trust will comply with all statutory requirements and Departmental directions, including the DoH Framework Document, Management Statement and Financial Memorandum, the Codes of Conduct and Accountability for Board Members of Health and Social Care bodies (October 2022) and other Codes of Conduct and directions as these apply to the functions, activities and conduct of Boards of Health and Social Care Trusts. Where these are updated or replaced, the new provisions and requirements will apply.

1.3 Delegation of Powers

1.3.1 The Trust has powers to delegate and make arrangements for delegation. The Standing Orders set out the detail of these arrangements. Under the Standing Order relating to the Arrangements for the Exercise of Trust Functions by Delegation (SO 5) the Trust is given powers to "make arrangements for the exercise, on behalf of the Trust of any of their functions by a committee, sub-committee or joint committee appointed by virtue of Standing Order 4 or by an officer of the Trust, in each case subject to such restrictions

and conditions as the Trust thinks fit or as the Minister for Health may direct". Delegated Powers are covered in Section C of this document – Scheme of Reservation and Delegation.

1.4 Governance

1.4.1 Trust Boards are required to have in place integrated governance structures and arrangements that will lead to good governance and to ensure that decision-making is informed by intelligent information covering the full range of corporate, financial, clinical, social care, information and research governance aspects. This will better enable the Board to take a holistic view of the organisation and its capacity to meet its legal and statutory requirements and clinical, social care, quality, safety and financial objectives.

2. THE TRUST BOARD: COMPOSITION OF MEMBERSHIP, TENURE AND ROLE OF MEMBERS

2.1 Composition of the Membership of the Trust Board

In accordance with The Northern Ireland Ambulance Service Health and Social Services Trust (Establishment) Order (NI) 1995, the composition of the Board shall be:

2.1.1 The Chair of the Trust (appointed by the Minister for Health through the ~~in accordance with the relevant legislation (following a recruitment process overseen by the~~ DoH Public Appointments Unit~~)~~).

2.1.2 Up to five Non-Executive members (appointed by the Minister for Health through the DoH Public Appointments Unit).

2.1.3 Up to five Executive members (but not exceeding the number of Non-Executive members) including:

(a) the Chief Executive; and

(b) the Director of Finance;

The Trust Board shall have not less than eight members (unless otherwise determined by the Minister for Health and set out in the Trust's Establishment Order or such other communication from DoH).

2.2 Appointment of Chair and Members of the Trust

2.1.1 The Chair and Non-Executive Directors of the Trust are appointed by the DoH Public Appointments Unit following approval by the Minister for Health ~~in accordance with the relevant legislation~~.

2.3 Terms of Office of the Chair and Members

2.3.1 The regulations setting out the period of tenure of office of the Chair and members and for the termination or suspension of office of the Chair and members are contained in Part 2, Articles 7 - 9 of the HSS Trusts (Membership and Procedure) Regulations (NI) 1994.

2.4 Appointment and Powers of Vice-Chair

Commented [NH5]: To reflect above change

Commented [NH6]: To reflect above change

2.4.1 Subject to Standing Order 2.4.2 below, the Chair and members of the Trust may appoint one of their numbers, who is not also an Executive member, to be Vice-Chair, for such period, not exceeding the remainder of his term as a member of the Trust, as they may specify on appointing him/her.

2.4.2 Any member so appointed may at any time resign from the office of Vice-Chair by giving notice in writing to the Chair. The Chair and members may thereupon appoint another member as Vice-Chair in accordance with the provisions of Standing Order 2.4.1.

2.4.3 Where the Chair of the Trust has died or has ceased to hold office, or where they have been unable to perform their duties as Chair owing to illness or any other cause, the Vice-Chair shall act as Chair until a new Chair is appointed or the existing Chair resumes their duties, as the case may be; and references to the Chair in these Standing Orders shall, so long as there is no Chair able to perform those duties, be taken to include references to the Vice-Chair.

2.5 Joint Members

2.5.1 Where more than one person is appointed jointly to a post mentioned in Part 2, regulation 6 of the HSS Trusts (Membership and Procedure) Regulations (NI) 1994, those persons shall count for the purpose of Standing Order 2.1 as one person.

2.5.2 Where the office of a member of the Board is shared jointly by more than one person:

(a) Either or both of those persons may attend or take part in meetings of the Board;

(b) If both are present at a meeting they should cast one vote if they agree;

(c) In the case of disagreements, no vote should be cast;

(d) The presence of either or both of those persons should count as the presence of one person for the purposes of Standing Order 3.11 Quorum.

2.6 Role of Members

The Board will function as a corporate decision-making body. Executive and Non-Executive members will be full and equal members. Their role as members of the Trust Board will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions.

2.6.1 Chair

The Chair shall be responsible for the operation of the Board and chair all Board meetings when present. The Chair has certain delegated executive powers. The Chair must comply with the terms of appointment and with these Standing Orders.

The Chair shall liaise with the DoH Public Appointments Unit over the appointment of Non-Executive Directors and, once appointed, shall take responsibility for their induction, their portfolios of interests and assignments, and their performance.

The Chair shall work closely with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.

The Chair is responsible for leading the Board and for ensuring that it successfully discharges its overall responsibility for the organisation as a whole. The Chair is accountable to the Minister through the Departmental Accounting Officer. The Chair shall ensure that the Trust's policies and actions support the wider strategic policies of the Minister and that the Trust's affairs are conducted with probity.

The Chair has a particular leadership responsibility on:-

- Formulating the Board's strategy for discharging its duties;
- Ensuring that the Board, in reaching decisions, takes proper account of guidance provided by the Minister, the sponsor department, the SPPG or the PHA;
- Ensuring that risk management is regularly and formally considered at Board meetings;
- Promoting the efficient, economic and effective use of staff and other resources;
- Encouraging and delivering high standards of regularity and propriety;
- Representing the views of the Board to the general public;

- Ensuring that the Board meets at regular intervals throughout the year and that the minutes of meetings accurately record the decisions taken and, where appropriate, the views of individual Board members.

The Chair shall also:

- Ensure that all members of the Board, when taking up office, are fully briefed on the terms of their appointment and on their duties, rights and responsibilities, and receive appropriate induction training, including on the financial management and reporting requirements of public sector bodies and on any differences which may exist between private and public sector practice;
- Advise the DoH of the needs of the Trust when Board vacancies arise, with a view to ensuring a proper balance of professional, financial or other expertise;
- Assess the performance of individual Board members. Board Members will be subject to ongoing performance appraisal, with a formal assessment being completed in consultation with Committee Chairs as appropriate by the Chair of the Board at the end of each year and prior to any proposed re- appointment or extension of the term of appointment of individual members taking place. Members will be made aware that they are being appraised, the standards against which they will be appraised, and will have an opportunity to contribute to and view their report. The Chair of the Board will also be appraised on an annual basis by the DoH.
- Ensure the completion of the Board Governance Self-Assessment Tool on an annual basis. Assurance will be provided through the mid-year assurance statement that the tool is being completed, actions are being addressed and that any exception issues will be raised with the DoH.
- The Chair shall also ensure that Trust Board members are made aware of the Code of Conduct for Board Members of HSC Bodies (October 2022) including the Nolan "seven principles of public life", and the requirement for a comprehensive and publicly available register of Board Members' Interests. Communications between the Board, the Minister and the DoH shall normally be through the Chair. The Chair shall ensure that the other Board members are kept informed of such communications on a timely basis.

2.6.2 Non-Executive Members

The Non-Executive Members shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may however, exercise collective authority when acting as members of or when chairing a Committee of the Trust which has delegated powers.

2.6.3 Executive Members

Executive Members shall exercise their authority within the terms of these Standing Orders, the Scheme of Delegation and the Standing Financial Instructions.

2.6.4 Chief Executive

The Chief Executive shall be responsible for the overall performance of the executive functions of the Trust. He/she is the **Accounting Officer** for the Trust and shall be responsible for ensuring the discharge of obligations under Financial Directions and in line with the requirements of the Accounting Officer Memorandum for Trust Chief Executives issued by DoH.

The Chief Executive shall be directly accountable to the Chair and Non-Executive Members of the Board for ensuring Board decisions are implemented, that the organisation works effectively in accordance with government policy and public service values, and for the maintenance of proper financial stewardship. The Chief Executive should be allowed full scope, within clearly defined delegated powers, for action fulfilling the decisions of the Board.

2.6.5 Director of Finance

The Director of Finance shall be responsible for the provision of financial advice to the Trust and to its members and for the supervision of financial control and accounting systems. He/she shall be responsible along with the Chief Executive for ensuring the discharge of obligations under relevant Financial Directions.

2.7 Corporate Role of the Board

2.7.1 All business shall be conducted in the name of the Trust.

2.7.2 All funds received in trust shall be held in the name of the Trust as corporate trustee.

2.7.3 The powers of the Trust established under statute shall be exercised by the Board meeting in public session except as otherwise provided for in Standing Order 3.

2.7.4 The Board shall define and regularly review the functions it exercises on behalf of the Minister for Health.

2.8 Schedule of Matters Reserved to the Board and Scheme of Delegation

2.8.1 The Board may resolve that certain powers and decisions may only be exercised by the Board in formal session. These powers and decisions should be set out in Section C - 'Schedule of Matters Reserved to the Board' and shall have effect as if incorporated into the Standing Orders. Those powers which it has delegated to officers and other bodies are contained in the Scheme of Delegation.

2.9 Lead Roles for Board Members

2.9.1 The Chair will ensure that the designation of lead roles or appointments of Board members as required by DoH or as set out in any statutory or other guidance will be made in accordance with that guidance or statutory requirements (e.g. appointing a Lead Board Member with responsibilities for Infection Control or Child Protection Services etc.).

3. MEETINGS OF THE TRUST BOARD

3.1 Calling Meetings

3.1.1 Ordinary meetings of the Board shall be held at regular intervals at such times and places as the Board may determine. The Board shall determine the minimum number of meetings to be held each year.

3.1.2 The Chair of the Trust may call a meeting of the Board at any time.

3.1.3 One third or more members of the Board may requisition a meeting in writing. If the Chair refuses, or fails, to call a meeting within seven days of a requisition being presented, the members signing the requisition may forthwith call a meeting.

3.2 Notice of Meetings and the Business to be Transacted

3.2.1 Before each meeting of the Board, a written notice specifying the business proposed to be transacted shall be delivered to every member and to everyone on the Board distribution list and posted on the Trust website at least ~~five~~ three working days before the meeting. Lack of service of such a notice on any member shall not affect the validity of a meeting.

Commented [NH7]: Suggested change in line with Belfast Trust and Western Trust SOs

3.2.2 In the case of a meeting called by members in default of the Chair calling the meeting, the notice shall be signed by those members.

3.2.3 No business shall be transacted at the meeting other than that specified on the agenda, or emergency motions allowed under Standing Order 3.6.

3.2.4 A member desiring a matter to be included on an agenda shall make his/her request in writing to the Chair at least 10 working days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 10 working days before a meeting may be included on the agenda at the discretion of the Chair.

3.2.5 ~~Before each meeting of the Board, a public notice in accordance with Circular HSS (PPM) 4/2001 shall be issued detailing the time and place of the meeting. The public part of the agenda shall be posted on the Trust website www.nias.hscni.net at least one week before the meeting (required by section 54 of the Health and Personal Social Services Act (Northern Ireland) 2001).~~
Members of the public and staff will be advised of the date and time of all meetings through a notice on the Trust website.

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Commented [NH8]: Suggested change in line with Belfast Trust SOs

3.3 Agenda and Supporting Papers

3.3.1 The Agenda will be sent to members at least five working days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will be despatched no later than three working days before the meeting, save in emergency.

3.4 Petitions

3.4.1 Where a petition has been received by the Trust, the Chair may include the petition as an item for the agenda of the next meeting, ~~providing it is appropriate for consideration by the Board~~. The Chair shall advise the Board meeting of any petitions received that are not tabled as agenda items, ~~that are not granted and the grounds for refusal~~

Commented [NH9]: Suggested wording changes

3.5 Notice of Motion

3.5.1 Subject to the provision of Standing Orders 3.7 'Motions: Procedure at and during a meeting' and 3.8 'Motions to rescind a resolution', a member of the Board wishing to move a motion shall send a written notice to the Chief Executive who will ensure that it is brought to the immediate attention of the Chair.

3.5.2 The notice shall be delivered at least five ~~clear~~ working days before the meeting. The Chief Executive shall include in the agenda for the meeting all notices so received that are in order and permissible under governing regulations. This Standing Order shall not prevent any motion being withdrawn or moved without notice on any business mentioned on the agenda for the meeting.

Commented [NH10]: Assumed typo "clear"

3.6 Emergency Motions

3.6.1 Subject to the agreement of the Chair, and subject also to the provision of Standing Order 3.7 'Motions: Procedure at and during a meeting', a member of the Board may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Trust Board at the commencement of the business of the meeting as an additional item included in the agenda. The Chair's decision on the inclusion of an item shall be final.

3.7 Motions: Procedure at and during a Meeting

3.7.1 Who may propose

A motion may be proposed by the Chair of the meeting or any member present. It must also be seconded by another member.

3.7.2 Contents of motions

The Chair may exclude from the debate at his/her discretion any such motion of which notice was not given on the notice summoning the meeting other than a motion relating to:

(a) The reception of a report;

(b) Consideration of any item of business before the Trust Board;

(c) The accuracy of minutes;

(d) That the Board proceeds to next business;

(e) That the Board adjourns; and

(f) That the question be now put.

3.7.3 Amendments to motions

A motion for amendment shall not be discussed unless it has been proposed and seconded.

Amendments to motions shall be moved relevant to the motion, and shall not have the effect of negating the motion before the Board.

If there are a number of amendments, they shall be considered one at a time. When a motion has been amended, the amended motion shall become the substantive motion before the meeting, upon which any further amendment may be moved.

3.7.4 Rights of reply to motions

a) Amendments

The mover of an amendment may reply to the debate on their amendment immediately prior to the mover of the original motion, who shall have the right of reply at the close of debate on the amendment, but may not otherwise speak on it.

b) Substantive/Original motion

The member who proposed the substantive motion shall have a right of reply at the close of any debate on the motion.

3.7.5 Withdrawing a motion

A motion, or an amendment to a motion, may be withdrawn.

3.7.6 Motions once under debate

When a motion is under debate, no motion may be moved other than:

(a) An amendment to the motion;

(b) The adjournment of the discussion, or the meeting;

(c) That the meeting proceeds to the next business;

(d) That the question should be now put;

(e) The appointment of an 'ad hoc' committee to deal with a specific item of business;

(f) That a member be not further heard; and

(g) A motion under Section 23(2) of the Local Government Act (NI) 1972 resolving to exclude the public, including the press (see Standing Order 3.17).

In those cases where the motion is either that the meeting proceeds to the 'next business' or 'that the question be now put', in the interests of objectivity, these should only be put forward by a member of the Board who has not taken part in the debate and who is eligible to vote.

If a motion to proceed to the next business or that the question be now put, is carried, the Chair should give the mover of the substantive motion under debate a right of reply, if not already exercised. The matter should then be put to the vote.

3.8 Motions to Rescind a Resolution

3.8.1 Notice of motion to rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the member who gives it and also the signature of three other members, and before

considering any such motion of which notice shall have been given, the Trust Board may refer the matter to any appropriate Committee or the Chief Executive for recommendation.

3.8.2 When any such motion has been dealt with by the Trust Board, it shall not be competent for any Executive Member, other than the Chair, to propose a motion to the same effect within six months. This Standing Order shall not apply to motions moved in pursuance of a report or recommendations of a Committee or the Chief Executive.

3.9 Chair of Meeting

3.9.1 At any meeting of the Trust Board, the Chair shall preside. In the Chair's absence, a Non-Executive Member who has been predesignated by the Chair will deputise as Chair for the meeting.

3.9.1 Alternatively, if a Non-Executive Member has not been predesignated, the Non-Executive members present may choose a member to act as Chair for the meeting. ~~the Chair of Audit and Risk Assurance Committee shall assume the position of Chair.~~

3.9.2 ~~In the absence of the Chair and Chair of the Audit and Risk Assurance Committee, any such member (who is not also an Executive Member of the Trust) as the members present shall choose, shall preside.~~

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Commented [NH11]: Suggested change to align with the information contained in the Definitions Section.

3.10 Chair's Ruling

3.10.1 The decision of the Chair of the meeting on questions of order, relevancy and regularity (including procedure on handling motions) and their interpretation of the Standing Orders and Standing Financial Instructions, at the meeting, shall be final.

3.11 Quorum

3.11.1 No decisions may be taken at a meeting unless at least ~~one-third of the whole number of the Chair and voting members appointed, (including at least one~~ two Non-Executive Director Members and ~~one~~ two Executive Director Members who have voting rights~~)~~ are present.

Commented [NH12]: Suggested changes to quoracy requirements. As written quoracy for a Trust Board meeting would be a lower requirement than that for Committees.

3.11.2 An officer in attendance for an Executive Director Member but without formal acting up status, may not count towards the quorum.

3.11.3 If the Chair or member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (Standing Order 7), that person shall no longer count towards the quorum. If a quorum is then not available for the passing of a resolution on any matter, that matter may be discussed further but not voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting.

3.12 Voting

3.12.1 Save as provided in Standing Orders 3.13 – 'Suspension of Standing Orders' and 3.14 – 'Variation and Amendment of Standing Orders', every question put to a vote at a meeting shall be determined by a majority of the votes of members present and voting on the question. In the case of an equal vote, the person presiding (ie: the Chair of the meeting shall have a second, and casting vote).

3.12.2 At the discretion of the Chair, all questions put to the vote shall be determined by oral expression or by a show of hands, unless the Chair directs otherwise, or it is proposed, seconded and carried that a vote be taken by paper ballot.

3.12.3 If at least one third of the members present so request, the voting on any question may be recorded so as to show how each member present voted or did not vote (except when conducted by paper ballot).

3.12.4 If a member so requests, their vote shall be recorded by name.

3.12.5 In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote.

3.12.6 An Officer ~~manager~~ who has been formally appointed to act up for an ~~Officer~~ Member during a period of incapacity or temporarily to fill an Executive Director vacancy shall be entitled to ~~exercise the voting rights of the Officer Membe~~voter.

3.12.7 An Officer ~~manager~~ attending the Trust Board meeting to represent an ~~Officer~~ Member during a period of incapacity or temporary absence without formal acting up status may not exercise ~~the~~ voting rights ~~of the Officer Member~~. An Officer's status when attending a meeting shall be recorded in the minutes.

Commented [NH13]: Changes to ensure consistent terminology used throughout these paragraphs.

3.12.8 For the voting rules relating to joint members, see Standing Order 2.5.

3.13 Suspension of Standing Orders

3.13.1 Except where this would contravene any statutory provision or any direction made by the Minister for Health or the rules relating to the Quorum (Standing Order 3.11), any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the whole number of the members of the Board are present (including at least one Executive and one Non- Executive Mmember ~~who is an Officer Member of the Trust and one Member who is not~~) and that at least two-thirds of those members present signify their agreement to such suspension. The reason for the suspension shall be recorded in the Trust Board's minutes.

Commented [NH14]: Change to have consistent terminology

3.13.2 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chair and Members of the Trust.

3.13.3 No formal business may be transacted while Standing Orders are suspended.

3.13.4 The Governance, Audit, and Risk Assurance ~~and Risk Assurance~~ Committee shall review every decision to suspend Standing Orders.

Commented [NH15]: To reflect revised Committee TORs

3.14 Variation and Amendment of Standing Orders

3.14.1 These Standing Orders shall not be varied except in the following circumstances:

(a) Upon a notice of motion under Standing Order 3.5;

(b) Upon a recommendation of the Chair or Chief Executive included on the agenda for the meeting;

(c) That two thirds of the Board members are present at the meeting where the variation or amendment is being discussed, and that at least half of the Trust's Non-Executive members vote in favour of the amendment;

(d) Providing that any variation or amendment does not contravene a statutory provision or direction made by the Minister for Health

3.15 Record of Attendance

3.15.1 The names of the Chair and Directors/members present at the meeting shall be recorded and, if necessary, the point at which they join, leave or resume their place at the meeting shall also be noted.

3.16 Minutes

3.16.1 The minutes of the proceedings of a meeting shall be drafted, signed and presented to the next Board meeting.

No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate.

A copy of the approved minutes will be posted on the Trust website www.nias.hscni.net following their approval ~~at the next ensuing meeting~~by Trust Board.

3.16.2 The approved minutes of meetings of Committees constituted by the Board will be presented at meetings of Trust Board for information, along with a written report from the Chair of the Committee. ~~The minutes of all Board Committees shall be formally recorded and brought to the public Board meeting for information except where confidentiality needs to be expressly protected. After each meeting, the Chair of the Committee shall present a written report to the next Trust Board meeting. At any point, the Committee Chair shall also draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action.~~

Commented [NH16]: Suggested simplified wording

3.17 Admission of Public and the Press

3.17.1 Reserved sections

Trust Board meetings are held in public to openly demonstrate how decisions within the Trust are made and recorded. On occasion, there may be issues which the Board requires to discuss in private and in this case a "reserved section" of the meeting may be convened with a separate agenda which is not made public.

These may include subjects that are:

a) Demonstrably protected in terms of the Data Protection Act (ie staff or service user personal information); or

b) Commercially sensitive; or

c) Constituted information intended for publication at a later date.

Where a meeting or part of a meeting is dealing with a potentially sensitive or confidential issue, the Chair of the meeting should inform those present that the item under consideration is confidential and a reserved section is required. The public shall be required to withdraw upon a resolution of the Trust Board as follows:

'that representatives of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest', Section 23(2) of the Local Government Act (NI) 1972.

3.17.2 General disturbances

The Chair ~~or the person presiding over the meeting~~ shall give such directions as they think fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Trust's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Trust Board resolving as follows:

`That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Trust Board to complete its business without the presence of the public', Section 23(2) of the Local Government Act (NI) 1972.

3.17.3 Business proposed to be transacted when the press and public have been excluded from a meeting

Matters to be dealt with by the Trust Board following the exclusion of representatives of the press, and other members of the public, as provided in 3.17.1 and 3.17.2 above, shall be confidential to the members of the Board.

Notwithstanding the provisions of 3.17 (1&2) above, the Trust Board shall make arrangements to ensure that any discussion of confidential matters relating to staff, patients or commercially sensitive issues are conducted by the Board meeting "In Committee". A separate confidential minute of such meetings will be maintained and approved by the Board at its next meeting. In addressing such matters, they shall operate with full executive powers.

Members and Officers or any employee of the Trust in attendance shall not reveal or disclose the contents of any "In Committee" meeting or papers marked 'In Confidence' or minutes headed 'Items Taken in Reserved section' outside of the Trust, without the express permission of the Trust. This prohibition shall apply equally to the content of any discussion during the Board meeting which may take place on such reports or papers.

3.17.4 Use of mechanical or electrical equipment for recording or transmission of meetings

~~In order to avoid undue disruption to Board meetings, television crews/press photographers or other media representatives can have access for a maximum of ten minutes prior to the meeting commencing. This will be subject to agreement of the Chair.~~

Commented [NM17]: This wording does not appear in Belfast Trust or Western Trust SOs, suggest removing.

Nothing in these Standing Orders shall be construed as permitting the introduction by the public, or press representatives, of recording, transmitting, video or similar apparatus into meetings of the Trust or

Committee thereof. Such permission shall be granted only upon resolution of the Trust Board.

3.18 Observers at Trust Meetings

3.18.1 The Trust will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any of the Trust Board's meetings and may change, alter or vary these terms and conditions as it deems fit.

3.19 Procedures for Addressing the Board

3.19.1 Individuals or groups may request the opportunity to address a meeting of the Board. ~~Deputations from any meeting, association, public body or an individual may be permitted to address a meeting of the Board~~, subject to the following conditions:

- The subject is on the agenda;
- The Board Secretary has received ~~three~~ five working days' notice, in writing, of the intended deputation, its purpose and a brief synopsis of content.
- The presentation/speaking notes must be submitted to the Board Secretary in advance of the meeting.

3.19.2 The Chair will decide on the appropriateness of the presentation.

3.19.3 The specified notice may be waived at the discretion of the Chair. Any deputation will be confined to a presentation by not more than two persons, per agenda item, and will not ~~to~~ exceed 10 minutes duration. The Chair may at his/her discretion vary the number of individuals permitted to address the meeting. The Chair will decide if a Trust response is appropriate and there will be no right of reply by the speaker. The decision of the Chair will be final on this matter.

The Chair will also consider requests for questions from the public based on the following conditions:

- all questions must be relevant to an item included on the agenda;
- individuals will be restricted to a maximum of two questions;
- once a question is answered by a member of Trust Board, as directed by the Chair, there will be no further discussions on this question; and
- the decision of the Chair will be final in relation to public questions.

Commented [NH18]: Suggested wording change

Commented [NH19]: Suggest giving at least a full working week to consider such a request

3.19.3 The Trust recognises the important statutory role the Patient and Client Council has in relation to representing the interests of the public in all matters of health and social care ~~within the Trust's area~~. The Trust will therefore grant the right for the Council to request attendance at any Trust Board meeting to raise specific agenda items. The Chair may at his/her discretion allow the Council to be heard during Board discussion of the item in question~~s~~.

Commented [NH20]: Suggest removing this.

4. APPOINTMENT OF COMMITTEES AND SUB-COMMITTEES

4.1 Appointment of Committees

4.1.1 Subject to such directions as may be given by the Minister for Health, the Trust Board may appoint Committees of the Trust.

The Trust shall determine the membership and Terms of Reference of Committees and Sub-Committees and shall receive and consider reports of such Committees. Only in exceptional circumstances will the Trust Board delegate executive powers to a Committee. A Committee may only exercise such executive powers as are delegated to it by the Trust Board. The Terms of Reference for each Committee will outline any executive powers which are delegated by Trust Board.

The Chair of the Trust Board will appoint Non-Executive Directors to Committees of the Board and will nominate one of them as Chair of the Committee.

4.2 Joint Committees

4.2.1 Joint Committees may be appointed by the Trust by joining together with one or more other Trusts consisting, wholly or partly, of the Chair and members of the Trust or other health service bodies, or wholly of persons who are not members of the Trust or other health bodies in question.

4.2.2 Any Committee or joint Committee appointed under this Standing Order may, subject to such directions as may be given by the Minister for Health or the Trust or other health bodies in question, appoint Sub-Committees consisting wholly or partly of members of the Committees or Joint Committee (whether or not they are members of the Trust or health bodies in question) or wholly of persons who are

not members of the Trust or health bodies in question or the Committee of the Trust or health bodies in question.

4.3 Applicability of Standing Orders and Standing Financial Instructions to Committees

4.3.1 The Standing Orders and Standing Financial Instructions of the Trust, as far as they are applicable, shall, as appropriate, apply to meetings and any Committees established by the Trust. In which case the term "Chair" is to be read as a reference to the Chair of other Committee as the context permits, and the term "member" is to be read as a reference to a member of other Committee also as the context permits. (There is no requirement to hold meetings of Committees established by the Trust in public.)

4.4 Terms of Reference

4.4.1 Each such Committee shall have such Terms of Reference and powers and be subject to such conditions (as to reporting back to the Board), as the Board shall decide and shall be in accordance with any legislation and regulation or direction issued by the Minister for Health. Such Terms of Reference shall have effect as if incorporated into the Standing Orders. Each Committee's Terms of Reference will be reviewed annually by the Committee and approved by the Board.

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4.5 Delegation of Powers by Committees to Sub-Committees

4.5.1 Where Committees are authorised to establish Sub-Committees, they may not delegate executive powers to the Sub-Committee unless expressly authorised by the Trust Board.

4.6 Approval of Appointments to Committees

4.6.1 The Board shall approve the appointments to each of the Committees which it has formally constituted. Where the Board determines, and regulations permit, that persons, who are neither members nor officers, shall be appointed to a Committee the terms of such appointment shall be within the powers of the Board as defined by the Minister for Health. The Board shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

4.7 Appointments for Statutory functions

4.7.1 Where the Board is required to appoint persons to a Committee and/or to undertake statutory functions as required by the Minister for Health, and where such appointments are to operate independently of the Board, such appointments shall be made in accordance with the regulations and directions made by the Minister for Health.

4.8 Committees Established by the Trust Board

The Committees, Sub-Committees, and Joint-Committees established by the Board are:

4.8.1 Governance, **Audit and Risk Assurance Committee**

In line with the requirements of the Cabinet Office's Code of Conduct for Board Members of Public Bodies (June 2019), the Audit and Risk Assurance Handbook (NI) 2018, and the Codes of Conduct and Accountability (October 2022), a Governance, ~~a~~ Audit and Risk Assurance Committee will be established and constituted to provide the Trust Board with an independent and objective review of its financial systems, governance and internal control arrangements.

~~The Terms of Reference will be approved by the Trust Board, will be reviewed on a periodic basis and will be posted on the Trust website www.nias.hscni.net~~

Commented [NH21]: Suggest removing the requirement to refresh TORs on Trust website when they are updated

The Committee will be comprised exclusively of Non-Executive Directors and shall consist of not less than three members, of which one must have significant, recent and relevant financial experience. A quorum shall be two Non-Executive Directors including the Committee Chair. A quorum shall be two members. None of these members should be the Chair or members of the Remuneration and Terms of Service Committee. ~~One member of the Committee shall be the Chair of the Safety Committee.~~ The Committee will meet on at least three occasions per year.

4.8.2 **Remuneration and Terms of Service Committee**

In line with the requirements of the Codes of Conduct and Accountability (October 2022), and the Higgs report (2003), a Remuneration and Terms of Service Committee will be established and constituted. As a minimum, the role of the Committee will be to

advise the Trust Board about appropriate remuneration and terms of service for the Chief Executive and other Senior Executives including:

(a) All aspects of salary (including any performance related elements/bonuses);

(b) Provisions for other benefits, including pensions and cars; and

(c) Arrangements for termination of employment and other contractual terms.

~~The Terms of Reference will be approved by the Trust Board, will be reviewed on a periodic basis and will be posted on the Trust website www.nias.hscni.net.~~

The Committee will be comprised exclusively of the Chair of the Trust and at least two Non-Executive Directors. ~~None of these members should be members of the Audit and Risk Assurance Committee.~~ A quorum shall be two members. The Committee will meet on at least two occasions per year.

4.8.3 **Safety, Quality and, Patient Experience ~~and Performance~~ Committee**

In line with the statutory duty of quality which is carried by the Chief Executive, a Safety, Quality and, Patient Experience ~~and Performance~~ Committee will be established and constituted to provide the Trust Board with an independent and objective review that that effective clinical and non-clinical governance arrangements are in place and that processes to identify and manage risks are effective ~~effective and regularly reviewed arrangements are in place to support the implementation, maintenance and development of governance (both clinical and non-clinical) and risk management~~ and that such matters are properly considered and communicated to the Trust Board.

Commented [NH22]: Changes from revised TORs

~~The Terms of Reference will be approved by the Trust Board, will be reviewed on a periodic basis and will be posted on the Trust website www.nias.hscni.net.~~

The Committee will be comprised exclusively of Non-Executive Directors and shall consist of not less than three members. ~~One member of the Committee shall be the Chair of Audit and Risk~~

~~Assurance Committee.~~ A quorum shall be two members. The Committee will meet on at least three occasions per year.

4.8.4 **People, ~~Finance~~ Culture and Organisational Development Committee**

Commented [NH23]: Changes from revised TORs

A People, ~~Finance~~ Culture and Organisational Development Committee will be established and constituted to provide the Trust Board with an independent and objective review of Human Resources~~, Finance~~ and Organisational Development functions.

~~The Terms of Reference will be approved by the Trust Board, will be reviewed on a periodic basis and will be posted on the Trust website www.nias.hscni.net~~

The Committee will be comprised exclusively of Non-Executive Directors and shall consist of not less than three members. A quorum shall be two members. The Committee will meet on at least three occasions per year.

4.8.5 **Strategic Performance and Finance Committee**

Commented [NH24]: Changes from revised TORs

A Strategic Performance and Finance Committee will be constituted to provide Trust Board with an independent and objective review of financial and organisational performance, and of progress against delivery of corporate and strategic plans.

The Committee will be comprised exclusively of Non-Executive Directors and shall consist of not less than three members. A quorum shall be two members. The Committee will meet on at least three occasions per year.

4.8.6 **Charitable Funds Advisory Committee**

In line with its role as a corporate trustee for any funds held in trust, either as charitable or non-charitable funds, the Trust Board will establish and constitute a Trust Charitable Funds Advisory Committee to administer those funds in accordance with any statutory or other legal requirements. This will be a sub-committee of the Strategic Performance and Finance Committee.

Commented [NH25]: Added to reflect Charitable Funds Advisory Committee

4.8.76 **Other Committees**

The Board may also establish such other Committees as required to discharge the Trust's responsibilities.

5. ARRANGEMENTS FOR THE EXERCISE OF TRUST FUNCTIONS BY DELEGATION

5.1 Delegation of Functions to Committees, Officers or Other Bodies

5.1.1 Subject to such directions as may be given by the Minister for Health, the Board may make arrangements for the exercise, on behalf of the Board, of any of its functions by a Committee, Sub-Committee appointed by virtue of Standing Order 4, or by an officer of the Trust, or by another body as defined in Standing Order 5.1.2 below, in each case subject to such restrictions and conditions as the Trust thinks fit.

5.1.2 Section 13, Schedule 3 of the HPSS (NI) Order 1991 allows for regulations to provide for the functions of Trust's to be carried out by third parties. In accordance with The HSS Trusts (Membership and Procedure) Regulations (NI) 1994, the functions of the Trust may also be carried out in the following ways:

(a) By another Trust or service providing body;

(b) Jointly with any one or more of the following: HSC Trusts, Boards, agencies or a Centre of Procurement Expertise (in respect of procurement and logistics) or service providing body.

5.1.3 Where a function is delegated by these Regulations to another Trust, then that Trust or health service body exercises the function in its own right; the receiving Trust has responsibility to ensure that the proper delegation of the function is in place.

5.1.4 In situations involving the delegation to Committees, Sub-Committees or officers, the Trust delegating the function retains full responsibility.

5.1.5 Where a function is to be carried out on behalf of the Trust by a third party, appropriate arrangements will be put in place by contract or Service Level Agreement to ensure performance standards, monitoring arrangements and accountability.

5.2 Emergency Powers and Urgent Decisions

5.2.1 The powers which the Board has reserved to itself within these Standing Orders (see Standing Order 2.9) may in emergency or for an urgent decision be exercised by the Chair and the Chief Executive

after having consulted at least two Non-Executive Members. The exercise of such powers by the Chair and the Chief Executive shall be reported to the next formal meeting of the Trust Board in public session for formal ratification.

5.3 Delegation to Committees

5.3.1 The Board shall agree from time to time to the delegation of executive powers to be exercised by other Committees, or Sub-Committees, or Joint-Committees, which it has formally constituted in accordance with directions issued by the Minister for Health. The constitution and terms of reference of these Committees, or Sub-Committees, or Joint Committees, and their specific executive powers shall be approved by the Board.

5.3.2 When the Board is not meeting as the Trust in public session, it shall operate as a Committee and may only exercise such powers as may have been delegated to it by the Trust in public session.

5.4 Delegation to Officers

5.4.1 Those functions of the Trust which have not been retained as reserved by the Board or delegated to other Committee or Sub-Committee or Joint-Committee shall be exercised on behalf of the Trust by the Chief Executive. The Chief Executive shall determine which functions he/she will perform personally and shall nominate officers to undertake the remaining functions for which he/she will still retain accountability to the Trust. However, he/she shall not assign absolutely to any other person any of the responsibilities set out in the Management Statement/Financial Memorandum.

5.4.2 The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals which shall be considered and approved by the Board. The Chief Executive, or in his/her absence the Director of Finance, may approve interim amendments to the Scheme of Delegation, which shall be considered and given retrospective approval by the Board at its next annual review.

5.4.3 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of the Director of Finance to provide information and advise the Board in accordance with statutory or DoH requirements. Outside these statutory requirements, the roles of the

Director of Finance shall be accountable to the Chief Executive for operational matters.

5.5 Schedule of Matters Reserved to the Board and Scheme of Delegation of Powers

5.5.1 The arrangements made by the Board as set out in the "Schedule of Matters Reserved to the Board" and "Scheme of Delegation" of powers shall have effect as if incorporated in these Standing Orders.

5.6. Duty to Report Non-Compliance with Standing Orders and Standing Financial Instructions

5.6.1 If, for any reason, these Standing Orders or the Standing Financial Instructions are not complied with in any significant or material respect, full details shall be reported to the Governance, Audit and Risk Assurance Committee. All members of the Trust Board and staff have a duty to disclose any significant or material non-compliance to the Chief Executive as soon as possible.

~~**5.7 Charitable Trust Funds**~~

~~5.7.1 In line with its role as a corporate trustee for any funds held in trust (Standing Order 2.7.2), either as charitable or non-charitable funds, the Trust Board will establish 'Financial Procedures – Charitable Trust Funds' to administer those funds in accordance with any statutory or other legal requirements.~~

Commented [NH26]: Covered now above

6. OVERLAP WITH OTHER TRUST POLICY STATEMENTS/ PROCEDURES, REGULATIONS AND THE STANDING FINANCIAL INSTRUCTIONS

6.1 Policy Statements: General Principles

6.1.1 The Trust Board will determine an appropriate mechanism for the formal approval of policies and procedures. The formal approval will be recorded in an appropriate minute and will be deemed, where appropriate, to be an integral part of the Trust's Standing Orders and Standing Financial Instructions.

6.2 Standing Financial Instructions

6.2.1 Standing Financial Instructions adopted by the Trust Board in accordance with the Financial Regulations shall have effect as if incorporated in these Standing Orders.

6.3 Specific Guidance

6.3.1 Notwithstanding the application of Standing Order 6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with all relevant guidance and legislation.

7. DUTIES AND OBLIGATIONS OF BOARD MEMBERS/DIRECTORS AND SENIOR MANAGERS UNDER THESE STANDING ORDERS

7.1 Codes of Conduct and Accountability (October 2022)

7.1.1 The Code of Conduct and Code of Accountability for Board Members of Health and Social Care bodies (October 2022), provides the basis on which Board members of HSC bodies should seek to fulfil the duties and responsibilities conferred upon them by DoH. The Codes of Conduct and Accountability ~~(October 2022)~~ shall be made available to all Board members. Board members shall subscribe to it and shall be judged upon the manner in which it is observed.

The HSC Code of Conduct for HSC Employees (2016) incorporates the principles contained within the Code of Conduct for HPSS Managers 2013 and supercedes it. It is applicable to all HSC employees, including managers, and sets out the core standards of conduct expected by all HSC staff.

7.2 Declaration of Interests

7.2.1 Requirements for Declaring Interests and Applicability to Board Members

The ~~Trust's policy on~~ Standards of Business Conduct, set out below, require~~s~~ Trust Board Members to declare interests which are relevant and material to the HSC Trust of which they are a member. All existing Board members should declare such interests and any Board members appointed subsequently should do so on appointment. Any future relevant and material interests should also be declared immediately by the member upon acquisition.

7.2.2 Interests which are Relevant and Material

Interests which should be regarded as "relevant and material" are:

(a) Directorships, including Non-Executive Directorships held in private companies or PLCs (with the exception of those of dormant companies);

(b) Ownership or part-ownership of private companies, businesses or consultancies likely, or possibly seeking, to do business with the HSC;

(c) Majority or controlling shareholdings in organisations likely, or possibly seeking, to do business with the Trust;

(d) A position of authority in a charity or voluntary organisation in the field of health and social care;

(e) Any connection with a voluntary or other organisation contracting for Trust services;

(f) Research funding/grants that may be received by an individual or their department;

(g) Interests in pooled funds that are under separate management.

Where any member of the Trust Board comes to know that the Trust has entered into, or proposes to enter into, a contract in which he/she or any person connected with him/her (as defined in Standing Order 7.3 below and elsewhere) has any pecuniary interest, direct or indirect, the Board member shall declare his/her interest by giving notice in writing of such fact to the Trust as soon as practicable.

7.2.3 Advice on Interests

If Board members have any doubt about the relevance of an interest, this should be discussed with the Chair of the Trust or with the Trust's Chief Executive.

Influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

7.2.4 Recording of Interests in Trust Board Minutes

At the time Board members' interests are declared, they should be recorded in the Trust Board minutes.

Any changes in interests should be declared at the next Trust Board meeting following the change occurring and recorded in the minutes of that meeting. The Chief Executive will be responsible for ensuring that the Trust Register of Interests is duly updated. ~~Where a conflict of interest is established or perceived, the Board member shall withdraw and play no part in the relevant discussion unless the Chair deems that it is unnecessary for them to do so.~~

Commented [NH27]: This is covered below.

7.2.5 Publication of Declared Interests in Annual Report

Where a Board member has an interest in any body which has transacted with the Trust, then the financial quantification of that transaction(s) shall be published in the Trust's Annual Report and Accounts for the year in question, together with an appropriate description of the member's interest. The Chief Executive is responsible for ensuring that this information is reflected in the Register of Interests.

7.2.6 Conflicts of interest which arise during the course of a meeting

During the course of a Trust Board meeting, if a conflict of interest is established, the Board member concerned should withdraw from the meeting and play no part in the relevant discussion or decision (see overlap with Standing Order 7.4).

7.2.7 Declaration of Objectivity and Interests for those Officers Engaged in Award of Contract

Trust Officers participating in the preparation, evaluation and award of contracts must complete a declaration of objectivity and interests during the course of the tendering process to ensure the transparency of the process and that decisions made are not compromised. The administration of the declaration process will be handled by the Trust's procurement provider in accordance with appropriate guidance. Where a potential conflict of interest is apparent, the procurement provider will contact the Chief Executive or Director of Finance to agree the appropriate course of action.

7.3 Register of Interests

7.3.1 The Chief Executive will ensure that a Register of Interests is established to record formally any declarations of interests of Board or Committee members. In particular the Register will include details of all directorships and other relevant and material interests (as defined in Standing Order 7.2.2) which have been declared by both Executive and Non-Executive Trust Board members.

7.3.2 These details will be kept up to date by means of an annual review of the Register in which any changes to interests declared during the preceding twelve months will be incorporated.

7.3.3 The Register will be posted on the Trust website ~~www.nias.hscni.net~~ on an annual basis.

7.4 Exclusion of Chair and Members in Proceedings on Account of Pecuniary Interest

7.4.1 Definition of Terms used in Interpreting 'Pecuniary' Interest

For the sake of clarity, the following definition of terms is to be used in interpreting this Standing Order:

(a) **"Spouse"** shall include any person who lives with another person in the same household (and any pecuniary interest of one spouse shall, if known to the other spouse, be deemed to be an interest of that other spouse);

(b) **"Contract"** shall include any proposed contract or other course of dealing.

(c) **"Pecuniary interest"**

Subject to the exceptions set out in this Standing Order, a person shall be treated as having an indirect pecuniary interest in a contract if:

(1) He/she, or a nominee of his/her, is a member of a company or other body (not being a public body), with which the contract is

made, or to be made or which has a direct pecuniary interest in the same, or

(2) He/she is a partner, associate or employee of any person with whom the contract is made or to be made or who has a direct pecuniary interest in the same.

(d) **Exception to Pecuniary interests**

A person shall not be regarded as having a pecuniary interest in any contract if:

(1) Neither he/she or any person connected with him/her has any beneficial interest in the securities of a company of which he/she or such person appears as a member, or

(2) Any interest that he/she or any person connected with him/her may have in the contract is so remote or insignificant that it cannot reasonably be regarded as likely to influence him/her in relation to considering or voting on that contract, or

(3) Those securities of any company in which he/she (or any person connected with him/her) has a beneficial interest, do not exceed £5,000 in nominal value or one per cent of the total issued share capital of the company or of the relevant class of such capital, whichever is the less.

Provided however, that where paragraph (3) above applies, the person shall nevertheless be obliged to disclose/declare their interest in accordance with Standing Order 7.2.2(b).

7.4.2 Exclusion in Proceedings of the Trust Board

(a) Subject to the following provisions of this Standing Order, if the Chair or a member of the Trust Board has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust Board at which the contract or other matter is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

(b) The Minister for Health may, subject to such conditions as he/she may think fit to impose, remove any disability imposed by this Standing Order in any case in which it appears to him/her in the interests of the HSC that the disability should be removed. (see Standing Order 7.4.3 on the 'Waiver' which has been approved by the Minister for Health).

(c) The Trust Board may exclude the Chair or a member of the Board from a meeting of the Board while any contract, proposed contract or other matter in which he/she has a pecuniary interest is under consideration.

(d) Any remuneration, compensation or allowance payable to the Chair or a Member by virtue of paragraph 9, Schedule 3 of the Health and Personal Social Services (Northern Ireland) Order 1991 shall not be treated as a pecuniary interest for the purpose of this Standing Order.

(e) This Standing Order applies to a Committee or Sub-Committee and to a Joint Committee or Sub-Committee as it applies to the Trust and applies to a member of any such Committee or Sub-Committee (whether or not he/she is also a member of the Trust) as it applies to a member of the Trust.

7.4.3 Waiver of Standing Orders made by the Minister for Health

(a) Power of the Minister for Health to make Waivers

Under regulation 20(2) of the HSS Trusts (Membership and Procedure) Regulations (NI) 1994, DoH may issue waivers if it appears in the interests of the HSC that the disability in regulation 11 (which prevents a Chair or a member from taking part in the consideration or discussion of, or voting on any question with respect to, a matter in which he has a pecuniary interest) should be removed. Any waiver that has been agreed will be in line with sub-sections (b) to (d) below.

(b) Definition of 'Chair' for the Purpose of Interpreting this Waiver

For the purposes of paragraph 7.4.3(c) below, the "relevant Chair" is:

(1) At a meeting of the Trust, the Chair of that Trust;

(2) At a meeting of a Committee:

(i) In a case where the member in question is the Chair of that Committee, the Chair of the Trust:

(ii) In the case of any other member, the Chair of that Committee.

(c) Application of Waiver

A waiver will apply in relation to the disability to participate in the proceedings of the Trust on account of a pecuniary interest.

It will apply to:

(1) A member of the Trust, who is a healthcare professional, within the meaning of regulation 5(5) of the Regulations, and who is providing or performing, or assisting in the provision or performance, of –

(i) Services under the Health and Personal Social Services (Northern Ireland) Order 1991; or

(ii) Services in connection with a pilot scheme under the Health and Personal Social Services (Northern Ireland) Order 1991;

For the benefit of persons for whom the Trust is responsible:

(2) Where the 'pecuniary interest' of the member in the matter which is the subject of consideration at a meeting at which he is present:

(i) Arises by reason only of the member's role as such a professional providing or performing, or assisting in the provision or performance of, those services to those persons;

(ii) Has been declared by the relevant Chair as an interest which cannot reasonably be regarded as an interest more substantial than that of the majority of other persons who:

(a) Are members of the same profession as the member in question,

(b) Are providing or performing, or assisting in the provision or performance of, such of those services as he provides or performs, or assists in the provision or performance of, for the benefit of persons for whom the Trust is responsible.

(d) Conditions which apply to the Waiver and the removal of having a pecuniary interest

The removal is subject to the following conditions:

(1) The member must disclose his/her interest as soon as practicable after the commencement of the meeting and this must be recorded in the minutes;

(2) The relevant Chair must consult the Chief Executive before making a declaration in relation to the member in question pursuant to paragraph 7.4.3(b)(2) above, except where that member is the Chief Executive;

(3) In the case of a meeting of the Trust:

(i) The member may take part in the consideration or discussion of the matter which must be subjected to a vote and the outcome recorded;

(ii) May not vote on any question with respect to it.

(4) In the case of a meeting of the Committee:

(i) The member may take part in the consideration or discussion of the matter which must be subjected to a vote and the outcome recorded;

(ii) May vote on any question with respect to it; but

(iii) The resolution which is subject to the vote must comprise a recommendation to, and be referred for approval by, the Trust Board.

7.5 Standards of Business Conduct

7.5.1 Trust Policy and National Guidance

All Trust staff and members ~~of~~ must comply with the Code of Conduct for HSC Employees (September 2016).

7.5.2 Interest of Officers in Contracts

(a) Any Oofficer or employee of the Trust who comes to know that the Trust has entered into or proposes to enter into a contract in which he/she or any person connected with him/her (as defined in Standing Order 7.4) has any pecuniary interest, direct or indirect, the Officer shall declare their interest by giving notice in writing of such fact to the Chief Executive as soon as practicable.

(b) An Officer should also declare to the Chief Executive any other employment or business or other relationship of his/her, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

(c) The Trust will require interests, employment or relationships so declared to be entered in a Register of Interests of staff.

7.5.3 Canvassing of and Recommendations by Members in Relation to Appointments

(a) Canvassing of members of the Trust or of any Committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

(b) Members of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment; but this paragraph of this Standing Order shall not preclude a member from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

7.5.4 Relatives of Members or Officers

(a) Candidates for any staff appointment under the Trust shall, when making an application, disclose in writing to the Trust whether they are related to any member or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him liable to instant dismissal.

(b) The Chair and every member and officer of the Trust shall disclose to the Trust Board any relationship between himself and a candidate of whose candidature that member or officer is aware. It shall be the duty of the Chief Executive to report to the Trust Board any such disclosure made.

(c) On appointment, members (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Trust whether they are related to any other member or holder of any office under the Trust.

(d) Where the relationship to a member of the Trust is disclosed, the Standing Order headed 'Disability of Chair and members in proceedings on account of pecuniary interest' (Standing Order 7.4) shall apply.

8. CUSTODY OF SEAL, SEALING OF DOCUMENTS AND SIGNATURE OF DOCUMENTS

8.1 Custody of Seal

8.1.1 The common seal of the Trust shall be kept in a secure place by the Chief Executive or a Manager nominated by him/her.

8.2 Sealing of Documents

8.2.1 Documents should only be sealed following a resolution by the Trust Board. In exceptional circumstances, a document shall be sealed in advance of a resolution by the Trust Board and retrospective resolution sought at the following Trust Board meeting. Where it is necessary that a document shall be sealed, the seal shall be affixed in the presence of the Chief Executive/or other Executive Director nominated by the Chief Executive, who is not from the originating department, along with one Non-Executive Director and shall be attested by them.

8.3 Register of Sealing

8.3.1 The Chief Executive shall keep a register in which he/she, or another manager of the Trust authorised by him/her, shall enter a record of the sealing of every document.

8.4 Signature of Documents

8.4.1 Where any document will be a necessary step in legal proceedings on behalf of the Trust, it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Executive or any Executive Director.

8.4.2 In land transactions, the signing of certain supporting documents will be delegated to Managers and set out clearly in the Scheme of Delegation but will not include the main or principal documents effecting the transfer (e.g. sale/purchase agreement, lease, contracts for construction works and main warranty agreements or any document which is required to be executed as a deed).

SECTION C - SCHEDULE OF POWERS RESERVED TO THE BOARD

The 'Schedule of Powers reserved to the Board' is sub-divided to correspond with the seven key functions of the Board for which it is held accountable by the Department of Health on behalf of the Minister.

These are:-

1. To establish the overall strategic direction of the organisation within the policy and resources framework determined by the Department/Minister;

2. To oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary;

3. To ensure effective financial stewardship through value for money, financial control and financial planning and strategy;

4. To ensure that high standards of corporate governance and personal behaviour are maintained in the conduct of the business of the whole organisation;

5. To appoint, appraise and remunerate senior executives;

6. To ensure effective dialogue between the organisation and the local community on its plans and performance and that these are responsive to the community's needs;

7. To ensure that the Trust has robust and effective arrangements in place for clinical and social care governance and risk management.

These matters are to be regarded as a guideline to the minimum requirement and shall not be interpreted as to exclude any other issues which it might be appropriate, because of their exceptional nature, to bring to the Board. The Chair, in consultation with the Chief Executive shall determine whether other issues outwith the following schedules of reserved powers shall be brought to the Board for consideration.

SECTION C - SCHEME OF RESERVATION AND DELEGATION

1.1 DECISIONS RESERVED TO THE BOARD

DELEGATED TO	AUTHORITIES / DUTIES DELEGATED
Trust Board	**General Enabling Provision** The Board may determine any matter, for which it has delegated or statutory authority, in full session within its statutory powers.
Trust Board	**Regulations and Control** 1. Approve Standing Orders (SOs), a Schedule of Matters Reserved to the Board and Standing Financial Instructions for the regulation of its proceedings and business. 2. Suspend Standing Orders. 3. Vary or amend the Standing Orders. 4. Ratify any urgent decisions taken by the Chair and Chief Executive in public session in accordance with Standing Order 5.2 5. Approve a Scheme of Delegation of powers from the Board to Committees and Officers. 6. Require and receive the Declaration of Board members' interests that may conflict with those of the Trust and determine the extent to which that member may remain involved with the matter under consideration.

DELEGATED TO	AUTHORITIES / DUTIES DELEGATED
	7. Require and receive the Declaration of Officers' interests that may conflict with those of the Trust. 8. Approve arrangements for dealing with complaints. 9. Adopt the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto. 10. Receive reports from Committees including those that the Trust is required by the Minister for Health, or other regulation to establish and to take appropriate action on. 11. Consider the recommendations of the Trust's Committees where the Committees do not have executive powers. 12. Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate Trustee for funds held on trust. 13. Establish Terms of Reference and reporting arrangements of all Committees and Sub-Committees that are established by the Board. 14. Approve arrangements relating to the discharge of the Trust's responsibilities as an appointee for patients' and clients' property. 15. Authorise use of the seal. 16. Ratify or otherwise instances of failure to comply with Standing Orders brought to the Chief Executive's attention in accordance with Standing Order 5.6. 17. Initiate disciplinary procedures for members of the Board or employees who are in breach of statutory requirements or Standing Orders.

DELEGATED TO	AUTHORITIES / DUTIES DELEGATED
Trust Board	**Appointments / Dismissal** 1. Appoint a Vice Chair of the Board. 2. Appoint and dismiss Committees (and individual members) that are directly accountable to the Board. 3. Appoint, appraise, discipline and dismiss Executive Directors (subject to Standing Order 2.2). 4. Confirm appointment of members of any Committee of the Trust as representatives on outside bodies. 5. Appoint, appraise, discipline and dismiss the Secretary (if the appointment of a Secretary is required under Standing Orders). 6. Approve proposals of the Remuneration Committee regarding Executive Directors and the Chief Executive.
Trust Board	**Strategy, Plans and Budgets** 1. Define the strategic aims and objectives of the Trust, and approve strategic plans. 2. Approve proposals for ensuring quality and developing clinical and social care governance in services provided by the Trust, having regard to any guidance issued by the Minister for Health. 3. Approve the Trust's policies and procedures for the management of risk. 4. Approve Outline and Final Business Cases for Capital Investment.

DELEGATED TO	AUTHORITIES / DUTIES DELEGATED
	5. Approve budgets on an annual basis. 6. Approve the Trust's proposed organisational development proposals. 7. Ratify proposals for acquisition, disposal or change of use of land and/or buildings. 8. Approve PFI proposals. 9. Approve the opening of bank accounts and Trust banking arrangements. 10. Approve proposals on individual contracts (other than HSC contracts) of a capital or revenue nature in accordance with the Scheme of Delegation. 11. Approve proposals in individual cases for the write off of losses or making of special payments in accordance with the Scheme of Delegation. 12. Approve individual compensation payments in accordance with the Scheme of Delegation. 13. Approve proposals for action on litigation against or on behalf of the Trust in accordance with the Scheme of Delegation.
Trust Board/ Committee	**Policy Determination** All policies, including any updates, will be approved at Committee level and brought to the attention of Trust Board through the regular updates brought forward by the Committee Chairs. Procedures related to policies deemed relevant by a Director will also, where necessary, be presented with its associated policy. These procedures will have previously been considered by the Senior Management Team.

DELEGATED TO	AUTHORITIES / DUTIES DELEGATED
	~~In addition, Trust Board will, once per year, be presented with a register detailing the policies, and including such information as review dates and monitoring information, including scrutiny at Committee level. In exceptional circums~~ Commented [NH28]: Suggested removal to reflect practice ~~the Trust's Senior Management Team may take a view that the significance of the policy and its impact on the organisation is such that it merits direct consideration by the Trust Board. The Chief Executive will agree this in consultation with the Chair. There may also be regional policies which the Trust Board is required to adopt and these will be considered at Trust Board.~~ Formatted: Left, Indent: Left: 0 cm, Hyphenate, Tab stops: Not at -2.54 cm + -1.27 cm + 2.68 cm + 3.81 cm
Trust Board	**Audit** 1. Receipt of the annual Report to Those Charged With Governance from the external auditor and agreement of proposed action, taking account of the advice, where appropriate, of the Governance, Audit and Risk Assurance Committee. 2. Receipt of an annual report from the Internal Auditor and agree action on recommendations where appropriate of the Governance, Audit and Risk Assurance Committee.
Trust Board	**Annual Reports and Accounts** 1. Receive and approve the Trust's Annual Report and Accounts. 2. Receive and approve the Accounts for Charitable Trust Funds.

DELEGATED TO	AUTHORITIES / DUTIES DELEGATED
Trust Board	**Monitoring** 1. Receipt of such reports as are required by statute or DoH regulation and other such reports as the Board sees fit from Committees in respect of their exercise of powers delegated. 2. Continuous appraisal of the affairs of the Trust by means of the provision to the Board as the Board may require from Directors, Committees, and Officers of the Trust as set out in management policy statements. All monitoring returns required by the DoH shall be reported, at least in summary, to the Board. 3. Receive reports on financial performance against budget and Trust Delivery Plan, including progress in meeting specific strategic, SPPG ~~HSCB~~ and DoH objectives and targets.
Trust Board	Approve procedure for declaration of hospitality and sponsorship.
Trust Board	Ensure proper and widely publicised procedures for voicing complaints, concerns about misadministration, breaches of Code of Conduct, and other ethical concerns.
Trust Board	Board members share corporate responsibility for all decisions of the Board.

Trust Board	The Board has seven key functions for which it is held accountable by the DoH on behalf of the Minister for Health: 1. To establish the overall strategic direction of the organisation within the policy and resources framework determined by the Department/Minister; 2. To oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary; 3. To ensure effective financial stewardship through value for money, financial control and financial planning and strategy; 4. To ensure that high standards of corporate governance and personal behaviour are maintained in the conduct of the business of the whole organisation; 5. To appoint, appraise and remunerate senior executives; 6. To ensure effective dialogue between the organisation and the local community on its plans and performance and that these are responsive to the community's needs; 7. To ensure that the Trust has robust and effective arrangements in place for clinical and social care governance and risk management.

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Trust Board	It is the Board's duty to: 1. act within statutory financial and other constraints; 2. be clear what decisions and information are appropriate to the Board and draw up Standing Orders, a Schedule of Decisions Reserved to the Board and Standing Financial Instructions to reflect these, ensure that management arrangements are in place to enable responsibility to be clearly delegated to Senior Executives for the main programmes of action and for performance against programmes to be monitored and Senior Executives held to account; 3. establish performance and quality measures that maintain the effective use of resources and provide value for money; 4. specify its requirements in organising and presenting financial and other information succinctly and efficiently to ensure the Board can fully undertake its responsibilities; 5. establish Governance, Audit and Risk Assurance, Remuneration and other Committees ~~People, Safety and Remuneration Committees~~ on the basis of formally agreed Terms of Reference that set out the membership of the Sub-Committee, the limit to their powers, and the arrangements for reporting back to the main Board.

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1.2 SCHEME OF DELEGATION DERIVED FROM THE CODES OF CONDUCT AND ACCOUNTABILITY (OCTOBER 2022)

DELEGATED TO:	AUTHORITIES / DUTIES DELEGATED:
Trust Board	HSC Trust Boards must comply with legislation and guidance issued by the DoH on behalf of the Minister for Health, respect agreements entered into by themselves or on their behalf and establish terms and conditions of service that are fair to the s for taxpayers' money.
All Board Members	Subscribe to Codes of Conduct and Accountability (October 2
Chair and Non-Executive Members	Chair and Non-Executive members are responsible for monit management of the organisation and are responsible to the Minister for Health for the discharge of those responsibilities.
Chair	It is the Chair's role to: 1. provide leadership to the Board; 2. enable all Board members to make a full contribution to the Board's affairs and ensure that the Board acts as a team; 3. ensure that key and appropriate issues are discussed by the Board in a timely manner, 4. ensure the Board has adequate support and is provided efficiently with all the necessary data on which to base informed decisions; 5. lead Non-Executive Board members through a formally-appointed Remuneration & Terms

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	of Service Committee of the main Board on the appointment, appraisal and remuneration of the Chief Executive and (with the latter) other Senior Executives; 6. appoint Non-Executive Board members to all Sub-Committees of the main Board; 7. advise the Minister for Health on the performance of Non-Executive Board members.
Chief Executive	The Chief Executive is accountable to the Chair and Non-Exe for ensuring that its decisions are implemented, that the organisation works effectively, in accordance with Government policy and public service values and for the maintenance of proper financial stewardship. The Chief Executive should be allowed full scope, within clearly defined delegated powers, for action in fulfilling the decisions of the Board. The other duties of the Chief Executive as Accounting Officer are laid out in the Accounting Officer Memorandum.

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1.3 DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES

DELEGATED TO:	*AUTHORITIES / DUTIES DELEGATED:*
Non-Executive Directors	Non-Executive Directors are appointed by the Minister for Health following a recruitment process overseen by the DoH Public Appointments Unit to bring independent judgement to bear on issues of strategy, performance, key appointments and accountability through the DoH to the Minister and to the local community.
Chair and Directors	Declaration of potential conflict of interests.
Governance, Audit and Risk Assurance Committee	The Committee will ensure that the system of integrated gov across the Trust's activities is effective in supporting achievement of its objectives. The Committee shall ensure that there is an effective internal audit function established by management that meets the Government Internal Audit Standards and provides appropriate independent assurance to the Chief Executive and Board. The Committee shall review the work and findings of the External Auditor appointed by the NI Audit Office and consider the implications of, and management's responses to, their work. ~~The Committee shall contribute to the establishment, review and maintenance of an effective system of integrated governance, risk management and internal control, across~~

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Commented [NH29]: To reflect new TORs

	the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisation's objectives. The Committee will: Review the adequacy of all risk and control related disclosure statements (in particular the Governance Statement), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board. Review the adequacy of the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.
DELEGATED TO:	*AUTHORITIES / DUTIES DELEGATED:*
	1. Review the adequacy of the policies for ensuring c regularity, legal and code of conduct requirements, incl Orders and Standing Financial Instructions. ***2. Review the adequacy of the policies and procedures for all work related to fraud and corruption.*** ***3. Review the Schedule of Losses and Special Payments and will make recommendations to the Board.*** ***4. Review the effectiveness and findings of the internal and external audit services, considering the implications of, and managements responses to their work.*** ***5. Review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation.***

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	~~6. Review the Trust's Annual Report and the Financial Statements before submission to the Board, focusing particularly on:~~ ~~• The wording in the Governance Statement and other disclosures relevant to the Terms of Reference of the Committee~~ ~~• Changes in, and compliance with, accounting policies and practices~~ ~~• Unadjusted mis-statements in the financial statements~~ ~~• Major judgemental areas~~ ~~• Significant adjustments resulting from the audit~~ ~~7. Ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.~~ ~~8. Consider and approve relevant policies.~~
DELEGATED TO:	*AUTHORITIES / DUTIES DELEGATED:*
Remuneration and Terms of Service Committee	The Committee will: • Advise the Board about appropriate remuneration and terms of service for the Chief Executive and Senior Executives. • All aspects of salary (including any performance-related elements/bonuses); • Provisions for other benefits, including pensions and cars; • Arrangements for termination of employment and other contractual terms; • Make recommendations to the Board on the remuneration and terms of service of the Chief Executive and Senior Executives to ensure they are fairly rewarded for their individual contribution to the Trust - having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such staff;

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	• Proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate advise on and oversee appropriate contractual arrangements for such staff; • Determine the necessary arrangements for remuneration of Senior Executives, taking account of DoH guidance. • Consider and approve relevant policies.
DELEGATED TO:	*AUTHORITIES/DUTIES DELEGATED:*
Safety, Quality and ~~,~~ Patient Experience ~~and Performance~~ Committee	The Committee will be responsible for assuring Trust Board clinical governance arrangements are in place and that proc risks are effective. ~~**The Committee will be responsible for assuring the NIA regularly reviewed arrangements are in place to support the implementation, maintenance and development of Governance (clinical and non-clinical) and risk management and that such matters are properly considered and communicated to the Board. The Committee will also consider and approve relevant policies.**~~

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Commented [NH30]: To reflect revised TORs

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People, Finance Culture and Organisational Development Committee	The Committee will be responsible for providing assurance Commented [NH31]: To reflect new TORs strategic issues relating to Human Resources, workforce and organisational development to deliver the Trust's strategic objectives and other plans as determined by Trust Board. ~~The Committee will be responsible for assuring the NIAS Board that effective and regularly reviewed arrangements are in place to support Human Resources, Finance and Organisational Development functions within the Trust. The Committee will also consider and approve relevant policies.~~
Strategic Performance and Finance Committee	The Committee has delegated oversight responsibility to en Commented [NH32]: To reflect new TORs statutory responsibility to "break-even". Performance reports will be considered by the Committee to seek assurance about Trust performance compared to the Service Delivery Plan and associated targets, key performance indicators and trajectories.
Trust Board	HSC Trust Boards must comply with legislation and guidance issued by the DoH on behalf of the Minister for Health, respect agreements entered into by themselves or on their behalf and establish terms and conditions of service that are fair to the staff and represent good value for taxpayers' money.

1.4 SCHEME OF DELEGATION DERIVED FROM THE ACCOUNTING OFFICER MEMORANDUM

DELEGATED TO:	AUTHORITIES / DUTIES DELEGATED:
Chief Executive	Accountable through HSC Accounting Officer to Parliament/NI Assembly for stewardship of Trust resources.
Chief Executive	Ensure the accounts of the Trust are prepared under principles and in a format directed by the DoH. Accounts must disclose a true and fair view of the Trust's income and expenditure and its state of affairs. Sign the accounts on behalf of the Trust Board.
Chief Executive	Sign a statement in the accounts outlining responsibilities as the Accounting Officer. Sign a statement in the accounts outlining responsibilities in respect of Internal Control.
Chief Executive	Ensure effective management systems that safeguard public funds and assist the Trust Chair to implement requirements of corporate governance including ensuring managers: • "have a clear view of their objectives and the means to assess achievements in relation to those objectives • be assigned well defined responsibilities for making best use of resources having the information, training and access to the expert advice they need to exercise their

	responsibilities effectively."
Chief Executive	Implement requirements of corporate governance.
Director of Finance	Achieve value for money from the resources available to the Trust and avoid waste and extravagance in the organisation's activities. Follow through the implementation of any recommendations affecting good practice as set out on reports from the Northern Ireland Audit Office (NIAO).
Director of Finance	Operational responsibility for effective and sound financial management and information.

DELEGATED TO:	AUTHORITIES / DUTIES DELEGATED:
Chief Executive	Primary duty to ensure that Director of Finance discharges the function of providing effective and sound financial management and information.
Chief Executive	Ensuring that expenditure by the Trust complies with all necessary regulatory ~~Parliamentary/NI Assembly~~ requirements.
Chief Executive	Chief Executive, supported by Director of Finance, to ensure appropriate advice is given to the Board on all matters of probity, regularity, prudent and economical administration, efficiency and effectiveness.
Chief Executive	If the Chief Executive considers that the Board or Chair is doing something that might infringe probity or regularity, he/she should set this out in writing to the Chair and the Board. If the matter is unresolved, he/she should ask the Governance, Audit and Risk Assurance Committee to enquire and if necessary the DoH.
Chief Executive	If the Board is contemplating a course of action that raises an issue not of formal propriety or regularity but affects the Chief Executive's responsibility for value for money, the Chief Executive should draw the relevant factors to the attention of the Board. If the outcome is that he/she are overruled, it is normally sufficient to ensure that his/her advice and the overruling of it are clearly apparent from the papers. Exceptionally, the Chief Executive should inform the DoH. In such cases, the Chief Executive should, as a member of the Board, vote against the course of action rather than merely abstain from voting.

1.5 SCHEME OF DELEGATION FROM STANDING ORDERS

DELEGATED TO	AUTHORITIES / DUTIES DELEGATED:
Chair	Final authority in interpretation of Standing Orders.
Trust Board	Appointment of Member acting as Chair
Chair	Call meetings.
Chair	Chair all Board meetings and associated responsibilities.
Chair	Give final ruling in questions of order, relevancy and regularity of meetings.
Chair	Having a second or casting vote
Chair	Suspension of Standing Orders
Governance, **Audit and Risk Assurance Committee**	~~Audit and Risk Assurance Committee T~~to review every decision to suspend Standing Orders (power to suspend Standing Orders is reserved to the Board)
Trust Board	Variation or amendment of Standing Orders
Trust Board	Formal delegation of powers to Sub-Committees or Joint Committees and approval of their constitution and terms of reference. (Constitution and terms of reference of Sub Committees may be approved by the Chief Executive.)

DELEGATED TO	AUTHORITIES / DUTIES DELEGATED:
Chair & Chief Executive	The powers which the Board has retained to itself within these Standing Orders may in emergency be exercised by the Chair and Chief Executive after having consulted at least two Non-Executive members.
Chief Executive	The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals that shall be considered and approved by the Board, subject to any amendment agreed during the discussion.
Trust Board	Disclosure of non-compliance with Standing Orders to the Chief Executive as soon as possible.
Trust Board & Officers	Declare relevant and material interests.
Director of Finance	Maintain Register(s) of Interests.
All	Comply with the guidance contained in the ~~Trust's Policy on~~ Standards of Business Conduct for HSC Staff.
All	Disclose relationships between self and candidates for staff appointment. (Chief Executive to report the disclosure to the Board.)
Director of Finance	Keep seal in safe place and maintain a register of sealing.

DELEGATED TO	AUTHORITIES / DUTIES DELEGATED:
Chief Executive	Approve and sign all documents which will be necessary in legal proceedings.

Audit and Risk Assurance Committee

Title:	**Audit and Risk Assurance Committee Terms of Reference**		
Author(s):	Paul Nicholson, Andrew Phillips		
Ownership:	Committee Chair		
Date of Committee Approval:	7 October 2021	**Date of Trust Board Approval:**	21 October 2021
Operational Date:	21 October 2021	**Review Date:**	October 2023
Version No:	V1.0	**Supersedes:**	Version approved in October 2019
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Version Control:			
Date:	**Version:**	**Author:**	**Comments:**
21/10/21	V1.0	C Mooney	
9/2/23	V1.0	C Mooney	

~~Audit and Risk Assurance Committee~~

~~TERMS OF REFERENCE~~

CONTENTS

1. CONSTITUTION

1.1 The Trust Board (The Board) hereby resolves to establish a Committee of the Board to be known as the Audit and Risk Assurance Committee (The Committee).

1.2 The Committee is a non-executive Committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference or as may be delegated by the Board on an ad hoc basis.

1.3 All procedural matters in respect of the conduct of the meetings of the Committee shall be in accordance with the Trust's Standing Orders.

1.4 The Committee will regularly review and reflect on best practice and adopt new learning as part of a commitment to continuous improvement.

2. MEMBERSHIP OF THE COMMITTEE

2.1 Trust Non-Executive Directors that are to be included as members of this Committee will be nominated by the Trust Board Chair and the Committee shall consist of not less than three members.

2.2 One of the members of the Committee will be appointed Chair of the Committee by the Chair of the Trust Board.

2.3 The Chair of the Trust Board shall not be a member of the Committee.

2.4 None of these members should be members of the Remuneration Committee.

2.5 One member of the Committee shall be the Chair of the Safety, Quality, Patient Experience and Performance Committee.

2.6 In the absence of the Committee Chair, another Non-Executive Member may be temporarily appointed

to that role by agreement of the Non-Executive Directors.

2.7 One member of the Committee must have significant, recent and relevant financial experience.

2.8 A quorum shall be two non-Executive members including the Committee Chair.

3. ATTENDANCE

3.1 The Director of Finance, Director of Planning, Performance and Corporate Services and appropriate Internal and External Audit representatives shall normally attend meetings. However, at least once a year, the Committee should meet privately with the External and Internal Auditors.

3.2 The Chief Executive, Executive Directors and other Officers of the Trust may be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of

that Director or Officer. The Trust Board Chair may attend by invitation as an observer.

3.3 The Chief Executive should be invited to attend at least twice annually, to discuss with the Committee the process for assurance that supports the Mid-Year Assurance Statement and the Governance Statement.

3.4 A representative from the Sponsor Department (Department of Health) will be invited and may attend meetings of the Committee as an observer.

3.5 The Board Secretary shall attend to take minutes of the meeting and provide appropriate support to the Chair and Committee members.

4. FREQUENCY OF MEETINGS

4.1 Meetings shall be held not less than three times a year and, where necessary, can be conducted remotely

using such as teleconference/video conferencing.

4.2 The Chair of the Committee may convene additional meetings as is deemed necessary.

4.3 The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

5. AUTHORITY

5.1 The Audit and Risk Assurance Committee's primary role is to independently contribute to the Board's overall process for ensuring that an effective internal financial control system is maintained.

5.2 The Board will always retain responsibility for such control and will act after taking account of the recommendations and assurances of the Committee. The Committee, therefore, does not have the executive authority of the Board, but does

have sufficient membership, authority and resources to perform its role independently and effectively.

5.3 The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee.

5.4 The Committee is authorised by the Board to obtain external legal, clinical or other independent professional advice and to secure the attendance of individuals with relevant experience and expertise if it considers this necessary.

6. DUTIES

The duties of the Committee can be categorised as follows:

Governance, Risk Management and Internal Control

6.1 The Committee shall contribute to the establishment, review and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisation's objectives.

6.2 In particular the Committee will review:

- The adequacy of all risk and control related disclosure statements (in particular the Mid-Year Assurance Statement and the Governance Statement), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board;
- The adequacy of the underlying assurance

processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;

- The adequacy of the policies for ensuring compliance with relevant regularity, legal and code of conduct requirements, including the Trust's Standing Orders and Standing Financial Instructions;
- The adequacy of the policies and procedures for all work related to fraud and corruption as required by the Department of Health (DoH) and the Business Services Organisation's (BSO) Counter Fraud and Probity Service (CFPS);
- The annual schedule of losses and compensation payments;
- The register of Direct Award Contracts;
- Health and Safety;

- Information Governance, Performance and Compliance – UK GDPR;
- NIAS ICT Performance and Cyber Security;
- Procurement and Logistics including NIAS Stores operation.

6.3 In carrying out its work, the Committee will primarily utilise the work of Internal Audit, External Audit, and other assurance functions where appropriate, but will not be limited to these functions.

6.4 The Committee will also seek reports and assurances from other Trust Committees through their respective Chairs, Directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

6.5 This will be evidenced through the

Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

Internal Audit

6.6 The Committee shall seek to ensure that there is an effective internal audit function established by management that meets the Public Sector Internal Audit Standards and provides appropriate independent assurance to the Audit and Risk Assurance Committee, Chief Executive and Board. This will be achieved by:

- Consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal;
- Review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the

Assurance Framework;

- Consideration of the Head of Internal Audit's annual report, major findings of internal audit work (and management's response), and ensure co-ordination between the Internal and External Auditors to optimise audit resources;
- Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation;
- Annual review of the effectiveness of internal audit.

External Audit

6.7 The Committee shall review the work and findings of the External Auditor appointed by the Northern Ireland Audit Office and consider the implications of, and management's responses to, their work. This will be achieved by:

- Consideration of the performance of the External Auditor;

- Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Audit Strategy;
- Discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust;
- Review of all External Audit reports, including consideration of the annual Report to Those Charged with Governance before submission to the Board and any work carried out outside the Annual Audit Strategy, together with the appropriateness of management responses.

Other Assurance Functions

6.8 The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the

implications for the governance of the organisation.

6.9 These may include, but will not be limited to, any reports issued by the Comptroller and Auditor General or Public Accounts Committee, reviews by DoH commissioned bodies, the Regulation and Quality Improvement Authority (RQIA) or professional and regulatory bodies with responsibility for the performance of staff or functions (e.g. Joint Royal Colleges Ambulance Liaison Committee (JRCALC), Health Care Professions Council (HCPC), Royal Colleges, accreditation bodies, etc.).

Financial Reporting

6.10 The Committee shall review the Trust's Annual Report and Accounts as well as the Charitable Trust Funds Annual Report and Accounts before submission to the Board, focusing particularly on:

- The wording in the Governance

Statement and other disclosures relevant to the Terms of Reference of the Committee;

- Changes in, and compliance with, accounting policies and practices
- Unadjusted mis-statements in the financial statements;
- Major judgemental areas;
- Significant adjustments resulting from the audit;
- The Committee should also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided to the Board.
- Banking and Treasury Management including Charitable Trust Funds

Value for Money

6.11 The Committee shall oversee the adequacy of the Trust's arrangements for ensuring that Value for

Money (VFM) is obtained in the expenditure of all public funds entrusted to its care. This will include a review of the findings from, and management's response to, all value for money audit reports issued to the Trust as part of the regional VFM programme sponsored by DoH.

6.12 Consider and approve relevant policies.

7. REPORTING

7.1 The minutes of Committee meetings shall be formally recorded and submitted to the Board following approval by the Committee. After each meeting, the Chair of the Committee shall make a written report to the next Trust Board meeting. At any point, the Chair shall draw to the attention of the Board any issues that require disclosure to the full Board or require executive action.

7.2 The Committee will report to the Board annually on its work in

support of the Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the organisation, the integration of governance arrangements and the appropriateness of the self-assessment against quality and assurance standards.

7.3 The Chair shall liaise with the Chairs of other Committees on any issues or matter which may be relevant to their areas of responsibility.

8. REVIEW

8.1 The Terms of Reference should be reviewed annually.

9. OTHER MATTERS

9.1 The Agenda will be sent to members at least five working days before the meeting and supporting papers, wherever possible, shall accompany the

~~agenda, but will be dispatched no later than three working days before the meeting, save in an emergency.~~

~~9.2 An explanatory cover note will be provided for each agenda item.~~

People, Finance and Organisational Development Committee

Title:	People, Finance and Organisational Development Committee Terms of Reference		
Author(s):	Paul Nicholson, Michelle Lemon		
Ownership:	PFOD Chairs		
Date of Committee Approval:	2 December 2020	**Date of Trust Board Approval:**	21 October 2021
Operational Date:	21 October 2021	**Review Date:**	October 2023
Version No:	V2.0	**Supersedes:**	V1.0
Key Words:			
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Version Control:			
Date:	**Version:**	**Author:**	**Comments:**
21/10/21	V2.0	C Mooney	
9/2/23	V2.0	C Mooney	

~~People, Finance and Organisational Development Committee~~

~~TERMS OF REFERENCE~~

CONTENTS

1 CONSTITUTION

1.1 The Trust Board (The Board) hereby resolves to establish a Committee of the Board to be known as the People, Finance & Organisational Development Committee (The Committee).

1.2 The Committee is a Non-Executive Committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference or as may be delegated by the Board on an ad hoc basis.

1.3 All procedural matters in respect of conduct of meetings of the Committee shall be in accordance with the Trust's Standing Orders.

1.4 The Committee will regularly review and reflect on best practice and adopt new learning as part of a commitment to continuous improvement.

2 MEMBERSHIP OF THE COMMITTEE

2.1 Trust Non-Executive Directors that are to be included as members of this Committee will be nominated by the Trust Board Chair.

2.2 Two Non-Executive Members of the Committee will be appointed as Co-Chairs of the Committee by the Trust Board Chair. One Co-Chair shall have responsibility for all matters relating to People and Organisational Development and one Co-Chair shall have responsibility for all matters relating to Finance.

2.3 In the absence of the Committee Co-Chairs, another Non-Executive Member may be temporarily appointed to that role by agreement of the Non-Executive Directors.

2.5 A quorum shall be two Non-Executive members.

3 ATTENDANCE AT MEETINGS

3.1 The Director of Human Resources and the Director of Finance shall normally attend meetings.

3.2 The Chief Executive, all Directors, Assistant Directors and senior managers with responsibility for workforce and finance related functions will be invited to attend as appropriate.

3.3 The Board Secretary shall attend to the minutes of the meeting and provide appropriate support to the Committee Co-Chairs and Committee members.

4 FREQUENCY OF MEETINGS

4.1 Meetings shall be held not less than three times a year, and where necessary can be conducted remotely using such as teleconference/video conferencing.

5 AUTHORITY

5.1 The Committee will be responsible for assuring the NIAS Board that effective and regularly reviewed arrangements are in place to support Human Resources, Finance and Organisational Development functions within the Trust.

5.2 The Board will always retain responsibility for such control and will act after taking account of the recommendations and assurances of the Committee. The Committee, therefore, does not have the executive authority of the Board, but does have sufficient membership, authority and resources to perform its role independently and effectively.

5.3 The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

5.4 The Committee is authorised by the Board to obtain external legal, clinical or other independent professional advice and to secure the attendance of individuals with relevant experience and expertise if it considers this necessary.

6 DUTIES

The duties of the Committee can be categorised as follows:

6.1 Provide assurance to Trust Board in relation to all strategic issues relating to Human Resources, workforce and organisational development to deliver the Trust's Strategy, Plans and standards as determined by Trust Board.

These include those related to:

- Health and Wellbeing
- Learning and Development
- Employment Law
- Workforce Planning
- Recruitment and Retention

- Equality and Diversity
- Whistleblowing
- Pay and Conditions
- Culture

This list is not exhaustive and focus will evolve as the work of the Committee develops.

6.2 Provide assurance on the quality and effectiveness of targeted plans to support the organisation in delivering a positive patient centred culture, embedding the values and behaviours that the Trust aspires to demonstrate, including collective and compassionate leadership.

6.3 Provide assurance on the development and implementation of the Workforce Planning, Estates and Fleet strategies.

6.4 Ensure consideration of an evidence-based approach to workforce and organisational development work streams to include quantitative and qualitative information.

6.5 To independently contribute to the Board's overall process for ensuring that the Trust Board delivers its statutory responsibility to break even. This includes:

- To review in detail the financial strategy, so as to be able to confirm to the Trust Board the basis of acceptance.
- To review the financial monitoring information in sufficient detail to advise the Trust Board, with confidence, concerning the financial performance of the Trust.
- To keep Directors up-to-date regarding the financial outlook for the Trust, and to review the key financial assumptions used in estimating the projected position.
- To review achievement of cost improvements and income

generation activities in line with the Trust Delivery Plan.

- To receive regular updates on actions taken by the Director of Finance to ensure the provision of effective and sound financial management and information.
- To ensure the Director of Finance provides assurance that adequate training is delivered on an on-going basis to budget holders to enable them to manage their responsibilities.
- To assist and recommend training for SMT and Board, as appropriate.

6.6 Consider and approve relevant policies.

7 REPORTING

7.1 The Minutes of Committee meetings shall be formally recorded and submitted to the Board following approval by the Committee. After each meeting, the relevant

Co-Chair of the Committee shall make a written report to the next Trust Board meeting. At any point, the Co-Chair shall draw to the attention of the Board any issues that require disclosure to the full Board or require executive action.

7.2 The Committee will report to the Board annually on its work in support of the Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the organisation, the integration of governance arrangements and the appropriateness of the self-assessment against quality and assurance standards.

7.3 The Co-Chairs shall liaise with the Chairs of other Committees on any issues or matter which may be relevant to their areas of responsibility.

8 REVIEW

8.1 The Terms of Reference should be reviewed annually.

9 OTHER MATTERS

9.1 The agenda will be sent to members at least five working days before the meeting and supporting papers, wherever possible, shall accompany the agenda, but will be dispatched no later than three working days before the meeting, save in an emergency.

9.2 An explanatory cover note will be provided for each agenda item.

Remuneration and Terms of Service Committee

Title:	**Remuneration and Terms of Service Committee Terms of Reference**		
Author(s):	C Mooney		
Ownership:	Trust Chair		
Date of Committee Approval:		**Date of Trust Board Approval:**	21 October 2021
Operational Date:	June 2018	**Review Date:**	October 2023
Version No:	V2.0	**Supersedes:**	V1.0
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Version Control:			
Date:	**Version:**	**Author:**	**Comments:**
21/10/21	V2.0	C Mooney	
9/2/23	V2.0	C Mooney	

~~Remuneration and Terms of Service Committee~~

~~TERMS OF REFERENCE~~

CONTENTS

1 CONSTITUTION

1.1 The Trust Board (The Board) hereby resolves to establish a Committee of the Board to be known as the Remuneration and Terms of Service Committee (The Committee)

1.2 The Committee is a Non-Executive Committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference or as may be delegated by the Board on an ad hoc basis.

1.3 All procedural matters in respect of the conduct of the meetings of the

Committee shall be in accordance with the Trust's Standing Orders.

1.4 The Committee will regularly review and reflect on best practice and adopt new learning as part of a commitment to continuous improvement.

2 MEMBERSHIP OF THE COMMITTEE

2.1 Trust Non-Executive Directors that are to be included as members of this Committee will be nominated by the Trust Board Chair and the Committee shall consist of not less than three members.

2.2 The Chair of the organisation shall be Chair of the Committee.

2.3 None of these members should be members of the Audit and

Risk Assurance Committee.

2.4 In the absence of the Committee Chair, another Non-Executive Member may be temporarily appointed to that role by agreement of the Non-Executive Directors.

2.5 A quorum shall be two members including the Committee Chair.

3 ATTENDANCE

3.1 The Trust Board Chair, Chief Executive and Director of Human Resources shall normally attend meetings.

3.2 The Board Secretary shall attend to take minutes of the meeting and provide appropriate support to the Chair and

Committee members.

4 FREQUENCY OF MEETINGS

4.1 Meetings shall be held not less than two times a year and where necessary can be conducted remotely using such as teleconference/video conferencing.

5 AUTHORITY

5.1 The Committee's primary role is to advise the Board about appropriate remuneration and terms of service for the Chief Executive and all other direct reports to the Chief Executive. Advice to the Board on remuneration should include all aspects of salary (including any performance-related elements/bonuse

s and any allowances), provisions for other benefits including pensions and cars, as well as arrangements for termination of employment and other contractual terms.

5.2 The Board will always retain responsibility for such control and will act after taking account of the recommendations and assurances of the Committee. The Committee, therefore, does not have the executive authority of the Board, but does have sufficient membership, authority and resources to perform its role independently and effectively.

5.3 The Committee is authorised by the Board to investigate any activity within its

terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

5.4 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

6 DUTIES

The duties of the Committee can be categorised as follows:

6.1 Recommend to the Board about appropriate remuneration and terms of

service for the Chief Executive and Executive Directors employed by the Trust, having proper regard to the Trust's circumstances and performance. Recommendations will also take into account Directions and/or guidance issued by the Department of Health and to the provisions of any national/regional arrangements where appropriate. Matters considered shall include:-

- All aspects of salary (including any performance-related elements/bonuses)
- Provisions for other benefits e.g. Lease cars
- Arrangements for termination of employment

and other contractual terms.

6.2 Monitor and evaluate the performance management process in respect of the Chief Executive and Executive Directors (and other senior employees where appropriate). This will include:-

- Encouraging effective appraisal of staff
- Scrutinising objectives for:
  - Consistency
  - Robustness
  - Alignment with Government and Departmental priorities and local priorities
- Ensuring robust

process has taken place
- Monitoring for consistency of assessment
- Recommending overall banding and award for Senior Executives

6.3 Advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

6.4 Ensure that all provisions regarding disclosure of remuneration, including pensions, are fulfilled.

6.5 Consider and approve relevant policies.

7 REPORTING

7.1 The Minutes of Committee meetings shall be formally recorded and submitted to the Board following approval by the Committee. After each meeting, the Chair of the Committee shall make a written report to the next Trust Board meeting. At any point, the Chair shall draw to the attention of the Board any issues that require disclosure to the full Board or require executive action.

8 REVIEW

8.1 The Terms of Reference should be reviewed annually.

9 OTHER MATTERS

9.1 The Agenda shall be sent to members at least five working days

~~before the meeting and supporting papers, wherever possible, shall accompany the agenda, but shall be dispatched no later than three working days before the meeting, save in an emergency.~~

~~9.2 An explanatory cover note will be provided for each agenda item.~~

Safety, Quality, Patient Experience and Performance Committee

Title:	**Safety, Quality, Patient Experience and Performance Committee Terms of Reference**		
Author(s):	C Mooney		
Ownership:	Committee Chair		
Date of Committee Approval:	11 June 2020	**Date of Trust Board Approval:**	21 October 2021
Operational Date:	21 October 2021	**Review Date:**	October 2023
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Key Words:			
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Version Control:			
Date:	**Version:**	**Author:**	**Comments:**
21/10/21	V2.0	C Mooney	
9/2/23	V2.0	C Mooney	

~~Safety, Quality, Patient Experience and Performance Committee~~

~~TERMS OF REFERENCE~~

CONTENTS

1 CONSTITUTION

1.1 The Trust Board (The Board) hereby resolves to establish a Committee of the Board to be known as the Safety, Quality, Patient Experience and Performance Committee (The Committee).

1.2 The Committee is a Non-Executive Committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference or as may be delegated by the Board on an ad hoc basis.

1.3 All procedural matters in respect of conduct of meetings of the Committee shall be in accordance with the Trust's Standing Orders.

1.4 The Committee will regularly review and reflect on best practice and adopt new learning as part of

a commitment to continuous improvement.

2 MEMBERSHIP OF THE COMMITTEE

2.1 Trust Non-Executive Directors that are to be included as members of this Committee will be nominated by the Trust Board Chair.

2.2 A Non-Executive Member of the Committee will be appointed Chair of the Committee by the Trust Board Chair.

2.3 The Trust Board Chair shall not be a member of the Committee but may attend meetings in an ex-officio capacity.

2.4 In the absence of the Committee Chair, another Non-Executive Member may be temporarily appointed to that role by agreement of the Non-Executive Directors.

2.5 One member of the Committee

shall be the Chair of the Audit and Risk Assurance Committee.

2.6 Where practicable, one member of the Committee should have a clinical background.

2.7 A quorum shall be two Non-Executive members including the Committee Chair.

3 ATTENDANCE AT MEETINGS

3.1 All Directors shall normally attend meetings (subject to the issues to be considered on the agenda).

3.2 The Trust Board Chair, Chief Executive and other Officers of the Trust may attend and will be particularly expected to do so when the Committee is discussing areas of risk or operation that are the responsibility of that Officer.

3.3 The Board Secretary shall

attend to the minutes of the meeting and provide appropriate support to the Committee Chair and Committee members.

4 FREQUENCY OF MEETINGS

4.1 Meetings shall be held not less than three times a year, and where necessary can be conducted remotely using such as teleconference/video conferencing.

5 AUTHORITY

5.1 The Committee will be responsible for assuring the NIAS Board that effective and regularly reviewed arrangements are in place to support the implementation, maintenance and development of Governance (clinical and non-clinical) and risk management and that such matters are properly considered and communicated to the Board.

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5.2 The Board will always retain responsibility for such control and will act after taking account of the recommendations and assurances of the Committee. However, the Committee does have the delegated authority of the Board, through sufficient membership, authority and resources to perform its role independently and effectively.

5.3 The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee.

5.4 The Committee is authorised by the Board to obtain external legal, clinical or other independent professional advice

and to secure the attendance of individuals with relevant experience and expertise if it considers this necessary. In particular, the Committee must be satisfied that it is able to provide appropriate clinical assurance.

6 DUTIES

The duties of the Committee can be categorised as follows:

6.1 Governance, Risk Management, Internal Control, Safety, Quality, Patient Experience and Performance - The Committee shall contribute to the establishment, review and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the

organisation's objectives with a particular focus on safety, quality, patient experience and performance.

6.2 In particular the Committee will:

6.2.1 Provide assurance that adequate systems and processes are in place to support the achievement of the organisation's objectives and strategically manage clinical and non-clinical risks.

6.2.2 Provide assurance that adequate systems and processes are in place for the delivery of high-quality patient care that is safe, effective and patient

focused through the review and monitoring of:

- Clinical and operational activities;
- Operational performance;
- Safeguarding;
- Professional self-regulation;
- Development and implementation of national standards of care and practice;
- Clinical audit activity;
- Professional and clinical performance standards;
- Continuing professional development for all staff;

- Adverse incidents and complaints with a clinical component;
- Infection prevention and control arrangements;
- Clinical research and development activity;
- Personal and public involvement (PPI) arrangements and activities;
- Corporate social responsibility;
- Emergency planning and business continuity;
- Information governance;
- Compliance with the relevant

DoH controls assurance standards and associated action plans.

- Clinical Effectiveness Audit
- Compliments and Complaints
- Quality Assurance and Annual Quality Report
- Complex Case Team
- Medicines Management
- Clinical Practice and Guidance
- Community First Responders
- Control Room Performance
- Clinical Support Desk

- Voluntary Car Service and Independent Sector Management

6.2.3 Review the Trust's Assurance Framework and the Trust's Risk Register and to make recommendations to Trust Board for action as required to ensure high quality patient care. In reporting to the Trust Board the committee will seek to reach consensus in any decisions made. Where consensus cannot be reached, the issue will be referred to the Trust Board for further

discussion and if necessary a decision.

6.2.4 Report and review the outcome of Serious Adverse Incidents (SAI) including Serious Clinical Adverse Incidents in line with DoH guidance and to ensure that appropriate remedial action has been taken including measures to prevent recurrence.

6.2.5 Receive reports from other Committees and Working Groups in relation to areas of risk and governance.

6.2.6 Provide Trust Board with regular reports on

the management of risk and quality of patient care, an annual report on clinical governance and an annual quality report.

6.3 [2]In carrying out its work, the Committee will utilise the work of Internal Audit, External Audit, and other assurance functions where appropriate, but will not be limited to these functions. It will also seek reports and assurances from other Trust Committees through their respective Chairs, Directors and managers as appropriate, concentrating on the overarching systems of integrated

[2] Safety First – A framework for sustainable Improvement in the HPSS (March 2006)

[3] Procedure for reporting and follow up of SAI (April 2010)

governance, risk management and internal control, together with indicators of their effectiveness.

6.4 This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

6.5 Other Assurance Functions - The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation.

6.6 These may include, but will not be limited to, any reports issued by the Comptroller and Auditor General or Public Accounts Committee, reviews by DoH commissioned bodies, the Regulation and

Quality Improvement Authority (RQIA) or professional and regulatory bodies with responsibility for the performance of staff or functions (e.g. Joint Royal Colleges Ambulance Liaison Committee (JRCALC), Health and Care Professions Council (HCPC), Royal Colleges, accreditation bodies, etc.).

6.7 Governance Statement - The Committee shall review the Governance Statement and other disclosures relevant to the Terms of Reference of the Committee.

6.8 Consider and approve relevant policies.

7 REPORTING

7.1 The minutes of Committee meetings shall be formally recorded and submitted to the Board following approval by the Committee. After

each meeting, the Chair of the Committee shall make a written report to the next Trust Board meeting. At any point, the Chair shall draw to the attention of the Board any issues that require disclosure to the full Board or require executive action.

7.2 The Committee will report to the Board annually on its work in support of the Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the organisation, the integration of governance arrangements and the appropriateness of the self-assessment against the Quality Standards and Controls Assurance Standards.

7.3 The Chair shall liaise with the

Chairs of other Committees on any issues or matter which may be relevant to their areas of responsibility.

8 REVIEW

8.1 The Terms of Reference should be reviewed annually.

9 OTHER MATTERS

9.1 The agenda will be sent to members at least five working days before the meeting and supporting papers, wherever possible, shall accompany the agenda, but will be dispatched no later than three working days before the meeting, save in an emergency.

9.2 An explanatory cover note will be provided for each agenda item.


N.I.A.S.

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

PRESENTATION OF PAPER

Date of Trust Board:	18 February 2025
Title of paper:	Standing Financial Instructions (SFIs)
Brief summary:	A review of the Trust's Standing Financial Instructions has been carried out as the SFIs have not been updated since December 2019. The review included bench marking with other HSC Trusts SFIs and consideration of current DOH policies, financial circulars, and legislation. The Standing Financial Instructions were approved by ARAC on 6 February 2025. If Trust Board are content to approve, the revised Standing Financial Instructions will be disseminated to all staff. It should be noted that a further review will be carried out in October 2025 as additional updates are expected to be required to ensure that the SFIs are compliant with new procurement legislation and changes to the Trust's planning and monitoring process.

Recommendation:	**For Approval** ☒ **For Noting** ☐ *Click the appropriate box*
Previous forum:	
Prepared and presented by:	Brona McAuley, Assistant Director Finance Simon Christie.
Date:	7/2/2025

Northern Ireland Ambulance Service
Health and Social Care Trust

STANDING FINANCIAL INSTRUCTIONS

January 2025

Northern Ireland Ambulance Service
Health and Social Care Trust

Title:	Standing Financial Instructions		
Author:	Assistant Director of Finance		
Ownership:	Director of Finance		
Date of Audit Committee Approval:	6 February 2025	Date of Trust Board Approval:	
Operational Date:		Review Date:	October 2025
Version No:	V2.0	Supercedes:	Standing Financial Instructions v1.0 Dec 2019
Key words:	Standing Orders, Scheme of Reservation and Delegation, Standing Financial Instructions		
Other Relevant Policies:	Standing Orders and Scheme of Reservation and Delegation		

Date	**Version**	**Author**	**Comments**
6 February 2025	V2.0	Brona McAuley	Approved at Audit Committee
16 January 2025	V0.1	Brona McAuley	Standing Financial Instructions benchmarked with HSC Trusts consideration of current DOH policies, financial circulars, and legislation.
15 October 2019	V1.0	Andrew Phillips	Approved at Audit Committee
5 December 2019	V1.0	Andrew Phillips	Approved at Trust Board

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SECTION A

1. DEFINITIONS FOR STANDING FINANCIAL INSTRUCTIONS

1.1 Any expression to which a meaning is given in the HPSS (NI) Order 1991, the Health and Social Care (Reform) Act (Northern Ireland) 2009 and other Acts / Orders relating to the HSC shall have the same meaning in these Standing Financial Instructions and in addition:

1.1.1 **"Accounting Officer"** means the HSC Officer responsible and accountable for funds entrusted to the Trust. The officer shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive.

1.1.2 **"Trust"** means the Northern Ireland Ambulance Service (NIAS) Health & Social Care Trust.

1.1.3 **"Board"** means the Chair, Executive and Non-Executive members of the Trust collectively as a body.

1.1.4 **"Budget"** means a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.

1.1.5 **"Budget holder"** means the Director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation.

1.1.6 **"Chair of the Board (or Trust)"** is the person appointed in accordance with the relevant legislation to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression "the Chair of the Trust" shall be deemed to include the member acting as Chair of the Trust if the Chair is absent from the meeting or is otherwise unavailable.

1.1.7 **"Chief Executive"** means the Chief Officer of the Trust. The Chief Executive is the Trust's Accounting Officer.

1.1.8 **"Assurance Committee"** means a committee whose functions are concerned with the arrangements for the purpose of monitoring and improving the quality and safety of health and social care for which the Northern Ireland Ambulance Service Health and Social Care Trust has responsibility.

1.1.9 **"Commissioning"** means the process for determining the need for and for

obtaining the supply of healthcare, social care and related services by the Trust within available resources.

1.1.10 **"Committee"** means a committee or Sub-Committee created and appointed by the Trust.

1.1.11 **"Committee members"** means persons formally appointed by the Board to sit on or to chair specific committees.

1.1.12 **"Director of Finance"** means the Chief Financial Officer of the Trust.

1.1.13 **"Member"** means executive or non-executive member of the Board as the context permits. Member, in relation to the Board, includes its Chair.

1.2.16 **"Nominated officer"** means an officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.

1.2.17 **"Officer"** means employee of the Trust or any other person holding a paid appointment or office with the Trust.

1.2.18 **"SFI's"** means Standing Financial Instructions.

1.2.19 **"SO's"** means Standing Orders.

1.2.20 **"Member acting as Chair"** means the non-executive member appointed by the Board to take on the Chair's duties if the Chair is absent for any reason.

1.2.21 **"DoH"** means the Department of Health.

Northern Ireland Ambulance Service
Health and Social Care Trust

SECTION B - STANDING FINANCIAL INSTRUCTIONS

1. INTRODUCTION

KEY POINTS

- Standing Financial Instructions identify the **key financial responsibilities** which apply to everyone working for the Trust.
- The Trust Board exercise financial supervision control via a number of measures.
- The Chief Executive and Director if Finance will delegate financial responsibilities but remain accountable for financial control.
- **Employees are responsible for:** Trust property, avoiding loss, exercising economy and efficiency in use of resources, complying with the Trust's Standing Orders, Standing Financial Instructions, Financial Procedures, Financial Policies and Scheme of Delegated Authority.

1.1 General

1.1.1 These Standing Financial Instructions (SFIs) are issued for the regulation of the conduct of the Trust's members and officers in relation to all financial matters. They shall have effect as if incorporated in the Standing Orders (SO's). They are the "business rules" that Directors and employees (including employees of third parties contracted by the Trust) must follow when acting on behalf of the Trust.

1.1.2 These Standing Financial Instructions detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Standing Orders, and the Scheme of Reservation and Delegation (which includes the Schedule of Decisions Reserved to the Board and the Scheme of Delegation adopted by the Trust).

1.1.3 These Standing Financial Instructions identify the financial responsibilities which apply to everyone working for the Trust including third parties contracted to NIAS

acting on behalf of the Trust. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Director of Finance. Standing Financial Instructions **are mandatory on all Members, Directors and employees of the Trust.**

1.1.4 Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the Director of Finance must be sought before acting. The user of these Standing Financial Instructions should also be familiar with and comply with the provisions of the Trust's Standing Orders.

1.1.5 **Failure to comply with Standing Financial Instructions and Standing Orders can in certain circumstances be regarded as a disciplinary matter that could result in dismissal.**

1.1.6 Overriding Standing Financial Instructions – If for any reason these Standing Financial Instructions are not complied with in any significant or material respect, full details and any justification for non-compliance shall be reported to the next formal meeting of the Audit Committee for referring action or ratification. All members of the Board and staff have a duty to disclose any significant or material non-compliance with these Standing Financial Instructions to the Director of Finance as soon as possible.

1.2 Responsibilities and Delegation

1.2.1 The Trust Board

The Board exercises financial supervision and control by:

(a) formulating the financial strategy.

(b) requiring the submission and approval of an annual financial plan within the approved opening revenue and capital allocations / overall income.

(c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain best value for money).

(d) defining specific responsibilities placed on members of the Board and employees as indicated in the Scheme of Reservation and Delegation; and

(e) ensuring that it receives and reviews regular financial information concerning the management of the Trust and that it is informed on a timely basis about any concerns regarding the activities of the Trust.

The Trust Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the Standing Orders and Scheme of Reservation & Delegation. All other powers have been delegated to the Chief Executive or such other committees as the Trust has established.

1.2.2 **The Chief Executive and Director of Finance**

The Chief Executive and Director of Finance will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

Within the Standing Financial Instructions, it is acknowledged that the Chief Executive is ultimately accountable to the Board, and as Accounting Officer, to the Minister for the Department of Health (DoH). The Chief Executive is personally responsible for safeguarding the public funds for which he/she has charge; for ensuring propriety and regularity in the handling of those funds and for the day-to-day operations and management of the Trust. In addition, he/she should ensure that the Trust meets the standards set out in Managing Public Money NI (MPMNI) in relation to governance, decision making and financial management.

The Chief Executive has overall executive responsibility for the Trust's activities; is responsible to the Chair and the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

It is a duty of the Chief Executive to ensure that Members of the Board and, employees and all new appointees are notified of, and put in a position to understand their responsibilities within these Instructions.

1.2.3 **The Director of Finance**

The Director of Finance is responsible for:

(a) implementing the Trust's financial policies/procedures and for coordinating any corrective action necessary to further these policies.

(b) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions.

(c) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time.

(d) the provision of financial advice to the Trust Board, the Chief Executive, Directors and employees.

(e) the design, implementation and supervision of systems of internal financial control; and

(f) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

1.2.4 **Trust Board Members, Chief Executive, Executive Directors and Employees**
All are severally and collectively responsible for:

(a) the security of the property of the Trust.

(b) avoiding loss and fraud.

(c) exercising economy and efficiency in the use of resources; and

(d) conforming to the requirements of Standing Orders, Standing Financial Instructions, the Scheme of Delegated Authority and any Financial Procedures or Policies which the Director of Finance may issue.

1.2.5 **Contractors and their employees**
Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

For all members of the Trust Board and any employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Trust Board and employees discharge their duties must be to the satisfaction of the Director of Finance.

2. AUDIT

KEY POINTS

- Audit and Risk Assurance Committee is a sub-committee of the Trust Board which will provide an independent and objective view of internal control in the organisation.
- It will rely on work performed by Internal Audit and External Audit and other appropriate assurance functions;
- The Director of Finance is responsible for ensuring there are arrangements to review evaluate and reports on the effectiveness of internal financial control; *and*
- The Director of Finance is responsible for assessing, identifying, evaluating and responding to fraud, bribery and corruption risks and reporting on counter fraud work annually to the Audit and Risk Assurance Committee.

2.1 Audit and Risk Assurance Committee

2.1.1 In accordance with Standing Orders and the Code of Conduct and Code of Accountability for Board Members of Health and Social Care Bodies (2012), the Trust Board shall formally establish an Audit Committee, with clearly defined terms of reference and following guidance from the Audit and Risk Assurance Committee Handbook (NI) 2018.

2.1.2 The Audit and Risk Assurance Committee will provide an independent and objective view of governance and internal control arrangements by:

(a) overseeing Internal and External Audit services.

(b) reviewing the adequacy of all risk and control related disclosure statements, in particular the mid-year assurance statement and the Governance Statement, together with any accompanying Head of Internal Audit assurance statement, external audit opinion and other appropriate independent assurances prior to endorsement by the Trust Board.

(c) reviewing financial and information systems and monitoring the integrity of the financial statements and reviewing significant financial reporting judgments.

(d) contributing to the review of the establishment and maintenance of an effective system of integrated governance, risk management and internal

control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

(e) monitoring compliance with Standing Orders and Standing Financial Instructions.

(f) reviewing schedules of losses and compensations and making recommendations to the Board regarding their approval.

(g) reviewing the adequacy of the policies and procedures for all work related to fraud and corruption.

(h) contributing to the arrangements in place to support the Assurance Framework process prepared on behalf of the Board and advising the Board accordingly; and

(i) providing, or arranging to have provided, any other assurances that are required by Trust Board.

2.1.3 Where the Audit Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wishes to raise, the Chair of the Audit Committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to the DoH (in the first instance to the Director of Finance).

2.1.4 It is the responsibility of the Director of Finance to ensure an adequate Internal Audit service is provided and the Audit Committee shall be involved in the selection process when / if an Internal Audit service provider is changed.

2.2 Director of Finance

2.2.1 The Director of Finance is responsible for:

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function.

(b) ensuring that the Internal Audit function is adequate and meets the mandatory Public Sector Internal Audit Standards (PSIAS) having due regard to DoH guidance detailing internal audit arrangements between a sponsoring Department and its Arm's Length Bodies.

(c) deciding at what stage to involve the police in cases of misappropriation and

other irregularities in accordance with the Trust's Fraud Response Plan.

(d) ensuring that an Annual Internal Audit Report is prepared by the Head of Internal Audit (Business Services Organisation) for the consideration of the Audit and Risk Assurance Committee. The report must cover:

(1) a clear opinion on the effectiveness of internal control in accordance with assurance framework guidance issued by DoH.

(2) major internal control weaknesses discovered.

(3) progress on the implementation of internal audit recommendations; and

(4) progress against plan over the previous year.

(e) ensuring that an Annual Internal Audit Strategic Audit Plan covering the coming three years is produced from which an annual Operational Plan is derived.

2.2.2 The Director of Finance or designated auditors are entitled without necessarily giving prior notice to require and receive:

a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature.

b) access at all reasonable times to any land, premises or members of the Trust Board or employee of the Trust.

c) the production of any cash, stores or other property of the Trust under the control of a member of the Trust Board or an employee; and

d) explanations concerning any matter under investigation.

2.3 Role of Internal Audit

2.3.1 Internal Audit will review, appraise and report upon:

a) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures.

b) the adequacy and application of financial and other related management controls.

c) the suitability, accuracy, reliability and integrity of financial and other ~~related~~ management information.

d) the extent to which the Trust's assets and interests are acquired economically, accounted for and safeguarded from loss of any kind.

(e) the adequacy of follow up action taken by management in response to Internal Audit reports; and

(f) the integrity of processes and systems to ensure that controls offer adequate protection against error, fraud and loss of all kinds.

(g) the adequacy of governance arrangements to provide assurance to the Chief Executive and Trust Board.

(h) the Head of Internal Audit shall provide an annual opinion on the Trust's risk management, control and governance arrangements. This opinion is based upon, and limited to, the results of the Internal Audit work performed during the year as approved by the Audit Committee.

2.3.2 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Director of Finance must be notified immediately.

2.3.3 The Head of Internal Audit will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chair and Chief Executive of the Trust.

2.3.4 The Head of Internal Audit shall be accountable to the Audit and Risk Assurance Committee. The reporting system for internal audit shall be agreed between the Director of Finance, the Audit and Risk Assurance Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the Public Sector Internal Audit Standards. The reporting system shall be reviewed at least every three years.

2.4 External Audit

2.4.1 The Comptroller and Auditor General (C&AG) for Northern Ireland is the appointed External Auditor for the Trust, who may outsource the delivery of the external audit programme to an appropriately qualified third-party organisation.

2.4.2 The Audit Committee will consider the performance of the External Auditor. If there are any problems relating to the service provided by an outsourced External Auditor, then this should be raised initially with the External Auditor and referred on to NI Audit Office if the issue cannot be resolved. The Director of Finance will notify the Audit Committee and Trust Board of any such instances.

2.4.3 Value-for-money assignments carried out by an External Auditor are directed by a nominated senior officer within DoH. The cost of such assignments is borne by DoH.

2.4.4 The Comptroller & Auditor General (C&AG) has a statutory right of access to all relevant documents as provided for in Articles 3 and 4 of the Audit and Accountability (NI) Order 2003.

2.5 Fraud and Corruption

2.5.1 In line with their responsibilities, the Chief Executive and Director of Finance shall monitor and ensure compliance with all guidance issued by the DoH Counter Fraud Policy Unit on fraud, bribery and corruption.

2.5.2. The Director of Finance is responsible for:

(a) assessing, identifying, evaluating and responding to risks of bribery or fraud.

(b) ensuring appropriate arrangements are in place for deterring, preventing, detecting and investigating fraud or bribery.

(c) ensuring that the Trust's Audit Committee formally considers the anti-fraud measures in place.

(d) reporting immediately all suspected or proven frauds, including attempted fraud to Business Services Organisation's Counter Fraud & Probity Services Unit; and

(e) complying with all guidance issued by DoH.

(f) Developing an anti-fraud policy and fraud response plan which is updated at least every five years and sent to Counter Fraud and Probity Services Unit at BSO for review.

2.5.3 The Director of Finance shall nominate a suitable person to carry out the duties of the Fraud Liaison Officer, as specified by the DoH Counter Fraud Policy and

guidance.

2.5.4 The Fraud Liaison Officer shall report to the Director of Finance and shall work with staff in the Counter Fraud and Probity Service within the Business Services Organisation (BSO) and the Regional Counter Fraud Policy Unit in accordance with the DoH Counter Fraud Policy.

2.5.5 The Assistant Director of Financial Services will provide a written report to the Audit and Risk Assurance Committee, at least annually, on counter fraud work within and on behalf of the Trust.

3. RESOURCE LIMIT CONTROL

KEY POINTS

- The Trust is required to operate within the revenue and capital budgets delegated to it by the DoH/Commissioning Body; *and*
- The Trust is required to work closely with Commissioners, the DoH and other HSC organisations to demonstrate efficient use of resources, manage cost pressures and gain approval for service developments and enhancements.

3.1 The Trust's revenue and capital expenditure form part of the DoH Department's Resource Delegated Expenditure Level (DEL) and Capital DEL respectively.

3.2 The Trust shall not, without prior written DoH approval, enter into any undertaking to incur any expenditure which falls outside the Trust's delegations, or which is not provided for in the Trust's annual budget as approved by the DoH or the Commissioning Body on its behalf. This reflects the general principles set out in Managing Public Money (NI) (MPMNI) relating to the authority for expenditure, regularity, propriety, and value for money which applies to all public expenditure.

3.3 The Trust is obliged to act in line with the guidance as set out in circular HSC (f) 37/2023 which deals with the HSC Finance Regime.

This states that the Trust is obliged to:

(a) contain expenditure within the overall resources allocated subject to any ring-fencing constraints.

(b) maintain a constructive dialogue with other HSC organisations.

(c) ensure that their services are offered at a price which reflects economic and efficient use of resources and complies fully with financial requirements.

(d) take a joint risk sharing approach with Commissioners to the management of cost pressures identified.

(e) work jointly with Commissioners to reprofile services, incorporating bridging finance milestones and timeframes within SBA.

(f) work with the DoH and Commissioners to manage the service implications of the

capital programme.

(g) commission services from the independent sector as part of an agreed strategy which acknowledges and accounts for the short and long run implications for the statutory sector; and

(h) undertake service developments or enhancements only with the approval of Commissioners except in the most exceptional of circumstances.

3.4 Where patient, service user or staff safety requires expenditure to be incurred beyond the current approved budget, the Director of Finance is required to prepare a contingency plan to bring expenditure back to within budget limits and within an agreed timeframe. Should that not be possible, then the Director of Finance is required to inform the Department of Health where material.

3.5 The Trust Director of Finance must obtain the prior approval of the Department of Health for any transactions which set precedents, are novel, potentially contentious or could cause repercussions elsewhere in HSC or other public sector bodies. DoH approval must be obtained even where such transactions are within the Trust's delegated limits.

Examples include:

- Incurring expenditure for any purpose which is or might be considered novel or contentious, or which has or could have significant future cost implications.
- Making any significant changes in the operation of funding of initiatives or particular schemes previously approved by the sponsor Department.
- Unusual financing transactions, especially those with lasting commitments.
- Making any change of policy or practice which has wider financial implications (e.g. because it might prove repercussive among other public sector bodies) or which might significantly affect the future level of the resources required.

This applies whether the expenditure relates to revenue, capital, IT, Direct Award Contracts (DAC), consultancy, gifting etc. and is irrespective of existing delegations.

4. REVENUE RESOURCE LIMIT, PLANNING, BUDGETS, BUDGETARY CONTROL, AND MONITORING

KEY POINTS

- The Chief Executive will submit to the Commissioning body a Trust Delivery Plan which takes into account financial targets and forecast limits of available resources.
- The Director of Finance will prepare and submit revenue and capital budgets for approval by Trust Board in line with the Trust Delivery Plan.
- The Chief Executive delegates the management of budgets to budget holders to permit the performance of a defined range of activities.
- The Director of Finance reports monthly on performance against budget to Trust Board; *and*
- Budget holders are responsible for:
  - remaining within budget.
  - using the budget for the purpose intended.
  - not appointing permanent employees outside available resources; *and*
  - attending budgetary training.

4.1 Revenue Resource Limit (RRL)

4.1.1 The Director of Finance will:

(a) secure the Trust's entitlement to funds (both Revenue & Capital).

(b) at the start of each financial year, submit to the Commissioning Body for approval a Financial Plan showing the total RRL and other forecast income and will include a budget of estimated payments and receipts together with a profile of expected expenditure and cash draw down of funding and/or other income over the year; and

(c) regularly update the Trust Board on significant changes to the initial Revenue Resource Limit and the uses of such funds.

4.2 Preparation and Approval of Plans and Budgets

4.2.1 The Chief Executive will compile and submit to the Commissioning Body a Trust Delivery Plan (TDP) which takes into account financial targets and forecast limits of available resources. The TDP will contain:

(a) a statement of the significant assumptions on which the plan is based, taking into account its approved funding provision and any forecast receipts.

(b) details of the organisation's priorities and objectives; and

(c) details of major changes in workload, delivery of services or resources required to achieve the plan.

4.2.2 Prior to the start of the financial year the Director of Finance will, on behalf of the Chief Executive, prepare an opening revenue and capital budget. Such budgets will:

(a) be in accordance with the aims and objectives set out in any business plan for the Trust.

(b) accord with workload and workforce plans.

(c) be produced following discussion with appropriate budget holders.

(d) be prepared within the limits of available funds and where applicable, any control total either approved or for approval by DoH; and

(e) identify potential risks.

4.2.3 The Director of Finance shall monitor financial performance against budget and plan, review them on a monthly basis and report to Trust Board.

4.2.4 All budget holders must provide information as required by the Director of Finance to enable budgets to be compiled.

4.2.5 The Director of Finance has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully.

4.3 Budgetary Delegation

4.3.1 The Chief Executive delegates the management of budgets to budget holders to permit the performance of a defined range of activities. This delegation is implied in line with these Standing Financial Instructions. Budget holders have the responsibility to be aware of:

(a) the total amount of the budget they are responsible for.

(b) the purpose(s) of each budget heading.

(c) individual and group responsibilities.

(d) their authority to exercise virement only within total revenue or total capital (no virement of budget is permitted between revenue and capital); and

(e) the performance against their budget.

4.3.2 The Chief Executive and delegated budget holders must not exceed the budgetary total Revenue Resource Limit set by the Commissioning Body taking account of any approved control total.

4.3.3 All budget holders must ensure that the necessary business case preparation and approvals have been obtained for expenditure decisions before committing to recurrent revenue expenditure or to support any other proposed investment. Failure to obtain the required approvals will mean that the expenditure has been incurred without the required authority and is therefore deemed to be irregular. This could lead to a qualification of the audit opinion in the Trust's annual financial statements. Budget holders should refer to the latest DoH and Trust guidance on business cases and the NI Better Business Case (BBC) Guidance. It is recommended that Budget Holders consult with the Assistant Director of Financial management for advice before committing to any proposed recurrent investment.

4.3.4 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement. Where DoH resources allocated for a particular purpose are not required or not required in full for that purpose, approval of the Commissioning Body/DoH must be obtained before any redistribution within the Trust. This is to be coordinated by the Director of Finance.

4.3.5 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Director of Finance.

4.3.6 All budget holders are required to regularly review all projected expenditure and identify to the Director of Finance on a timely basis where inescapable expenditure has the potential to breach their delegated budget.

4.4 Budgetary Control and Reporting

4.4.1 The Director of Finance will devise and maintain systems of budgetary control, which will include:

(a) Monthly financial reports to the Trust Board in a form approved by the Board containing:

(1) income and expenditure to date showing trends and forecast year-end position.

(2) capital project spend and projected outturn against plan.

(3) explanations of any material variances from plan; and

(4) details of any corrective action where necessary and the Chief Executive's and / or Director of Finance's view of whether such actions are sufficient to correct the situation.

(b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible.

(c) investigation and reporting of variances from financial, workload and workforce budgets.

(d) monitoring of management action to correct variances; and

(e) arrangements for the authorisation of budget transfers.

4.4.2 Each Budget Holder is responsible for ensuring that:

(a) any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Board or its delegated representative.

(b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement.

(c) no permanent employees are appointed without the approval of the Chief Executive, or his / her delegated representative, other than those provided for within the available resources and budgeted establishment; and

(d) budget holders should attend such training as is deemed necessary by the Director of Finance.

(e) Assistant Director of Financial Management should be consulted for advice

and support as required.

4.4.3 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the TDP and a balanced budget.

4.5 Capital Expenditure

4.5.1 The general rules applying to delegation and reporting shall also apply to capital expenditure.

4.6 Monitoring Returns

4.6.1 The Assistant Director of Financial Management is responsible for ensuring that the appropriate financial monitoring forms are submitted to the requisite monitoring organisation.

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5. ANNUAL ACCOUNTS AND REPORTS

KEY POINTS

- The Director of Finance will prepare financial returns, and the Annual Report and Accounts for the Trust as required by the DoH; *and*
- The Annual Report and Accounts will be subject to audit by the Comptroller and Auditor General, laid before the NI Assembly and presented in a public meeting of the Trust.
- The Annual Report & Accounts are to be published on the Trust's website.

5.1 The Director of Finance, on behalf of the Trust, will:

(a) prepare financial returns in accordance with the accounting policies and guidance given by the DoH and the Department of Finance (FReM), the Trust's accounting policies, and International Financial Reporting Standards.

(b) prepare and submit an audited Annual Report of the Trust's activities together with its audited consolidated annual accounts to the DoH certified in accordance with issued timetable and guidelines; and

(c) submit financial returns to the DoH for each financial year in accordance with the timetable prescribed by the DoH.

5.2 The Trust's Annual Report and annual accounts must be audited either by an external auditor appointed by or the Comptroller and Auditor General (C&AG) for Northern Ireland. The Trust's audited Annual Report and annual accounts must be presented to a public meeting of the Trust Board and made available to the public after laying before the NI Assembly. The document must comply with the DoH Manual of Accounts, the Financial Reporting Manual (FReM) and any other relevant guidance.

5.3 The Trust shall maintain and publish a Freedom of Information (FOI) Publication Scheme in a format approved by the Information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about the Trust that are made publicly available. This will include the Annual Report and Accounts.

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6. BANK ACCOUNTS

KEY POINTS

- The Director of Finance is responsible for managing the Trust's banking arrangements and ensuring detailed instructions on their operation are in place; *and*
- The Trust Board will approve the banking arrangements.

6.1 General

6.1.1 The Director of Finance is responsible for managing the Trust's banking arrangements, including establishing and developing the interface with the BSO where it provides banking services on behalf of the Trust. The Chief Executive, as Accounting Officer, is responsible for the credit risk to which public funds are exposed when held in commercial banks. The Director of Finance is also responsible for advising the Trust Board on the provision of banking services and operation of accounts. This advice will take into account guidance and directions issued from time to time by the DoH.

6.1.2 The Chief Executive is responsible for ensuring that the Trust's banking arrangements are in accordance with the requirements outlined in Managing Public Money Northern Ireland (MPMNI).

6.1.3 The Trust Board shall approve the banking arrangements.

6.2 Bank Accounts

6.2.1 The Director of Finance is responsible for:

(a) the operation of bank accounts.

(b) establishing separate bank accounts for the Trust's non-public funds.

(c) ensuring payments made from bank accounts do not exceed the amount credited to the account except where prior arrangements have been made.

(d) reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn.

(e) monitoring compliance with DoH guidance on the level of cleared funds; and

(f) setting the parameters for the BSO within the SLA for any of the above as appropriate.

6.3 Banking Procedures

6.3.1 The Director of Finance will prepare detailed instructions on the operation of bank accounts which must include:

(a) the conditions under which each bank account is to be operated, including the use of electronic banking.

(b) those authorised to sign cheques or other orders drawn on the Trust's accounts.

(c) the limit to be applied to any overdraft.

(d) when and how payment by cheque, credit card or debit card is acceptable.

(e) record keeping, including bank reconciliations.

(f) adequate records are maintained of payments and receipts and adequate facilities are available for the secure storage of cash; and

(g) setting the parameters for the BSO within the SLA for any of the above as appropriate.

6.3.2 The Director of Finance must advise the Trust's bankers in writing of the conditions under which each account will be operated including the nominated officers who are authorised to release monies from the bank accounts.

6.4 Tendering and Review

6.4.1 The Director of Finance is responsible for reviewing the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking, in co-operation with other HSC organisations, competitive tenders for the Trust's commercial banking business. The Trust should avail of the regional HSC banking contract, save in exceptional circumstances.

6.4.2 Competitive tenders for HSC banking business should be sought at least every five years. The results of the tendering exercise should be reported to the Board.

7. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

KEY POINTS

- The Director of Finance is responsible for ensuring that BSO Accounts Receivable Shared Services have appropriate procedures in place for the recording, invoicing, debt management, receipting and coding of all income due to the Trust.
- The Director of Finance is responsible for ensuring Trust staff have appropriate guidance regarding the above.
- The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges.
- Trust staff must promptly advise of income due to the Trust and follow the appropriate procedures to ensure an invoice is raised; *and*
- The Director of Finance is responsible for ensuring adequate security arrangements are in place over stationery, safes, safe keys, cash, cheques etc.

7.1 Income Systems

7.1.1 The Director of Finance is responsible for ensuring, via the Service Level Agreement with the BSO, that there is compliance with agreed systems for the proper recording, invoicing, collection and coding of all monies due.

7.1.2 The Director of Finance is also responsible for ensuring that the BSO and Trust staff comply with the requirement for the prompt banking of all monies received.

7.1.3 The Director of Finance will seek annual assurance from the BSO on the reliability of the information processed by BSO for accounting purposes on behalf of the Trust.

7.1.4 The Director of Finance will seek assurance that the BSO systems, controls and processes are subject to audit on an annual basis and that the Trust formally advised of any assurance levels that are categorised as less than satisfactory.

7.1.5 The Assistant Director of Financial Services is responsible for designing, maintaining and training Trust staff in appropriate financial procedures regarding the above.

7.1.6 The Assistant Director of Financial Services will ensure that the Trust receives

regular reports in an agreed format in relation to all areas of income, debt and banking that are managed by BSO on the Trust's behalf.

7.2 Fees and Charges

7.2.1 All fees or charges for any services supplied by the Trust, including services provided between HSC bodies shall be determined in accordance with MPMNI and should be charged on a full cost recovery basis. Where it is decided to charge less than full costs, if the subsidy is intended to last this will require the decision to be documented and periodically reviewed.

7.2.2 The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the DoH or by Statute. Fees or charges for any services supplied shall be determined in accordance with MPMNI. Independent professional advice on matters of valuation shall be taken as necessary.

7.2.3 Charges for commercial services should be set at a commercial rate in line with market practice and reflect fair competition with private sector providers. The requirements of commercial law and State Aid must be considered. Decisions to set rates at below market price must have DoH approval.

7.2.4 All employees must inform the Director of Finance promptly of money due to the Trust arising from transactions which they initiate / deal with, including all contracts, leases, tenancy agreements, and other transactions.

7.2.5 Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered, the Trust will follow all relevant DoH guidance including Commercial Sponsorship – Ethical standards in the HSC as well as the Trust's policy on Gifts & Hospitality.

7.2.6 Receipts arising from the sale of goods and services, and dividends can be retained by the Trust and provide additional spending power for the Trust.

7.2.7 If there is any doubt about the correct treatment of a receipt, the Trust will consult the DoH.

7.3 Debt Recovery

7.3.1 The Director of Finance is responsible for ensuring that the BSO undertakes the appropriate recovery action on all outstanding debts.

7.3.2 Income not received should be dealt with in accordance with the DoH guidance on losses and special payments.

7.3.3 Appropriate controls should be put in place to prevent overpayments and measures put in place to detect overpayments. Where overpayments are detected, recovery must be initiated in line with DOH guidance, BSO Payroll Shared Services and Trust Policies and Procedures.

7.3.4 The Director of Finance shall ensure that regular reports in the agreed format are provided to the Trust by the BSO in relation to those debts managed by the BSO on the Trust's behalf.

7.4 Security of Cash, Cheques and other Negotiable Instruments

7.4.1 The Director of Finance is responsible for:

(a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable.

(b) ordering and securely controlling any such stationery.

(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines.

(d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust; and

(e) obtaining assurance from BSO that suitable arrangements for the above exist where relevant within the Accounts Receivable Shared Services Centre.

7.4.2 Official money shall not under any circumstances be used for the encashment of private cheques or IOUs.

7.4.3 All cheques, postal orders, cash etc., shall be banked in full and intact. Disbursements shall not be made from cash received, except under arrangements approved by the Director of Finance.

7.4.4 All unused cheques and other orders will be subject to the same security precautions as are applied to cash.

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7.4.5 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

7.4.6 Any shortfall in cash, cheques or other negotiable instruments, however occasioned, will be reported immediately to the Director of Finance (in accordance with the Trust's losses procedure) and the Trust's Fraud Liaison Officer.

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8. PROCUREMENT AND CONTRACTING PROCEDURE

KEY POINTS

- Procurement is defined as "the process of acquisition, usually by means of a contractual arrangement after public competition, of goods, services, works and other supplies by the public service.".
- The Trust must use the existing Centres of Procurement Expertise for the procurement of works, goods and services.
- The Director of Finance will prepare a Procurement Strategy and an Annual Procurement Plan.
- The Director of Finance is responsible for ensuring that the Trust has appropriate systems in place for controlling risks associated with purchasing activities; and

Trust managers and officers must:

- Ensure they comply fully with DoH Policies and Trust guidance on procurement (including Direct Award Contracts) and contract management.
- Complete a declaration of objectivity and interest if participating in an evaluation process; and
- Accept tenders from suppliers who provide the lowest cost or the best value for money, being the optimum combination of whole life cost and quality.

8.1 Duty to comply with Standing Orders and Standing Financial Instructions

8.1.1 The procedure for making all contracts by or on behalf of the Trust shall comply with all relevant legislation, Northern Ireland Public Procurement Policy, the Standing Orders and Standing Financial Instructions (except where Standing Order No. 3.13 Suspension of Standing Orders is applied).

8.2 Northern Ireland Public Procurement Policy, DoH Mini-Code Guidance, DOH HSC(F) circulars and other professional Estates guidance.

8.2.1 Northern Ireland Public Procurement Policy, Procurement Guidance Notes and any other guidelines or guidance issued by DoH prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in the Standing Orders and Standing Financial Instructions. The Trust shall also ensure that it complies with any other relevant UK and EU or other international procurement rules.

8.3 Scope of Procurement

8.3.1 As per the Northern Ireland Public Procurement Policy 2002 (as amended), Public Procurement is defined as "the process of acquisition, usually by means of a contractual arrangement after public competition, of goods, services, works and other supplies by the public service".

8.3.2 These Standing Financial Instructions encompass the procurement of any works, goods, services and personnel from any external supplier in the marketplace awarded through Direct Award Contract, Quotations, Tenders or Open Competition.

8.3.3 It does not cover:

(a) The supply of services provided internally within the HSC e.g. supply of administration, finance, personnel, ICT support and arrangements with CoPEs;

(b) Expenditure which is regulated by DoH directive, such patient travelling expenses, or others, such as business rates and water and sewerage.

8.4 Procurement Arrangements

8.4.1 General

The Director of Finance will ensure that the Trust has appropriate systems in place for controlling the risks associated with purchasing activities. These include:

(a) Establishing and documenting accountability, ensuring appropriate top-level commitment.

(b) Implementing a procurement strategy and work plan.

(c) Demonstrating legal compliance.

(d) Pursuing best practice and demonstrating best value for money.

(e) Managing effective relationships with key suppliers, customers and other stakeholders.

(f) Following an appropriate, documented procurement process.

(g) Managing contracts and contractor performance.

(h) Professional competence.

(i) Monitoring and review of overall performance management; and

(j) Audit.

8.4.2 The Director of Finance will compile and submit to the Board, or a nominated Committee, a Trust Procurement Strategy and Annual Procurement Plan which take into account key strategic procurement requirements to deliver efficient and effective procurement.

8.4.3 The Director of Finance will, on behalf of the Chief Executive, prepare a Procurement Plan and submit for approval by the Trust Board or a nominated Committee. The Annual Procurement Plan will:

(a) be in accordance with the aims and objectives set out in the Trust Procurement Strategy.

(b) be produced following discussion with appropriate CoPEs and other stakeholders.

(c) be prepared within the limits of available funds.

(d) identify potential risks; and

(e) cover all areas of externally sourced expenditure on works, equipment, goods, supplies, service and personnel.

8.4.4 The Director of Finance shall monitor performance against the work plan with key stakeholders, review it on a quarterly basis and report to the Board or a nominated Committee.

8.4.5 Staff from all key areas involved in procurement shall provide information as required by the Director of Finance to enable a plan to be compiled and progress monitored.

8.4.6 The Director of Finance has a responsibility to ensure that adequate training and documented procedures are available to Trust employees commensurate with their roles and responsibilities. These procedures will include appropriate guidance on procurement, the management of contracts and management of

contractor performance.

8.4.7 The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

The Director of Finance will maintain, and present annually to the Trust's Audit Committee, a register of all Direct Award Contracts.

8.4.8 **Duties of Managers and Officers**

(a) Managers and officers acting on behalf of the Trust must ensure that they comply fully with the Trust guidance on procurement (including Direct Award Contracts) and contract management.

(b) Prior to participation in an evaluation process, those officers participating in the evaluation will be required to complete a Declaration of Objectivity and Interests; and

(c) Officers participating in an evaluation must accept tenders from suppliers who provide the best value for money overall. This is defined as the most advantageous combination of costs, quality and sustainability to meet customer and Trust requirements. In this context, cost means consideration of the whole life cost; quality means meeting a specification which is fit for purpose and sufficient to meet customer's requirements; and sustainability means economic, social and environmental benefits. Finding value for money involves an appropriate allocation of risk.

8.5 Procurement through a Centre of Procurement Expertise (CoPE)

8.5.1 **Goods and Services**
The Trust should use the CoPE within BSO Procurement and Logistics Service (PaLS) for the majority of its goods and services procurements. This provides strategic and operational procurement services covering both contracting for goods and services and where no contract exists, negotiating prices and placing orders on behalf of the Trust.

8.5.2 **Construction, Works and Design Services**
For construction, works and design related services the Trust should use the CoPE within the Department of Finance's Central Procurement Directorate (CPD) – Health Projects.

8.6 Use of Centres of Procurement Expertise (CoPE)

8.6.1 The Director of Finance is responsible for managing the arrangements regarding

the procurement and logistics service with the BSO, including setting clarity for the BSO within the Service Level Agreement (SLA) and for advising the Trust Board on the provision of procurement and logistics services. This advice will take into account guidance and directions issued from time to time by the DoH.

8.6.2 The Director of Finance is responsible for managing the procurement of construction works and design services with the Central Procurement Directorate below the Trust delegated limit. This encompasses adherence to the Estates Procedure Manual by the Trust and for advising Trust Board on the provision of construction works and design services. This advice will take into account guidance and directions issued from time to time by the DoH.

8.6.3 The Director of Finance and the Director of Planning, Performance & Corporate Services are responsible for seeking assurance that the following are in place within the CoPEs for Goods, Services and ICT Systems:

(a) clear and appropriately detailed specifications for all purchases.

(b) the purchase of all works, goods and services conform to an appropriate method of procurement.

(c) all potential suppliers are identified through the use of pre-determined criteria that ensure regularity and propriety.

(d) tenders and contract awards are evaluated through the use of pre-determined criteria that ensure the delivery of best value, where best value is defined as "the most advantageous combination of cost, quality and sustainability to meet customer requirements".

(e) all contracts for goods, works, personnel, ICT systems and services are managed and regularly monitored and reviewed.

(f) up-to-date legislation and guidance relevant to the management of purchasing is used.

(g) performance indicators are in place and regularly reviewed; and

(h) the service is subject to audit to ensure that an appropriate and effective system of managing purchasing is in place and the necessary levels of controls and monitoring are implemented.

8.7 Trust Estates Procurement and Contract Management

8.7.1 The Director of Finance is responsible for ensuring compliance by the Trust with the Construction Procurement Directorate – Health Projects Estates Procurement Manual (or equivalent relevant guidance), DoH Mini-code and other relevant guidance as appropriate and for ensuring appropriate monitoring procedures and processes are in place including evidence of compliance.

8.8 Competition

8.8.1 Competition promotes economy, efficiency and effectiveness in public expenditure. Works, goods and services should be acquired through public competition unless there are convincing reasons to the contrary, and where appropriate should comply with EU and domestic advertising rules and policy. The form of competition chosen should be appropriate to the value and complexity of the goods and services to be acquired.

8.8.2 Contracts shall be placed on a competitive basis and tenders accepted from suppliers who provide best value for money overall.

8.8.3 Where a contract is awarded to an economic operator without competition, this is referred as a Direct Award Contract (DAC). In light of their exceptional nature, all DACs should be dealt with in accordance with the advice, requirements and delegations set out in DoH and DoF guidance and in accordance with SLA or any formal general guidance on direct awards given by the relevant CoPE (in addition to complying with any other applicable delegations not arising as a result of DAC status e.g. capital or IT delegations).

8.9 Contracting / Tendering Procedure

8.9.1 The Trust shall obtain and follow the advice of the relevant CoPE(s) in relation to the following processes:

(a) Invitation to tender.

(b) Receipt and safe custody of tenders.

(c) Opening tenders and registration of tenders.

(d) Admissibility of tenders.

(e) Late tenders.

(f) Evaluation of tenders.

(g) Assessment of financial standing and technical competence of contractors.

(g) Exceptions to using approved contractors; and

(h) Competitive and non-competitive quotations.

8.10 Authorisation of Tenders and Competitive Quotations

8.10.1 Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with, formal authorisation and awarding of a contract may be decided in accordance with delegated limits set out in the Trust's Scheme of Reservation and Delegation.

8.10.2 Formal authorisation must be put in writing. In the case of authorisation by the Trust Board this shall be recorded in their minutes.

8.10.3 Where the contract to be awarded is a multi-Trust or Regional Contract then the Chief Executive shall nominate in advance a Trust employee(s) to participate in the tender evaluation and adjudicate the contract on behalf of the Trust. In doing so the Chief Executive shall delegate authority to that officer(s) to award the contract on behalf of the Trust.

8.10.4 **Items which subsequently breach thresholds after original approval**
Items estimated to be below the limits set in this Standing Financial Instruction for which formal tendering procedures are used which subsequently prove to have a value above such limits shall be reported to the Chief Executive (or appropriate delegated Trust Officer) and be recorded in an appropriate Trust record.

8.10.5 **Quotations to be within Financial Limits**
No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with Standing Financial Instructions except with the authorisation of either the Chief Executive or Director of Finance.

8.11 Private Finance for capital procurement

8.11.1 The Trust may consider the use of private sector financing for major capital schemes. In such cases, the Trust shall follow the advice and guidance of the DOH, CPD and the Department of Finance & Personnel in relation to the process to be followed. VFM should be considered as a major element of this advice and

guidance.

8.11.2 Any proposal to utilise private sector finance must be specifically agreed by the Trust Board and the decision recorded in the minutes of the relevant meeting.

8.12 Health Service Agreements

8.12.1 Service agreements between HSC organisations shall not be regarded for any purpose as giving rise to contractual rights or liabilities, but if any dispute arises with respect to such an arrangement, either party may refer the matter to the DoH for determination.

8.13 In-house Services

8.13.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering.

8.13.2 Appropriate groups shall be established within the Trust to manage the tender process and to present an in-house bid. All groups shall work independently of each other. No member of the in-house tender group shall be permitted to participate in the evaluation of tenders.

8.13.3 The evaluation team shall make recommendations to the Board.

8.13.4 The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.

8.14 Applicability of SFI's on Procurement and Contracting to Charitable Trust funds

8.14.1 These Instructions shall not only apply to expenditure from public funds but also to works, services and goods purchased from the Trust's Charitable Trust funds and from other funds provided to the Trust.

9. HSC SERVICE AGREEMENTS FOR PROVISION OF SERVICES (see overlap with SFI No. 8)

KEY POINTS

- The Chief Executive is responsible for ensuring the Trust enters into suitable Service and Budget Agreements (SBA) with service commissioners for the provision of health and social care services. They should aim to implement the agreed priorities contained in the Trust Delivery Plan.

9.1 Service and Budget Agreements (SBAs)

9.1.1 The Chief Executive, as the Accounting Officer, is responsible for ensuring the Trust enters into suitable Service and Budget Agreements (SBA) with service commissioners for the provision of health and social care services.

9.1.2 All SBAs should aim to implement the agreed priorities contained within the Trust Delivery Plan (TDP) and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive should take into account:

(a) The standards of service quality expected.

(b) The provision of reliable information on cost and volume of services.

(c) that SBA's build where appropriate on existing investment plans; and

(d) That SBAs are based on integrated care pathways.

9.2 Involving Partners and Jointly Managing Risk

9.2.1 A good SBA will result from a dialogue of clinicians, users, carers, public health professionals and managers. It will reflect knowledge of local needs and inequalities. This will require the Chief Executive to ensure that the Trust works with all partner agencies involved in both the delivery and the commissioning of the service required. The SBA will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the event and financial arrangements should reflect this. In this way the Trust can jointly manage risk with

all interested parties.

9.3 Reports to Board on SBAs

9.3.1 The Chief Executive, as the Accounting Officer, will need to ensure that regular reports are provided to the Board detailing actual and forecast income from the SBA.

10. TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF MEMBERS OF THE TRUST BOARD, SENIOR EXECUTIVES AND EMPLOYEES

KEY POINTS

- The Remuneration and Terms of Service Committee is a sub-committee of the Trust Board and makes recommendations to the Trust Board about appropriate remuneration and terms of service for the Chief Executive and other senior executives.
- The funded establishment of any department may not be varied without the approval of the Chief Executive or delegated to a nominated officer.
- The Director of Finance is responsible for ensuring that appropriate arrangements are in place for payroll processing, that proper controls exist and are operating effectively.
- All employees will be issued with a contract of employment in an approved form which complies with employment legislation and DoH regulations/circulars; *and*
- Trust nominated managers have delegate responsibility for:
  - Submitting accurate time records and other notifications in accordance with agreed timetables and in a prescribed format.
  - Submitting manual or electronic contractual amendments on time and in a prescribed format; *and*
  - Submitting appropriate claims for reimbursement in accordance with agreed timetables and in a prescribed format.

10.1 Remuneration and Terms of Service (see overlap with SO No. 4)

10.1.1 In accordance with Standing Orders the Trust Board shall establish a Remuneration and Terms of Service Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

10.1.2 The role of the Remuneration Committee is:

i. To advise the Board on performance, development, succession planning and appropriate remuneration and terms of service for the Chief Executive and all Senior Executives, guided by DoH policy and best practice.

ii. Provide advice to the Board on remuneration including all aspects of salary as well as arrangements for termination of employment and other contractual terms.

iii. To ensure robust objectives, performance measures and evaluation processes are in place within the Trust in respect of all Senior Executives.

iv. To monitor and evaluate the performance and development of the Chief Executive and on the advice of the Chief Executive, the other Senior Executives of the Trust.

v. To make such recommendations to the Board on succession planning and on the remuneration, allowances and terms of service of the Chief Executive and, on the advice of the Chief Executive, other Senior Executives.

vi. To ensure that the Chief Executive and Senior Executives are rewarded for their individual contribution to the Trust having proper regard to the Trust's circumstances and performance and to the provision of national arrangements including DoH NI Arrangements.

vii. To oversee appropriate contractual arrangements for the Chief Executive and Senior Executives including the proper calculation and scrutiny of termination payments taking account of relevant guidance as appropriate and advise the Board accordingly.

viii. The Chief Executive is responsible for ensuring that the Director of Human Resources & Organisational Development brings forward the necessary information in a timely manner to enable the Committee to discharge its functions and takes appropriate follow-up action.

10.1.3 The Remuneration Committee shall report in writing to the Trust Board the basis for its recommendations. The Trust Board shall use the report as the basis for their decisions but remain accountable for taking decisions on the remuneration and terms of service of Directors not already directed by the DoH. Any change to the remuneration of Senior Executives will be in line with guidance provided in relevant circulars from the DoH or with the prior approval of the Permanent Secretary of the DoH where the circumstances are out with the terms of extant circulars. Minutes of the Board's meetings should record such decisions.

10.1.4 The Trust Board will consider and need to approve proposals presented by the Chief Executive or by the Remuneration Committee for the setting of pay, terms and conditions of service for those employees and officers not covered by either DoH direction.

10.1.5 Recruitment exercises to fill permanent senior executive vacancies or new senior executive posts in the Trust should proceed only on approval of the Permanent

Secretary of the DoH. Interim appointments of less than twelve months' duration will be progressed in line with extant guidance from DoH.

10.1.6 The Trust will pay allowances to the Chair and non-executive members of the Board in accordance with the Payment of Remuneration to Chairmen and Non-Executive Members Determination issued by the DoH.

10.2 Funded Establishment

10.2.1 The workforce plans incorporated within the annual budget will form the funded establishment.

10.2.2 The funded establishment of any department may not be varied without the approval of the Chief Executive or nominated officer.

10.2.3 It is the budget-holders' responsibility to ensure that the funded establishment is not exceeded without the prior approval of the Assistant Director Financial Management. The Director of Finance will regularly report to the Executive Management Team any material over-commitment against the funded establishment. Where patient or staff safety requires expenditure to be incurred beyond the current approved budget, the Directorate concerned is required to prepare a contingency plan to bring expenditure back to within budget limits and within an agreed timeframe. Should that not be possible, then the Director of Finance is required to inform the Commissioning Body and DoH where material.

10.3 Staff Appointments

10.3.1 No Director or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

(a) unless authorised to do so by the Chief Executive or nominated officer (as noted in the Scheme of Reservation and Delegation); and

(b) within the limit of their approved budget and funded establishment as confirmed by the Director of Finance.

10.3.2 The Trust will administer Agenda for Change Terms and Conditions as adopted by DoH and in accordance with the Trust's Partnership Agreement.

10.3.3 Any proposal by the Trust to move from existing pension arrangements, or to pay redundancy, or compensation for loss of office, requires the approval of the Doh and DoF. Proposals on severance payments must comply with the MPMNI and

any related DoF/DoH guidance.

10.4 Payroll Processing

10.4.1 The processing of Trust payroll is outsourced to the BSO. The Director of Finance will ensure that there is an appropriate Service Level Agreement and monitoring arrangements in place with the BSO to ensure that the Trust's responsibilities with regard to payroll processing are addressed, that proper controls are in place and are operating effectively. This includes the need for a robust business continuity plan.

10.4.2 The Director of Finance will seek an annual assurance statement from the BSO Head of Internal Audit on the reliability of the information processed by BSO for accounting purposes on behalf of the Trust.

10.4.3 The Director of Finance will seek assurance that the BSO systems, controls and processes are subject to audit on an annual basis and that the Trust is made aware of any assurance levels that are categorised as less than satisfactory.

10.4.4 The Director of Finance is responsible for:

(a) specifying timetables for submission of properly authorised time records and other notifications.

(b) the payroll processing of pay and allowances including travel and subsistence, in accordance with DoH guidance.

(c) making arrangements for ensuring payment on agreed dates; and

(d) agreeing method of payment.

10.4.5 The Director of Finance will agree and ensure the issue of instructions, including by the BSO where appropriate, regarding:

(a) verification and documentation of data.

(b) the timetable for receipt and preparation of payroll data and the payment of pay and allowances including travel and subsistence to employees and non-executive appointee.

(c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay,

(d) security and confidentiality of payroll information.

(e) checks to be applied to completed payroll before and after payment.

(f) authority to release payroll data under the provisions of the General Data Protection Regulation / Data Protection Act.

(g) methods of payment available to various categories of employee and officers.

(h) procedures for payment by bank credit to employees and officers.

(i) procedures for the recall bank credits.

(j) pay advances and their recovery.

(k) maintenance of regular and independent reconciliation of pay control accounts.

(l) separation of duties of preparing records and handling cash if applicable; and

(m) a system to ensure the recovery from those in and leaving the employment of the Trust of sums of money and property due by them to the Trust.

(n) a system to ensure all statutory returns, e.g. HMRC are completed.

10.4.6 Appropriately nominated managers have delegated responsibility for:

(a) Approving and submitting manual or electronic time records, and other notifications in accordance with agreed timetables, and in the form prescribed by the BSO Payroll Service Centre.

(b) Approving and submitting manual or electronic claims for re-imbursement of travel and subsistence expenses or other allowances in accordance with agreed timetables, and in the prescribed form; and

(c) approving and submitting manual or electronic termination / contract amendment forms in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination, retirement or other contractual change. Where an employee fails to report for duty or to fulfill obligations in circumstances that suggest they have left without notice, the Director of HR must be informed immediately to take a

decision on whether to terminate future payments.

(d) Regular review of issued Staff in Post reports to ensure that it correctly reflects those staff under their responsibility.

10.4.7 Regardless of the arrangements for providing the payroll service, the Director of Finance shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

10.5 Contracts of Employment

10.5.1 The Trust Board shall delegate responsibility to the Director of Human Resources for:

(a) ensuring that all employees are issued with a Contract of Employment in a format which complies with employment legislation.

(b) dealing with variations to, or termination of, contracts of employment; and

(c) ensuring compliance with any legislation on contract workers.

11. NON-PAY EXPENDITURE

KEY POINTS

- The Trust Board will approve the level of non-pay expenditure authorisation limits on an annual basis.

- The Chief Executive will set out in the Scheme of Delegated Authority (SoDA), the list of Non-Executive Directors, Chairman, Directors and employees who are authorised to procure the supply of goods, services, personnel and, along with the financial limit of each purchase or payment.
- The Trust Board shall approve any increases to the approval limit for the Chairman and the Chief Executive.
- Non-pay expenditure should be committed in accordance with procurement guidance.
- The Director of Finance is responsible for ensuring that appropriate arrangements are in place for processing payments, that proper controls exist and are operating effectively.
- The Director of Finance is responsible for issuing procedural instructions and guidance on obtaining goods, works and services and certification of associated accounts and claims.
- The Director of Finance is responsible for the prompt payment of accounts and claims and in accordance with Government Accounting guidance; and

- **Trust managers and officers must ensure they:**
  - Apply the principles of economic appraisal, with appropriate and proportionate effort, to all decisions and proposals concerning spending.
  - Adhere to procurement guidance.
  - Order all goods, services or works on an official order, except works and services executed in accordance with contract and purchases from petty cash or purchase cards.
  - Do not split orders to avoid financial thresholds.
  - Do not place orders for items for which there is no budget provision, unless authorised by the Director of Finance.
  - Only use verbal orders in exceptional circumstances.
  - Do not take goods on loan/trial in circumstances that could commit the Trust to a future uncompetitive purchase.
  - Restrict purchases from petty cash and adequate records are maintained.
  - Do not issue orders to any firm which has made an offer of gifts/rewards or benefits to Non-Executive Directors, Chief Executive, Directors or employees.

- Notify the Director of Finance of staff changes to the list approved signatories in the Trust.

11.1 Delegation of Authority

11.1.1 Within the administrative ceiling set by the Department of Health, the Trust Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers.

11.1.2 The Chief Executive will set out:

(a) The list of managers who are authorised to place requisitions for the supply of goods and services and minor works; and

(b) The maximum level of each requisition and the system for authorisation above that level.

11.1.3 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services to ensure proper stewardship of public funds and assets.

11.1.4 Non-pay expenditure should be committed in accordance with the Northern Ireland Public Procurement Policy, Procurement Guidance Notes, DoH circulars and other relevant guidance.

11.1.5 The processing of Trust payments is outsourced to the BSO. The Director of Finance will ensure that there is an appropriate Service Level Agreement and monitoring arrangements in place with the BSO to ensure the Trust's responsibilities with regard to the processing of non-pay expenditure are addressed and that proper controls are in place and operating effectively. This should include a business continuity plan.

11.1.6 The Director of Finance will seek an annual assurance from the BSO on the reliability of the information processed by BSO for accounting purposes on behalf of the Trust.

11.1.7 The Director of Finance will seek assurance that the BSO systems, controls and processes are subject to audit on an annual basis and that the Trust is made aware of any assurance levels that are categorised as less than satisfactory.

11.1.8 The Director of Finance shall:

(a) prepare procedural instructions or guidance that reflect the Scheme of Reservation and Delegation on the obtaining of goods, works and services incorporating the thresholds.

(b) be responsible for the prompt payment of all properly authorised accounts and claims.

(c) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

(1) a list of those senior employees who are authorised to certify invoices and to authorise expenditure.

(2) certification, either manually or electronically that:

(i) goods have been duly received, examined and are in accordance with specification and the prices are correct.

(ii) work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct.

(iii) in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;

(iv) where appropriate, the expenditure is in accordance with regulations including taxation and all necessary authorisations have been obtained.

(v) the account is arithmetically correct; and

(vi) the account is in order for payment.

(3) a timetable and process for submission of accounts to the BSO for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment; and

(4) instructions to employees regarding the processes for requesting payments of invoices/accounts by the BSO Accounts Payable Shared Service Centre.

(d) be responsible for ensuring that payment for goods and services is only made by BSO Accounts Payable Shared Service Centre once the goods and services are received.

11.2 Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services

11.2.1 Requisitioning

The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust; namely the optimum combination of whole life cost and quality (or fitness for purpose).

The NI Procurement Policy Statement sets out four public procurement principles to adhere to, where are:

- Transparency
- Accessibility
- Social Value; and
- Efficiency and effectiveness

Therefore, the Trust requires that the BSO Procurement and Logistics Service (PaLs), the Centre of Procurement Expertise 9CoPE) is consulted in the first instance to ensure that procurement is carried out in a professional way.
Where this advice is not acceptable to the requisitioner, the Director of Finance (and / or the Chief Executive) shall be consulted.

Requisitions should be placed using the FPL e-Procurement system for goods and services.

11.2.2 Official Orders

Official orders must:

(a) be consecutively numbered.

(b) be in a form approved by the Director of Finance.

(c) state the Trust / HSC terms and conditions of trade; and

(d) only be issued to, and used by, those duly authorised by the Chief Executive.

11.2.3 **System of Payment and Payment Verification**

The Director of Finance shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with the Public Sector Prompt Payment Policy.

11.2.4 **Prepayments**

Prepayments are only permitted where exceptional circumstances apply. This excludes normal regular expenditure such as telephone rentals, insurance or other rental agreements. In such instances:

(a) prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e. cashflows must be discounted to NPV) and the intention is not to circumvent cash limits.

(b) the appropriate officer must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments.

(c) the Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed and on occasions the Director of Finance may require a report to be presented to the Senior Management team; and

(d) the budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director/Director of Finance or Chief Executive if problems are encountered.

11.2.5 **Duties of Managers and Officers**

Managers and officers must ensure that they comply fully with the guidance and limits specified by the Director of Finance and:

(a) they must apply the principles of economic appraisal, with appropriate and proportionate effort, to all decisions and proposals concerning spending.

(b) all contracts (except as otherwise provided for in the Scheme of Reservation and Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Finance in advance of any commitment being made.

(c) contracts above specified thresholds are advertised, and contract managed in accordance with published Procurement Policy Notes as issued to DoH Arms' Length Bodies under HSC(F) circulars, and the Procurement Act 2023.

(d) where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued on the use of Management Consultants by the DoH.

(e) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

(1) isolated gifts of low intrinsic value (under £50) or inexpensive seasonal gifts, such as calendars; and

(2) conventional hospitality, such as lunches in the course of working visits.

(This provision needs to be read in conjunction with Standing Order No. 7, the principles outlined in the Standards of Business Conduct and the Trust's policy on Gifts and Hospitality).

(f) no requisition / order is placed for any item or items for which there is no budget provision unless authorised by the Director of Finance on behalf of the Chief Executive.

(g) all goods, services, or works are ordered on an official order except works and services executed in accordance with a contract and purchases from petty cash.

(h) verbal orders must only be issued very exceptionally - by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed the next working day by an official order and clearly marked "Confirmation Order".

(i) orders must not be split or otherwise placed in a manner devised so as to avoid the financial thresholds.

(j) goods must not be taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase.

(k) changes to the list of employees and officers authorised to certify invoices are notified in a timely manner to the Director of Finance.

(l) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance; and

(m) petty cash records are maintained in a form as determined by the Director of Finance.

11.2.6 The Chief Executive and Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within Estates Procurement Manual and the Land Transactions Handbook. The technical audit of these contracts shall be the responsibility of the relevant Director.

Northern Ireland Ambulance Service
Health and Social Care Trust

12. GRANTS AND OTHER BODIES

KEY POINTS

- Payments to community and voluntary organisations shall comply with procedures laid down by the Director of Finance and in accordance with DoH guidance.

12.1 Payments to community and voluntary organisations for services provided for, or on behalf of the Trust shall comply with procedures laid down by the Director of Finance which shall be in accordance with DoH guidance and relevant legislation.

12.2 Grants to other bodies for the provision of services to patients or clients shall, regardless of the source of funding, incorporate the principles set out in DoH guidance.

12.3 The Trust shall comply with the five main principles that apply to the management and administration of grant making. These are:

(a) Regularity – funds should be used for the authorised purpose.

(b) Propriety – funds should be distributed fairly and free from undue influence.

(c) Value for Money – funds should be used in a manner that minimises costs, maximises outputs and always achieves intended outcomes.

(d) Proportionate Effort – resources consumed in managing the risks to achieve and demonstrate regularity, propriety and value for money should be proportionate to the likelihood and impact of the risks materialising and losses occurring.; and

(e) Clarity of responsibility and accountability – within partnership working arrangements there should be clearly documented lines of responsibility and accountability of each partner involved. Those who delegate responsibility should ensure that there are suitable means of monitoring performance.

Northern Ireland Ambulance Service
Health and Social Care Trust

13. CASH MANAGEMENT

KEY POINTS

- Grant in aid is paid in instalments to the Trust on the basis of need.
- The Director of Finance is responsible for ensuring that cash balances in the Trust are kept to a minimum.
- The Trust is not normally allowed to borrow.

13.1 Grant-in-aid will be paid to the Trust in instalments on the basis of need and should not be drawn down in advance of need.

13.2 The Director of Finance is responsible for submitting a written application to the DoH, forecasting cash requirements and for drawing down grant-in-aid according to need.

13.3 The Director of Finance is responsible for ensuring that cash balances are kept at a minimum level consistent with the efficient operation of the Trust. Any interest earned on overnight deposits may have to be returned to DoH.

13.4 Temporary cash surpluses must be held only in such public or private sector investments as authorised by the Board and in accordance with DoH guidance.

13.5 Where applicable the Director of Finance is responsible for advising the Board on investments and shall report periodically to the Board, or delegated sub-committee, concerning the performance of investments held.

13.6 The Director of Finance will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

13.7 Normally the Trust will not be allowed to borrow. Where the Trust proposes to borrow funds, the Director of Finance shall seek the approval of the DoH and where appropriate the Department of Finance to ensure that it has the necessary authority and budgetary cover for any borrowing or the expenditure to be financed by such borrowing. Any expenditure by the Trust that is financed by borrowing shall count towards DEL.

13.8 The Trust will not enter into any other unconventional financial arrangement without the approval of the DoH and the Department of Finance.

Northern Ireland Ambulance Service
Health and Social Care Trust

14. CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

KEY POINTS

- The Chief Executive will ensure there is an adequate economic appraisal of capital expenditure proposals in line with all relevant guidance.
- For every capital expenditure proposal, the Chief Executive will ensure there is a business case, that the Director of Finance has certified the costs and revenue consequences, and that DoH approval has been secured where appropriate.
- The Chief Executive must obtain DoH approval for all property and finance lease.
- The Chief Executive is responsible for the overall control of assets and maintenance of asset registers, advised by the Director of Finance concerning asset control procedures; and
- Each employee has responsibility for the security of property of the Trust and reporting any loss of assets in accordance with the procedure for reporting losses.

14.1 Capital Investment

14.1.1 The Chief Executive:

(a) shall ensure that there is an adequate economic appraisal of capital expenditure proposals in line with the Northern Ireland Guide to Better Business Cases, HM Treasury guidance and the DoH guidance.

(b) shall ensure that there is an approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans.

(c) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost.

(d) shall ensure that the capital investment is not undertaken without confirmation of purchaser(s) support and the availability of resources to finance all revenue consequences.

14.1.2 For every capital expenditure proposal, the Chief Executive shall ensure:

(a) that a business case (in line with DoH guidance) is produced setting out:

(1) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs.

(2) the involvement of appropriate Trust personnel and external agencies; and

(3) appropriate project management and control arrangements, including post-project evaluation.

(b) that the Director of Finance has certified professionally to the costs and revenue consequences detailed in the business case; and

(c) that DoH approval is obtained for projects costing more than the Trust's delegated limit for capital schemes.

14.1.3 For capital schemes where the contracts stipulate stage payments, the Director of Finance will issue procedures for their management, incorporating the recommendations of the Land Transactions Handbook.

14.1.4 The Director of Finance shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with HMRC guidance and shall put procedures in place for the operation of the scheme.

14.1.5 The Director of Finance shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

14.1.6 The approval of a capital programme shall not constitute approval for expenditure on any scheme.

The Chief Executive or the Director of Finance shall issue to the manager responsible for any scheme:

(a) specific authority to commit expenditure.

(b) authority to proceed by delegated limits to procurement; and

(c) approval to accept a successful tender.

The Director of Finance will issue a scheme of delegation for capital investment management in accordance with the DoH guidance and the Trust's Standing Orders.

14.1.7 The Director of Finance shall be responsible for the development and issuing of procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures shall fully take into account the delegated limits for capital schemes as issued by DoH.

14.2 Private Finance (PFI) Schemes

14.2.1 The Trust should follow DoH guidance with regard to testing for PFI schemes when considering capital procurement. When the Trust proposes to use finance which is to be provided other than through its allocations, the following procedures shall apply:

(a) the Director of Finance shall demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.

(b) the Director of Finance will consult with the DoH over the accounting and budgeting treatment for a PFI. Where judgement over the level of control is difficult, the DoH will consult with the Department of Finance.; and

(c) the proposal must be specifically agreed by the Trust Board and other relevant bodies as specified by DoH.

14.3 Leasing

14.3.1 The Chief Executive must obtain DoH approval for all property and finance leases.

14.3.2 Before entering into a lease, the Director of Finance shall ensure that a process is in place to demonstrate that the lease offers better value for money than an outright purchase.

14.4 Asset Registers

14.4.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Director of Finance concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted on a regular basis.

14.4.2 The Trust shall maintain an asset register recording non-current assets. The minimum data set to be held within this register shall be as specified in the Capital Accounting Manual and any other DoH guidance.

14.4.3 Additions to the asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties.

(b) stores, requisitions and wages records for own materials and labour including appropriate overheads; and

(c) lease agreements in respect of assets held on the Trust's Statement of Financial Position and capitalised.

14.4.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

14.4.5 The Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

14.4.6 The value of each asset shall be indexed to current values in accordance with methods specified in the Capital Accounting Manual issued by the DoH.

21.3.7 The value of each asset shall be depreciated and / or impaired using methods and rates as specified in the Capital Accounting Manual issued by the DoH.

14.5 Security of Assets

14.5.1 The overall control of non-current assets is the responsibility of the Chief Executive.

14.5.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Director of Finance. This procedure shall make provision for:

(a) recording managerial responsibility for each asset.

(b) identification of additions and disposals.

(c) identification of all repairs and maintenance expenses.

(d) physical security of assets.

(e) periodic verification of the existence of the condition of, and title to, assets recorded.

(f) identification and reporting of all costs associated with the retention of an asset; and

(g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

14.5.3 All discrepancies revealed by verification of physical assets to the asset register shall be notified to the Director of Finance.

14.5.4 Whilst each employee and officer has a responsibility for the security of property of the Trust, it is the responsibility of Directors in all disciplines to apply such appropriate routine security practices in relation to HSC property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

14.5.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be dealt with in accordance with the procedure for reporting losses.

14.5.6 Where practical, assets should be marked as Trust property.

15. STORES AND RECEIPT OF GOODS

KEY POINTS

- The Chief Executive delegates the control of stores to designated officers in the Trust.
- Designated officers are responsible for security arrangements and the custody of keys for any stores.
- The Director of Finance will set out procedures and systems to control and regulated stores, including a physical check of items in the store at least annually; *and*
- Designated officers are responsibility for the review of slow moving and obsolete items in the stores and adherence to the procedures for the reporting of losses.

15.1 General Position

15.1.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) kept to a minimum.

(b) subjected to annual stock take; and

(c) valued at the lower of cost and net realisable value in accordance with relevant DoH circulars and any other relevant guidance.

15.2 Control of Stores, Stocktaking, Condemnations and Disposal

15.2.1 Subject to the responsibility of the Director of Finance for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by him / her to departmental employees and stores managers / keepers, subject to such delegation being entered in a record available to the Director of Finance. The control of any pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer, the control of any fuel oil and coal of a designated manager.

15.2.2 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager / Pharmaceutical Officer. Wherever practicable, stocks should be marked as Trust property.

15.2.3 The Director of Finance shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

15.2.4 Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items in store at least once a year.

15.2.5 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Director of Finance.

15.2.6 The designated Manager / Pharmaceutical Officer shall be responsible for a system approved by the Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice (see also overlap with SFI No. 16 Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

15.3 Goods supplied by Centres of Procurement Expertise (CoPE)

15.3.1 For goods supplied via BSO central warehouses, the Chief Executive shall delegate to officers the requisitioning and acceptance of goods from PaLS. The delegated officers shall check receipt against the delivery note and notify PaLS of any shortages or discrepancies using established Trust procedures.

15.4 Goods supplied directly from Suppliers

15.4.1 For goods supplied directly from suppliers, the Chief Executive shall delegate to officers the requisitioning and acceptance of goods. The delegated officers shall check receipt against the delivery note and order and notify of any shortages or discrepancies using established Trust procedures.

16. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

KEY POINTS

- The Assistant Director of Finance must prepare detailed procedures for the disposal of assets including condemnations and ensure these are notified to managers.
- Assets shall be sold for best price, taking into account the costs of sales. Generally, assets will be sold by auction or competitive tender.
- Heads of Service are responsible for ensuring that all data held on assets for disposal are dealt with appropriately and securely.
- The Director of Finance must prepare procedural instructions on the recording of and accounting for condemnations, losses and special payments in line with DoH guidance; and
- Any employee discovering or suspecting a loss of any kind must either immediately inform their Head of Department and the Trust's Fraud Liaison Officer.

16.1 Disposals and Condemnations

16.1.1 The Director of Finance must prepare detailed procedures for the disposal of assets including condemnations and ensure that these are notified to managers.

16.1.2 When it is decided to dispose of a Trust asset, the Head of Department or authorised deputy will determine and advise the Assistant Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate. Assets shall be sold for best price, taking into account any costs of sale. Generally, assets shall be sold by auction or competitive tender. All receipts derived from the sale of assets must be declared in accordance with DoH guidance by the Director of Finance.

Competitive Tendering or Quotation procedures shall not apply to the disposal of:

(a) any matter in respect of which a fair price can be obtained by negotiation or sale by auction as determined (or pre-determined with a reserve) by the Director of Finance or his/her nominated officer.

(b) obsolete or condemned articles and stores.

(c) items to be disposed of with an estimated sale value of less than £20,000.

(d) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract.
(e) land or buildings subject to compliance with DoH guidance.

16.1.3 All unserviceable articles shall be:

(a) Condemned or otherwise disposed of by an employee authorised for that purpose by the Director of Finance; and

(b) Recorded in a form approved by the Director of Finance which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Director of Finance.

16.1.4 The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance who will take the appropriate action.

16.1.15 Heads of Department will be responsible for ensuring that all data held on assets for disposal are dealt with appropriately and securely.

16.2 Losses and Special Payments

16.2.1 The Director of Finance must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments in line with DoH guidance.

16.2.2 The Director of Finance will consult with the DoH where proposed losses:

(a) Raise doubts about the effectiveness of existing systems.
(b) Contain lessons which might be of wider interest: or
(c) Might create a precedent of other NICS/NHS departments.

16.2.3 Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Director of Finance or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the Director of Finance.

16.2.4 Where a criminal offence is suspected, the Director of Finance must immediately inform the police if theft or arson is involved. In cases of fraud or corruption, the Trust Fraud Liaison Officer, upon receipt of advice from BSO Counter Fraud & probity Service will determine when to inform the PSNI.

16.2.5 The Trust Fraud Liaison officer must notify the BSO Counter Fraud and Probity Services Team on discovery of a loss or suspected loss to public funds or property as a result of fraud, misappropriation, theft, arson or malicious damage.

16.2.6 Within limits delegated to it by the DoH, the Director of Finance shall approve the writing-off of losses. These delegated limits are noted in the Trust's Scheme of Reservation and Delegation.

16.2.7 The Director of Finance shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

16.2.8 For any loss, the Director of Finance should consider whether any insurance claim can be made. Losses shall not be written off until all reasonable attempts to make a recovery have been made, proved unsuccessful and there is no feasible alternative.

16.2.9 The Director of Finance shall maintain a Losses and Special Payments Register in which write-off action is recorded.

16.2.10 No special payments exceeding delegated limits shall be made without the prior approval of the DoH.

16.2.11 All losses and special payments must be reported to the Audit Committee at least once per annum.

Northern Ireland Ambulance Service
Health and Social Care Trust

17. INFORMATION TECHNOLOGY

KEY POINTS

- Director of Finance is responsible for the accuracy and security of the computerised financial data of the Trust.
- The Director of Finance will ensure that contracts for computer services for financial applications with another organisation clearly defines the responsibilities of all parties.
- The Director of Planning, Performance and Corporate Communication will ensure that risks to the Trust arising from the use of IT are effectively identified and considered; *and*
- Where computer systems have an impact on corporate financial systems, the Director of Finance will need to be satisfied across a range of measures.

17.1 Responsibilities and duties of the Director responsible for ICT

17.1.1 The Director of Planning, Performance and Corporate Services will have responsibility to:

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which the Director is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the General Data Protection Regulations.

(b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system.

(c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment; and

(d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the Director may consider necessary are being carried out.

17.1.2 The Director of Finance shall ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly

tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

17.2 Responsibilities and duties of other Directors and Officers in relation to Computer Systems of a general application

17.2.1 In the case of computer systems which are proposed General Applications (i.e. normally those applications which HSC bodies wish to sponsor jointly) all responsible directors and employees will send to the Director of Planning, Performance and Corporate Services:

(a) details of the outline design of the system; and

(b) in the case of packages acquired either from a commercial organisation, HSC, or from another public sector organisation, the operational requirement.

17.3 Contracts for Computer Services with other health bodies or outside agencies

17.3.1 The Director of Finance shall ensure that contracts for computer services for financial applications with another organisation (e.g. BSO) shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

17.3.2 Where another organisation (e.g. BSO) provides a computer service for financial applications, the Director of Finance shall periodically seek assurances that adequate controls are in operation.

17.4 Risk Assessment

17.4.1 The Director of Planning, Performance & Corporate Communication shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

17.5 Requirements for Computer Systems which have an impact on corporate Financial Systems

17.5.1 Where computer systems have an impact on corporate financial systems the Director of Planning, Performance and Corporate Services will consult with the Director of Finance to ensure that:

(a) systems acquisition, development and maintenance are in line with corporate

policies such as an ICT Strategy.

(b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists.

(c) Finance staff have access to such data; and

(d) computer audit reviews that are considered necessary are being carried out.

Northern Ireland Ambulance Service
Health and Social Care Trust

18. PATIENTS' PROPERTY

KEY POINTS

- The Trust has a responsibility to securely hold any patients' property received.
- Line managers must ensure that staff appropriately informed of their responsibilities and duties for the administration of patients' property.

18.1 The Chief Executive will take all reasonable steps (taking account of the situations confronting ambulance personnel particularly in emergency cases) to ensure that patients property handed in or discovered is securely held.

18.2 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

19. CHARITABLE TRUST FUNDS (CTF)

KEY POINTS

- The Director of Finance has primary responsibility to the Trust Board (and Charitable Trust Funds Committee if appropriate) for ensuring that Charitable Trust funds are managed appropriately with regard to their purpose and requirements.
- The Director of Finance will arrange for the administration of all new and existing funds.
- The Director of Finance will provide guidelines to Trust officers on how to proceed with donations, legacies and bequests.
- The Director of Finance will deal with all arrangements for fundraising; ensure that appropriate banking arrangements are in place and be responsible for all aspects of the investment of Charitable Trust funds.
- Donated assets will be maintained along with the general estate and inventory of assets; *and*
- The Director of Finance will ensure regular reporting to the Trust Board (and Charitable Trust Funds Committee if appropriate) and preparation of the Annual Trustee's Report and Accounts.

19.1 Trust responsibilities for Charitable Trust funds are distinct from responsibilities for exchequer (public) funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. The Director of Finance should ensure that each fund is managed appropriately with regard to its purpose and requirements.

19.2 This section of the SFI's should be interpreted and applied in conjunction with the rest of these instructions, subject to modifications contained herein.

19.3 The Director of Finance has primary responsibility to the Trust Board (and Charitable Trust Funds Committee if appropriate) for ensuring that these SFI's are applied and for compliance with the requirements of the Charities Commission for Northern Ireland (CCNI).

19.4 Existing Trust Funds

19.4.1 The Director of Finance should arrange for the administration of all existing Charitable Trust funds. They should ensure that a governing instrument exists for every trust fund and should produce procedures covering every aspect of the

financial management of Charitable Trust funds, for the guidance of directors and employees. Such guidelines should identify the restricted or unrestricted nature of certain funds.

19.4.2 The Assistant Director of Finance should periodically review the Charitable Trust funds in existence and should make recommendations to the Trust Board (or Charitable Trust Funds Committee if appropriate) regarding the potential for rationalisation of such funds within statutory guidelines.

19.5 New Trust Funds

19.5.1 The Director of Finance should arrange for the creation of a new Charitable Trust fund where funds and / or other assets, received in accordance with policies, cannot adequately be managed as part of an existing Charitable Trust fund and where it is cost effective to do so.

19.5.2 The governing document for each new Charitable Trust fund should clearly identify, amongst other things, the objectives of the new fund, the capacity to delegate powers to manage and the power to assign the residue of the Charitable Trust fund to another fund contingent upon certain conditions, e.g. discharge of original objects.

19.6 Sources of New Trust Funds

19.6.1 **Donations**

In respect of donations, the Director of Finance should:

(a) Provide guidelines to officers of the Trust as to how to proceed when offered funds. These include:

(1) the identification of the donor's intention in line with the structure of Trust Funds available.

(2) where possible, the avoidance of new Charitable Trust funds.

(3) the avoidance of impossible, undesirable or administratively difficult intentions of the donor.

(4) treatment of offers of personal gifts.

(5) The promotion of gift aid where conditions allow.

(b) Provide secure and appropriate receipting arrangements which will indicate that funds have been accepted directly into Charitable Trust funds and that the donor's intentions have been noted and accepted.

19.6.2 **Legacies and Bequests**

In respect of legacies and bequests, the Director of Finance should:

(a) provide guidelines to officers covering any approach regarding:

(1) the wording of wills; and

(2) the receipt of funds / other assets from executors.

(b) where necessary, obtain grant of probate, or make application for grant of letters of administration, where the Charitable Trust fund is the beneficiary.

(c) be empowered to negotiate arrangements regarding the administration of a will with executors and to discharge them from their duty; and

(d) be directly responsible for the appropriate treatment of all legacies and bequests.

19.6.3 **Fund Raising**

In respect of fund-raising, NIAS are currently not permitted to carry out fund raising activity.

19.6.4 **Investment Income**

In respect of investment income, the Director of Finance shall be responsible for the appropriate treatment of all dividends, interest and other receipts from this source (see below).

19.7 Investment Management

19.7.1 The Director of Finance shall be responsible for all aspects of the management of the investment of Charitable Trust funds. The issues on which he / she should be required to provide advice to the Trust Board (or Charitable Trust Funds Committee if appropriate) should include:

(a) the formulation of investment policy within the powers of the Charitable Trust

fund under statute and within governing instruments to meet its requirements with regard to income generation and the enhancement of capital value.

(b) the appointment of advisers, brokers, and where appropriate, fund managers. The Director of Finance should agree the terms of such appointments and for such appointments written agreements should be signed by the Chief Executive.

(c) pooling of investment resources with other Trusts and the preparation of a submission to the DoH for them to make a scheme.

(d) the participation in common investment funds and the agreement of terms of entry and withdrawal from such funds.

(e) that the use of Trust investments shall be appropriately authorised in writing and charges raised within policy guidelines.

(f) the review of the performance of brokers and fund managers; and

(g) the reporting of investment performance.

19.8 Expenditure from Funds

19.8.1 The use of funds shall be managed by the Director of Finance in conjunction with the Board (or Charitable Trust Funds Committee if appropriate). In so doing he / she shall be aware of the following:

(a) the purposes of various funds and the designated objectives.

(b) the availability of cash funds within each trust fund.

(c) the powers of delegation available to commit resources.

(d) the avoidance of the use of exchequer (public) funds to discharge Charitable Trust fund liabilities (except where administratively unavoidable), and to ensure that any reimbursement to the exchequer (public) funds shall be discharged by Charitable Trust funds at the earliest possible time.

(e) that Charitable Trust funds are to be spent rather than preserved, subject to the wishes of the donor and the needs of the Charitable Trust fund; and

(f) The definitions of "charitable purposes" as agreed by the DoH.

19.9 Banking Services

The Director of Finance should advise the Board and, with its approval, should ensure that appropriate banking services are available to the Charitable Trust fund. A financial system is to be in place that permit identification of income, expenditure and the balance of cash available to each fund.

19.10 Asset Management

19.10.1 Assets in the ownership of or used by the Charitable Trust fund, shall be maintained along with the general estate and inventory of assets. The Director of Finance shall ensure:

(a) in conjunction with the legal adviser, that appropriate records of all assets owned are maintained, and that all assets, at agreed valuations, are brought to account.

(b) that appropriate measures are taken to protect and / or to replace assets. These to include decisions regarding insurance, inventory control, and the reporting of losses.

(c) that donated assets received on trust rather than into the ownership of the Trust shall be accounted for appropriately; and

(d) that all assets acquired from Charitable Trust funds which are intended to be retained within the Charitable Trust funds are appropriately accounted for, and that all other assets so acquired are brought to account in the name of the Trust.

19.11 Reporting

19.11.1 The Director of Finance shall ensure that regular reports are made to the Board (or Charitable Trust Funds Committee if appropriate) in respect of the receipt of funds, investments, and the disposition of resources.

19.11.2 The Director of Finance shall prepare Annual Trustees' Report and Charitable Trust fund accounts in the required manner which shall be submitted to the Trust Board (Charitable Trust Funds Committee if appropriate) and DoH within agreed timescales.

19.12 Accounting and Audit

19.12.1 The Director of Finance shall maintain all financial records to enable the

production of Charitable Trust fund reports as above and to the satisfaction of internal and external audit.

19.12.2 The Trust Board shall be advised by the Director of Finance on the outcome of the external annual audit. The Chief Executive shall submit the Report to Those Charged with Governance to the Board.

19.13 Administration Costs

19.13.1 The Director of Finance shall identify all costs directly incurred in the administration of Charitable Trust funds and, in agreement with the Board, shall charge such costs to the appropriate Charitable Trust accounts.

19.14 Taxation and Excise Duty

19.14.1 The Director of Finance shall ensure that any Charitable Trust fund liability to taxation and excise duty is managed appropriately, taking full advantage of available concessions, through the maintenance of appropriate records, the preparation and submission of the required returns and the recovery of deductions at source.

20. ACCEPTANCE OF GIFTS BY STAFF AND LINK TO STANDARDS OF BUSINESS CONDUCT

KEY POINTS

- Trust staff are required to comply with the Trust's Gifts and Hospitality Policy.

20.1 The Director of Finance shall ensure that all staff are made aware of the Trust policy on acceptance of gifts and other benefits-in-kind by staff. This policy follows DoH guidance and is also deemed to be an integral part of the Standing Orders, these Standing Financial Instructions and the Gifts and Hospitality Policy.

20.2 The Director of Finance shall ensure a written record is maintained of any such gifts, bequests or donations and of their estimated value and whether they are disposed of or retained.

21. RETENTION OF RECORDS

KEY POINTS

- The Chief Executive is responsible for maintaining records in accordance with DoH guidelines, Good Management and Good Records (GMGR) and the Trust Retention and Disposal Schedule.

21.1 The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with DoH guidelines as set out in the Good Management Good Records document.

21.2 The records held in archives shall be capable of retrieval by authorised persons.

21.3 Records held in accordance with latest DoH guidance shall only be destroyed in accordance with the provisions of GMGR. Detail shall be maintained of records so destroyed.

22. RISK MANAGEMENT AND INSURANCE

KEY POINTS

- The Chief Executive shall ensure that the Trust has a programme of risk management which is approved and monitored by Trust Board; *and*
- There are only three exceptions of when the Trust may enter into arrangements for commercial insurance.

22.1 Programme of Risk Management

22.1.1 The Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with current DoH assurance framework requirements, which must be approved and monitored by the Audit and Risk Assurance Committee on behalf of the Trust Board.

22.1.2 The Chief Executive shall ensure that the risks the Trust faces are dealt in an appropriate manner, in accordance with the relevant aspects of best practice in corporate governance and shall develop a risk management strategy in accordance with DoH / HM Treasury guidance and Managing Public Money NI (MPMNI).

22.1.3 The programme of risk management shall include:

(a) a process for identifying and quantifying risks and potential liabilities.

(b) developing among all levels of staff a positive attitude towards the control of risk.

(c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk (risk appetite).

(d) contingency plans to offset the impact of adverse events.

(e) audit arrangements including Internal Audit, clinical audit, health and safety review.

(f) a clear indication of which risks shall be insured (see 22.2); and

(g) on-going arrangements to review the Risk Management programme and to assess the effectiveness of existing arrangements.

22.1.4 The existence, integration and evaluation of the above elements will assist in providing a basis to make a statement on the effectiveness of Internal Control within the Mid-Year Assurance Statement and the Governance Statement within the Annual Report and Accounts as required by current DoH guidance.

22.2 Insurance Arrangements with Commercial Insurers

22.2.1 There is a general prohibition on entering into insurance arrangements with commercial insurers, other than insurance which is a statutory obligation, or which is permitted under MPMNI.

22.2.2 There are, however, **three exceptions** when Trust's may enter into insurance arrangements with commercial insurers. The exceptions are:

(a) Trust's may enter commercial arrangements for **insuring motor vehicles** owned by the Trust including insuring third party liability arising from their use.

(b) Where the Trust is involved with a consortium in a **Private Finance Initiative contract / Public Private Partnership** and the other consortium members require that commercial insurance arrangements are entered into; and

(c) Where **income generation activities** take place. Income generation activities should normally be insured against all risks using commercial insurance. In any case of doubt concerning a Trust's powers to enter into commercial insurance arrangements the Director of Finance should consult the DoH

22.2.3 In the case of a major loss or third-party claim, the Trust shall liaise with DoH about the circumstances in which an appropriate addition to budget will be considered.

22.2.4 The Trust falls under Schedule 2 of the Employer's Liability (Compulsory Insurance) Regulations (Northern Ireland) 1999, and therefore is not required to insure against liability for personal injury suffered by its employees.

23. HSC TRUST FINANCIAL GUIDANCE

KEY POINTS

- The Director of Finance will ensure that members of the Trust Board are aware of extant finance guidance from the DoH.

23.1 The Director of Finance shall ensure that members of the Board are aware of the extant finance guidance issued by DoH and that this direction and guidance are followed by the Trust.

Northern Ireland Ambulance Service
Health and Social Care Trust

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

PRESENTATION OF PAPER

Date of Committee:	20 February 2025
Title of paper:	Charitable Trust Funds Registration with Charity Commission Northern Ireland (CCNI)
Brief summary:	NIAS has been working with DLS and CCNI to register the charitable trust funds as a charity. The Charity Commission has reviewed NIAS's proposed governing document and public benefit statement and are happy for NIAS to proceed with the application for registration. The Trust Board is asked to approve these two documents to progress the application for registration.
Recommendation:	**For Approval** ☒ **For Noting** ☐ *Click the appropriate box*
Previous forum:	SMT 11 February 2025
Prepared and presented by:	Brona McAuley, Assistant Director Finance Simon Christie.
Date:	7/2/2025

THIS DECLARATION OF TRUST IS MADE

The day of 20

By

The Northern Ireland Ambulance Service Health and Social Care Trust of Headquarters, Site 30, Knockbracken Healthcare Park, Saintfield Road, Belfast, BT8 8SG (the first trustees" who together with the future trustees are referred to as "trustees")

The first trustees hold the sum of £459,811 on the trusts declared in this deed and they expect that more money or assets will be acquired by them on the same trusts.

NOW THIS DEED WITNESSES AS FOLLOWS;

1. Administration:

The charitable trust created by this deed ('the charity') and its trust property ("the trust fund") must be administered by the trustees under the name of "The Northern Ireland Ambulance Service Charitable Funds" or as such other name as the trustees from time to time decide with approval of the Charity Commission of Northern Ireland ("the Commission").

2. Trustees

The trustees of the Charity and the trust fund shall be "Northern Ireland Ambulance Service Health and Social Care Trust", acting as corporate trustee and managed by the Trust Board in accordance with the Standing Orders and Standing Financial Instructions of the *Northern Ireland Ambulance Service Health and Social Care Trust* and such other trustees as may be appointed by virtue of any legislation from time to time in force.

3. Purposes

The Trustees shall hold the trust fund upon trust to apply the income, and at its discretion, so far as may be permissible, the capital, for the advancement of health or the saving of lives by supporting the ambulance service across Northern Ireland.

The charity will support the Northern Ireland Ambulance Service Health and Social Care Trust ('NIAS') in efforts to enhance service user experience and

achieve better health outcomes across its service and, where appropriate support patient and staff welfare, education, research and development.

4. Powers

In addition to any other powers they have, the trustees may exercise any of the following powers in order to further the purposes (but not for any other purposes);

a. to raise funds and invite and receive contributions. In exercising this power, the trustees must not undertake any taxable permanent trading activity and must comply with any relevant statutory regulations;

b. to buy, take on lease or in exchange, hire or otherwise acquire property necessary for the achievement of the purposes and to maintain and equip it for use;

c. subject to any consents required by law to sell, lease or otherwise dispose of all or any part of the property belonging to the charity

d. subject to any consents required by law to borrow money and to charge the whole or any part of the trust fund as security for repayment of the money borrowed.

e. to deposit or invest funds in any manner including within the Northern Ireland Health and Personal Services Charities Common Investment Fund (but to invest only after obtaining such advice from a financial expert as the Trustees consider necessary and having regard to the suitability of investments and the need for diversification);

f. to co-operate with other charities, voluntary bodies and statutory authorities operating in furtherance of the purposes or of similar charitable purposes and to exchange information and advice with them;

g. to establish or support any charitable trusts, associations or institutions formed for the purposes;

h. to acquire, merge with or enter into any partnership or joint venture arrangement with any other charity formed for any of the purposes;

i. to create such committees as the trustees think fit;

j. to employ and remunerate such staff as are necessary for carrying out the work of the charity;

k. to charge against the trust fund the proportion of the cost of administrative overheads incurred by the trustees both in the

administration of the Charity and in the discharge of other functions which is attributable to the administration of the Charity.

l. to designate, at their discretion, particular funds out of the trust fund in order to give effect to the wishes of any donor to the Charity or for administrative or other purposes and power to vary and cancel such designation: Provided that any such designation or variation does not permit the use of any part of the trust fund other than for the purposes of the charity.

m. to accept and or create and administer, restricted funds for any purpose within the purposes of the Charity but so that any restricted funds shall be administered in accordance with the trusts attaching to them;

n. to spend money on the insurance of any property comprised in the trust fund to its full value against such perils and upon such terms as the trustees think fit;

o. to make regulations from time to time, within the limits of this deed, for the management of the Charity and for the conduct of its business;

p. to do any other lawful thing that is necessary or desirable for the achievement of the purposes.

5. Statutory Powers

Nothing in this deed restricts or excludes the exercise by the trustees of the powers given by the Trustee Act (Northern Ireland) 1958 or the Trustee Act (Northern Ireland) 2001 as regards investment, the acquisition or disposal of land and the employment of agents, nominees and custodians.

6. Delegation of Powers

In addition to their statutory powers, the trustees may delegate any of their powers to a committee or committees in accordance with the Terms of Reference and/or Standing Orders and Standing Financial Instructions of the Northern Ireland Ambulance Service Health and Social Care Trust.

7. Accounts, Annual Report and Annual Return

The Trustees will comply with their obligations under Article 91 of the Health and Personal Social Services (NI) Order 1972 (as amended by Article 6 of the Audit and Accountability (NI) Order 2003 and all other relevant Northern Ireland charity legislation, with regard to;

a. the keeping of accounting records for the charity;

b. the preparation of annual statements of account for the charity;

c. the auditing or independent examination of the statements of account of the charity to the Commission;

d. the preparation of an Annual Report and its transmission to the Commission;

e. the preparation of an Annual Return and its transmission to the Commission.

8. Registered Particulars

The trustees must notify the Commission promptly of any changes to the charity's entry on the register.

9. Amendment of the Trust Deed

1) The trustees may amend the provisions of this deed, provided that:

a) no amendment may be made to clause 3 (Purposes), and clause 11 (Dissolution) or this clause without the prior consent in writing of the Commission;

b) no amendment may be made that would have the effect of making the charity cease to be a charity at law.

c) no amendment may be made which would have the effect of undermining or working against the purposes of the charity.

2) Any amendment of this deed must be made by deed following a decision of the trustees made at a special meeting by a 2/3 majority.

(3) The trustees must send to the Commission a copy of the deed effecting any amendment made under this clause within three months of it being made.

10. Dissolution

1) The trustees may dissolve the charity if they decide that it is necessary or desirable to do so. To be effective, a proposal to dissolve the charity must be passed at a special meeting by a two-thirds majority of the trustees. Any

assets of the charity that are left after the charity's debts have been paid ('the net assets') must be given:

a) to another charity (or other charities) with purposes that are the same or similar to the charity's own, for the general purposes of the recipient charity (or charities); or

b) to any charity for use for particular purposes which fall within the charity's purposes; or

c) directly for purposes within the charity's purposes; or

d) in any other manner with the written approval of the Commission.

2) The Commission must be notified promptly that the charity has been dissolved and, if the trustees were obliged to send the charity's accounts to the Commission for the accounting period which ended before its dissolution, they must send the Commission the charity's final accounts.

IN WITNESS of the above this document has been executed as a deed and is delivered and takes effect on the date stated at the beginning of the Deed.

Chairman .....

Chief Executive .....

Please state the purposes (also known as objects) of your organisation as stated in your governing document:

The Trustees shall hold the trust fund upon trust to apply the income, and at its discretion, so far as may be permissible, the capital, for the advancement of health or the saving of lives by supporting the ambulance service across Northern Ireland.

The charity will support the Northern Ireland Ambulance Service Health and Social Care Trust ('NIAS') in efforts to enhance service user experience and achieve better health outcomes across its service and, where appropriate support patient and staff welfare, education, research and development.

Tell us how the organisation carries out its purpose? (that is, what does the organisation do?)

The charity provides support to NIAS by complementing and supplementing the provision of high-quality emergency, urgent and primary care services throughout the whole of Northern Ireland. The charity provides additional funding for patient and staff welfare, new equipment and services.

The charity also supports the education and development of NIAS staff by providing funding for training, education and research in those specialities relevant to NIAS.

Please tell us how your organisation's purpose(s) meets the public benefit requirement.

What are the direct benefits flowing from your organisation's purposes?

The direct benefits include improved health outcomes and quality of life for those who rely on the high-quality emergency, urgent and primary care provided by NIAS in all communities across Northern Ireland.

Our beneficiaries benefit directly from the high-quality service provided by NIAS, often in times of medical emergency where preservation of life, prevention of deterioration and promotion of recovery are key. The provision of specialist medical equipment, education and training leads to effective diagnoses and treatments, resulting in improved health outcomes.

How can the benefits identified above be demonstrated?

Improved health and quality of care can be demonstrated by the training and wellness initiatives provided by NIAS for both staff and service users. For example, in 2023/24 funding was provided for the following initiatives;

- The Wellness Programme focusing on staff wellbeing and trauma training. Critical Incident Stress Management (CISM) training for volunteers has led to an increase in the number of volunteers able to provide 1-2-1 support and post traumatic incident group debriefing to NIAS staff members.
- The Frequent Caller Project allows NIAS to work closely with the British Red Cross to provide bespoke, person centred support for service users who call 999 for assistance with complex unmet health and social care needs. This 12-month pilot scheme is currently being evaluated for further roll out.
- Funds were spent on improving staff comforts at the 46 stations and deployment points across Northern Ireland eg. kitchen and entertainment equipment.

Improved health and quality care are also demonstrated through the provision of specialist equipment. For example, during the financial year 2022-23, NIAS partnered with the Children's Heartbeat Trust and Northern Ireland Specialist Transport and Retrieval Service (NISTAR) to deliver a bespoke ambulance vehicle solely for children. The ambulance is equipped with specialist medical equipment and children's comforts to ensure the safe and comfortable transport of children needing medical treatment.

Is there any harm arising from any of the purposes?

There is no harm arising from the charity's purposes. The charity is not involved in the direct provision of care, education or research but exists to provide additional funding for new and existing services.

Who are the charity's beneficiaries?

The beneficiaries of the charity are the people of Northern Ireland. NIAS is a regional service operating across Northern Ireland with 46 stations and deployment points.

Is there any private benefit flowing from any of the purposes? Is it incidental and necessary?

There is some private benefit to NIAS staff who receive additional training and education however, this is incidental and necessary for the furtherance of the charity's purposes and this education and training is subsequently shared for the benefit of other colleagues.

Northern Ireland Ambulance Service Health and Social Care Trust

PEOPLE, FINANCE & ORGANISATIONAL DEVELOPMENT COMMITTEE (PFOD)

Thursday 28 November 2024 at 09:30 – NIAS HQ, Boardroom

1.	Attendees and Apologies			

Present:

- Mr Dennison, Committee Chair
- Mr Corrigan, Non-Executive Director

In Attendance:

- Ms Lemon, Director of Human Resources
- Ms Byrne, Director of Operations
- Mr Simon Christie
- Ms Turley, Senior HR Business Partner & Change Manager
- Ms Anne Marie McStocker Health & Wellbeing Project Manager

Apologies:

- Mr Phelim Quinn, Non-Executive Director
- Ms Maxine Paterson, Deputy CEx & Director of Planning, Performance and Corporate Services
- Ms Lorraine Gardner, Assistant Director of Human Resources

2.	Procedure			
	2.1	Declaration of Potential Conflicts of Interest		

No conflicts of interest were declared.

	2.2	Quorum		

The meeting was confirmed as quorate.

	2.3	Confidentiality of Information		

Attendees were reminded of the confidentiality of the meeting.

3	Previous Minutes – 29/09/2024 **For Approval**	PC28/11/24/01	Chair

The minutes for previous meetings were approved.

- Proposer Mr Dennison
- Secondar Mr Corrigan

4	Matters Arising **For Noting**	PC28/11/24/02	

Matters arising were noted.

5	**Finance**		
5.1	Finance Report (Month 7)	PC28/11/24/03	Dir of Finance

Mr Christie presented the Month 7 finance report. He indicated that the team had now fully caught up and expected that going forward finance reports would be presented on a standard reporting timeframe.

Mr Christie provided an overview on the presentation paper attached and highlighted on the following slides:

- Slide 3 Executive summary. Some minor movement between assumed income and allocation from SPPG with the budget remaining largely the same.
- Slide 4 Financial management development is now complete and now operating in a business as usual context. An underspend year to date of £1m is being reported with a forecast easement from pay budgets due to recruitment not progressing as originally anticipated. £900k of an easement in the workforce service development funding has been agreed to be retracted non-recurrently by SPPG. In effect, we will now operate with £12.1million with new workforce money for 2024/25. Work is being done to increase capacity through overtime and increased use of IAS along with the potential to support Trusts in reducing delayed handover, particularly at end of shifts. NIAS may also be able to support Trusts with patient transport costs if required and subject to affordability.
  Mr Christie provided a brief summary on HSC pay gap. Negotiations are ongoing with regular engagements with the DoH, SPPG, all Trusts and any further easement that NIAS may incur may be utilised by DoH to help support the current pay gap.
- Slide 5 Summary of Directorate Positions. This provides detail of the variances driving the underspend year to date. The year end forecast remains at break even with the prescribed plans and activities as articulated.
- Slide 7 Expenditure Trends. This is a new slide included for reporting. Forecasting expected increased expenditure in coming months due to new recruits of Paramedics, NQPs and Ambulance Care Attendants filling of vacancies together with additional winter pressures.
- Slide 10 and 11 highlight the significant capital pressures that have emerged over the last 2 months. A bid has been submitted to DoH and in the absence of additional funding a contingency has been developed in order to live within the Capital Resource Limit (CRL).
- Slide 14 details the plans to deliver the savings of £2.475m. This plan now removes the TBC element of the previous plan. NIAS are on track to deliver the plan.

Mr Corrigan thanked Mr Christie and Finance team for their efforts to bring the financial reporting up to date and presenting on current months projections and updates. Mr Corrigan requested for Mr Christie to elaborate on report.
Mr Christie provided further explanations as per attached slides. More expenditure is taking place in the second half of the year as profiled in the budgets. Planned spending over the budget for IAS due to internal capacity constraints and underspend. A bid made to DoH for the capital pressure of £1.1million. Biggest capital pressure is fleet and the increased price to convert ambulance chassis. If the bid is not granted, we may need to defer some conversions into 2025-26. A bid has been made for more trolleys in the anticipation that they may be required to support delayed handovers. Prompt payment is acceptable.
Mr Christie gave an additional overview on slide 14 Statutory financial performance targets and explained the rates. Achievement of RRL is green. CRL is amber due to the financial pressure. Saving plans have been categorised as green and prompt payment rated amber due to 10 day actual being at 68%.

Mr Corrigan mentioned the up to date reporting provides him with confidence and assurance. This allows for increased strength and confidence with engaging with SPPG.

Mr Corrigan queried where is the contingency of £500k previously reported within slide 5. Mr Christie indicated that this is no longer required, and the budget line has been allocated to Operations departments. Small amount of funds has been utilised for training.

Mr Corrigan highlighted that we should take some of the learning developed this year into the financial planning process for 2025-26. Mr Christie concurred with this view. He indicated that the financial management team were still quite new to the organisation and that there was good development occurring within the team.

Ms Lemon provided a brief summary on the pressures of HR and recruitment. The delay and impact on recruitment, timelines, allocations, training and capacity to deliver educational programmes etc. Monthly robust meetings taking place with Mr Christie at Director level reviewing spends and projections for regular update and accountability.

5.2	Independent Review of Finance processes (Final Report)	PC28/11/24/04	Dir of Finance

Mr Christie provided a brief summary on Independent Review of Financial Process, Progress Update paper. Mr Christie indicated that he considered all recommendations have been implemented and complete and is now in a business as usual environment.
Mr Corrigan was content.
Mr Dennison thanked Mr Christie and team for their efforts and work.

6	**Human Resources and Organisational Development**		
6.1	HROD Balance Scorecard	PC28/11/24/05	Dir of HR&OD

Ms Turley briefed the committee on HROD Balance Scorecard. She advised hat significant work had been undertaken to address legacy cases within the HROD sphere, with a dedicated employee relations workshop having taken place to establish robust plans against outstanding cases complete. She advised the committee that this work had involved the triaging of a case load of 81. In this regard she reported that the team had sought to resolve and close cases as appropriate.

Ms Lemon acknowledged that the legacy case load was disproportionately high for an organisation of NIAS's size. However, she reminded the Committee of the related recognition of matters pertaining to organisational culture in ambulance services across the UK.
She illustrated this by explaining that HCPC had published information which indicated that Paramedics represented 11% of their AHP workforce membership but 64% of the organisations complaints of bullying and harassment.

Ms Turley provided high level summary on statutory mandatory training compliance. She acknowledged that improvement in this regard was necessary, indicating particular challenges associated with release of frontline staff. She further advised that a proposal for improvement would be developed and submitted to SMT for approval.

Mr Corrigan asked how the mandatory training items were identified. Ms Lemon advised that a matrix of key elements based in statute or high priority policy and best practice is reviewed and approved by the Senior Management Team.

Mr Dennison asked specifically about delivery of Safeguarding Training given this is a high priority area for the Trust. Ms Lemon advised that delivery of this training across the Trust was currently in train.

Mr Corrigan asked a question about the financial risks associated with delivery of this training. Mr Christie advised that this was dependent on the delivery model with potential consequences if payment of overtime for delivery was considered moving forward. However, he advised that this must be balanced against the potential impact on service delivery associated with release of staff from frontline shifts.

6.2	Maximising Attendance Report	PC28/11/24/06	Dir of HR&OD

Ms Lemon provided an overview on the Maximising Attendance Report provided to the committee. She outlined some positive trends in the data with improvements in absence figures but acknowledged that the Trust remained an outlier in comparison to regional HSC and national

ambulance organisations. As such she explained that the work to embed the changes and seek to achieve further improvement continued. Focused on hotspot areas and complex cases.
Mr Corrigan acknowledged the progress delivered and advised that the key measure of success was the additional frontline capacity associated with improved cover levels as absence levels reduced.
Ms Lemon further advised that the majority of internal audit recommendations that pertained to absence management had been closed with some outstanding recommendations related to Occupational Health arrangements. In this regard Ms Lemon advised that Anne Marie McStocker was now leading this work stream. She further advised that this work would be focused on the development of Key Performance Indicators to monitor OH performance and work to improve the OH service model for the Trust.

Ms Lemon advised that consideration of reasonable adjustments and management within the requirements of the Disability Discrimination Act was a key element of the work associated with managing the absence of those with long term, underlying conditions. In this regard she advised that there had been an increase in grievances and legal challenges. To support the Trusts work in this regard, she advised that the Trust had engaged an organisation called 'Employers for Disability' to provide advice and training as well as to support governance related to decision making in consideration of reasonable adjustments.
Mr Dennison acknowledged the improved position, particularly in comparison to the same period the previous year where absence levels were significantly higher. He acknowledged that the management processes needed to be sensitively handled and that difficult decisions would be involved.

6.3	Addressing Organisational Culture	PC28/11/24/07	Dir of HR&OD

Ms Lemon referred the committee to a paper related to Organisational Culture paper highlighting Organisational Culture as a key priority for the organisation. She advised that given the Board and Committee commitment to this as a high priority work stream, the paper contained a proposed approach to taking this work forward.
She proposed that a dedicated organisational-level programme be established She advised that this would be a cross-directorate programme, chaired by the Chief Executive and including non-executive director and independent membership. She described work planned to build capacity to deliver this programme of work including potentially engaging support from an independent external organisation. The Committee were asked to approve the approach outlined within the paper.

Mr Dennison asked how the Committee could help to facilitate future work. Ms Lemon advised that the support of Mr Quinn as the NED lead had already been a significant help and this would add value moving forward. She further suggested that the ongoing engagement of committee members would be helpful as the work progressed, particularly in the establishment of the Programme Board.

Mr Corrigan indicated that it was critical the work be mainstreamed throughout the organisation rather than being viewed as a HR programme only. He further agreed that Chief Executive Leadership of the programme was important.

The Committee approved the proposed approach and asked for further updates as the work progressed.

Action: Further updates to be provided to PFOD Committee.

6.4	CISM Update-the journey towards Trauma Informed	PC28/11/24/08	Dir of HR&OD

Ms Lemon introduced Anne Marie McStocker Health & Wellbeing Project Manager to present the provided paper entitled, CISM Update-the journey towards Trauma Informed

Ms McStocker explained the CISM Model to the committee, outlining the related principles of a trauma-informed and evidence-based approach. She described the peer-led model which involves post incident support to those staff who have had exposure to trauma or experienced difficulties in the course of their role.

Ms McStocker outlined the key themes and trends associated with peer support contacts which included. Ms Lemon commended Ms McStocker for the significant work undertaken and achievements in delivery of the Health and Wellbeing Strategy. She outlined the importance of the newly established permanent team within the new structure.

Mr Corrigan asked how the peer support team recognise someone is in need of the support. Ms McStocker advised that awareness sessions had been provided to managers from whom an increasing number of referrals are received.
Mr Dennison asked about the capacity within the team given the demand described. Ms McStocker advised that the new team represented an increased level of capacity but indicated a desire to further evolve the model and potentially establish a role to support the work stream moving forward.
Mr Dennison asked how the team record and monitor any themes or learning from the work. Ms McStocker advised that evaluations are undertaken with key learning and feedback identified. She indicated that this was continuing to evolve with the introduction of a QR code to support timely effective feedback. The committee thanked Ms McStocker for the presentationR and for the work of her team.

7	**Operations**		
7.1	Operations Restructure Implementation Plan Update	PC28/11/24/09	Dir of Ops

Ms Byrne provided an update on progress since the last meeting in respect of the restructuring within the Operations Directorate on Operations Restructure Implementation Plan. Ms Byrne advised on the following job updates:

- Engagement with Clinical Education Team
- Engagement with EPRR team
- HR project support appointed
- Engagement with finance team regarding spend plan
- Estates manager and Head of strategy now part of team
- AD Scheduled Care now advertised
- Scheduled Care Service Lead job evaluation complete
- Scheduled Care Sector Lead job evaluation complete
- Scheduled Care Service Team Leader job evaluation postponed but rescheduled for 20th Nov
- Unscheduled Care Service Lead job description with HR for review prior to going to job evaluation

A risk register has been developed which contains 13 risks. Of note 5 have a grading of 20 and the following are deemed extreme:

- Project team workload – the current project team are involved in multiple other priority projects in addition with dealing with daily BAU. Attempts to delegate tasks and protect diary time have provided very limited success.
- Workforce destabilisation – Multiple staff in current management roles have indicated their intention to apply for both scheduled care posts and other posts being advertised by both NIAS and the wider HSC. This has the potential to create gaps within the current management structure. In addition, multiple staff have also advised of their intention to apply for Partial Retirement once introduced.
- Delay with job evaluations – while there was a delay with job evaluations there has been progress in recent weeks.
- Staff consultations – staff consultations are required before posts can be advertised. Meeting taking place on 3rd December to plan staff consultations.

- Impact of Ops structure on other directorates / teams. Engagement with other teams / directorates to be included in Communications strategy. Meeting with Communications team planned for 26th Nov.

It is also important to note that while not graded as Extreme, there is a medium risk regarding Trade Union engagement. One Trade Union advised that they would not be engaging as part of their Action Short of Strike.

Ms Byrne advised that whilst ASOS impacted on engagement around transformation, trade unions were prepared to engage in an organisational change context. Ms Turley outlined to the committee, organisational change processes that had been established and related early discussions with trade unions.

8	**Any Other Business**		
8.1	Update on Industrial Relations pay dispute	Verbal Update	
8.2	Update on Senior Executive Recruitment	Verbal Update	

Update on Industrial Relations pay dispute
Ms Lemon advised that the Trust remains in an ASOS context. She advised that she had escalated this to the Department of Health to consider in the context of the regional dispute resolution.

Update on Senior Executive Recruitment
Ms Lemon provided an update on Senior Executive Recruitment.

The Committee discussed plans for interim recruitment to the roles of Chief Executive and Director of Finance. Discussion included the potential use of an executive search firm to support the permanent processes.

Action: Ms Lemon to engage with the Chair and Chief Executive and progress the requirements.

Committee Structure
Mr Corrigan advised the committee he received an update from Nick Henry Assistant Director of Governance, Risk and Assurance regarding revision of the Trust Board Committee Terms of Reference and remit. It is intended that draft documentation will be circulated to NEDs in the coming days setting out the proposed changes to the Board Committee TORs and requesting written comments/feedback Once finalised, the revised TORs would be tabled at ARAC and Trust Board meetings in February 2025 for ratification, with them coming into effect from 1 April 2025. The plan is subject to NIAS Chair approval.

	Next meeting: 13 February 2025, 09:30 – 13:00 NIAS Headquarters, Boardroom		

SIGNED: _____

DATE: _____13/2/25_____

Northern Ireland Ambulance Service
Health and Social Care Trust

Meeting of the Audit and Risk Assurance Committee (ARAC) held on Thursday 10 October 2024 at 9.30am in the Boardroom, NIAS HQ

Minutes

			Paper Enclosed
	Welcome, introduction and format of meeting		
1	**Present:** • The Chair Graham Committee Chair • Mr Dale Ashford Ashford Non-Executive Director • Mr Corrigan Corrigan Non-Executive Director **In Attendance:** • Ms Paterson Paterson Deputy CEx & Director of Planning, Performance and Corporate Services • Mr Christie Christie • Ms McAuleyMcAuley Assistant Director of Finance • Nick Henry Assistant Director of Governance, Risk and Assurance • Mr Charles Charles Internal Audit, BSO • Collette Kane, Northern Ireland Audit Office • Christine Hagan, ASM **Apologies:** • Dr Nigel Ruddell		
2	Declaration of Potential Conflict of Interest & Confirmation of Quorum		
The meeting was confirmed as quorate.			
3	Minutes of the previous meeting held on Thursday 27 June 2024 **For Approval**		AC10/10/24/01
The minutes for previous meetings were approved.			
4	**Matters Arising**		
	4.1	Action list **For Noting**	AC10/10/24/02
Action list confirmed closed as action was appearing on agenda.			
5	**Chair's Business**		No paper
	5.1	Annual Review of Best Practice for ARACs	AC10/10/24/03

		For Noting	

Risk register recognised making significant improvement.

Chair expressed gratitude towards Ms Lesley Mitchell, recognising all her hard work and dedication. Chair and Committee expressed their gratitude and thanks to Ms Lesley Mitchell.
The Chair advised there was a risk workshop being carried out to strengthen effectiveness of risk across the organisation.
Ms Paterson mentioned Board Effectiveness IA report received. Mr Henry was introduced to the committee.
Significant work has progressed which has enhanced board assurance. Board workshop is scheduled for 24 October 2024. This will go some way to addressing IA recommendations in Board Effectiveness.

6	**Standing Items**		
	6.1	NIAS Direct Award Contract Register **For Noting**	AC10/10/24/04 AC10/10/24/05 AC10/10/24/06 AC10/10/24/07

Mr Christie provided an overview on DACS.
Mr Corrigan queried if driver training was a Direct Award Contract (DAC). Mr Christie confirmed it was a DAC due to being specialist vehicles and therefore a DAC is required.
Mr Christie mentioned Taxi spend came up in IA report. Mr Christie aims for DAC to be signed off and brought to next committee meeting. It will support IA recommendations.
Mr Corrigan queried about the hiring does specialist vehicles for training whether NIAS should consider procuring their own. Mr Christie indicated that it was likely that due to the costs and limited requirement it may be more cost effective to hire than to buy. However, he indicated that he would discuss with the education team and update at the next meeting. Ms Paterson referenced DAC for refresher driving training. It was not on the existing specialist framework, and some difficulty in obtaining this training.

Action: Mr Christie to update on hire or buy of specialists training vehicles.

	6.2	Fraud Update – Written Update **For Noting**	AC10/10/24/08

The Chair welcomed the change from verbal to written report now submitted to the committee from previous meetings.
Ms McAuley provided short summary. Work is ongoing as per the information on attached paper.
Mr Corrigan provided positive feedback, praised current work and progress.

	6.3	Emergency Preparedness, Resilience & Response **For Noting**	No paper

Mr Dale Ashford provided update. Good direction of travel. New appointments of Assistant Director and other appointments being made. New Assistant Director for EPRR has had a positive impact. A number of recommendations still remain outstanding however, EPRR plan being well developed and progressing to implementation stage. Regular EPPR meetings are scheduled and taking place. It has been agreed to have AACE provide some third level of assurance. To get a sense check from AACE and an in depth check from internal audit. Good positive progress to date and a positive change in culture. Good energy and enthusiasm. DoH have been informed and made aware EPRR team are small in NIAS in comparison to UK. Work is underway with developing business case for additional resources and expansion of team.

Ms Rosie Byrne Director of Operations has been meeting with Chris Matthews in the Department and with EPRR within the Department to fully articulate risks, impacts and what it may mean. Ms Paterson meets the regulator NIS within the Department of Finance on a monthly basis regarding

assurance around EPRR. Meeting is described as confidence and compliance meeting. Positive outcome from meeting this month with the level of evidence submitted and self assessment. Minimum standards to be demonstrated by 2026. Until CAF is procured, minimum standards cannot be demonstrated.
The Chair stated he is content with current progress and operating changes.

7	**Internal Audit**		
	7.1	To advise on key issues	No paper
Internal Audit provided overview on papers provided.			
	7.2	IA Progress Report **For Noting**	AC10/10/24/09

Business Continuity 2024/25
Mr Charles provided a general update on Business continuity 2024/25 as per attached IA progress report paper. Mr Charles highlighted the findings within the audit and provided a satisfactory level of assurance.
Ms Paterson elaborated on the progress. The report was issued in May 2024. SMT have seen the evidence of improvement. Core 7 are key principles which are the focus of business continuity. This was tested effectively with Crowdstrike issue. Exercises planned to test policy and procedures in the plan.
Mr Corrigan asked Internal Audit if he felt this was a reasonable approach to undertake. Mr Charles agreed stating it is a reasonable approach and makes sense.
Mr Corrigan requested to have the responsible Director for audits being presented to ARAC to attend and to provide feedback to ARAC in order to respond to queries from committee members.
Mr Christie noted the request and advised appropriate Director/ Assistant Director will be asked to attend ARAC going forward to take and answer questions and respond to reports as required.
Mr Dale Ashford advised a deep dive will take place in each area for further understanding and reporting. Ms Paterson recognised the challenges and risks. The gaps will be monitored for improvements. Owners of the report were in invited and in attendance at previous ARAC for Q&A. Assistant Director is to be appointed for non-Emergency. The Chair advised for SMT to be made aware the next ARAC meeting in December will be more actions than noting and the importance of attendance.

Management of Complaints and SAI's 2024/25
Mr Charles provided feedback on Management of Complaints. Significant actions have taken place. Number of recommendations have been actioned and there is good work output. SAI training have been taking place. Training to be refreshed for those who deal with complaints. In comparison to previous years, NIAS has made good progress. Ms Paterson stated we are still faced with challenges; however, positive improvements are being made. More individual/ personalised letters are now issued, the team were prioritising quality over timeframes though acknowledging the balance would be optimal. The Department looking at redesigning the process of SAI's. Current outstanding gaps are due to the availability of resources, this is being corrected with temporary resource to increase capacity. Training to be completed in six months.
The Chair mentioned Quality vs Speed is being looked into with responses. Mr Corrigan expressed appreciation of work carried out. The Chair mentioned compliments are to be shared out.

Clinical Governance in Respect of Cardiac Arrests 2024/25
Mr Charles provided feedback on Clinical Governance in Respect of Cardiac Arrests 2024/25. Highlights were provided for NIAS Dashboard and Cardiac Register.
The Cardiac Register suggests the eight months backlog is due to the challenges faced with scanning of PRF forms. Register has not been updated for some time. Due to the absence of information NIAS cannot feedback/ measure correctly. A series of recommendations have been made and management are content. Ms Paterson provided some assurance on progress made to date. There are now dashboards capturing information for screening for audit for out of hospital

cardiac arrests. We are now up to 70% of electronic records which will mitigate the risks and challenges using paper records. We now have e-opportunities to access real time information available. Cardiac Arrest register will improve over time with new process in place as information is populated going forward.
There is now a step change out of hospital cardiac arrests survival rate. We have an action plan., it has developed since last review. We now have an over arching internal structure reviewing all aspects within this space including cardiac arrests on a monthly basis.
Mr Charles is content with Ms Paterson's explanation and reasonable approach.
Mr Dale Ashford questioned the percentages and why is it only 70% reached and not 100%. Ms Paterson explained that all care pathways do not have the ability to receive an electronic record, paper copies are still being provided. There is also scrutiny being carried around why electronic records have not been created and reasoning around paper copies being received.
Mr Dale Ashford asked about the data collected by community first responders (CFR) and will it be electronic and the issue of the coordinator posts. Ms Paterson stated the CFR provide a significant role.
and they help to stabilise the patients and then handover to the NIAS Clinicians who attends on scene and populates the record with any relevant information captured. Our current devices work well within encompass system.

Board Effectiveness 2024/25
Mr Charles provided a brief overview on Board Effectiveness 2024/25. Mr Charles highlighted the level of assurance provided is satisfactory on system of governance, risk management and control. Overall positive progress and assurance with one training section was incomplete for one NED. The Chair elaborated on the points mentioned by Mr Charles.
Mr Corrigan questioned the audit piece around board effectiveness and was this taken into account? Mr Charles mentioned a sample was reviewed and taken into consideration within the remit of the small audit. Areas such as frequency of meetings, finance, performance and quality. Mr Corrigan would like to see a written document outlining activities, components, mechanisms within various committees and outcomes. The Chair mentioned this is a good paper exercise, but we need to look at the linkage. The new piece of work will pull things together and provide clarification going forward.

	7.3	Mid-Year Follow-up Review: - Outstanding Internal Audit Recommendations 2024-25 - Cyber Recommendations **For Noting**	AC10/10/24/10 AC10/10/24/11

Outstanding Internal Audit Recommendations 2024-25
Mr Charles provided a brief overview on Management summary and conclusions. There were 29 recommendations, 20 have been implemented. Progress meetings between officers and IA are taking place to discuss further progress.
Working closely with Ms McAuley for progress. Ms McAuley provided assurance work is continuing, there is good engagement and discussions at Assistant Director Forums (ADF) and update follow up provided to SMT. Mr Corrigan gave praise and credit for the current working progress however, there are still 9 remaining recommendations yet to implement. Ms Paterson recognises there are a lot of items to focus on and welcomes the relationship with Internal Audit and Mr Christies guidance. They are working closely with Ms McAuley to close off items.
Mr Corrigan requested for up-to-date level of assurance to be provided by Ms McAuley. Ms McAuley will work closely with Mr Charles and provide evidence to help facilitate request. Ms McAuley will carry out an assessment on the evidence provided and determine whether recommendations can be implemented or not. This will be the subject of the single item ARAC meeting in December.

Cyber Recommendations
Paper noted.

	7.4	Head of Internal Audit Mid-Year Assurance Statement **For Noting**	AC10/10/24/12

Paper noted. Mr Charles mentioned there is a healthier follow up position.			
	7.5	Shared Service Update **For Noting**	AC10/10/24/13
Mr Charles provided a brief summary on Shared Services Update paper. NIAS is reliant on BSO to provide back office functions. Internal Audit provided Satisfactory assurance in relation to the Accounts Payable Shared Services. Ms Paterson asked what work has been commissioned with the equip programme as this is a significant risk. Mr Charles mentioned there has been some engagement however further developments are yet to take place.			
8	**External Audit**		
	8.1	To advise on key issues	No paper
Christine Hagan confirmed accounts were now certified.			
	8.2	Final Report To Those Charged With Governance **For Noting**	AC10/10/24/14 AC10/10/24/15
Collette Kane advised NIAO will be reporting shortly on Ambulance Handover was carried out. It is intended that the report will be published in February 2025.Good messages and feedback coming out of it. This will first have factual accuracy clearance in November-December 2024. Members welcome the report. Ms Paterson mentioned a factual accuracy checking is being undertaken for an RQIA report on SWAH and may be published prior to the above mentioned report.			
9	NIAS Mid-Year Assurance Statement **For Approval**		AC10/10/24/16
Ms Paterson provided brief update on NIAS Mid-Year Assurance Statement. Mid Year Assurance statement is carried out annually. Report is due to be returned and issued to DoH tomorrow with some minor adjustments and updates. Self assessment tool has been updated by DoH on 22nd August 2024. Paper approved by the Chair and seconder Mr Dale Ashford Ashford.			
10	Review of Corporate Risk Register – progress update **For Noting**		AC10/10/24/17 AC10/10/24/18
Ms Paterson provided a brief overview on the Review of Corporate Risk Register and introduced Nick Henry, Assistant Director of Governance, Risk and Assurance. Mr Henry has contributed his experience. While risks are at a satisfactory level of assurance, ongoing improvements are required. Nick praised Laura Hill for her contributions and efforts. Nick provided a summary as per the attached paper. Meetings took place with risk owners and updates were made. Two new risks for consideration are 1. Late Finishes graded as high risk however, work is underway to bottom this out. 2. Patient Care Service (PCS). Capacity challenges comprised of service delivery hospital flow of quick discharge. Mr Corrigan questioned why PCS is a new risk. Nick mentioned further recruitment exercise is being carried out. Ms Paterson stated approximately 50 new recruits is required, recruitment and capacity for training is difficult. Recruiting into Southern Division is presenting some challenges. Ms Paterson mentioned a risk appetite workshop has been scheduled in December to help inform target scores. To have consistent approach to risk appetite. The Chair gave thanks to Nick and his team for all their hard work and progress to date. Nick outlined 5 risks to reduce their grading: 1. Cyber can move extreme to high. 2. Risk 301Staff Wellbeing can be reduced from high to medium as advised by Director of HROD. 3. Financial stability risk is now deescalated. 4. Clinical Audit/ Clinical Supervision to be deescalated and closed out and be moved to Clinical Director risk register.			

5. Staff Competency/ Training to be deescalated and closed out and be moved to Clinical Director risk register.

Mr Dale Ashford raised concerns around staff being released to be able to carry out required tasks. Going forward, how can we ensure this will be taken into account within the remit of new training requirements? Ms Paterson provided assurance that we now have cover and financial support. Training team and Operations are collaborating to manage their approaches. Training officers have some increased capacity within training team to meet the required needs.
Mr Dale Ashford asked if Mr Sinclair can provide a paper/ update to ARAC. Ms Paterson mentioned Mr Sinclair can provide information and this sits within Safety Committee.
Mr Corrigan highlighted the work is in its infancy and further developments are required. Requested for Mr Sinclair's input.
The Chair mentioned to keep risks within Directorate risk register until Mr Sinclair's input has been received.

Action:
Mr Sinclair to provide paper and update to Safety Committee members on highlighted risks which can inform and provide assurance over decision to deescalate risk.

11	DoH correspondence re: 11.1 Revenue Business Case Test Drilling 2023/24 11.2 Departments Report To Those Charged With Governance (RTTCWG) – ALB implementation of audit recommendations **For Noting**	AC10/10/24/19 AC10/10/24/20 AC10/10/24/21 AC10/10/24/22

Revenue Business Case Test Drilling 2023/24
Mr Christie provided update on Revenue Business Case Test Drilling 2023/24. Business cases selected for NIAS were rated green.

Departments Report To Those Charged with Governance (RTTCWG) ALB implementation of audit recommendations
The Chair provided a brief overview. There has been many back and forth correspondence between the CEx and DoH. The CEx assured DoH actions are taking place and highlighted how it was internally managing this priority.

12	**Closed Meeting**	
13	**Any Other Business**	
Nil		
14	**Date, Time and Venue of Next Meeting**: Thursday 5 December 2024 at **9.30am** in the Boardroom, NIAS HQ. Please note that this meeting will be used to look at progress in addressing IA recommendations	
	ARAC dates for 2024-25 are as follows: - Thursday 6 February 2025 - Thursday 20 March 2025	

SIGNED: _____

DATE: 6 February 2025

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

PRESENTATION OF PAPER

Date of Trust Board:	20 February 2025
Title of paper:	**Reporting and Management of Adverse Incidents Policy**
Brief summary:	The Trust's Reporting and Management of Adverse Incidents Policy has been updated. The main amendments are summarised below: • Updated list of legislative requirements at section 1.5. • Roles and responsibilities section 3.0 updated, to include requirement for line managers to provide feedback to staff who report an incident and to ensure they are given opportunity to access support mechanisms (where required). • Expectations of incident investigators updated and refined at section 3.8. • Inclusion of RRG's role in the review of relevant adverse incidents (section 3.12). • Paragraph added under section 4.3.11 to cover management of "near miss" adverse incidents. • Internal NIAS procedures for reviewing adverse incidents updated at section 4.3.15. The policy was approved at ARAC on 6 February 2025.
Recommendation:	**For Approval** ☐ **For Noting** ☒
Previous forum:	Health and Safety Committee – December 2024 SMT – 28 January 2025 ARAC – 6 February 2025
Prepared and presented by: **Date:**	Maxine Paterson, Director for Planning and Performance and Corporate Services 13 February 2025

Northern Ireland Ambulance Service
Health and Social Care Trust

Title:	**Reporting and Management of Adverse Incidents Policy**		
Author(s):	Laura Hill, Risk Management Coordinator Nick Henry, Assistant Director for Governance, Assurance and Risk		
Ownership:	Maxine Paterson, Deputy Chief Executive and Director of Planning, Performance and Corporate Services		
Date of SMT Approval:	28 January 2025	**Date of Committee Approval:**	6 February 2025
Operational Date:	February 2025	**Review Date:**	February 2027
Version No:	5.0	**Supersedes:**	Version 4.0
Key Words:	Incidents, Near Misses, Learning, Investigation, Just Culture, Improvement, Regional Risk Matrix, Datix, Serious Adverse Incidents (SAIs).		
Links to Other Policies / Procedures:	Learning From Serious Adverse Incidents (SAIs) Procedure, Being Open Policy- saying sorry if things go wrong, RIDDR Policy, Management of Medical Devices Policy, Health and Safety Policy. Supporting Staff Involved in Incidents, Complaints, Claims & Coroner's Inquests Policy.		

Version Control:			
Date:	**Version:**	**Author:**	**Comments:**
December 2024	5.0	AD Governance, Assurance and Risk/Risk Management Coordinator	Review of 2020 Draft version
February 2020	4.0	Risk Manager	Regional Procedure
10.11.14	3.0	Risk Manager	
19.04.10	2.0	Risk Manager	
25.02.08	1.0	Risk Manager	

1.0 INTRODUCTION

1.1 Background

Arising out of the recommendations of the Regional Learning System Project Report (August 2015), it was agreed to develop a regional policy on the reporting and management of adverse incidents to be used by all Health & Social Care Trusts, the Strategic Planning and Performance Group (formerly the Health & Social Care Board) and the Northern Ireland Ambulance Service (NIAS) called ("the Trust").

1.2 Introduction

This policy outlines the Trust's framework for the reporting and management of adverse incidents which affect service users, staff and visitors to NIAS's premises or have an impact on NIAS's reputation or legal duty of care.

The manner in which a Trust manages and learns from adverse incidents is one of the key markers of success in relation to risk management, corporate and clinical and social care governance standards. Consistent identification, monitoring and review of incidents is central to the Trust's strategic and operational processes to ensure it can achieve its vision for safe and effective care.

The Trust recognises that no health and social care environment will ever be absolutely safe and, on occasions, errors or incidents will occur. Equally, it recognises that when incidents do occur it is important to identify causes to ensure that lessons are learned to prevent recurrence.

The Trust is committed to an open, honest and just culture and reporting of adverse incidents is encouraged so that the Trust can learn from incidents and take actions, including changes in practice, to reduce the risk of recurrence. It also will ensure that staff learn and are supported in making changes to their practice post incidents, as required.

1.3 Purpose

This policy provides guidance on the reporting and managing of adverse incidents which affect service users, staff and visitors to the Trust's premises or have an impact on the Trust, its reputation or its legal duty of care. It will also enable a robust and systematic approach to the management of adverse incidents that will be consistently applied across the Trust ensuring that it meets all relevant statutory or mandatory responsibilities and reporting requirements, thereby safeguarding the wellbeing of service users, staff and visitors.

It has been developed to ensure Trust-wide learning takes place within a structured framework and that any lessons learned are disseminated across the Trust, and to external agencies as appropriate.

1.4 Aims & Objectives

Adverse incident management systems assist Trusts to ensure that systems are in place to secure service user, staff and visitor safety, ensure internal accountability and safeguard the Trust's assets and reputation. Learning from adverse incidents enables the Trust to reduce risk proactively and improve services. It recognises that most incidents occur because of

problems with systems rather than individuals but may also on occasions be multifactorial in nature.

The objectives of this policy are:

- To promote and provide a unified regional Trust-wide system for the reporting, recording, review and analysis of all adverse incidents;
- To improve the safety and quality of care through reporting, analysing and learning from incidents involving service users, staff and visitors (including contractors);
- To comply with relevant legislation and standards relating to the reporting of incidents;
- To ensure all adverse incidents are dealt with appropriately and in a timely and consistent manner;
- To provide a means of analysing trends in incidents and identification of factors contributing to incidents to assist in implementation of service improvement and risk reduction strategies, thereby minimising risk to service users, staff, visitors and the Trust; and
- To support staff when mistakes happen and encourage staff to review and reflect on their practice post review of incidents.

1.5 Legislative Requirements

The key legislative reporting requirements for Trusts in respect of adverse incidents are as follows:

- Health & Safety at Work (NI) Order 1978.
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 1997.
- The General Data Protection Regulation and the Data Protection Act 2018
- Social Security Claims and Payments Regulations 1979.
- The Public Interest Disclosure Act 1998.
- Mental Health (NI) Order 1986.
- The Children (NI) Order 1995.
- Data Protection Act 1998.

2.0 SCOPE OF POLICY

2.1 This policy covers all areas of the Trust's business and applies to all incidents involving service users, staff and visitors, as well as those incidents where individuals are not affected. It covers contractors, students, volunteers, bank and agency staff or locums and any others to whom the Trust owes a duty of care.

2.2 This policy excludes detailed arrangements in respect of the following areas which are covered by separate regionally agreed policies:

- Procedure on the reporting of Early Alerts.
- Being Open Policy.
- Procedure on Reporting of Adverse Incidents under RIDDOR Regulations.
- Learning From Serious Adverse Incidents (SAIs) Procedure.

3.0 ROLES AND RESPONSIBILITIES

3.1 **NIAS Trust Board** is responsible for ensuring that a robust system is in place for the reporting and management of adverse incidents and will receive regular management reports on this subject matter.

3.2 **The Chief Executive** is the Accountable Officer for the Trust and is responsible for ensuring that it meets its statutory and legal requirements in respect of adverse incident reporting and management. He/she will ensure that the Trust adheres, and responds appropriately, to circulars and guidance issued by the Department of Health (DoH) in respect of adverse incident management.

3.3 **The Medical Director** is the lead Director responsible for the reporting and management of adverse incidents within the Trust. He/she will ensure that systems, policies and procedures are developed and implemented on an organisational basis including the onward reporting of relevant incidents to external agencies for example SPPG, HSENI and the Regulation, Quality Improvement Authority (RQIA). On a daily basis this function is delegated to the **Assistant Director for Governance, Risk & Assurance.**

3.4 **Directors** are responsible for ensuring that this policy is widely disseminated, promoted and implemented within their areas of responsibility. Directors are also responsible for ensuring that incidents reported within their Directorates are managed in accordance with this policy.

3.5 **Assistant Directors** are responsible and accountable to their respective Directors for ensuring that this policy, and any associated procedures, are effectively implemented within their areas of responsibility and that staff are appropriately trained in the reporting and management of adverse incidents. They should also promote an open, honest and just reporting culture and ensure that appropriate reviews are carried out.

3.6 **Line managers** are responsible for:

- Ensuring that this policy and associated procedures are effectively implemented across their area of responsibility;
- Promoting an open, honest and just reporting culture;
- Ensuring that appropriate review of adverse incidents is carried out;
- Ensuring incident reporters receive feedback. This can be via DatixWeb (Datix), on a one-to-one basis or at staff meetings;
- Ensuring appropriate support is offered to staff (see section 4.3.10 & 4.3.14).
- Reviewing, approving and/or escalation of incidents via Datix; and
- Ensuring staff are supported to report events which might constitute an adverse incident appropriately and that they are assessed and graded in line with this policy.

3.7 **Persons who report an incident** are responsible for reporting the incident using Datix in line with the Trust's reporting criteria and timescales.

All adverse incidents should be reported on Datix within 24 hours of their occurrence.

Should Datix be unavailable for any reason, the adverse incident should be reported via email to:datix.administrator@nias.hscni.net.

3.8 Incident Investigators:

The Investigator is responsible for reviewing, approving and/or escalation of an incident via Datix, and for:

- Ensuring that appropriate remedial actions are put in place immediately to prevent reoccurrence of the adverse incident;
- Securing and safeguarding any information, equipment, data, material, consumables etc. that may be required for investigation;
- Notifying senior management within the Trust about incident occurrence (as required); and
- Engaging with staff and incident reporters to provide feedback and share learning arising out of incident reviews.

The Investigator is responsible for ensuring that incidents are categorised and graded appropriately - all incidents should be reviewed and risk graded **within 5 working days** of being reported.

The Trust's Datix team carries out first line assessment and coding of all reported incidents. An incident is then forwarded to a nominated Investigator in the relevant Directorate for risk grading and review. The Datix Team may also add additional investigators from other departments if required.

The Investigator is responsible for ensuring that an appropriate investigation is carried out and that the outcome(s) is documented on Datix. The level of investigation and reporting should be commensurate with the severity and grading of the incident as outlined in this policy.

For example, an incident graded as Medium (Yellow) will require a higher level of investigation and reporting detail than one graded as Low (Green). The timescales for completing incident investigations vary depending on its risk grading (see Appendix 1).

Once the incident reporting and review process has been followed and (where relevant) all actions have been implemented, the Investigator is responsible for closing the incident on Datix.

3.9 All staff have a responsibility to:

- Ensure the safety of individuals (service users, visitors and staff), the environment and equipment;
- Avoid putting themselves and others in situations of danger;
- Ensure their line manager(s) and/or person in charge is informed of the incident;
- Record and report all adverse incidents using the Trust's reporting systems as soon as possible and ideally within 24 hours of occurrence or becoming aware of the adverse incident;
- Follow the guidance set out in this policy in respect of initial grading and categorisation of an incident on Datix; and

- Co-operate with any review process including providing a witness statement, if appropriate.

3.10 **The Senior Information Risk Owner (SIRO)** is the lead Director for ensuring that Information Governance (IG) incidents are reported and appropriately managed including reporting to Information Commissioner's Office, if necessary. He/she (or nominee) will provide advice and support to managers in respect of IG incidents, as appropriate.

3.11 **Regional Training Officers** will provide advice and support to Line Managers in the event of clinical incidents, manual handling, managing aggression etc. Divisional/Clinical Training Officers are responsible for conducting training needs analysis, developing individual training plans and providing training and clinical supervision as required. Call reflections must be completed for all significant clinical incidents. Any issues/concerns should be escalated via line management structures.

3.12 Rapid Review Group

The Rapid Review Group is responsible for monitoring and assessing reported Adverse Incidents which have been identified on the Datix system as potentially meeting the SAI criteria i.e. Query SAIs. In regard to Query SAIs and SAIs the Rapid Review Group will ensure:

- Timely review of all high-risk Adverse Incidents with the potential to meet SAI criteria, i.e. Query Serious Adverse Incidents (QSAIs).
- Identification of complaints/incidents to be notified as SAIs.
- Timely notification of SAIs to the SPPG.
- Urgent learning is shared immediately.
- Relevant KPIs are monitored.
- That any areas of learning are escalated to the Learning Outcomes Review Group (LORG) and / or Safety, Quality, Patient Experience & Performance Committee.

4.0 KEY PRINCIPLES

4.1 Definitions

4.1.1 **Adverse Incident:** Any event or circumstances that could have, or did, lead to harm, loss or damage to people, property, environment or reputation arising during the course of the business of an HSC Trust/Special Agency or commissioned service[1]. A suggested list of broad categories of adverse incidents to be reported is listed in Appendix 1, for guidance purposes.

4.1.2 **Harm:** "injury (physical or psychological), disease, suffering, disability or death".[2] In most instances, harm can be considered to be unexpected if it is not related to the natural cause of the service user's illness or underlying condition.

4.1.3 **Serious Adverse Incident (SAI):** is an adverse incident that must be reported to the SPPG because it meets at least one of the criteria as defined by the "Procedure

[1] HSCB Policy and Procedure for the reporting and follow up of Serious Adverse Incidents, November 2016

[2] Doing Less Harm, NHS, National Patient Safety Agency 2001

for the Reporting and Follow-up of Serious Adverse Incidents (SAI's), Oct 2016[3]. See Separate Learning from Serious Adverse Incidents Procedure.

4.1.4 Service User[4]: this term refers to a patient, service user, family (of a service user and/or family of a victim), carer or nominated representative / advocate.

4.2 Statement of Commitment

The Trust is committed to providing the best possible service for its service users, staff and visitors. It recognises that adverse incidents will occur and that it is important to identify causes to ensure that lessons are learned to prevent recurrence. It is therefore essential that a responsive and effective incident recording, reporting and management system is in place to achieve this aim. Where learning from adverse incidents is identified the necessary changes should be put in place to improve practice.

4.3 Policy Principles

4.3.1 Approach to Adverse Incident Reporting and Management: An open, honest and just culture[5]

As part of its proactive approach to risk management, the Trust promotes an open, honest and just culture in which errors or service failures can be admitted, reported and discussed without fear of reprisal. This will enable lessons to be identified and allow active learning to take place and the necessary changes made or reflected in policies, procedures and practices.

All staff must report and manage adverse incidents according to this policy (and any related operational procedures) for adverse incident reporting. Crucial to the effectiveness of adverse incident reporting and management is the Trust's commitment to the promotion of an open, honest and just culture where all staff can participate in reporting adverse incidents. Staff are encouraged to report incidents and to look critically at their own actions and those of their teams, to ensure the Trust can provide quality services for our service users, staff and visitors.

Ultimately, the Trust wants to encourage staff to report areas of concern and to foster a positive ethos around reporting. Staff who make a prompt and honest report in relation to an adverse incident should not expect to be subject to disciplinary action except under the following circumstances:

- A breach of law.
- Wilful or gross carelessness or professional misconduct.
- Repeated breaches of Trust policy and procedure.
- Where, in the view of the Trust, and/or any professional registration body, the action causing the incident is far removed from acceptable practice; or

[3] HSCB Policy and Procedure for the reporting and follow up of Serious Adverse Incidents, November 2016

[4] As per the draft Statement of what you should expect in relation to a Serious Adverse Incident Review, January 2019

[5] A just culture focuses on identifying and addressing systems issues that lead individuals to engage in unsafe behaviours, while maintaining individual accountability by establishing zero tolerance for reckless behaviour. Just organizations focus on identifying and correcting system imperfections, and pinpoint these defects as the most common cause of adverse events. Just culture distinguishes between human error (e.g., mistakes), at-risk behaviour (e.g., taking shortcuts), and reckless behaviour (e.g., ignoring required safety steps), in contrast to an overarching 'no-blame' approach" (Agency for Healthcare Research and Quality; Patient Safety Network 2016, US Department of Health).

- Where there is failure to report a serious incident in which a member of staff was involved or about which they were aware.

Completion of an adverse incident report does not discharge staff of their duty of care and their risk management responsibility. There should be timely and appropriate follow-up of adverse incidents. Where preventative measures and/or procedural changes are identified these should be put in place to minimise the risk of the adverse incident recurring.

All employees must be honest, open and truthful in all their dealings with service users and the public. Organisational and personal interests must never be allowed to outweigh the duty of openness, transparency and candour.

4.3.2 External reporting arrangements in respect of other incidents not covered by this procedure

Depending on the nature of the adverse incident the Trust may be required to report relevant details to other statutory agencies and external bodies for example SPPG, RQIA and HSENI. Staff should ensure that they are aware of their local reporting requirements to other statutory agencies and external bodies as per their local policy/procedures. These incidents must also be recorded on the Trust's incident reporting system.

With regard to Independent Service Providers (ISPs) and contractors, they will be required under their contractual arrangements to maintain a system of reporting and recording of adverse incidents related to service users referred to them by the Trust for assessment, treatment or care. ISPs are also required to submit monitoring information to the Trust as required. Both adverse incidents and SAIs are discussed at contract meetings between Trusts and ISPs. The Trust will decide whether an ISP adverse incident meets the criteria for reporting as a SAI and is therefore responsible for reporting the SAI to the SPPG.

This policy does not cover the arrangements for the reporting of Early Alerts to the DoH as this is the subject of separate guidance/policy.

4.3.3 Operational Procedures for Reporting of Adverse Incidents

The process for reporting, recording and reviewing adverse incidents is detailed below and also included in diagrammatic format in Appendix 1. Key points to remember are listed below.

4.3.4 What to do when an adverse incident occurs – immediate actions

The injured person or damaged property should be assessed immediately to ascertain extent of injury/damage and identify emergency or urgent treatment/action required. The situation must be made safe. Communicate with the service user and their relatives/carers, as appropriate following an adverse event. Ensure appropriate discussion with the service user and/or relatives/carers and give consideration to any additional support which may be required. Any equipment involved in the adverse incident, even if not directly implicated, should be removed from use and the following action taken:

- Clearly label "Do Not Use" including a short description of the nature of the fault, if possible;
- Retain any related evidence such as packaging (for batch or serial numbers) or consumables/accessories (e.g., defibrillator pads, giving sets for pumps etc.);
- Decontaminate any device that can be decontaminated without destroying evidence and attach a decontamination certificate to that effect (refer to IPC policy); and
- For medication – where packaging or labelling of a medicine is an issue, retain or photograph to facilitate further review and follow up with the pharmaceutical company/MHRA.

4.3.5 Who should report?

Any member of staff can report an adverse incident. It is the responsibility of **ALL** staff who are involved in, witness or become aware of an adverse incident to ensure it is reported using the Trust's incident reporting system. If the incident involves another area within the Trust, this area must be made aware of the adverse incident and remedial actions agreed.

4.3.6 When to report?

It is important that all adverse incidents are reported as soon as possible and ideally within 24 hours of occurrence or becoming aware of the adverse incident. This supports effective review and timely learning and ensures compliance with responsibilities for external reporting.

4.3.7 What types of incidents to report?

The incident reporting system will ensure that any event which meets the definition in section 4.1.1 involving service users, staff and visitors are reported promptly and action instigated where necessary. Appendix 2 provides a list of broad categories of possible adverse incidents which may assist reporters. This is not an exhaustive list but gives a broad indication of the types of adverse incidents to be reported.

4.3.8 How to report?

All incidents should be reported using the Trust's adverse incident reporting system (Datix).

In respect of incidents involving service users, please note that adverse incident reports are NOT health records and copies of any electronic adverse incident reports (or paper forms) should NOT be filed with patient report forms. However, details of the incident (including the incident reference number if available) that are relevant to the treatment and care being provided to the service user should be added to patient report forms / passed to HSC Trusts as necessary.

4.3.9 Other Reporting Systems

Some directorates/areas have additional error and incident monitoring arrangements (e.g. Medical Directorate and Information Governance) as part of specific legal, regional, accreditation or quality assurance framework requirements

for these services. Staff using these systems must ensure that incidents which meet the Trust's definition of adverse incidents are also reported via the Trust's adverse incident reporting system.

4.3.10 Staff Support directly following an incident

The Trust recognises that it has a responsibility to support all staff following adverse incidents. All staff involved in an adverse incident will need an appropriate level of support commensurate with the outcome of the incident. It is the line manager's responsibility to ensure that individuals are supported appropriately. Support can be provided by Occupational Health, Peer Support, Inspire, Trade Unions etc. Staff involved should be kept informed of the progress of a review at all stages.

In addition, individuals who have been absent from work may require additional support and supervision to aid confidence when returning to work.

Staff involved in the incident should also be involved in the review, where appropriate. All staff should receive feedback when the investigation has been completed.

4.3.11 Arrangements for Incident Review & Grading

Deciding what to review

Many Trusts report thousands of incidents each year. It is therefore unrealistic to suggest that all incidents should be reviewed to the same degree, or at the same level, within the Trust. Furthermore, the outcome of an incident, including a 'near miss', at the time of occurrence is sometimes a poor indicator of the level of review required. The application of a simple risk assessment process to incidents at the time of occurrence can enable the Trust to implement a much more structured approach to its incident management.

Events or circumstances which could have caused harm, loss or damage, but did not actually do so, i.e. "near misses" should be regarded as an adverse incident and should be reported and managed in the same manner as circumstances which brought about actual harm, loss or damage. Reviewing "near miss" adverse incidents can generate important learning and process changes to improve the quality and safety of services.

Reporters should grade all incidents in Datix for actual impact at the time of reporting the incident (Severity level) using the Regional Risk Matrix (Appendix 3). The Investigator should check, and where necessary amend, the severity level when reviewing the incident.

The Regional Risk Matrix is also used by a range of specialist advisers for grading of incidents. Not all incidents fit discreetly into individual categories within the matrix and therefore where there is any disagreement between the reporter and the person reviewing the incident, the final decision will be taken by the Assistant Director of Governance, Risk and Assurance or deputy. Incident grading should occur within five days of the incident being reported.

4.3.12 Communication with Service Users and/or relatives

A member of staff within the line management structure of the lead member of staff responsible for the treatment and/or care will retain the responsibility for communicating with the service user and their relatives about the incident. However, there may also be a liaison person at a senior level identified to make contact.

Harming a service user can have devastating emotional and physical consequences for the individual, their family and carers, and can be distressing for the professionals involved. ***'Being Open'*** is a set of principles that health and social care staff should use when offering an explanation and apologising to service users and/or their carers when harm has resulted from an incident. **"Saying sorry is not an admission of liability".**

'Being Open' involves:

- Acknowledging, apologising and explaining when things go wrong;
- Keeping service users and carers fully informed when an incident has occurred;
- Conducting a thorough review into the incident and reassuring service users, their families and carers that lessons learned will help prevent the incident reoccurring;
- Providing support for those involved to cope with the physical and psychological consequences of what happened; and
- Recognising that direct and/or indirect involvement in incidents can be distressing for health and social care staff.

The Trust is committed to improving the safety and quality of the care we deliver to the public. Our '*Being Open'* policy expresses this commitment to provide open and honest communication between health and social care staff and a service user (and/or their family and carers) when they have suffered harm as a result of their treatment. It is based on published guidance by the National Patient Safety Agency (NPSA) and also complies with step 5 of '*Seven Steps to Patient Safety*'.

4.3.13 Communication with the Media

All communications with the media should be co-ordinated by the Communications Team.

4.3.14 Debriefing of Staff after Adverse Incidents

Assistant Directors/Senior Managers should ensure that local procedures are in place for both the operational and psychological debriefing of staff after incidents.

The Line Manager should assess individual incidents, liaise with staff and should contact peersupport@nias.hscni.net where appropriate. Line Managers should note that to be effective, Peer Support should be able to offer a debrief within 14 days. In the event of cases with particularly significant outcomes/major incidents, etc. staff may be contacted directly by Peer Support. Staff can also avail of Peer Support services at any time.

The Line manager should also ensure that the staff member has access to appropriate help post incident as necessary e.g., referral for medical opinion in case of assault, counselling etc., Where immediate support is required out-of-hours, this should be arranged via On Call Officer / Senior On Call." Line managers should, where appropriate, seek advice from Occupational Health as to whether it is advisable for the staff member to return to (or stay in) the workplace.

Where a staff member is subject to an assault the incident must be reported via Datix and their line manager should encourage the staff member to notify the police. Line managers should make staff aware of support services that are available including Occupational Health Services, Inspire and Peer Support.

4.3.15 Review, Monitoring and Analysis of Adverse Incident Statistics

The Trust has mechanisms in place for the review, monitoring and analysis of adverse incidents and produces reports for consideration and discussion at relevant governance related committees/sub committees/team meetings, and externally as required. Incident statistics should also be used with other sources of statistics to help inform the management of risks and effectiveness of actions taken following incident reviews, quality improvement projects and other quality and safety initiatives.

Adverse incidents are monitored and reviewed through the Trust's corporate governance framework:

- Trust Board – scrutiny of how policies and procedures are being implemented. As necessary reviews incidents / trends highlighted by Committees. Leads 'Just Culture'.
- Safety, Quality and Patient Experience Committee receives reports on all aspects of Adverse Incidents and SAIs including thematic reporting, reporting against key performance indicators, identification of learning, sharing of recommendations and sharing of accounts of individual SAIs.
- Learning Outcomes Review Group (LORG) –provides a quarterly cross directorate forum for the sharing of identified learning arising from Adverse Incidents and SAIs.
- Medical Equipment Group – Incidents involving or related to medical devices.
- Health and Safety Committee – health and safety related incidents
- Emergency Preparedness & Business Continuity Group – EP / BCP related incidents.
- Infection Prevention and Control (IPC) Group – IPC incidents.
- Fire Compliance Group – Fire related incidents.
- Management of Aggression Working Group – work related violence incidents.

4.3.16 Learning and Feedback

Learning from adverse incidents can only take place when they are reported and investigated in a positive, open and structured way. Where learning from such adverse incidents is identified, the Trust will ensure that the necessary changes will be put in place to improve practice. Where learning from incidents is relevant to other areas across the Trust, and/or externally, the learning should be shared as per current organisational arrangements, e.g., established sub committees and groups.

Feedback to staff is vital in respect of incidents they report. Managers should ensure it occurs in their respective areas. This can be on a one-to-one basis or feedback can be given to all staff at meetings. Investigators are encouraged to provide feedback to all reporters using the Feedback and Communications section within Datix.

5.0 IMPLEMENTATION

5.1 Dissemination

This policy covers all areas of the Trust's business and applies to all incidents involving service users, staff and visitors, as well as those incidents where individuals are not affected. It also covers contractors, students, volunteers and bank and agency staff or locums and any others to whom the Trust owes a duty of care. All staff employed by the Trust should be provided with access to this policy.

5.2 Resources

5.2.1 Training

Adverse incident training is available for all staff and appropriate training and guidance will be provided by the Risk Management Team to ensure that all Trust employees understand their responsibilities under this policy and are able to effectively fulfil their obligations to report adverse incidents. The Risk Management Team will use LMS/HRPTS to record staff training.

5.3 Exceptions

There are no exceptions to this policy and to the Trust's commitment to learn from adverse incidents.

6.0 MONITORING

An audit will be undertaken post implementation to ensure adherence to the principles and procedures outlined. Changes will be made to the policy as required. This policy will be reviewed on a regular basis by the Risk Management Team in light of best practice, changing legislation or new/updated policy guidance.

7.0 EVIDENCE BASE/REFERENCES

- Health & Safety at Work (Northern Ireland) Order 1978.
- Management of Health & Safety at Work Regulations (Northern Ireland) 2000.
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1997.
- HSCB Procedure for the Reporting and Follow up of Serious Adverse Incidents, November 2016.
- Six steps to Root Cause Analysis, 2002, Consequence UK Limited.
- National Patient Safety Agency.
- Seven Steps to Patient Safety (2004).

8.0 CONSULTATION PROCESS

This policy was developed by the Regional Adverse Incident Work Group chaired by the Assistant Director, Risk Management & Governance, South Eastern Health & Social Care Trust. Consultation was completed via email with relevant Assistant Directors and staff within all Trusts included in the working group.

9.0 APPENDICES

Appendix 1 – Incident reporting and review process flowchart
Appendix 2 – Examples of Adverse Incidents
Appendix 3 – Regional Risk Matrix
Appendix 4 – Guidance for Incident Review and Grading

10.0 EQUALITY STATEMENT

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this procedure should be subject to a full impact assessment has been carried out. The outcome of the Equality screening for this procedure is:

Major impact	☐
Minor impact	☐
No impact.	☒

Lead Author	**Date:**
Nick Henry	
AD for Governance, Risk and Assurance	13 February 2025

Lead Director	**Date:**
Maxine Paterson	
Deputy Chief Executive and Director of Planning, Performance and Corporate Services	13 February 2025

APPENDIX 1 – PROCESS FOR REPORTING / MANAGING AN INCIDENT (INCLUDING LEVEL OF REVIEW BASED ON POTENTIAL RISK GRADIN

INCIDENT

IMMEDIATE ACTION

1. Make person(s) / area safe.
2. Obtain medical aid if required.
3. Inform manager on duty ASAP.
4. Complete an incident form **(incidents should be approved and graded within 5 working days).**
5. Consider level of communication with the service user if required.
6. Consider level of review required and action accordingly. If incident meets SAI criteria, follow relevant procedures.

GREEN INCIDENT (LOW RISK)

Green incidents – Should normally be reviewed locally in the area in which the event occurred. The investigative lead will normally be the line manager. It is the local team's responsibility to identify learning points, or safety improvement measures that are within the areas control and ensure that those safety measures identified that are not within the control of the department are appropriately communicated to the relevant Management Team for consideration.

Incident types frequently falling into this category should also be subject to aggregate analysis by Area Managers/Senior Management identify any need for more targeted data collection. It is acceptable for the line manager to close such incidents following review and recording of findings and lessons learned on Datix.

Review of this grade of incident should normally be completed and **closed within 5 working days**.

YELLOW INCIDENT (MEDIUM RISK)

Yellow Incidents – These should also be reviewed locally, as for Green Incidents, but reviewed by a more senior manager as necessary. Again it is the local team's responsibility to identify learning points, or safety improvement measures within the areas control and ensure that those which are not, are appropriately communicated to the relevant Management Team for consideration. Frequently occurring events attracting this risk category should also undergo Trust-wide aggregate review to identify any need for more targeted data collection.

It is acceptable for the line manager to close such incidents following review and proper recording of findings and lessons learned on Datix.

Review of this grade of incident should normally be completed and **closed within 4 weeks**.

AMBER INCIDENT (HIGH RISK)

Amber Incidents – These incidents should be subject to the appropriate level of review. The line manager should discuss with the relevant Area Manager / **Assistant Director**, who is going to take the lead. It is the responsibility of the relevant management team to ensure that all learning points and safety improvements are appropriately identified and those not within the control of the local management team are communicated to the relevant person/s and committee/s, whichever is the more appropriate.

Note – Improvement strategies arising out of this group of events should be monitored as part of the Trust's Governance arrangements.

Where necessary advice can be sought from the **Risk Management Team.**

Review of this grade of incident should normally be completed and **closed within 12 weeks**.

RED INCIDENT (EXTREME RISK)

Red Incidents – Where major (i.e., long-term permanent harm/disability [physical/emotional injuries/trauma]) or tragic harm (i.e., permanent harm/disability [physical/emotional trauma] or incident leading to death) has occurred the relevant Director, with the support and advice of the Risk Management Team, should appoint a team led by a trained facilitator in SEA/root cause analysis. All of the resulting reports and improvement strategies arising from these events should be monitored by the Trust's Learning Outcomes Review Group.

Review of this grade of incident should normally be completed and **closed within 12 weeks.**

The Health and Safety Advisor will monitor DATIX and complete reports under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1997 (RIDDOR)

The Risk Manager will monitor DATIX and report all Medical Device Events to NIAIC.

Ensure all staff sickness precipitated by an accident is reported to Occupational Health and recorded on GRS

If in doubt, contact the Risk Management Team.

Open, Honest and Just Culture

NIAS welcomes knowledge of adverse events as an opportunity to learn for the benefit of our service users, staff and visitors. Unless there is clear evidence of flagrant malpractice, a complete disregard for the safety of others, maliciousness, intent to harm, theft or fraud the disciplinary policy will not be used for review purposes. Incidents will be investigated for the purposes of learning and change and staff are required to engage as active participants of this.

APPENDIX 2 – EXAMPLES OF ADVERSE INCIDENTS THAT SHOULD BE REPORTED

Broad categories of possible adverse incidents are shown below and may assist reporters. This list is not comprehensive but gives a broad indication of what should be reported

- Abusive, violent, disruptive, challenging or self-harming behaviour
- Delays or difficulties during appointments, admissions, transfers or discharges
- Accidents e.g. falls, sharps injuries, manual handling, exposure to hazardous substance, burn or scalds
- Issues with clinical investigations
- Communication breakdowns between staff and/or with service users, issues with consent and confidentiality
- Diagnosis, missed or delayed
- Transportation delay to scene/ no available resources
- Financial loss to the Trust
- Infrastructure or resources (staffing, facilities, environment) – for example, unsafe environment, waste issues, misuse, failure or theft of IT equipment or systems, lack of facilities, equipment or supplies, inadequate staffing levels
- Infection control issues
- Any other issues relating to implementation of care or ongoing monitoring / review
- Labour or delivery adverse incidents
- Medical device/equipment related Incidents – any preventable equipment related event that could have or did lead to service user harm, loss or damage. Includes incidents related to training, servicing, disposal, storage, and suitability as well as failure of the equipment itself
- Medication incident (i.e., any preventable medication related event that could have or did lead to service user harm, loss or damage).
- Service user Information issues e.g. records, documents etc. This may also include any breach of security leading to the accidental or unlawful destruction, loss, alteration, unauthorised disclosure of, or access to, personal data transmitted, stored or otherwise processed.
- Treatment, procedure – any adverse incident immediately before, during or immediately after
- Security – for example, fires and fire risks, theft or damage to personal property, premises or vehicles, intruders or break-ins

APPENDIX 3 – REGIONAL RISK MATRIX

DOMAIN	IMPACT (CONSEQUENCE) LEVELS [can be used for both actual and potential]				
	INSIGNIFICANT (1)	MINOR (2)	MODERATE (3)	MAJOR (4)	CATASTROPHIC (5)
PEOPLE *(Impact on the Health/Safety/Welfare of any person affected: e.g. Patient/Service User, Staff, Visitor, Contractor)*	• Near miss, no injury or harm.	• Short-term injury/minor harm requiring first aid/medical treatment. • Any patient safety incident that required extra observation or minor treatment e.g. first aid. • Non-permanent harm lasting less than one month. • Admission to hospital for observation or extended stay (1-4 days duration). • Emotional distress (recovery expected within days or weeks).	• Semi-permanent harm/disability (physical/emotional injuries/trauma) (Recovery expected within one year). • Admission/readmission to hospital or extended length of hospital stay/care provision (5-14 days). • Any patient safety incident that resulted in a moderate increase in treatment e.g. surgery required.	• Long-term permanent harm/disability (physical/emotional injuries/trauma). • Increase in length of hospital stay/care provision by >14 days.	• Permanent harm/disability (physical/ emotional trauma) to more than one person. • Incident leading to death.
QUALITY & PROFESSIONAL STANDARDS/ GUIDELINES *(Meeting quality/ professional standards/ statutory functions/ responsibilities and Audit Inspections)*	• Minor non-compliance with internal standards, professional standards, policy or protocol. • Audit / Inspection – small number of recommendations which focus on minor quality improvements issues.	• Single failure to meet internal professional standard or follow protocol. • Audit/Inspection – recommendations can be addressed by low level management action.	• Repeated failure to meet internal professional standards or follow protocols. • Audit / Inspection – challenging recommendations that can be addressed by action plan.	• Repeated failure to meet regional/ national standards. • Repeated failure to meet professional standards or failure to meet statutory functions/ responsibilities. • Audit / Inspection – Critical Report.	• Gross failure to meet external/national standards. • Gross failure to meet professional standards or statutory functions/ responsibilities. • Audit / Inspection – Severely Critical Report.
REPUTATION *(Adverse publicity, enquiries from public representatives/media Legal/Statutory Requirements)*	• Local public/political concern. • Local press < 1day coverage. • Informal contact / Potential intervention by Enforcing Authority (e.g. HSENI/NIFRS).	• Local public/political concern. • Extended local press < 7 day coverage with minor effect on public confidence. • Advisory letter from enforcing authority/increased inspection by regulatory authority.	• Regional public/political concern. • Regional/National press < 3 days coverage. Significant effect on public confidence. • Improvement notice/failure to comply notice.	• MLA concern (Questions in Assembly). • Regional / National Media interest > 3 days < 7days. Public confidence in the Trust undermined. • Criminal Prosecution. • Prohibition Notice. • Executive Officer dismissed. • External Investigation or Independent Review (eg, Ombudsman). • Major Public Enquiry.	• Full Public Enquiry/Critical PAC Hearing. • Regional and National adverse media publicity > 7 days. • Criminal prosecution – Corporate Manslaughter Act. • Executive Officer fined or imprisoned. • Judicial Review/Public Enquiry.
FINANCE, INFORMATION & ASSETS *(Protect assets of the Trust and avoid loss)*	• Commissioning costs (£) <1m. • Loss of assets due to damage to premises/property. • Loss – £1K to £10K. • Minor loss of non-personal information.	• Commissioning costs (£) 1m – 2m. • Loss of assets due to minor damage to premises/ property. • Loss – £10K to £100K. • Loss of information. • Impact to service immediately containable, medium financial loss	• Commissioning costs (£) 2m – 5m. • Loss of assets due to moderate damage to premises/ property. • Loss – £100K to £250K. • Loss of or unauthorised access to sensitive / business critical information • Impact on service contained with assistance, high financial loss	• Commissioning costs (£) 5m – 10m. • Loss of assets due to major damage to premises/property. • Loss – £250K to £2m. • Loss of or corruption of sensitive / business critical information. • Loss of ability to provide services, major financial loss	• Commissioning costs (£) > 10m. • Loss of assets due to severe Trust wide damage to property/premises. • Loss – > £2m. • Permanent loss of or corruption of sensitive/business critical information. • Collapse of service, huge financial loss
RESOURCES *(Service and Business interruption, problems with service provision, including staffing (number and competence), premises and equipment)*	• Loss/ interruption < 8 hour resulting in insignificant damage or loss/impact on service. • No impact on public health social care. • Insignificant unmet need. • Minimal disruption to routine activities of staff and Trust.	• Loss/interruption or access to systems denied 8 – 24 hours resulting in minor damage or loss/ impact on service. • Short term impact on public health social care. • Minor unmet need. • Minor impact on staff, service delivery and Trust, rapidly absorbed.	• Loss/ interruption 1-7 days resulting in moderate damage or loss/impact on service. • Moderate impact on public health and social care. • Moderate unmet need. • Moderate impact on staff, service delivery and Trust absorbed with significant level of intervention. • Access to systems denied and incident expected to last more than 1 day.	• Loss/ interruption 8-31 days resulting in major damage or loss/impact on service. • Major impact on public health and social care. • Major unmet need. • Major impact on staff, service delivery and Trust - absorbed with some formal intervention with other Trusts.	• Loss/ interruption >31 days resulting in catastrophic damage or loss/impact on service. • Catastrophic impact on public health and social care. • Catastrophic unmet need. • Catastrophic impact on staff, service delivery and Trust - absorbed with significant formal intervention with other Trusts.
ENVIRONMENTAL *(Air, Land, Water, Waste management)*	• Nuisance release.	• On site release contained by Trust.	• Moderate on site release contained by Trust. • Moderate off site release contained by Trust.	• Major release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc).	• Toxic release affecting off-site with detrimental effect requiring outside assistance.

SET Risk Matrix – April 2013 (based on HSC Regional Risk Matrix - April 2013, updated June 2016) - Clean

Risk Likelihood Scoring Table			
Likelihood Scoring Descriptors	**Score**	**Frequency (How often might it/does it happen?)**	**Time framed Descriptions of Frequency**
Almost certain	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily
Likely	4	Will probably happen/recur, but it is not a persisting issue/circumstances	Expected to occur at least weekly
Possible	3	Might happen or recur occasionally	Expected to occur at least monthly
Unlikely	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually
Rare	1	This will probably never happen/recur	Not expected to occur for years

	Risk Matrix/Consequence (Severity Levels)				
Likelihood Scoring Descriptors	**Insignificant(1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
Almost Certain (5)	**Medium**	**Medium**	**High**	**Extreme**	**Extreme**
Likely (4)	**Low**	**Medium**	**Medium**	**High**	**Extreme**
Possible (3)	**Low**	**Low**	**Medium**	**High**	**Extreme**
Unlikely (2)	**Low**	**Low**	**Medium**	**High**	**High**
Rare (1)	**Low**	**Low**	**Medium**	**High**	**High**

APPENDIX 4 – GUIDANCE FOR INCIDENT REVIEW & GRADING

This section is a general guide to the review of incidents. **It is recognised that each Trust will have different organisational arrangements and therefore it is acceptable to replace this appendix with local arrangements provided they are based on the undernoted principles.**

Deciding what to review

Trusts should grade all incidents on Datix for actual impact at the time of reporting the incident. This is usually completed by the reporter of the incident using the Regional Risk Matrix (see Appendix 3). The Investigating Officer should update the risk grading is necessary following investigation also using the Regional Risk Matrix (Impact Assessment Table /Likelihood Descriptors) on Datix Web.

The Trust's on-line reporting system allows staff to input this information directly into the electronic system.

What is the actual impact/severity of the event?

Use the Impact Assessment Table at Appendix 3 to determine the **actual impact/severity** of the event by considering the outcome of the incident in terms of harm to: People, Quality & Professional Standards/guidelines, Reputation, Finance, Information & Assets, Resources or Environmental issues.

If two or more domains (see Appendix 3) have been affected by the incident, consider which has been affected the most to assist in your judgement of the impact/severity of the incident. The impact/severity categories are as follows: Insignificant, Minor, Moderate, Major or Catastrophic. This information should be recorded within the "Actual Impact/Severity" field within Datix.

Action required based on the Incident Grading

The Table in Appendix 1 details the actions required with regard to the level of review based on the potential risk grading.

APPENDIX 5 – OFFENCE OF ASSAULTING AN AMBULANCE WORKER

When PSNI bring a prosecution, the charge more often than not relates to 'Common Assault'. All staff are reminded to advise the PSNI Officer that the charge should be Assaulting an Ambulance Worker. See below for your reference.

Changes to legislation: There are currently no known outstanding effects for the Justice Act (Northern Ireland) 2016, Cross Heading: Assaulting ambulance workers etc. (See end of Document for details)

Justice Act (Northern Ireland) 2016

2016 CHAPTER 21

PART 3

Miscellaneous

Assaulting ambulance workers etc

Offence of assaulting ambulance workers etc

54—(1) A person commits an offence if he or she assaults—

(a) an ambulance worker in the execution of that ambulance worker's duty;

(b) a person who is assisting an ambulance worker in the execution of that ambulance worker's duty.

(2) 'Ambulance worker' means a person who provides ambulance services (including air ambulance services) under arrangements made by or at the request of—

(a) the Northern Ireland Ambulance Service Health and Social Care Trust;

(b) St. John Ambulance (NI);

(c) the British Red Cross Society; or

(d) the charity registered in the Republic of Ireland known as the Order of Malta Ireland.

(3) A person guilty of an offence under subsection (1) shall be liable—

(a) on summary conviction, to imprisonment for a term not exceeding 6 months or to a fine not exceeding the statutory maximum, or to both; or

(b) on conviction on indictment, to imprisonment for a term not exceeding 2 years or to a fine, or to both.