Agenda

1 Welcome, Apologies & Declarations of Conflict of Interest

For Information

Apologies from Jim Dennison

Lunch provided at the end of meeting prior to Cyber Security Training at 13.45 (90 minutes)

2 Minutes of the previous meeting held on 26 June 2025

For Approval

2 - Trust Board mins 26-6-25 draft.pdf ***Page 1***

3 Matters Arising

For Noting

3 - Public Trust Board action list 26.06.25.pdf ***Page 11***

4 Chair's Update

For Noting

5 Chief Executive's Update

For Noting

6 Trust Performance Report

For Noting

6 - 01 - Board cover paper_Trust Performance Report.pdf ***Page 12***

6 - 02 - NIAS Trustboard Performance Report July 2025.pdf ***Page 13***

7 Finance Report (Month 3)

For Noting

7 - 01 - TB Cover Paper - Finance Report Month 3 2025-26.pdf ***Page 54***

7 - 02 - NIAS Finance Report Month 3 2025-26 - Final.pdf ***Page 55***

8 LC - QI Programme feedback

For Noting

Sean Maguire and Ann McQueen to attend

8 - 01 - 20250813 NIAS SQ2 Programme Update to Trust Board.pdf ***Page 69***

9 LC - Annual Safeguarding Report

For Noting

Des Flanagan and Stacey Chambers to attend

10 LC - IPC Annual Report

For Noting

11 SM - Board Assurance Framework

For Approval

12 Committee Business

For Information

12.1 Summary of Items at the last Committees

For Noting

12.2 Committee Forward Workplan

For Noting

12.3 Signed Final C'ttee Minutes

For Noting

13 Any Other Business

14 Date & venue of next meeting:

23 October 2025 at 10.00am at Ballymena HQ

Invitees

Mr. Dale Ashford

Stacey Beggs

Ms. Lynne Charlton

Mr. Paul Corrigan

Mr. Jim Dennison

Ms. Leahann Donnelly

Dr. Philip Graham

Ms. Michele Larmour

Ms. Michelle Lemon

Mr. Seamus Mullen

Ms. Maxine Paterson

Mr. Phelim Quinn

Dr. Nigel Ruddell

Mr. Neil Sinclair

Northern Ireland Ambulance Service Health and Social Care Trust

Minutes of NIAS Trust Board held on Thursday 26 June 2025 at 10.35am in the Boardroom, NIAS HQ, Site 30, Knockbracken Healthcare Park, Saintfield Road, Belfast BT8 8SG

Present:	Mrs M Larmour	Chair
	Mr D Ashford	Non-Executive Director
	Mr P Corrigan	Non-Executive Director
	Dr P Graham	Non-Executive Director
	Ms M Paterson	Chief Executive (Interim)
	Mr N Sinclair	Director of Operations (Interim)
	Ms M Lemon	Director of Human Resources & Organisational Development (HR & OD)
	Ms L Donnelly	Director of Finance (Interim)
In Attendance:	Ms L Charlton	Director of Quality, Safety & Improvement (QSI)
	Mr S Mullen	Director of Planning, Performance & Corporate Services (Interim)
	Mr J McPoland	Comms Manager
	Mr A Hopper	National Ambulance Violence Prevention and Reduction Operational Lead (AACE)
	Ms C Barnham	National Ambulance Violence Prevention and Reduction Officer (AACE)
	Mr F Dillon	Violence Reduction Case Manager
	Ms S Beggs	Temporary Board Secretary
Apologies	Mr J Dennison	Non-Executive Director
	Mr P Quinn	Non-Executive Director
	Dr N Ruddell	Medical Director

1 Welcome, Apologies & Declarations of Conflict

The Chair welcomed members to the meeting and noted the apologies received.

The Chair also welcomed Mr McPoland, Comms Manager, attending the meeting as an observer and advised that colleagues from AACE are attending for item 6.

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

The meeting was declared as quorate.

2 **Previous Minutes (TB26/06/2025/01)**

The minutes of the previous meeting held on 15 May 2025 were **APPROVED** on a proposal from Mr Ashford and seconded by Mr Corrigan.

3 **Matters Arising (TB26/06/2025/02)**

Members **NOTED** there were no Matters Arising.

4 **Chair's Update**

The Chair confirmed that all NED appraisals are now complete and have been submitted to the Department.

The Chair attended the Long Service Medal Ceremony on the evening of the last Trust Board Meeting, and commended Mr McPoland and colleagues on a very successful event.

The Chair attended the National Women's Network on 17 June 2025 and gave a presentation on her experience as a woman leader. The Chair was impressed by the number of good practice initiatives occurring nationally and as a result has asked for a meeting with Ms Laura Turley to talk through some of the initiatives.

The Chair has met with Christine Collins, Chair of RQIA, they discussed the GIRFT report and RQIA review service reconfiguration at SWAH. The Chair has asked Ms Paterson to pull together an update on the recommendations from those reports to provide assurance to the Board. The Chair briefed Ms Collins on NIAS governance structures and has offered her to attend a future Trust Board Meeting.

The Chair confirmed that Director objectives for 2024-25 have been signed off at the recent Remuneration Committee and objectives for 2025-26 are in place. The Chair wished to formally recognise Ms Paterson for her efforts in finalising objectives for the required deadlines.

HSC Trust Chairs met with the Interim Permanent Secretary on Tuesday evening, where areas of focus were reiterated, including the financial savings plan for 2025-26 and the proposal to establish a Shared Committee in Common.

Mr Corrigan referred to one of the recommendations from the Audit office being in relation to regulation and oversight of the independent ambulance sector. Ms Charlton advised that the DoH have indicated they plan to consider regulation of independent ambulance providers in parallel with the current review of non-emergency transportation services.

5 **Chief Executive's Update**

Ms Paterson acknowledged the last six weeks had been particularly intense for NIAS and placed on record her thanks and commendation to all staff and commanders who responded during the recent civil unrest in Ballymena and other affected areas. She further acknowledged the personal sacrifices made by staff redeployed at short notice, and highlighted the support and commendation received from the Department of Health and the Executive Office. Initial reflections from the internal debrief have

been very positive, and NIAS will continue to learn from these events and strengthen resilience and multi-agency relationships.

Turning to regional ambulance handover reform, Ms Paterson confirmed that this remains a Ministerial priority, with an interim target to eliminate >2-hour breaches and a longer-term ambition to move towards a 45-minute standard. £10m regional funding has been identified to support this work ahead of winter, and four key performance measures will be used for accountability. NIAS, as RCC host, has proposed and secured agreement that RCC will coordinate delivery on behalf of Trusts. The Minister has also agreed to quarterly accountability meetings with trade unions to monitor progress, recognising the importance of timely crew release for patient outcomes and staff welfare. Ms Paterson stressed that ED engagement will be central to successful local implementation and suggested a workshop with clinical leads who had visited London to share learning from the W45 model.

Ms Paterson informed the Board that NIAS is participating fully in the development of a regional Committee in Common (CiC), alongside the five geographical Trusts, with NIAS's own CiC structure being established from July. She emphasised that this would complement, not replace, NIAS's statutory governance arrangements, and will provide a mechanism to address shared challenges across the system.

She reported that on 23 May the Interim Permanent Secretary had visited NIAS to review its contribution to the wider system reset plan. This initiative seeks to address financial pressures and drive sustainable transformation, with ambulance handover reform recognised as a critical enabler of flow and workforce resilience. NIAS is also leading the regional Falls Workstream as part of this reset and is contributing to the Support & Intervention Framework to align with system accountability arrangements.

Ms Paterson highlighted NIAS's ongoing investment in quality and workforce. On 25 June she attended the Quality Improvement

Level 2 Graduation, where 13 staff presented 11 projects aligned to the Quality Strategy.

Ms Paterson also welcomed Year 13 students participating in NIAS's second annual work experience week, and the intake of 24 newly qualified and 5 qualified paramedics who have joined operational service.

Ms Paterson noted the completion of DAO training on 4 June and the first meeting of the Culture Programme Board on 16 June.

Finally, Ms Paterson thanked Ms Donnelly and colleagues for their work on the Annual Report and Accounts, which received a satisfactory audit outcome. She noted that this was Ms Donnelly's first year-end as Director of Finance and commended the excellent result.

The Chair thanked Ms Paterson for her comprehensive update, which was NOTED.

6 **AACE Presentation: Violence and Aggression Work (TB26/06/2025/03)**

Mr Mullen introduced AACE colleagues, Mr Adam Hopper and Ms Clare Barnham who have been working with NIAS for a number of years, particularly with Mr Frankie Dillon, violence reduction lead.

Mr Hopper explained they provide support to all ambulance services, including those in the devolved nations. The violence prevention has been hitherto funded by NHS England. However, due to its dissolution, this funding will soon cease.

Mr Hopper shared promotional footage from four years ago which was shared on all social media platforms that demonstrates the abuse staff receive, not just front-line staff but call handlers also.

The Chair queried why there is a significant decline in the last year. Mr Dillon said there is nothing tangible to prove why but the introduction of body worn video in the last 12 months could be an enabling factor.

The presence of weapons has increased by 14% in the last five years and the Chair suggested it may be worth linking with the PSNI regarding related incidents as this will most likely correlate across and help form a preventative strategy.

Trust Board discussed leadership within NIAS in terms of the use of body worn videos and that staff should be encouraged by station officers and peers to use them. It was queried if the use of BWV is mandated, and Mr Corrigan said the policy states staff were mandated to carry and wear but not record.

Figures show that 30% of staff are signing out cameras and since the recent civil unrest this has increased.

The Chair said this poses a strategic risk if staff are in a challenging position and also a health and safety risk if there is a lack of evidence.

Mr Dillon continues to work with the Comms team to consistently get the message out to encourage staff to wear BWV cameras.

Some staff have been reluctant to use BWV cameras as they were concerned these may be used for disciplinary matters, this has not been the case and staff are now gaining trust.

Mr Dillon said there was an e learning package delivered with over 800 completed. There are a host of reasons that staff don't use BWV, but Mr Dillon's team continue to promote, encourage and provide different solutions.

Mr Hopper said the same challenges are represented across the country, but uptake is starting to improve. There is a BWV charter,

governance and policies for staff to feel safer in the use of BWV Cameras.

Ms Barnsley advised that they are encouraging Trusts to move away from the "zero-tolerance" approach to violence and aggression and engage in a health and preventative strategy. .

The team continue to collaborate with other partners e.g. PPS, CPS and Health Ministers to facilitate a partnership approach.

The immediate priorities were discussed which included ongoing education and encouragement of staff to report and use cameras. Mr Dillon and Mr Henry are working on a staff survey to gain intelligence on how NIAS can support staff and help manage violence and aggression.
There is a plan to develop a business plan with options on how to deliver refresher training for staff on conflict resolution.

Mr Ashford referenced another campaign 'we're the target, you are the victim' and suggested it may be worthwhile considering joint training with other blue light services, in particular NIFRS.

Mr Hopper said there are many models within other countries and Ms Paterson added that NIAS will collaborate with other services in NI to share resources and learning.

The Chair thanked colleagues on behalf of NIAS Trust Board and they acknowledge this is a key priority and welcome the good overview and oversight. She thanked Mr Dillon for what he has taken forward and prioritised to date and welcomes Mr Mullen's oversight in this area.

7 **Corporate Risk Register (TB26/06/2025/04)**

Trust Board **NOTED** the substantive changes since the last time the CRR was approved at Trust Board in February 2025, which has been discussed at GARAC.

Risk 825 (PCS Capacity) may be reconsidered due to the timeliness of recruitment and Ops Structure Review. Mr Sinclair confirmed that Mr Neil Duncan has a plan in place and doesn't think it will need escalated again.

Dr Graham said the risk register is working well particularly with the new element of assurance and the fact it has reduced down to 15 items demonstrates the improvement. He thanked Mr Mullen, Mr Henry and the team and confirmed the GARAC Committee approved the CRR for Trust Board to note at today's meeting.

8 **Performance Update (TB26/06/2025/05)**

Mr Mullen introduced the Performance Report which has been revised following feedback from the Committee and it now contains an Executive Summary highlighting the significant matters of the Key Performance indicators and actions being taken to address performance throughout the trust.

Trust Board **NOTED** the report which outlines the key performance metrics up to and including the 31 May 2025

Mr Mullen said that system performance in terms of hospital handover is still very challenging, and actions are being taken to address. The Trust is working actively with RCC on a daily basis on this issue.

The Chair pointed out a minor error on the first line on page 3 (should be April 2024) and Mr Mullen agreed to amend.
It was noted that the section on page 4 regarding safeguarding referrals needs to be updated.

ACTION: Mr Mullen

Mr Corrigan said the SPF Committee are satisfied with the style and content of the revised report and pointed out there may be occasions that this report will go to Trust Board before going to

SPF. As SPF the agenda is expanding and may not have the time to delve into everything in more detail the Committee will endeavour to ensure they are prioritising the right matters and will review at the NEDs meeting in October.

9 Committee Business (TB26/06/2025/06)

Trust Board **NOTED** the summary of items listed at Committees since April and the Committee / Trust Board forward Work Plan.

Dr Graham has agreed with members of the GARAC Committee that they will schedule an additional meeting in February 2026 to review the progress with Internal Audit.

10 Any Other Business

Committee ToR on website

Ms Beggs said that following a meeting with DoH Sponsor Branch it was requested that NIAS Committee Terms of Reference are added to the website and Ms Beggs sought Trust Board's approval to do so.

The Chair agreed but asked for a caveat to be added stating that the ToR are part of an ongoing governance review.

The Chair thanked members for their attendance and contribution at today's meeting and reminded members that there will be cyber training at the end of the next Board Meeting on 28 August 2025.

THIS BEING ALL THE BUSINESS, THE CHAIR CLOSED THE PUBLIC MEETING AT 2.30PM.

SIGNED: _____

DATE: _____

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD – 26 JUNE 2025

		INDIVIDUAL ACTIONING	UPDATE
	PUBLIC		
1	**3 – Performance Update** The Chair pointed out a minor error on the first line on page 3 (should be April 2024) and Mr Mullen agreed to amend. It was noted that the section on page 4 regarding safeguarding referrals needs to be updated.	SM	Performance Report updated on 27 June and replaced in files, on DT and on the NIAS website

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

PRESENTATION OF PAPER

Date of Trust Board:	28 August 2025
Title of paper:	Trust Board Performance Report
Brief summary:	This paper is presented to Trust Board for noting This report outlines the key performance metrics up to and including the 30 June 2025. The executive summary within the report outlines the Key Performance indicators and actions being taken to address performance throughout the trust.
Recommendation:	**For Approval** ☐ **For Noting** ☒
Previous forum:	If applicable
Prepared and presented by: **Date:**	Neil Walker (Head of Performance) Seamus Mullan (Director of PPCS) 15 August 2025

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST CORPORATE SCORECARD

NORTHERN IRELAND AMBULANCE SERVICE

July 2025

for June 2025 Data and Performance

Northern Ireland Ambulance Service
Health and Social Care Trust

Executive Summary

Operational Performance:

Demand:

- Call answer demand in the EAC decreased by 7.5% in June 2025 compared to June 2024.
- Incident demand remained broadly consistent year-on-year.
- The daily average of patients conveyed to hospital was 320, representing a 4% decrease compared to June 2024.

Response Times:

- Performance against national standards remained a significant challenge across all categories.
- Category 2 response times were notably concerning at 67 minutes, up from 52 minutes in June 2024.

Actions to Address:

- Automated Category 1 dispatch is currently in test phase, with future rollout planned to improve control room efficiency.
- Work continues to mitigate the operational impact of emergency leave and sickness absence.
- A demand and capacity review of operational staff has complete, and work is underway to develop a strategic implementation plan for the next 10 years.

Clinical Performance:

Clinical Hear & Treat and See & Treat

- Clinical Hear & Treat increased to 7.8% in June 2025.
- Clinical See & Treat rose to 11.6%, indicating progress in managing patients without hospital conveyance

Complex Cases

- 8% of all control room calls were from complex cases.
- Investment in a dedicated team is essential to improve response strategies for this cohort.

Out of Hospital Cardiac Arrest

Please note data only available to May 2025 due to data lag.

- Median ROSC for all arrests improved from 21.6% to 24.4%.
- Shockable rhythm ROSC median increased from 47.6% to 50%.
- 30-day survival for cardiac arrest rose from 7.1% to 7.4%; shockable rhythm survival increased from 23.8% to 25.0%.

Actions to Address:

- Control room strategies are being refined to improve clinical triage and decision-making.
- Training and development remain key to enhancing See & Treat rates.
- Expansion of the Advanced Practice Paramedic tier is under development.
- Continuous professional education underpins OHCA outcome improvements.

Northern Ireland Ambulance Service
Health and Social Care Trust

Executive Summary

System Performance:

Handover:

- Over 9,000 hours were lost due to handovers exceeding 15 minutes, a 5.5% reduction from May 2025.
- Despite reduced patient conveyances, 16% of arrivals waited over two hours.

Actions to Address:

- Ongoing engagement with regional coordination teams and acute trusts to tackle prolonged delays.
- Handover performance is tracked via monthly oversight metrics

Non-Emergency Performance:

*****NB. Any Performance Data shown for March & April 2025 is subject to ongoing Quality Assurance checks following unforeseen data quality issues resulting from the full installation of the new CAD system in March 2025. Therefore, the performance data for these months is subject to change following completion of the QA processes***.**

- Following on from the improvements in the share of activity to be completed by NIAS PCS resources over the past 2 years, a new improvement target has been set for PCS efficiency as 5% above the level achieved in 2024/25. In Q1 2025/26 we have increased PCS activity by 11%.
- The needs led additional IAS deployments are significantly reducing the number of "Cancellations by NIAS", June '25 figure was down by 53% in comparison to June '24
- Non-Emergency activity 1st quarter in 2025/26 has increased by 4.2% compared to the same period in 2024/25.

Actions to Address:

- Loading Factor has reduced to 1.33, and 1.42 for outpatient journeys. 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 programme of engagement with renal dialysis patients is ongoing, led by the Trust's PPI Lead to discuss and seek views on the most appropriate patient experience KPIs to be measured in the future

Independent Ambulance Performance: *please note - due to upgrade of the CAD system within Non-Emergency data is unavailable for year end at this time*.

Patient Experience

- KPI 1 Inward journeys – 2024/25 average of 48% compliance an increase from 41% in same period 23/24. Of the non-compliant journeys 56% were within 30 minutes of the target.
- KPI 2 Outward Journeys – 2024/25 average of 60% compliance a decrease from 65% in same period 23/24. Of the non-compliant Journeys 57% were within 30 minutes of the target.

Productivity

- In June '25 IAS activity accounted for 29% of non-emergency activity up from 24% in June '24.
- Increased use of IAS is due to vacancies within the tier, deployment of specific discharge vehicles and a targeting of reducing cancellation rates. Cancellations by NIAS in June '25 were 53% below June '24 figure

Northern Ireland Ambulance Service
Health and Social Care Trust

Executive Summary

Service Quality and Our People:

Serious Adverse Incidents, Complaints, Compliments and Care Opinion:

- There have been 10 potential SAIs reviewed, with the Trust notifying 3 during June 2025. The 8-week timeframe for submission of SAI reports to SPPG remains challenging and the current average time for completion has decreased to 98 days (14 weeks) down from a previous 104 days, which is in line with the 23/24 average of 98 days. Operational demands impacting timely completion of SAI reviews have been discussed at AD level, and the SAI Team are working with operational colleagues to improve this position and seek alternative solutions for improvement
- During June 2025, the Trust received 28 complaints, processed 20 compliments, and 6 Care Opinion stories. No complaints were accepted by NIPSO for investigation. Performance against the 2-day acknowledgement KPI remains strong at 100%. The percentage of complaints responded to within the 20-working-day timeframe improved by 4% at 48%. Operations are supporting a trial involving a dedicated part-time investigator (bank staff) to progress complaints investigations and reduce workload pressures at Station Officer level; early indications suggest this is positively impacting the timeliness of complaint resolutions and identified learning and will help inform the options paper currently being developed to support the implementation of the new Model Complaints Handling Procedure published by NIPSO on 1 July 25.

Actions to Address:

- The SUFT continues to work collaboratively with operational teams to address these constraints and at AD level to improve response timeliness.
- To support improvement, SUFT is working closely with operational senior management and developing an options paper to explore alternative investigative models that enhance response times and strengthen learning outcomes.
- Ongoing engagement with coterminous trusts to address system wide pressures that are impacting the ability of NIAS to respond to patients in the community.
- The SAI team, proactively continues to work collaboratively with operational teams to address these constraints and at AD level to improve response timeliness

Absence Management:

- The Financial Year Sickness absence rate is 9.00% for the trust. June 2025, monthly sickness absence rate has increased to 9.30% from 9.17%,. There has been a marked improvement in comparing the June Year on Year positions, where June 2024 was 11.00%.
- 66% 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.
- Occupational Health medical referrals had an 11-day average wait and physio referrals had an 11-day average wait against a target of 10-days and 5-days respectively.

Actions to Address:

- The Trust has a range of strategies to support those who experience exposure to trauma and other mental health issues including stress. These include a wide range of talking and other therapeutic interventions.
- The Trust's Health and Wellbeing Strategy also focuses on pro-active measures to support mental and physical health and wellbeing.
- Occupational Health action plan agreed between the trust and BHSCT to improve quality of referrals and increase prevention and early intervention programmes

Northern Ireland Ambulance Service
Health and Social Care Trust

Corporate Scorecard | System Oversight Measures (SOMs) | June 2025

Indicator	System Oversight Measures (SOMs)	SOMs Target 2025.26	Outturn Position 2024.25	Latest Reported Period: This Month Outturn Position	Measure Trend	This Month (RAG)
Response Times						
1.1	Category 1 (mean) (minutes)	10 mins	11	12		A
1.2	Category 1 (90th Percentile) (minutes)	21 mins	22	22		A
1.3	Category 1 T (mean) (minutes)	15 mins	15	15		G
1.4	Category 1 T (90th Percentile) (minutes)	30 mins	30	28		G
1.5	Category 2 (mean) (minutes)	36 mins	58	63		R
1.6	Category 2 (90th Percentile) (minutes)	80 mins	129	140		R
1.7	Category 3 (90th Percentile) (minutes)	233 mins	305	385		R

Hsopital Delays						
2.1	Total Number of Patients Conveyed	N/A	9,606	9,604		
2.2	Percentage of Patients <=15 minutes	25%	8%	8%		R
2.3	Percentage of Patients <=30 minutes	45%	31%	29%		R
2.4	Percentage of Patients <=60 minutes	85%	66%	63%		R
2.5	Percentage of Patients >2 hours	0%	14%	16%		R
2.6	Number of Ambulance Turnarounds	tbc	10,153	9,692		
2.7	Percentage of Ambulance Turnarounds within 30 mins	51%	11%	12%		R
2.8	Average Handover Time at Type 1 ED (mins)	N/A	72	77		
2.9	Lost Hours from Handover delays >15mins (hrs)	N/A	10,570	9,794		

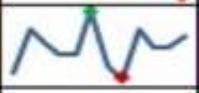
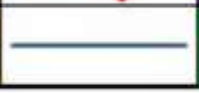
Demand Management						
3.1	Percentage of Patients Seen and Treated by NIAS	15.5%	13%	11%		A
3.2	Percentageof Calls Resolved with Telephone Advice	10%	6%	8%		A
3.2	Percentage of Patients Conveyed	80%	81%	81%		A
4.1	Percentage of Calls Answered within 5 Seconds	90%	91%	87%		A
4.2	Number of Calls Answered	N/A	17,299	18,784		

RAG Status Key

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

Northern Ireland Ambulance Service
Health and Social Care Trust

Corporate Scorecard | **Key Performance Measures** | **June 2025**

Corporate KPIs - Our People						
6.1	Monthly Percentage of Hours Lost	tbc	8.5%	9.2%		
6.2	Cumulative % Hours lost from Sickness	tbc	10.1%	9.6%		
6.3	Cumulative % Hours lost from Short Term Sickness	tbc	2.2%	2.1%		
6.4	Cumulative % Hours lost from Long Term Sickness	tbc	7.9%	6.7%		
Corporate KPIs - Our Communities will continue to value and trust us						
7.1	Number of potential SAIs reviewed	N/A	11	11		
7.2	Number of SAIs notified	N/A	10	3		
7.3	Number of Complaints	N/A	18	27		
7.4	Number of Compliments	N/A	27	20		
7.5	Nmber of patient stories received	N/A	10	6		
8.1	Forecast Revenue Expenditure	£ -	€ -	€ -		G

RAG Status Key:

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

Northern Ireland Ambulance Service
Health and Social Care Trust

Operational Performance

Northern Ireland Ambulance Service
Health and Social Care Trust

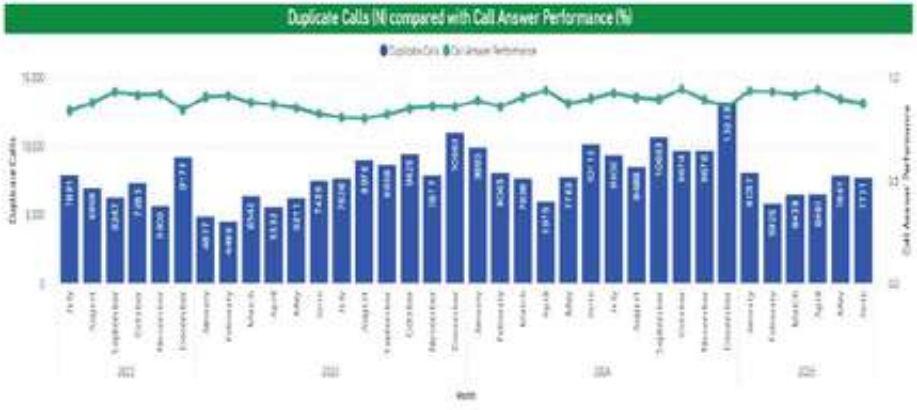
Our Patients | Emergency Demand Performance | Operational Demand

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

The analysis below describes: Calls Answered and Call Answering Performance

999 Calls Answered

Call Answering Performance and Duplicate Calls



- **June 2025** has seen a decrease in demand levels of 7.5% when compared with June 2024. The call answer demand into EAC for 2025.26 Financial Year to date has saw a decrease of 1% when compared with Financial Year 2024.25.
- **June 2025** saw an average of 626, 999 calls per day being answered by EAC which is a decrease from 677 calls per day in June 2024.
- **Call Answering performance** decreased from the expected outturn position, considering a reduced call demand in June 2025. The **June 2025 call answering performance was 87%** for the month.
- **Duplicate Calls** remained high in **June 2025** at 7,731 which is a decrease of 23% when compared with **June 2024**.

Northern Ireland Ambulance Service
Health and Social Care Trust

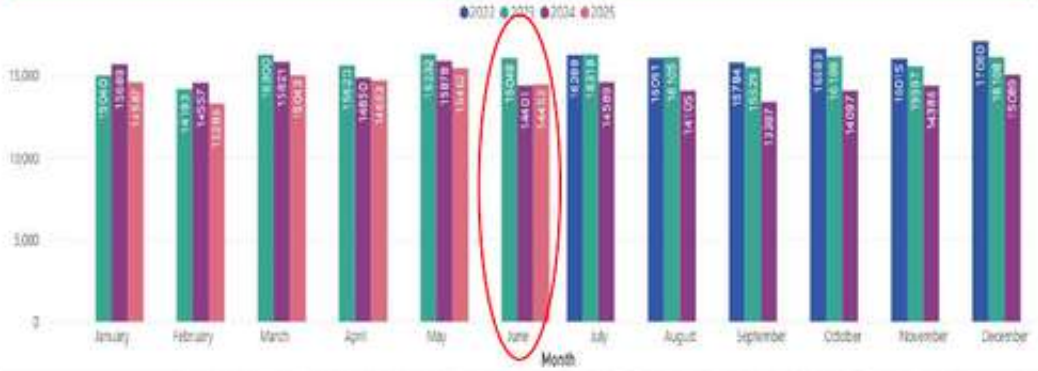
Our Patients | **Emergency Demand Performance** | **Operational Demand**

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

- **June 2025** has seen a very small increase in Incident levels of <0.5% when compared with June 2024. The incident demand for 2025.26 Financial Year to date has also decreased by 1% compared with Financial Year 2024.25.
- **June 2025** saw an average of 482 incidents per day requiring an ambulance clinical response.
- **June 2025** conveyances decreased by 4% when compared with June 2024. The numbers of patients conveyed to hospital 2025.26 Financial Year to date has also decreased by 5% compared with Financial Year 2024.25.
- **June 2025,** saw an average of 320 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	Jun-25

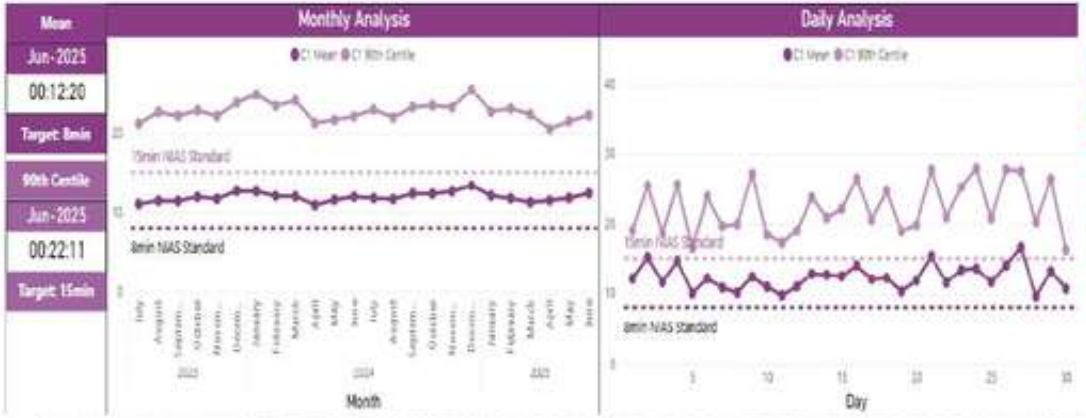
	Target	Current Performance: Latest Month	Current Performance: YTD (from April)	Current Performance: Rolling 12 Month	Benchmarking (Latest Month): National Data	Benchmarking (Latest Month): Best in Class	Benchmarking (Latest Month): Ranking (out of 12)
Category 1 response - Mean	8 Minutes	00:12:20	00:11:52	00:12:03	00:07:55	00:06:20	12
Category 1 response - 90th Centile	15 Minutes	00:22:11	00:21:30	00:22:53	00:14:05	00:10:55	12
Category 1T response - Mean	19 Minutes	00:15:39	00:15:30	00:15:57	00:09:39	00:07:11	12
Category 1T response - 90th Centile	30 Minutes	00:28:53	00:28:19	00:30:17	00:17:25	00:12:11	12
Category 2 response - Mean	18 Minutes	01:07:59	01:02:22	01:03:11	00:29:37	00:21:27	12
Category 2 response - 90th Centile	40 Minutes	02:33:54	02:19:12	02:20:49	01:00:14	00:43:01	12
Category 3 response - Mean	Not a target	02:27:37	02:12:51	02:24:38	01:44:56	00:51:09	11
Category 3 response - 90th Centile	2 Hours	06:27:10	06:02:33	06:25:11	03:59:03	01:55:46	12
Category 4 response - Mean	Not a target	00:50:45	01:58:37	02:05:19	02:20:40	01:04:14	1
Category 4 response - 90th Centile	3 Hours	01:20:33	02:46:58	04:31:59	05:15:10	02:28:27	1

Northern Ireland Ambulance Service
Health and Social Care Trust

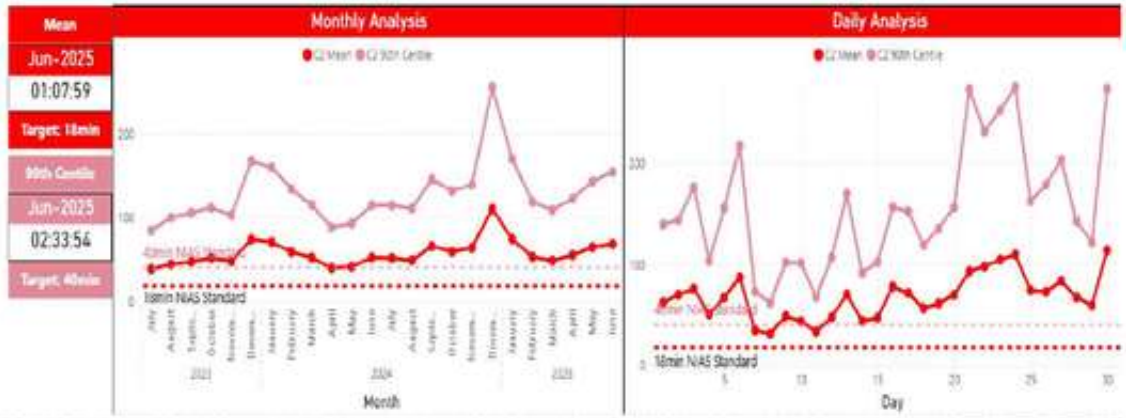
Our Patients | 999 Response Time Performance | Response Times

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

- June 2025 Category 1 mean response time was 12 minutes 20 seconds; while the Category 1 90th centile was 22 minutes 11 seconds.
- June 2025 saw a challenging period Category 1 mean response position for the Trust. This is replicated on the Category 1 90th centile performance.

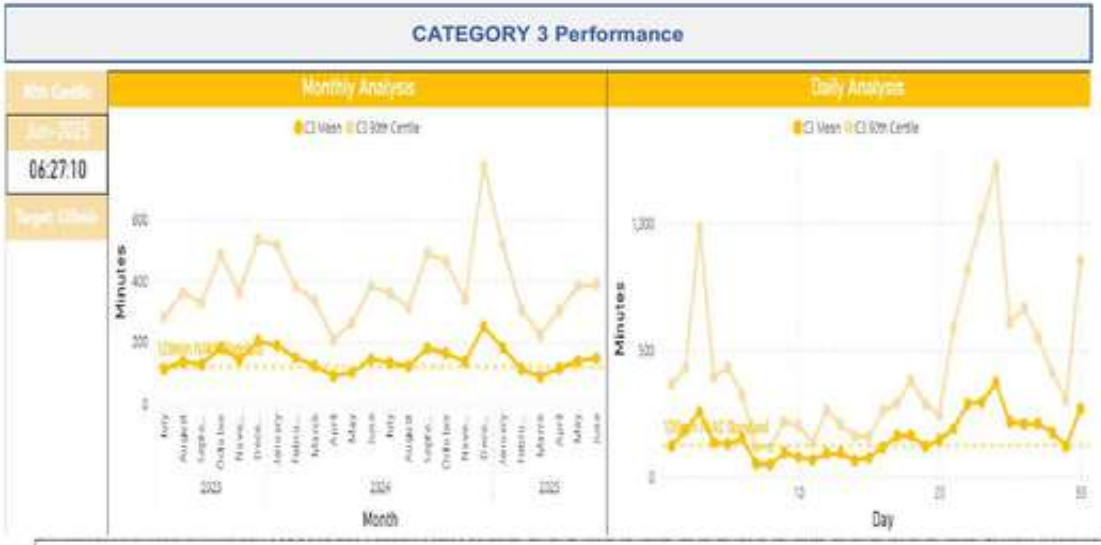
Category 2

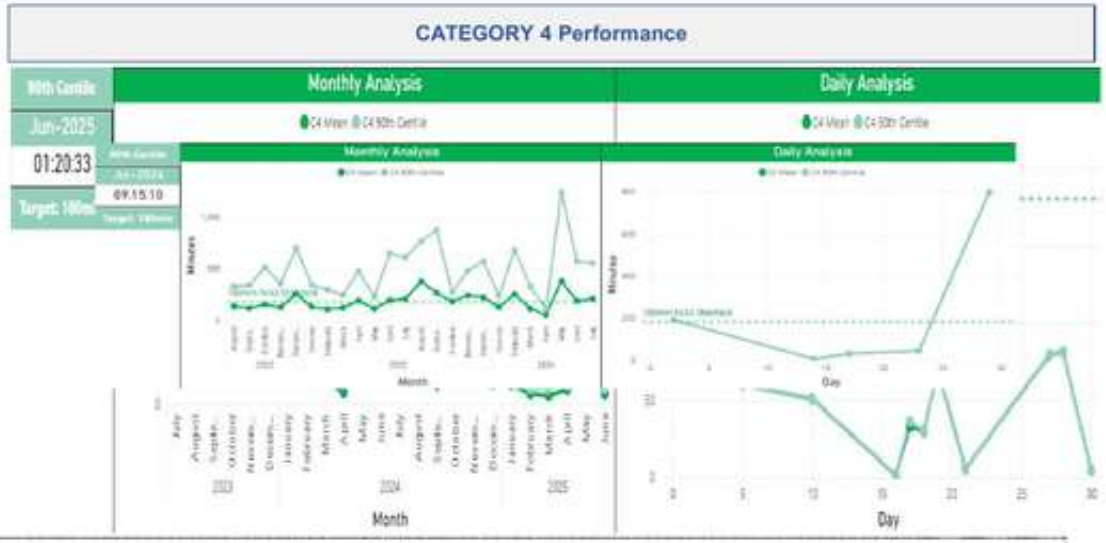
- June 2025 Category 2 mean response time was 67 minutes 59 seconds; while the Category 2 90th centile was 2 hours 33 minutes 54 seconds.
- Both the Category 2 mean and 90th centile response times remained challenging through June 2025. There are a number of actions that have been particularly impactful 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

- June 2025 Category 3 mean response time was 2 hours 27 mins; while the Category 3 90th centile was 6 hours 27 minutes, **over 4 hour above target.**
- As outlined in the previous slide, category 3 response times are impacted by the same root causes.

Category 4

- June 2025 Category 4 mean response time was 50 minutes; while the Category 4 90th centile was 1 hour 20 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.

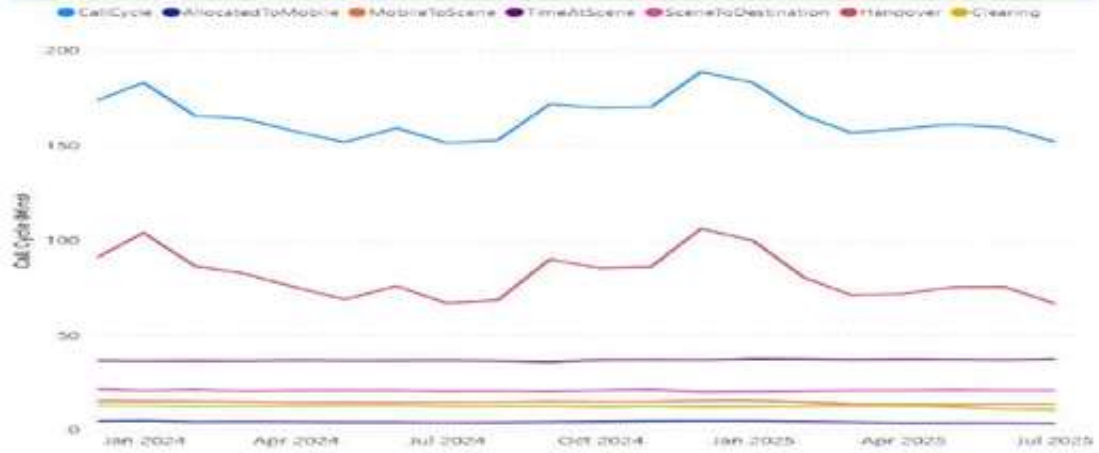
Northern Ireland Ambulance Service
Health and Social Care Trust

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

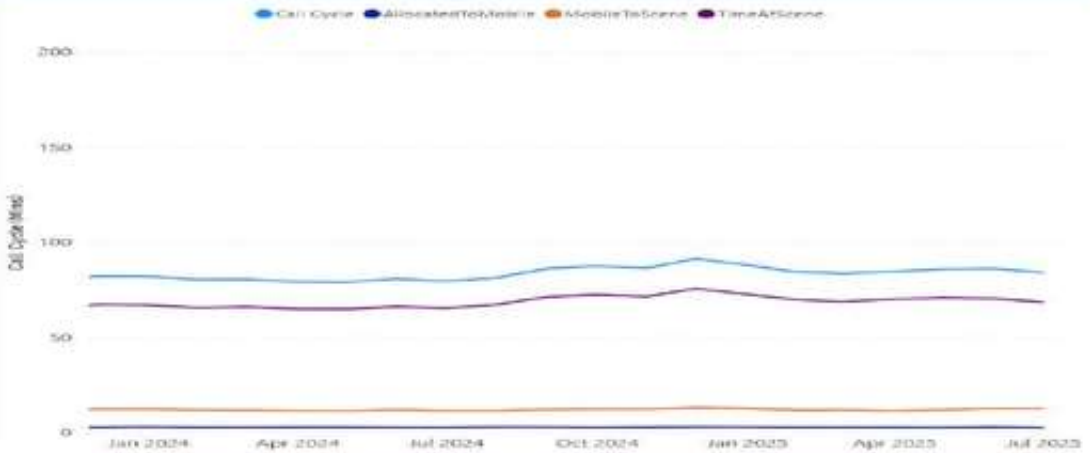
Efficient Job cycle times are critical to our response to patients across the region.

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

- June 2025 Conveyed average job cycle time was 2 hours 39 mins (159mins), when compared with June 2024 the average job cycle time was 2 hours 39mins (159mins).
- The 2025.26 YTD conveyed average job cycle time is 2 hours 39mins , whilst in 2024.25 the average job cycle time was 2 hours 37mins. This is an increase of 1mins between the two periods.

Non-Conveyed Average Job Cycle Times

- June 2025 Non-Conveyed average job cycle time was 1 hour 26mins (86mins), when compared with June 2024 the average job cycle time was similar at 1 hours 20mins (80mins).
- The 2025.26 YTD Non-Conveyed average job cycle time is 1 hour 25mins, whilst in 2024.25 the average job cycle time was 1 hours 19mins. This is an increase of 5 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. Scheduled Care has been taken forward further with job evaluation and imminent advertising of posts to support the new structure and team-based working. This includes the appointment process for the AD Unscheduled Care (interviews complete)
- 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.
- Automated C1 dispatch is being implemented in line with new technology within the EOC to further improve performance as well as further areas that can be automated for further improved efficiencies.
- Emergency Annual Leave SOP complete and endorsed by AD forum moving forward through required governance for approval and distribution once complete.
- Ongoing focus to support of absence management KPI to promote and improve management and rates
- 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. A scheduled trial in the SE was due to commence Q4 24/25 and following consultation with TU postponed. Ongoing engagement to drive forward improvements and included within RMC audit for improved schedule and implementation going forward
- 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.
- A dashboard has been designed for utilization within EOC, to enable the EMD's, ICH and Control Officers real time data to inform patients of the mean response times within the area based on the last 24 hours. Further benefits include early indication of CSP escalation divisionally and regionally amongst other areas of benefit to operations

Northern Ireland Ambulance Service
Health and Social Care Trust

Clinical Performance

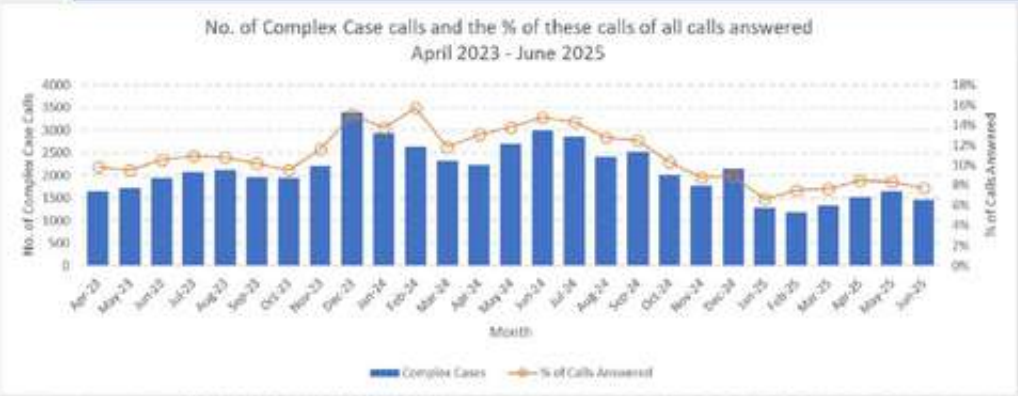
Northern Ireland Ambulance Service
Health and Social Care Trust

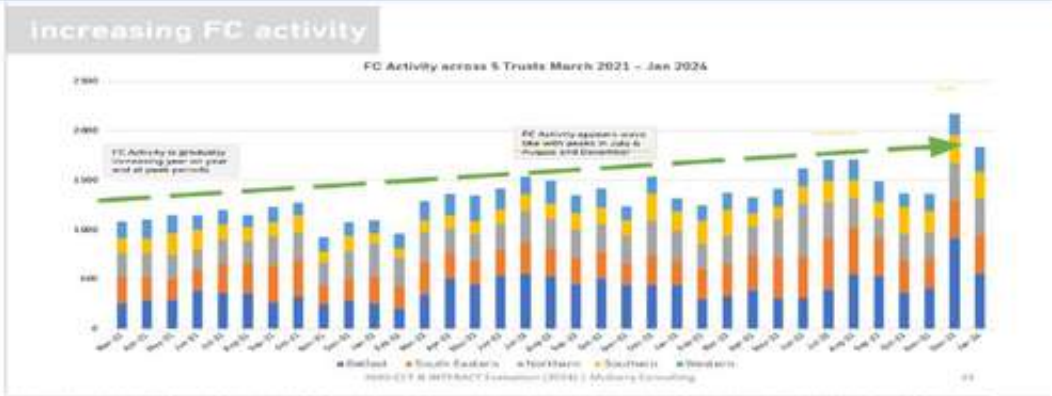
Our Patients | Demand Management | Prevention

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





June 2025 saw Complex Case calls at 8% of all the calls answered within the control room, a total of 1,463 calls were made by complex cases.

When comparing **June 2025**, there was a **35% decrease** in activity from these service users than the activity in **June 2024.**

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 | **Demand Management** | **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 %

June 2025 saw the Hear and Treat rate fall short of target at 7.8%, 936 calls were discharged or referred by our clinicians within the control room during the month. A significant number of patients dealt with by clinicians in our control room.

2025.26 YTD outturn position is 8.1%

Work continues to train and develop the Clinical hub to realise a continued improvement in the Trust's Hear & Treat rate as we move through 2025.26.

The new clinical approach within the team is continuing to be revised and developed to drive greater efficiency within the team by focusing on the most beneficial calls.

The aimed improvement trajectory is to increase Hear & Treat to 10%.

Clinical See & Treat

Monthly See & Treat %

June 2025 See & Treat rate was 11.2% which is a substantial decrease in performance during the month. Work is ongoing to work with Trusts to improve performance with See & Treat.

2025.26 YTD outturn position is 11.6%

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%.

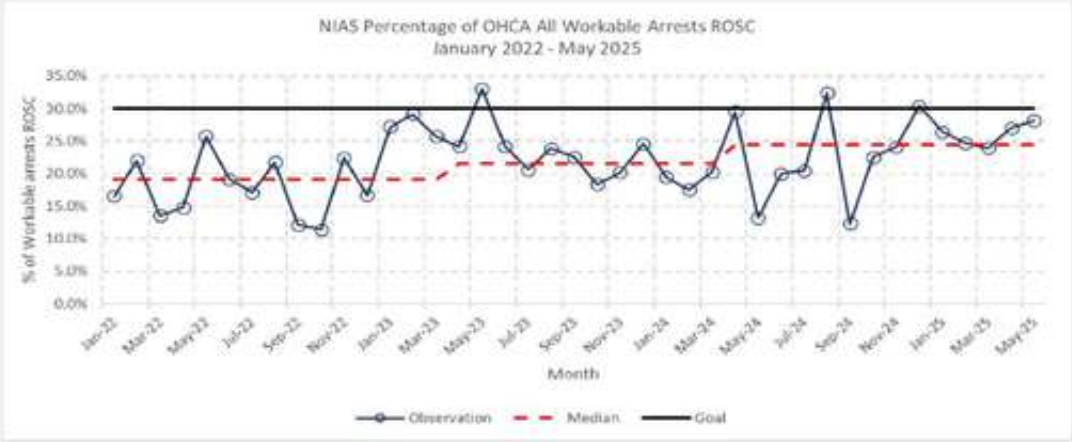
Northern Ireland Ambulance Service
Health and Social Care Trust

Our Patients | **Clinical Care 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.

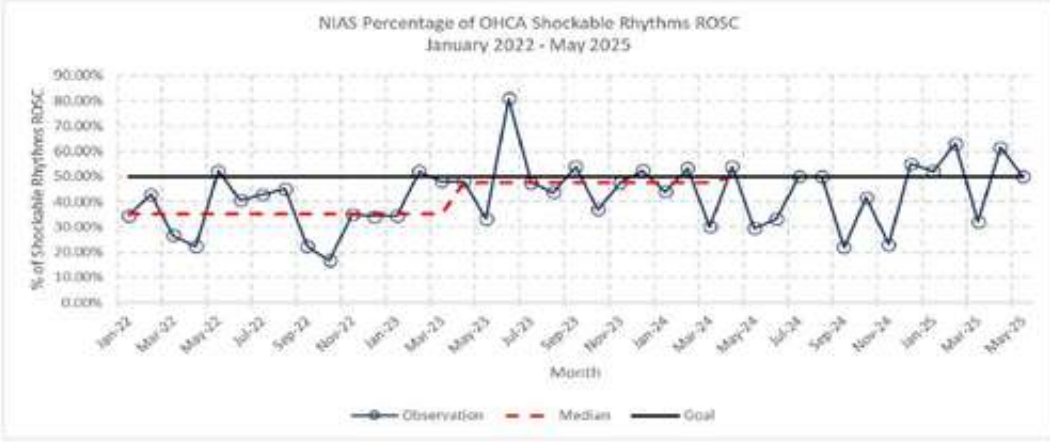
The analysis below describes: NIAS Return of Spontaneous Circulation (ROSC) Rates for Workable Arrests and Shockable Rhythms

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 16.9% in 2022, to 22.54% in 2023 and 21.24% in 2024.
- It is noted there is variance across the second half of 2024 and the improvement team continues to review and understand these variables.
- The impact of annual education delivery from across 2024 and 2025, 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.
- It is noted there is variance across the second half of 2024 and the improvement team continues to review and understand these variables
- This graph demonstrated an increase in the median for ROSC for shockable cardiac rhythms from 34.74% in 2023, to 50% in 2023 and 40.43% in 2024.
- 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.

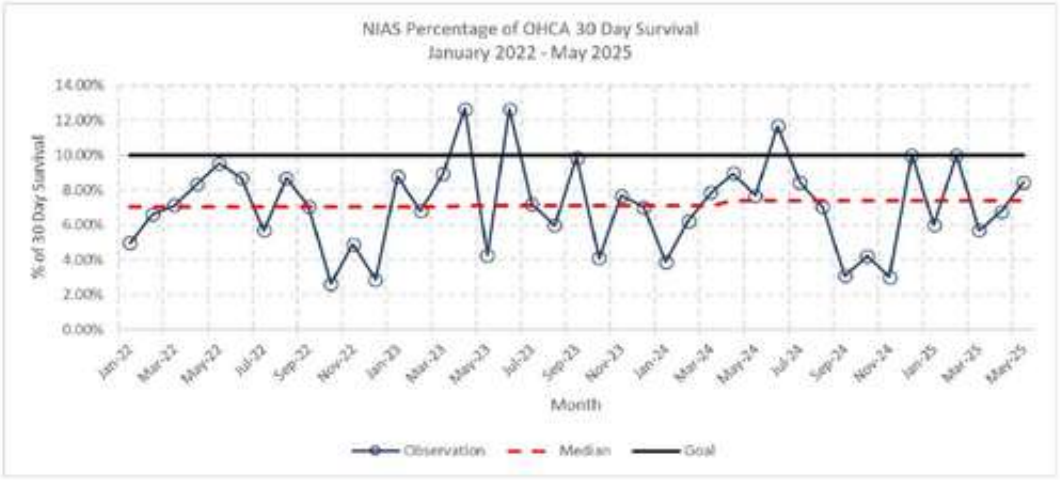
Northern Ireland Ambulance Service
Health and Social Care Trust

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.

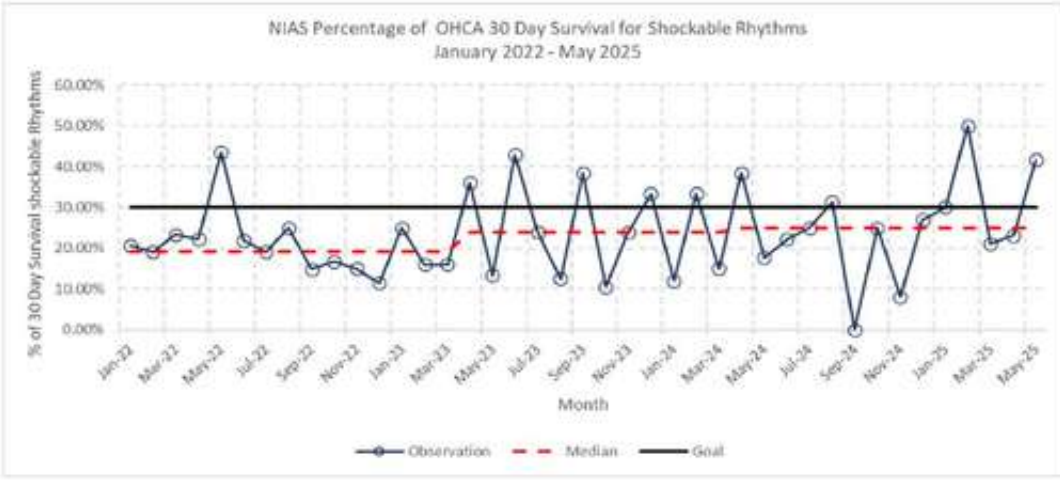
The analysis below describes: NIAS OHCA 30-day Survival and 30-day Survival Shockable Rhythms

OHCA 30-day Survival



- The goal of 10% survival is taken from benchmarking other UK ambulance trusts outcome performance.
- There is noted increasing monthly variance across the later half of 2024. The improvement programme is still investigating the variables and causes of this.
- There is an increase in survival from 5% in 2022, to 6.8% in 2023 and 6.7% in 2024
- 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 noted dip in survival in September and November 2024. The improvement programme is still investigating the variables and causes of this.
- There is a marked change of practice 2022 onwards, with an increase in the median from 2022 of 19.98%, 2023 23.81% and 2024 21.24%.
- 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

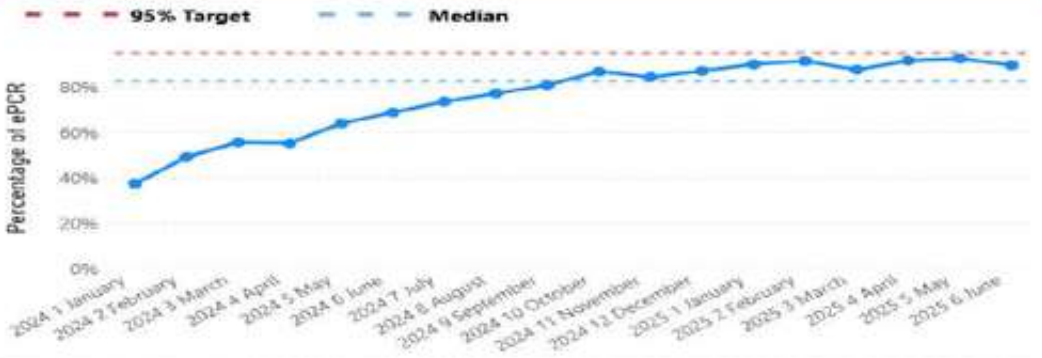
Our Patients | Electronic Patient Care Records | ePCR Compliance

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.

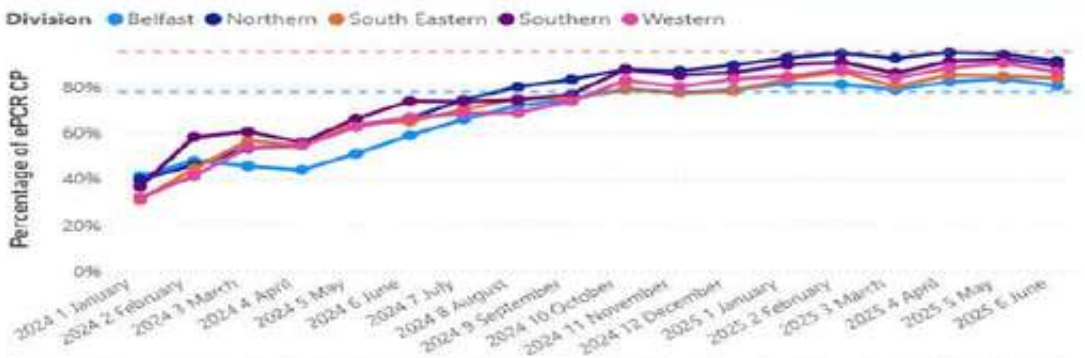
The analysis below describes: NIAS ePCR Compliance

ePCR Compliance

Trust Compliance with EPCR usage



Divisional Compliance with EPCR usage



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

June 2025 compliance across the trust is **90%** against an internal trust standard of 95%. Q1 2025.26, all divisions are showing ePCR compliance in excess of 80% compliance.

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.

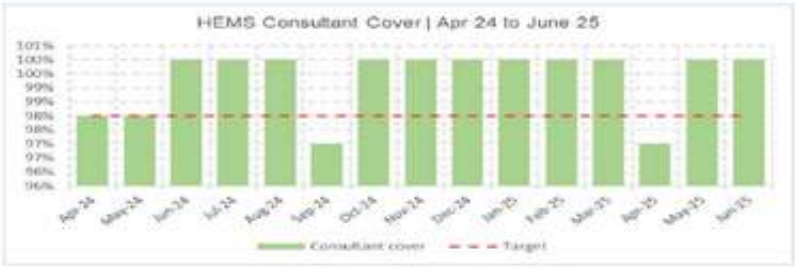
Northern Ireland Ambulance Service
Health and Social Care Trust

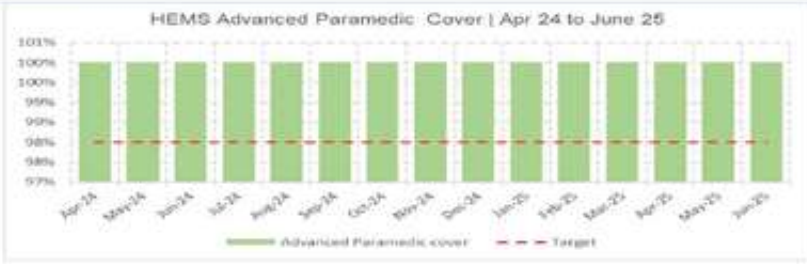
Our Patients | Critical Care Cover | HEMS

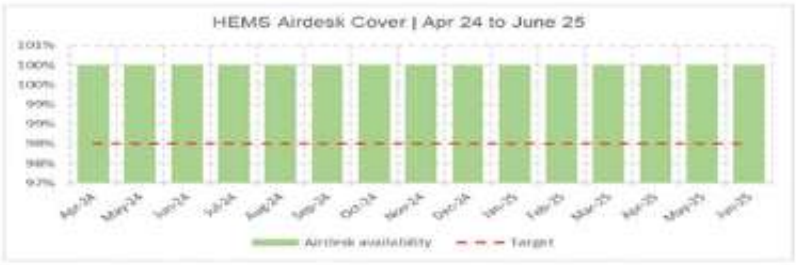
Critical Care Cover is a key enabler for delivery of critical care across Northern Ireland. This ensures the most appropriate clinical skills are available to deliver the required response to patients requiring critical interventions timely.

The analysis below describes: NIAS HEMS Cover

HEMS Cover







The Helicopter Emergency Service has a target of 98% cover for all the elements that make up the service.

The charts above outline the trend in cover for our Helicopter Emergency Medical Service, across all elements of the service. Consultant, Advanced Paramedic, Air Desk and RRV cover remains consistently high throughout the year, April 2025 Consultant cover was a challenge and feel below the 98% target.

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.

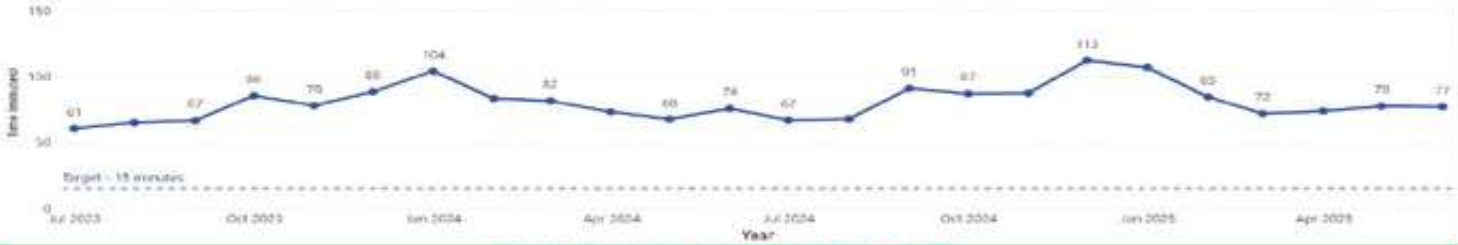
Arrival at Hospital to Patient Handover

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	1234	1234	1130	91.57%	550	44.57%	2,075.35	115.59
CRAIGAVON AREA	1219	1219	1135	93.11%	529	43.40%	1,772.97	101.99
DAISYHILL	509	509	485	95.28%	195	38.31%	541.19	78.62
ROYAL GROUP	1906	1906	1760	92.34%	828	43.48%	1,800.02	72.89
CAUSEWAY	591	591	562	95.09%	201	34.01%	316.54	67.41
ANTRIM AREA	1562	1562	1465	93.66%	394	25.22%	1,337.18	66.19
ALTNAGELVIN	1153	1153	1083	94.00%	474	41.11%	906.62	66.12
SOUTH WEST	589	589	556	94.40%	180	30.56%	386.26	55.33
MATER	514	514	463	90.08%	104	20.23%	272.61	46.44
RBSC	106	106	63	59.43%	8	5.66%	22.02	23.30
BELFAST CITY	40	40	28	70.00%	2	5.00%	6.88	23.61
DOWNE	38	38	25	65.79%	1	2.63%	4.48	20.91
LAGAN VALLEY	67	67	38	56.72%	1	1.49%	8.18	20.81
Total	**9528**	**9528**	**8801**	**92.37%**	**3466**	**36.38%**	**9,794.47**	**76.37**

Total Time Lost (Hours) - Last 12 months

128,443.68

Monthly Handover Times



Monthly Handover Times for Type 1 EDs, by Trust

In June 2025, NIAS experienced a total of 9,794 lost hours. This is the equivalent of 27 shifts per day where crews are waiting with patients outside EDs; 24% of our planned capacity. These lost hours were experienced from 8,801 instances where our crews waited longer than 15mins to handover their patient at ED. 3,466 handovers took longer than an hour in June 2025

In June 2025, >70% of the 9,794 lost hours occurred at the four ED sites listed below in order of hours lost:

- *Ulster Hospital (2.0k hours; 92% > 15min; 44% > 1hr)*
- *Antrim Area (1.3k hours; 93% > 15min; 25% > 1hr)*
- *Royal Victoria (1.8k hours; 92% > 15min; 43% > 1hr)*
- *Craigavon Hospital (1.7k hours; 93% > 15min; 43% > 1hr)*

In the last 12 months, >92% of the handovers exceeded the 15min target at our acute EDs, resulting in circa 128k hours lost. The lost hours experienced in June 2025 is a decrease of 572 hrs or 5.5% from May 25, whilst the number of instance of delayed handovers decreased by 5.5% in the same period.

The 9,794 operational hours being lost are equivalent to 816 12-hours shifts per month, or 27 12-hour shifts per day.

Northern Ireland Ambulance Service
Health and Social Care Trust

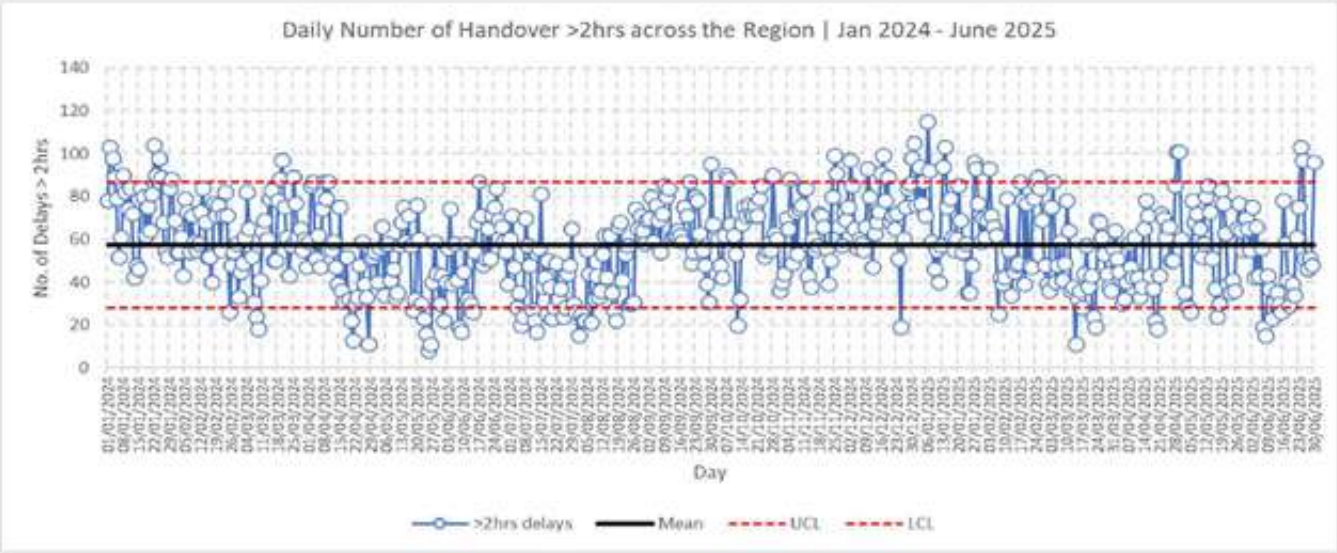
Our Patients | Emergency Performance | 2hr Back Stop Regional Performance

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	Q4 23.24	FY23.24	Q1 24.25	Q2 24.25	Q3 24.25	Q4 24.25	FY24.25	Q1 25.26
South Eastern	21.1%	23.5%	32.8%	34.7%	27.7%	29.6%	28.7%	33.8%	23.7%	28.9%	27.0%
Southern	9.5%	18.8%	20.2%	21.6%	17.3%	17.5%	17.8%	25.5%	22.7%	20.4%	21.0%
Belfast	6.6%	9.8%	18.9%	20.1%	13.5%	14.6%	14.0%	23.9%	17.7%	16.7%	14.0%
Northern	5.4%	7.2%	17.2%	17.3%	11.5%	11.1%	16.6%	20.7%	23.5%	18.9%	15.0%
Western	2.8%	5.3%	8.1%	11.1%	6.8%	5.7%	6.5%	8.2%	9.2%	7.4%	9.0%
Region	8.8%	12.2%	19.2%	20.5%	15.0%	14.9%	16.1%	21.8%	19.2%	18.0%	16.0%

The table shows the deterioration in >2hr delays by trust from March 2023.

- **Q1 2025.26** 2hr handovers have **increased by 1.1%** compared to **Q1 2024.25**
- **Q1 2025.26** 2hr handovers have **increased by 7.2%** compared **with Q1 2023.24**



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 59 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

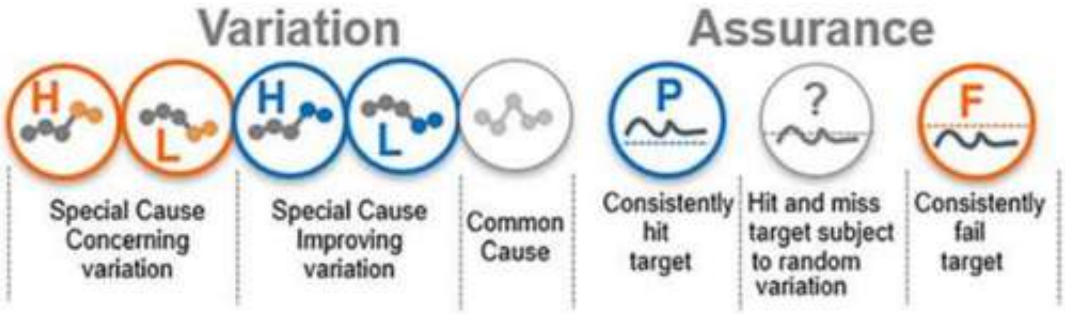
Our Patients | Non - Emergency Performance | Actions to improve Performance

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 6 of the 9 measures this month. Although data isn't currently available to update 3 of the 9 measures for May 2025.

NB. Any Performance Data shown for March, April & May 2025 is subject to ongoing Quality Assurance checks following unforeseen data quality issues resulting from the full installation of the new CAD system in March 2025. Therefore the performance data for these months is subject to change following completion of the QA processes.

Non-Emergency Services

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
KPI 1 Arrivals	Mar 25	42.51%	95.00%			38.00%	33.45%	42.56%
KPI 2 Departures	Mar 25	72.00%	95.00%			67.42%	63.25%	71.58%
PCS Journey's	Jun 25	6207	5500			5338	4293	6383
Cancellations	Jun 25	413	438			687	287	1087
Loading factor Outpatients	Jun 25	1.42	1.80			1.41	1.31	1.50
PCS complaints	Jun 25	5	0			7	-3	17
Loading factor total	Jun 25	1.33	1.80			1.34	1.27	1.40
PCS sickness absence	Jun 25	24	24			32	21	43
PCS WTE	Apr 25	233	265			223	208	238

Northern Ireland Ambulance Service
Health and Social Care Trust

Variation

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

Assurance

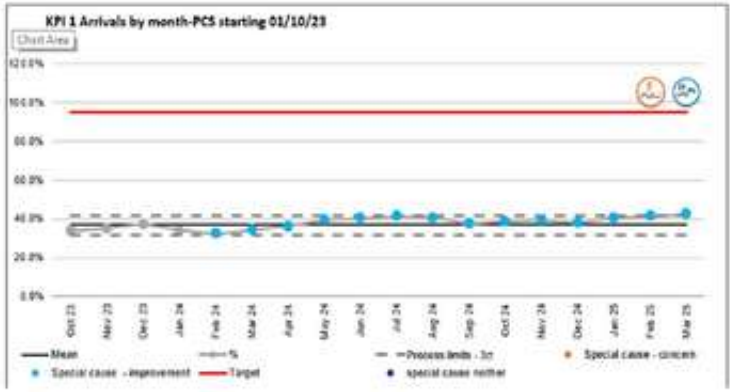
Consistently hit target | Hit and miss target subject to random variation | Consistently fail target

Our Patients | Non-Emergency Performance | 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

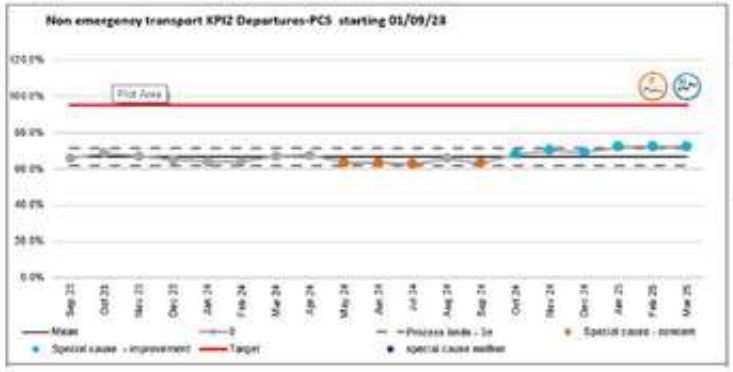
KPI 1 - That 95% of inward journeys will arrive within the 60mins prior to an appointment time.

- 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.
- We are currently carrying out Service User consultation in relation to Renal Dialysis patients to establish quality measures appropriate to their service.



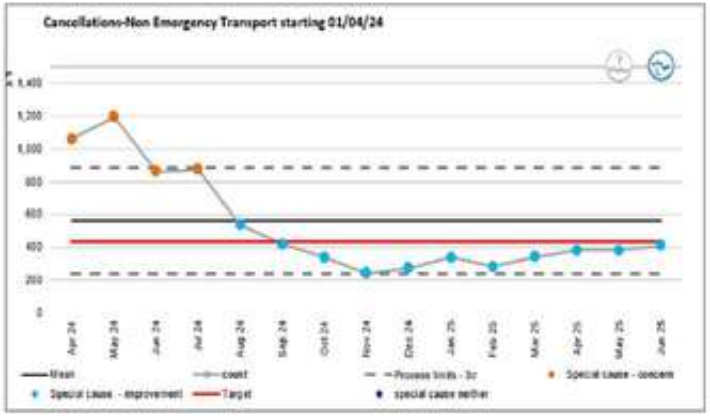
KPI 2 - That 95% of outward journeys will start within 60 minutes of the patient being booked as ready by the clinic/hospital.

Compliance at 72% 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.



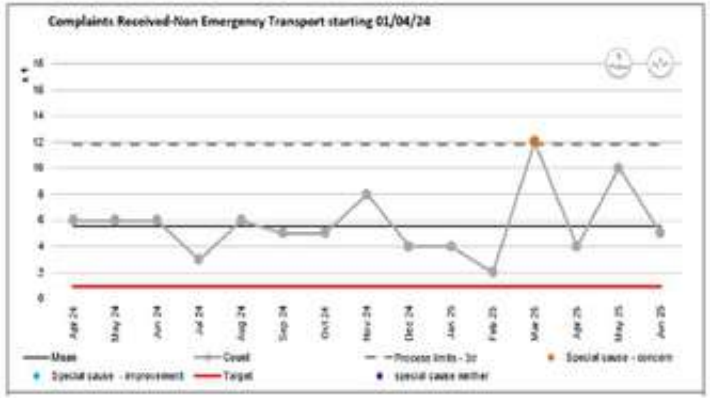
Cancellations by NIAS

- 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.
- Targeted action to reduce cancellations was instigated in Aug '24 with
- The improvement target remains to have cancellations below 3.2% of service demand, representing a 50% improvement on 2023/24 levels.
- This has been achieved in the last 9 consecutive months. June's cancellation rate was 2.9% of service demand



Complaints

- In June 5 complaints were received relating to Non-Emergency services. Only one of these (received on 23rd June) remains open with the other 4 being resolved at a local level.
- Whilst the service has an aim of receiving no complaints, the number of complaints received should be read in the context of the Service delivering over 13,000 patient journeys in June using a variety of internal and private sector provision.



Northern Ireland Ambulance Service
Health and Social Care Trust

Variation

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

Assurance

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

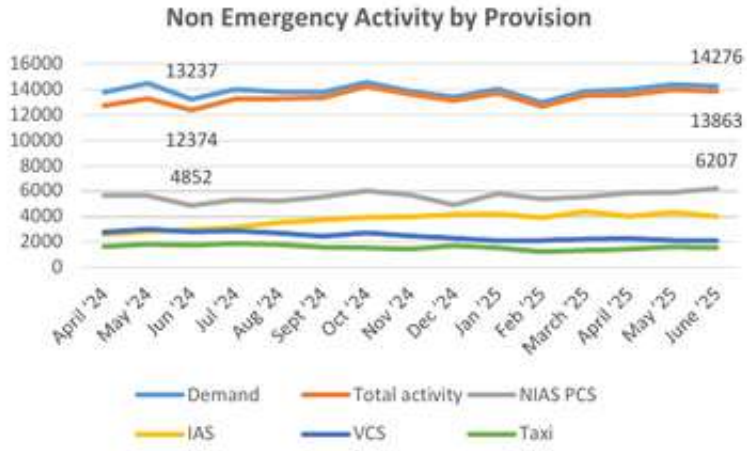
Our Patients

Non-Emergency Performance

Non-emergency transport journeys in Total and by Provision

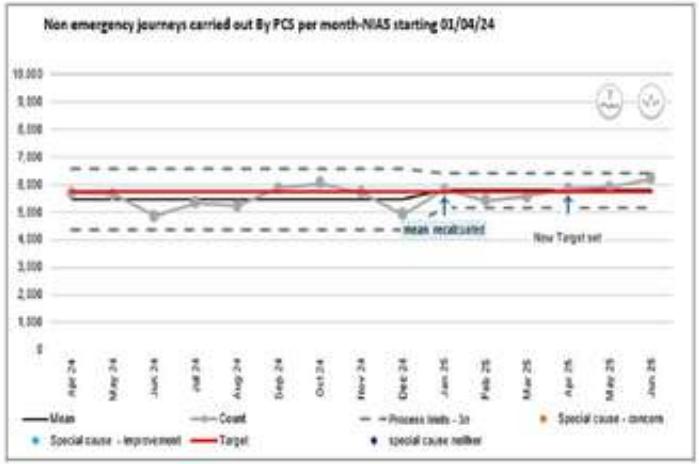
- This comparative graphic illustrates the share of activity undertaken via each of the delivery options.
- The underlying objectives are to maximise the activity share completed by NIAS resources either PCS or where suitable the VCS and to meet service demand within contract limits.
- In June '25, 45% of the journeys were completed by a NIAS Ambulance and overall activity equalled 97% of demand compared to 92% in June '24.
- The increase in the use of IAS resources from mid-2024/25 was as a result of a number of factors including ACA vacancy levels, an 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.*



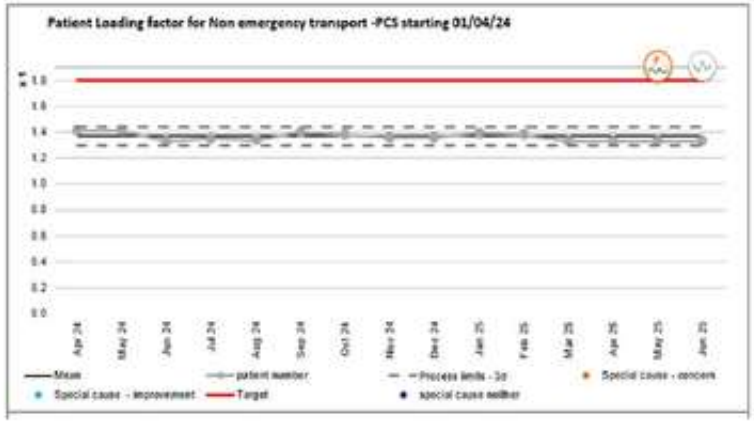
Non emergency transport Journeys completed by PCS

- Following on from the improvements in the share of activity to be completed by NIAS PCS resources over the past 2 years a new improvement target has been for PCS efficiency has been set as 5% above the level achieved in 2024/25
- In June '25 PCS completed 6209 patient journeys or 45% of the total non emergency activity.
- Quarter 1 activity levels are therefore meeting the new improvement target for 25/26



Patient Loading Total

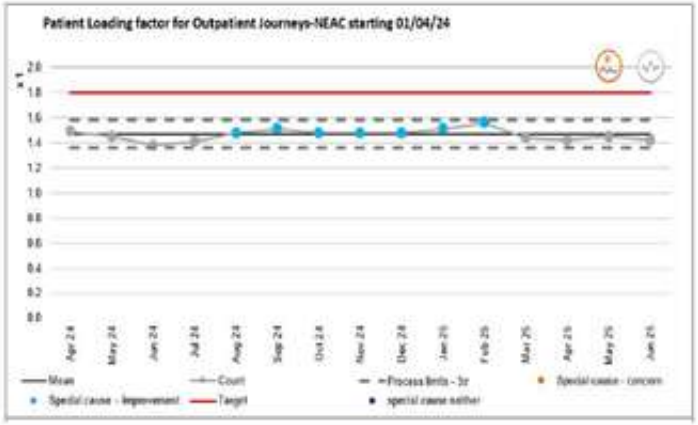
- This measure reflects the average number of patients carried on each non-emergency run. A change in journey planning in October '23 brought about some improvement which has largely been maintained. For 2024/25 this measure averaged 1.37 compared to 1.30 in 2023/24
- The PCS Team are currently engaged with the National Non Emergency Patient Transport Services (NEPTS) group to benchmark with other services. In relation to patient loading factor.
- Other change actions including an improvement in the day-to day availability of staff and a revision of 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.

This measure averaged 1.47 across 2024/25. compared to 1.33 in 2023/24



Northern Ireland Ambulance Service
Health and Social Care Trust

Variation

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

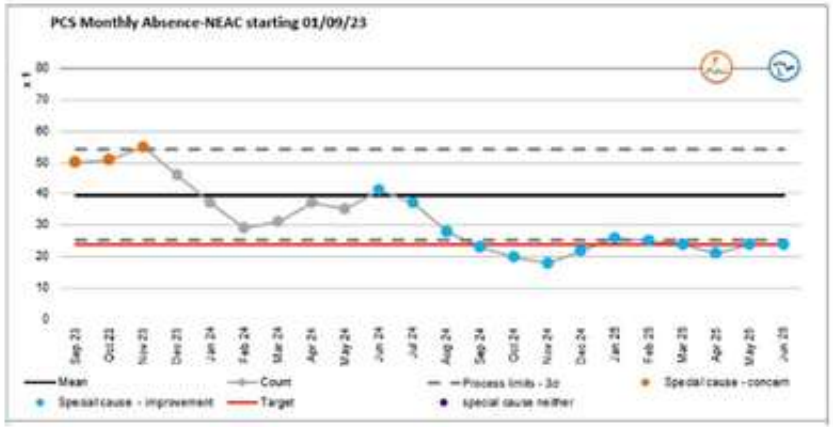
Assurance

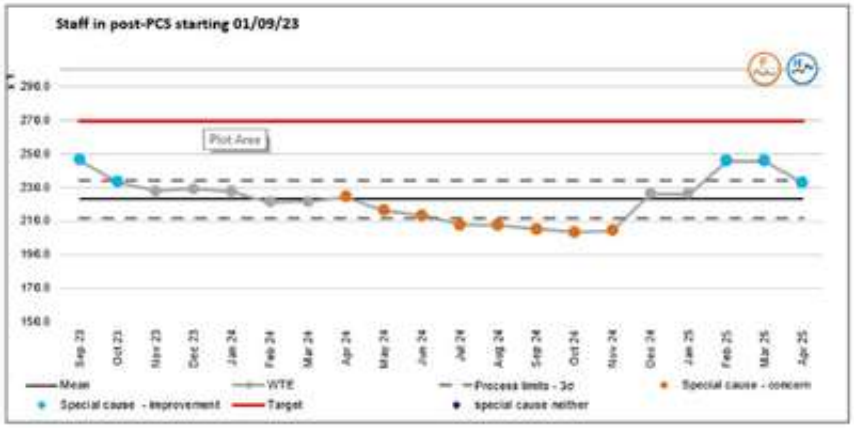
Consistently hit target | Hit and miss target subject to random variation | Consistently fail target

Our 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 daily number of staff absent through sickness per month. The general trend during 2024/25 with the application of Trust wide policies and initiative was generally downwards with some slight seasonal variations.
NB This data has been sourced from GRS

April '25 in month ACA absence is reported through HRPTS as 10.0% and the cumulative 2024/25 rate as 12.5%.

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 previous 12 months has been somewhat reversed in Jan '25 and again in March '25 with 45 new ACAs going through training and entering the service.
- This recruitment action shows the service with a net gain of 21wte staff from 1st April '24
- Career progression opportunities for ACA staff have led to the drop in staff in post for April as a number started EMT training.
- **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

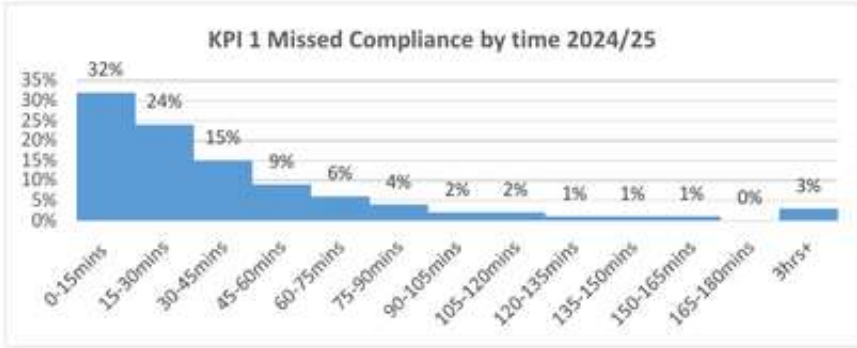
Directorate of Planning, Performance & Corporate Services

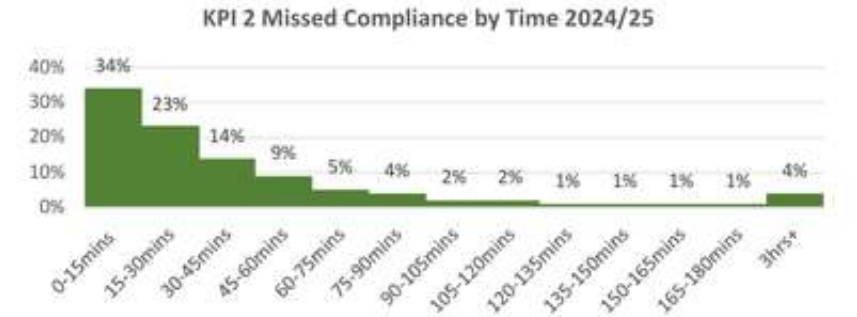
Northern Ireland Ambulance Service
Health and Social Care Trust

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





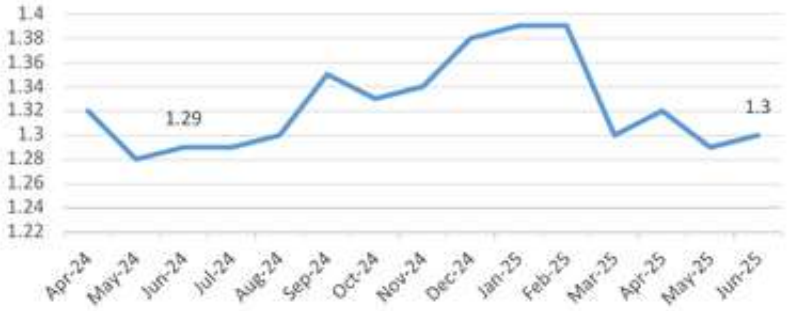
Analysis – 2024/25

- An analysis of the journeys that missed compliance shows that 32% 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 34% of journeys that missed the target were no more than 15 minutes over this and 80% 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.

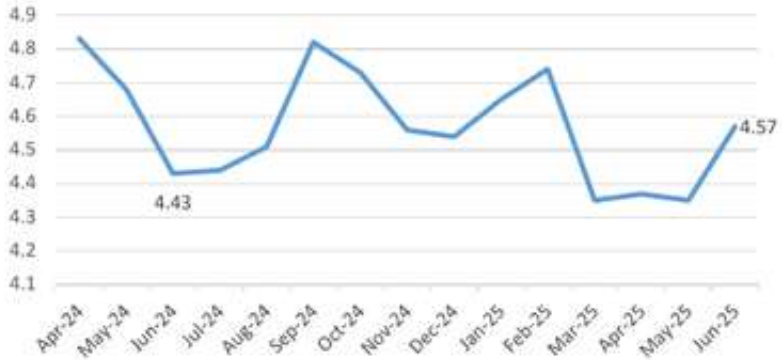
Northern Ireland Ambulance Service
Health and Social Care Trust

Our Patients | Non-Emergency IAS Performance | Productivity Performance

Loading Factor IAS

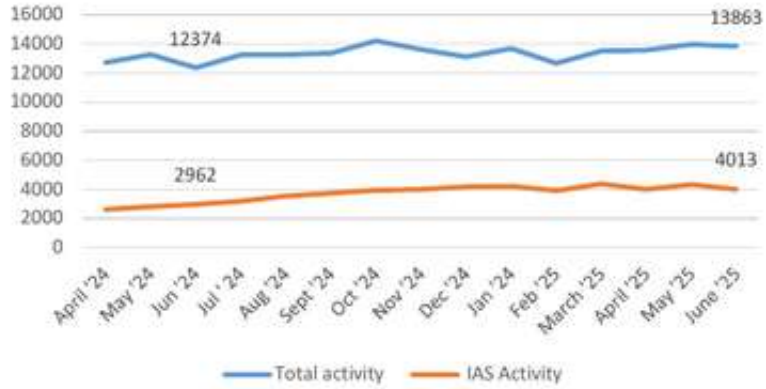


Average No of Patient Journeys per Shift



NB Any performance Data shown for March & April 2025 is subject to ongoing Quality Assurance Checks following some unforeseen data quality issues and is therefore subject to change

Non Emergency activity by IAS



Activity and IAS Share
The proportion of non-emergency activity completed by Independent Ambulances has generally been increasing since May '24, primarily to counter staff vacancies in PCS and in a targeted response to reduce cancellations due to no available NIAS 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. Following review these vehicles have been reduced to an 8 hour shift 5 days per week, effective from 14th April '25

In June '25 IAS activity accounted for 29% of non emergency activity, up from 24% in June '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.

Patients Transported Per Run
This measure also known as loading factor follows a similar pattern as the journeys per shift measure.

Northern Ireland Ambulance Service
Health and Social Care Trust

Service Quality and Our People

Northern Ireland Ambulance Service
Health and Social Care Trust

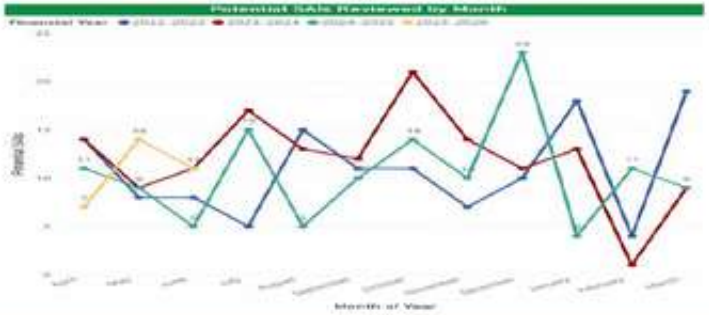
Our Patients

SAIs & Complaints

Serious Adverse Incidents

During June 2025, the Trust reviewed 10 potential SAI's resulting in 3 notifications to SPPG.

There are currently 22 ongoing SAI's, all of which are being reviewed at Level 1. 15 of the 22 are currently overdue for submission.



Themes

Early review of the 3 SAI's notified in June has identified the following themes:

- Delayed response out with standard
- Clinical assessment & diagnostic conclusions
- Self conveyance as per agreed scripts

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

Timeliness of process

100% of SAI's were notified to SPPG within the 72 hour reporting timeframe

2 SAI's were completed and closed within June 2025 and were completed at Level 1 with a required completion time of 8 weeks.

The average completion time was 18 weeks due to competing demands within the team completing the review.

Family engagement was required on 1 of the completed SAI's and was completed after 13 weeks. This is out with the recommended 10 day timeframe and was due to the review officers competing demands.

Recommendations & Learning

During June 2025, 2 SAI's were closed with the following learning identified:

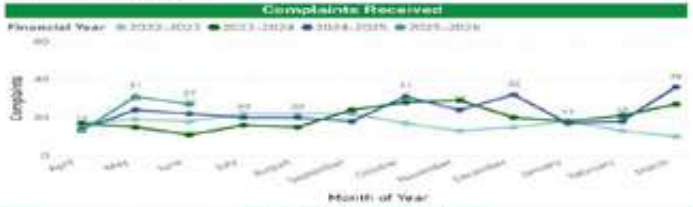
- System wide pressures are impacting the ability of NIAS to respond to patients in the community as delays at emergency departments are significantly longer than government recommended standard handover times.
- Importance of adherence to c-spine immobilisation guidelines
- Importance of accurate completion of clinical documentation in line with agreed standards

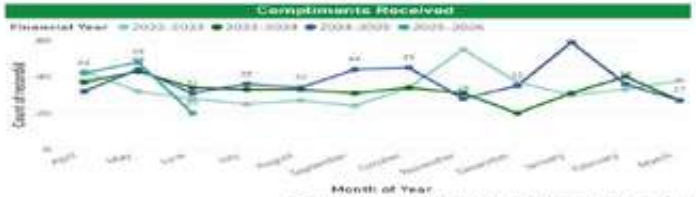
Implementation and evidencing of SAI recommendations remains an area of focus and to date we have completed and evidenced 96% of the outstanding SAI recommendations. 3% (17) have exceeded their due date and are currently being reviewed and the remaining 1% (2) are current.

Complaints, Compliments & Care Opinion

During June 2025, **20 compliments**** & **28 complaints** were received and **0 NIPSO complaints** were accepted for investigation.

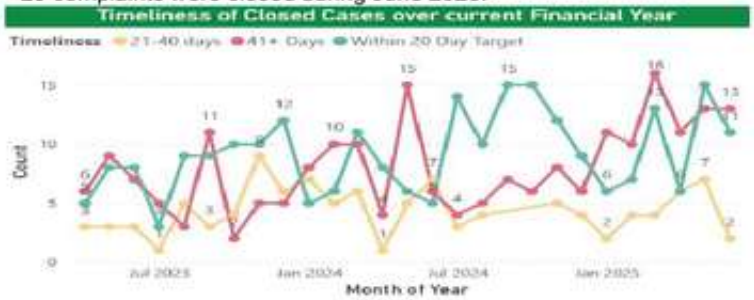
(** Due to the SUFT's administrator being promoted into another team and the ongoing recruitment process to replace them, more compliments have been received than registered.)





Timeliness of Process

29 complaints were closed during June 2025.



At the end of June 2025, 48 complaints remained opened with the average number of days opened being 30 working days.

Trends &Learning: Of the 29 complaints closed, 76% were upheld/ partially upheld with some of the following learning outcomes identified: communication, clinical decision making, ePRF documentation, EOC call handling, updated paramedic downgrade procedure, update CCE content re the use of peak flow assessment for patients with respiratory concerns.

Service Improvement Plans 2025/26

- Regional roll out of feedback leaflet for frontline staff to issue to service users
- NIPSO launched the new Model Complaints Handling Procedure for the health sector on 1 July 2025. Development of systems, training, new guidance and NIASs own policy is underway for an implementation date of 1 January 2026.

Care Opinion

During June 2025, 6 stories were submitted via Care Opinion. By 7th of July these stories were viewed 577 times.

The main areas of feedback were:

- What's good – Ambulance crew/ hardworking/ care
- Improvements – Communication
- Feelings – Thankful/ grateful/ well looked after

Northern Ireland Ambulance Service
Health and Social Care Trust

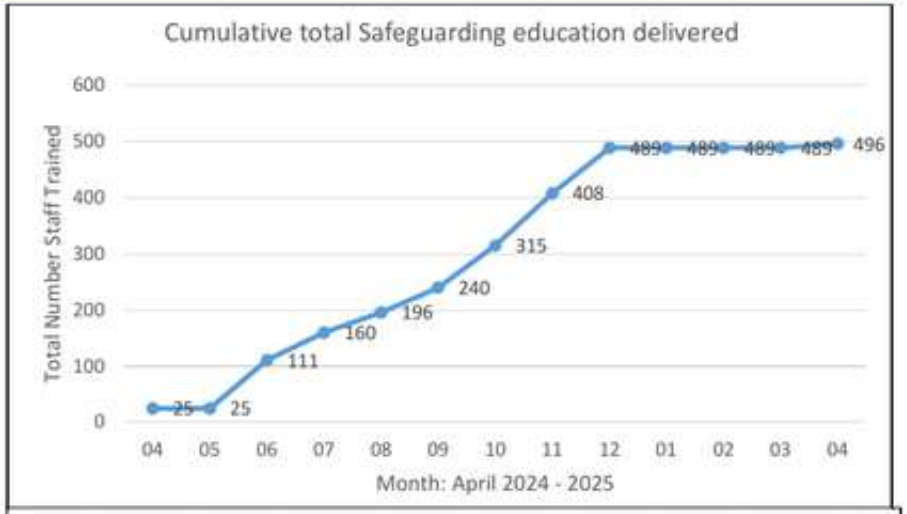
Our Patients | Safeguarding Education, Training and Referrals

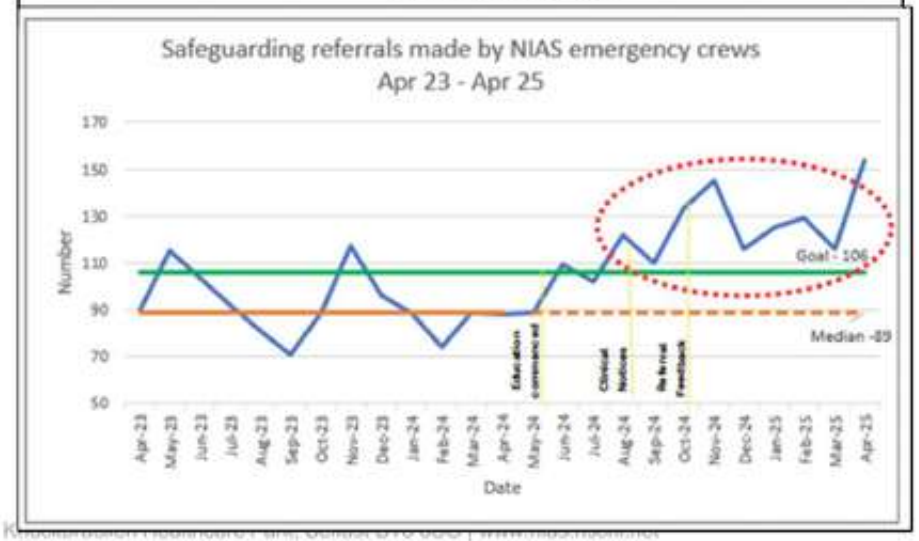
Safeguarding Education

- The National Ambulance Safeguarding Group (NASaG) peer review (Aug 2023) recommended that the Trust develop 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 are ongoing from April 2024 with 553 staff attending by June 2025 - this represents over 50% of our staff involved with the delivery of direct patient care and is currently surpassing the trajectory set.
- 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 work is progressing in the development of a Level 1 & 2 e-learning package for NIAS staff not involved in delivery of direct patient care.

Safeguarding & Welfare Referrals

- The NASaG review also engaged in a benchmarking exercise, identifying that the trust referral per contact rate was lower than that of other comparable UK ambulance services.
- There has been a 30% increase in referral rates, month - month received by the NIAS Safeguarding team between Apr 24-Mar 25 (n = 116) in comparison with the same reporting period 23-24 (n= 89).
- There is a direct correlation as shown in the graph, between the introduction of Safeguarding education and the increase in referral rates, this indicates a shift and sustained improvement..





Northern Ireland Ambulance Service
Health and Social Care Trust

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

The Absence Management Delivering Value Project continues to progress delivery of project workstreams against the Delivery Plan. **Cumulative** sickness absence rates for percentage of lost time is 9.00% to Month 3 (June) 2025. This is a slight increase on last month's **cumulative** figure however the trend remains below the cumulative rate of 10.06% to month 3 (June) 2024. The **monthly** figure for month 3 (June) 2025 increased to 9.30% up from 9.17% in May 2025. However, the continued downward trend since Q4 in 2023/24 is being sustained evidenced by these figures. Cumulative short-term absence reduced Month 1 (April) to Month 3 (June) from 2.19% to 2.05%. **Cumulative** long-term absence increased slightly from 6.34% to 6.94% over the same period.

Managerial action now focuses on the top 50 longest-term absences on a month by month basis. In addition, managers continue to place additional focus on those employees with the highest number of recurring short-term absences in the previous 12 month period. Progress is monitored and reported on a monthly basis va Directors to the Chief Executive.

In the reporting period 20 of the 50 employees with the longest absence had their absence came to an end. 12 of the 20 had a return to work facilitated, 3 retired on the grounds of ill-health; 1 is in process of being permanently redeployed and 1 employee's contract of employment was terminated on the grounds of ill health. 1 is related to a legal process due to conclude. A total of 2 of the employees were progressed for medical redeployment in the period. 1 has had a permanent redeployment confirmed. 1 remains in ongoing process of medical redeployment

A robust case management approach continues for the remaining 30 employees who remain on long-term absence, with focused case management, Occupational Health and health and wellbeing supporting interventions.

Top 5 Sickness Categories 2025/26*	
Mental Health	30.02%
Accident/Untoward Incident	13.26%
Injury, Fracture	11.36%
Gastrointestinal Problems	6.62%
Back Problems	6.16%
* Accounts for 67.43% of absence	

Mental Health Reasons	
Stress	15.64%
Stress-Work Related	6.76%
Grief/Bereavement	4.16%
Anxiety	2.01%
Other Mental Health	1.23%
Panic attacks	0.01%
Insomnia	0.19%
Depression	0.06%

Sickness absence due to mental health reasons continues to present the highest reason for absence with **cumulative** a figure of 30.02% for the reporting period, with stress and work-related stress accounting for 15.64% and 6.76% **cumulative** lost time to absence to month 3 (June) 2025 respectively. 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.

2025/26 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 (2025/26)						9.53%[1]						
2.	Current Status against Target						9.00% ↓						
3.	Cumulative % hours lost (24/25)	10.24%	9.64%	10.06%	10.49%	10.70%	10.79%	10.68%	10.43%	10.38%	10.35%	10.21%	10.07%
4	Cumulative % hours lost (25/26) (Total)	8.53%	8.85%	9.00%									
4.1	Cumulative % hours lost (25/26) Short-Term	2.19%	2.13%	2.05%									
4.2	Cumulative % hours lost (25/26) Long-Term	6.34%	6.72%	6.94%									
5.	Monthly % hours lost (25/26) Total	8.53%	9.17%	9.30%									
6.	Average standard working days lost/employee/month	1.82	1.95	1.89									
7.	Average estimated cost per month (£'000)	£609	£633	£628									

↑ 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

[1]To reduce absence rates to 92.5% of absence levels reported in 2024/25 (based on annual re-run) by end March the 2025/26 financial year.

Northern Ireland Ambulance Service
Health and Social Care Trust

Our People | Absence | Occupational Health

	KPI (in working days)	April 2025 Average wait time (Days)	May 2025 Average wait time (Days)
Medical Team	10	10	11
Physio Team	5	8	11
Psychology Team	10	24	28
OT Team	10	11	0
PPHA (routine)	2	5	1
PPHA (Drivers)	5	3	2

Quarter 4 monthly wait times in days by specialty

Note: Information presented on this summary is derived from the following data sources only; eOPAS, OH Tracker Database, OH shared Drive.

- Monthly meetings established in October 2024 between NIAS OH lead and Belfast Trust Business services manager.
- NIAS OH lead attending weekly HR Advisor forum for escalation.
- Key performance indicators agreed following a detailed review of service usage spanning four years. (example on next slide below)
- NIAS dashboard created with monthly reporting from April 1st, 2025
- BHSCT Capacity as been increased, NIAS referrals checked daily by two designated staff
- Escalation pathways established and working.
- Action plan agreed to improve quality of referrals and increase prevention and early intervention programmes.

Northern Ireland Ambulance Service
Health and Social Care Trust

Our People | Absence | Occupational Health

OH, KPI's Example

Service Activity	Aim	Key Performance Indicators for Service Delivery
Pre-Employment health checks (for new starts)	To ensure that prospective employees are fit to perform their role effectively and without risk to their own or to others' health and safety	Pre-employment health assessments to be carried out within 7 working days of the date of receipt of all documentation sought from the applicant and 'fit' reports to be provided within 2 working days of the assessment having taken place.
Professional Support and advice	To answer queries from HR, Managers, and employees.	Response to telephone queries and email correspondence within 2 working days of receipt of an enquiry Monthly review between NIAS HR and BHSCT OH of all long-term sickness absence cases.

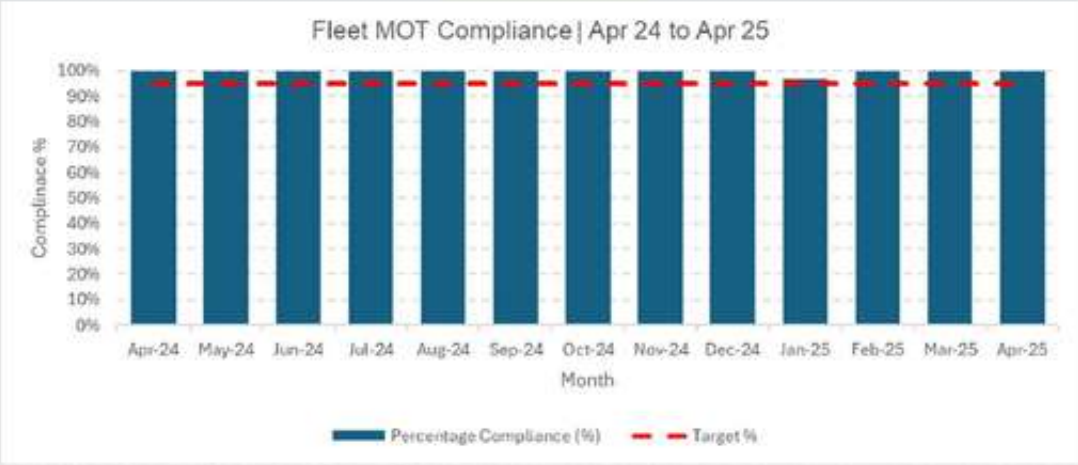
Northern Ireland Ambulance Service
Health and Social Care Trust

Our Infrastructure | Fleet Performance | MOT Compliance

Fleet MOT Compliance 2024.25

The analysis below describes: NIAS' performance for meeting the MOT requirements for our Fleet.

MOT Compliance



- NIAS has achieved compliance with MOT Compliance from April 2024 to April 2025. There has only been one vehicle that has missed an MOT appointment, in January 2025 on the day of Storm Eowyn as the test centre was closed.
- NIAS Fleet department actively manage MOTs across the entire fleet to ensure compliance with this regulation.

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD (TB)

PRESENTATION OF PAPER

Date of TB:	28 August 2025
Title of paper:	Trust Board Finance Report – June 2025 (Month 3)
Brief summary:	• Attached is the finance report for month 3 - June 2025. • The Trust is reporting year-to-date (YTD) expenditure of £33.280m with an underspend of £0.166m 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. This is being offset by increased costs against non-payroll (specifically IAS costs). • The savings plan to deliver the full £3.675m is on track to be achieved. • The CRL allocation for 2025-26 is £6.135m. • At this stage of the financial year, the Trust is forecasting a break-even position at year-end for both Revenue and Capital.
Recommendation:	**For Approval** ☐ **For Noting** ☒ *Click the appropriate box*
Previous forum:	SMT 12 August 2025
Prepared and presented by: **Date:**	William Abernethy Leahann Donnelly 12 August 2025

Trust Board Finance Report

June 2025 (Month 3)

Northern Ireland Ambulance Service
Health and Social Care Trust

Contents

Executive Summary

* As at June 2025, the Trust has received an indicative allocation from SPPG of £128.203m (inclusive of £0.104m from PHA and net of £2.475m of savings).

* At this stage of the financial year there is an assumed funding number of £3.154m. This represents funding relating to the holiday pay pressure, the National Insurance increase, Ulster University students and Cyber Staffing.

* The projected other income figure, which mainly relates to recharges to other Trusts, income from Road Traffic Accidents and income on disposal of fixed assets is £2.053m.

* As such, Directorate budgets have been updated to reflect total funding of £133.410m. This is an increase of £0.335m from the position reported in the opening allocations paper in June 2025. This is mainly due to confirmed increased funding from SPPG regarding the National Insurance contributions (£0.223m) and additional funding from PHA for Suicide Prevention (£0.073m).

* As the year progresses, the total funding position may change once final allocation and income figures are confirmed.

Financial Performance June 2025 (Month 3)

- For period ending June 2025, the Trust is reporting year-to-date (YTD) expenditure of £33.280m, resulting in a year-to-date underspend of £0.166m when compared to the profiled budget. A summary of each Directorate's position is included on the next slide.

- At this early stage of the financial year, NIAS is forecasting a break-even position at the end of the financial year.

Summary of Directorate Positions

Please note that in the following table, columns 1-3 show variances (budget (based on estimate expenditure profiles for 2025-26) vs actual). A negative figure represents an overspend against budget, with a positive figure indicating an underspend.

£ 000s	YTD Variances			YTD Actuals	YTD Var to Budget (%)	Full Year Forecast	Budget Allocation	Variance
	Payroll	Non-Pay	Total					
Chief Executive's Office	(13)	65	**52**	323	14%	1,455	1,455	0
Director of Finance	17	23	**39**	607	6%	2,599	2,599	0
Director of Human Resources	70	23	**93**	602	13%	2,889	2,889	0
Medical Director	(10)	3	**(7)**	146	-5%	558	558	0
Clinical Director	65	61	**126**	3,288	4%	14,883	14,883	0
Director of Safety, Qual & Imp	44	1	**45**	749	6%	3,184	3,184	0
Director Of Plan, Perf & Corp Services	(7)	87	**80**	2,130	4%	8,787	8,787	0
Director of Operations	535	(798)	**(263)**	25,435	-1%	100,616	100,616	0
Operations HQ	*31*	*27*	***58***	*876*	6%	*3,837*	*3,837*	*0*
Unscheduled Care	*252*	*107*	***359***	*18,239*	2%	*76,093*	*76,093*	*0*
Scheduled Care	*252*	*22*	***274***	*3,496*	7%	*15,083*	*15,083*	*0*
Independent Ambulance Service		*(953)*	***(953)***	*2,824*	-51%	*5,603*	*5,603*	*0*
Revenue Total	**702**	**(536)**	**166**	**33,280**		**134,971**	**134,971**	**0**
Contingency			0			364	364	0
Other Savings (TBC)			0			(1,925)	(1,925)	0
NIAS Total	**702**	**(536)**	**166**	**33,280**		**133,410**	**133,410**	**0**

* Directorate budget allocations have been updated as outlined in the 'Budget Allocation' column above to reflect the updated funding position and agreed reallocation of budgets to priority areas. All movements will be discussed with Directors at monthly finance meetings.

YTD Variances (>£50k)

Payroll Variances against budget

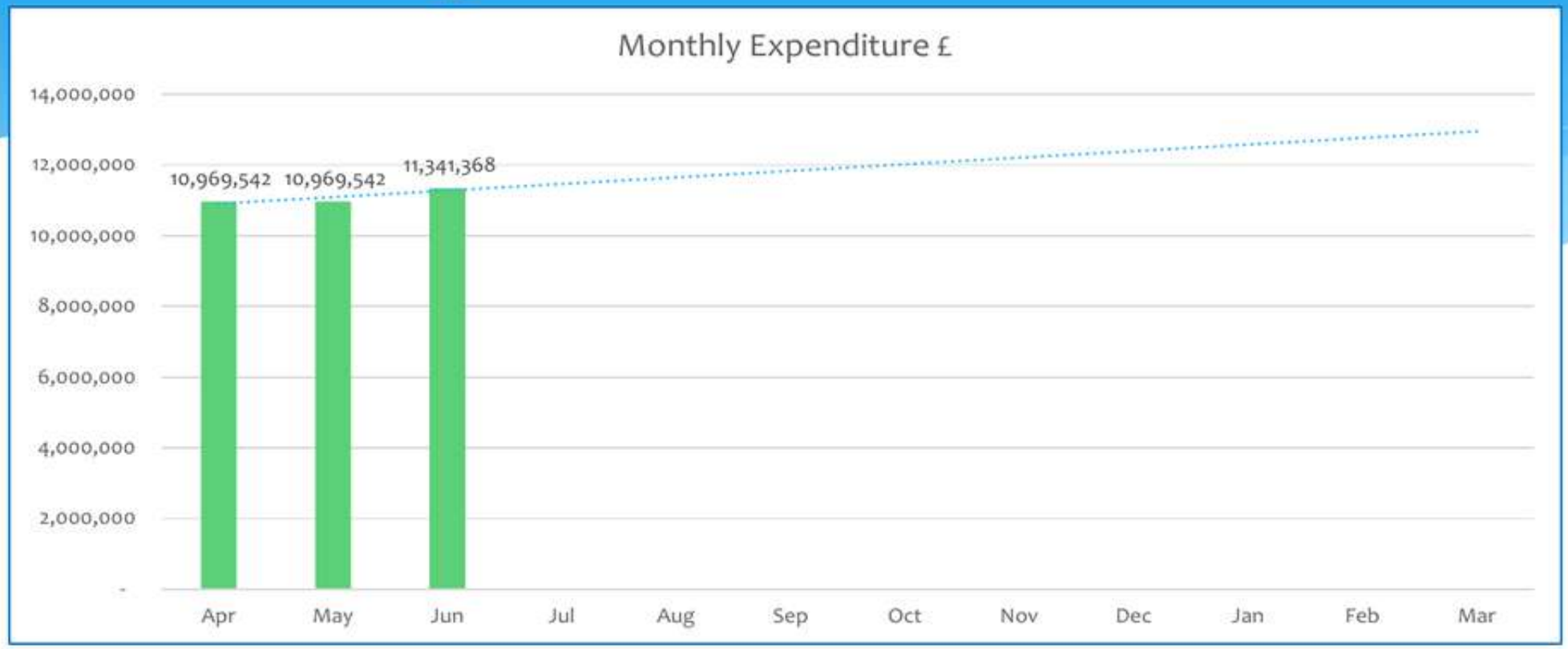
* Payroll variances are due to current vacancies in NIAS. This is being partly managed through the use of overtime and IAS (see following slides).

Non - Payroll Variances against budget

* **Chief Executives Office** – decreased costs in RCC due to timing of new starts.
* **Clinical Director** – underspend in relation to Computer Software for ePCR/REACH, budget to be reprofiled in month 5.
* **Planning, Performance and Corporate Services** – decreased costs on Computer Hardware Maintenance, Computer Software Maintenance, and Telephone Rent & Calls.
* **Operations:**
* **Unscheduled Care** – reduction in fuel costs. Budget based on 3-year average, however significant reduction in spend compared to last year.
* **Independent Ambulance Service** - increased spend due to increased activity. Offset by frontline vacancies (see future slide).

* Variances will be discussed in detail with Directors at monthly finance meetings

Expenditure Trends

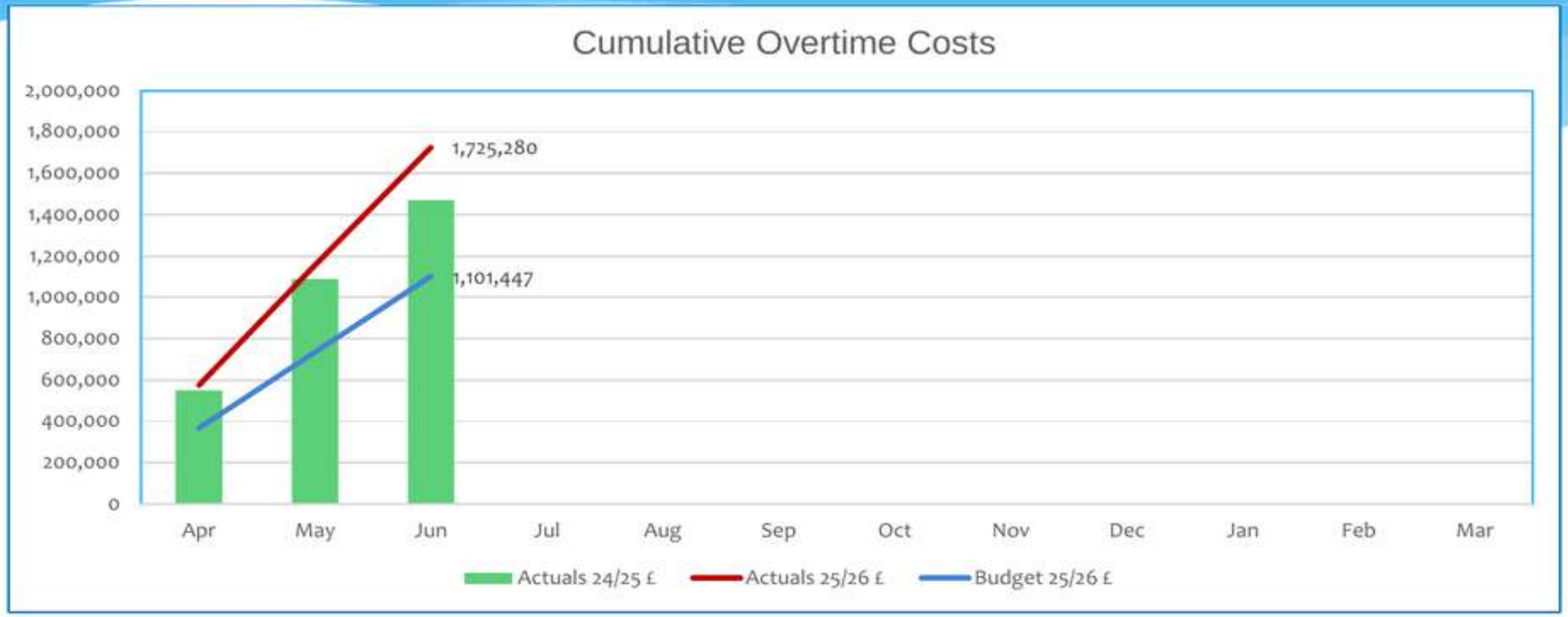


* YTD expenditure is averaging £11.093m a month (month 1 and month 2 have been split equally as year-end-accounts were prioritised over month end work at this time).

* Monthly finance meetings have been arranged to discuss year-to-date performance; to identify any areas that need investigating; and to discuss the full year forecast position for each directorate.

Overtime Expenditure

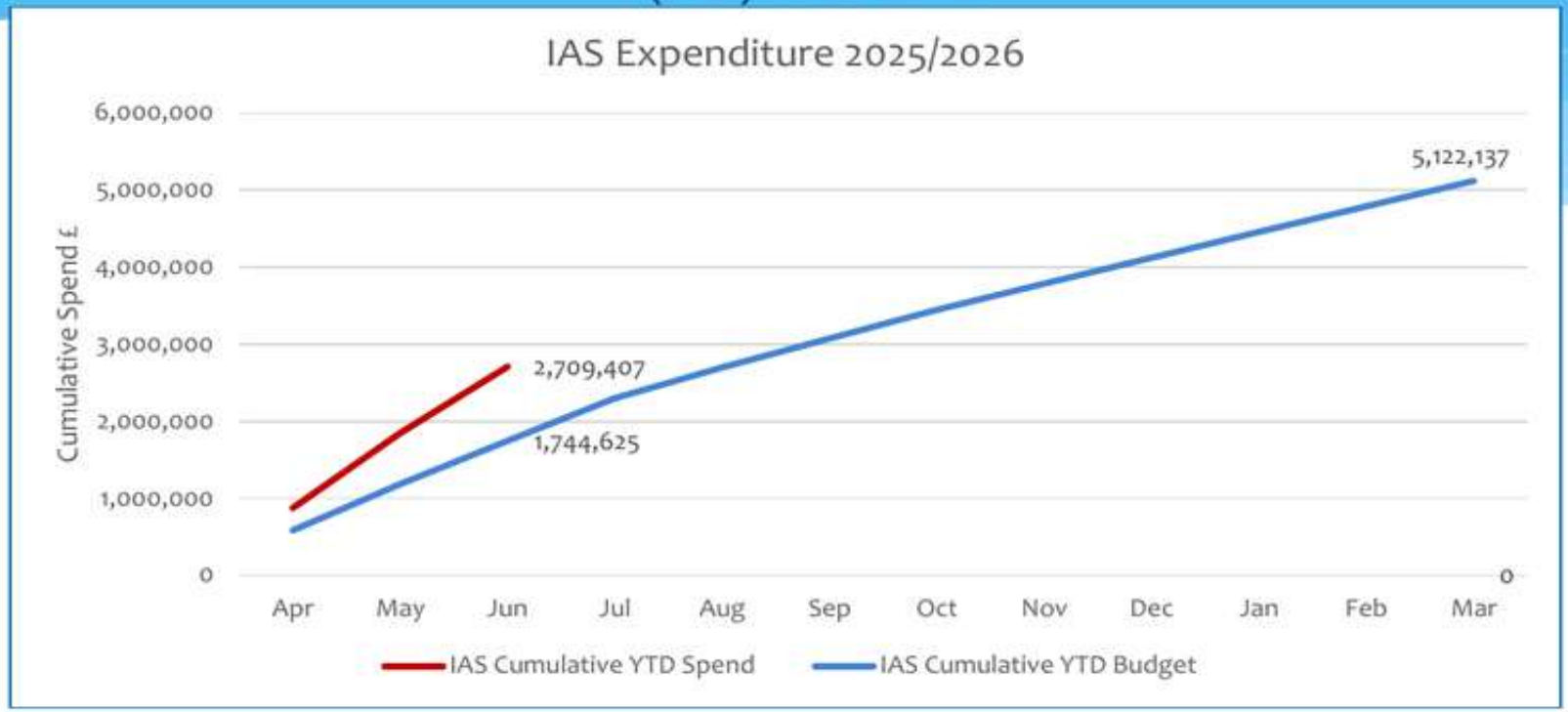
The Trust relies on the use of overtime for the provision of services. This reliance is for several reasons including vacancies, planned and unplanned absences and additional cover or programmes of work.



* Note this is the net overtime number and excludes National Insurance.

IAS Expenditure

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

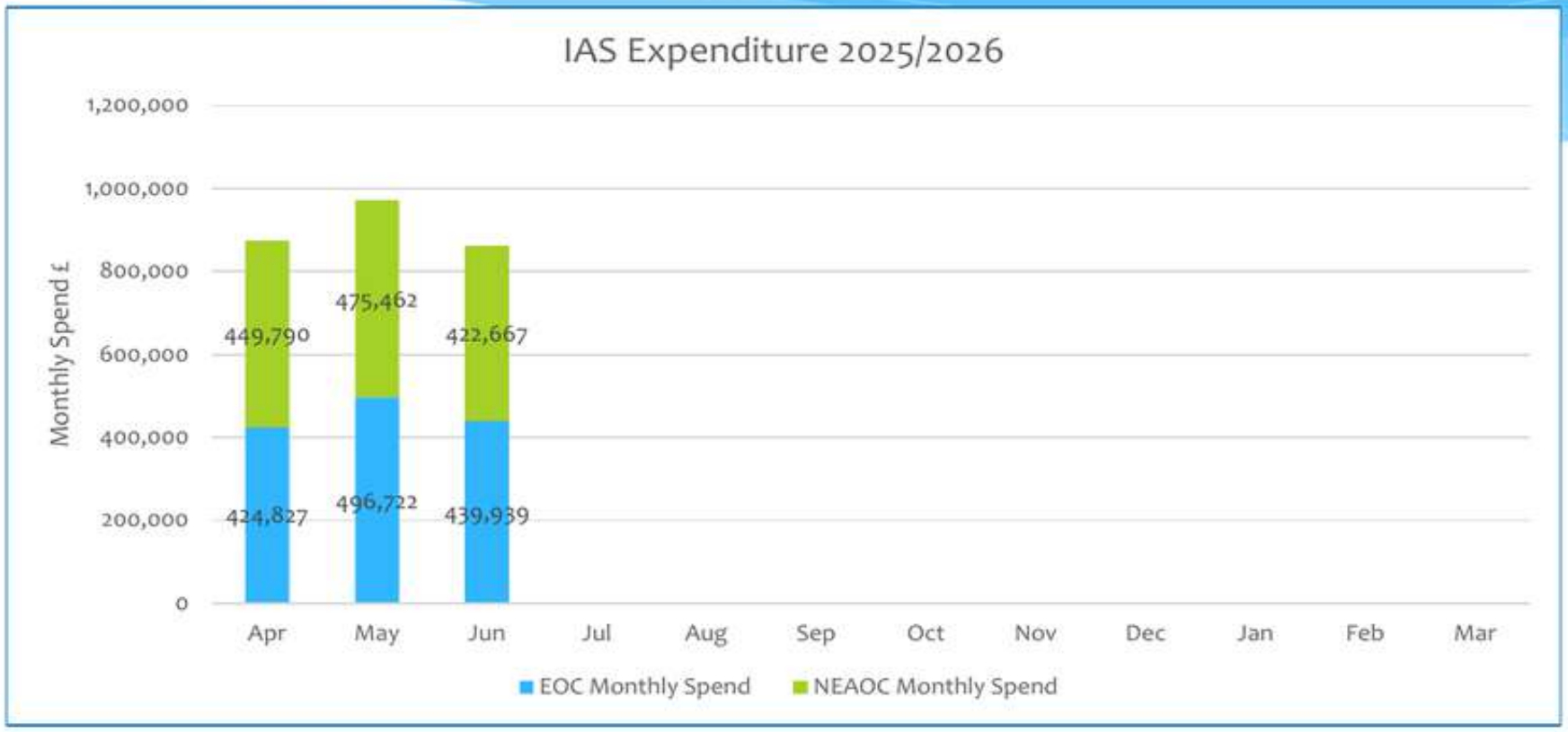


* NEAOC spend forecast to reduce from August onwards due to new framework rates, and additional staff joining Scheduled Care. EOC forecasting to maintain same spending levels throughout remainder of year.

* IAS Expenditure excludes spend in relation to Belfast Health Trust (NIAS recharges this expenditure).

IAS Expenditure

The chart below provides a breakdown of the monthly IAS expenditure between EOC and NEAOC



Capital Resource Limit

The Trust has received a Capital Resource Limit (CRL) allocation for 2025-26 of £6.135m.

Expenditure category	Capital Resources Limit Allocation £'k	25/26 Forecast Spend £'k
Fleet and Estates	5,700	5,700
Medical Equipment	0	0
Backlog Maintenance	125	125
ICT	310	310
R&D	0	0
Leases	0	0
Total	**6,135**	**6,135**

* NIAS has developed a plan to deliver a breakeven position for 2025-26.

Prompt Payment of Invoices

The Trust is required to pay non HSC trade creditors in accordance with the Better Payments Practice Code and Government Accounting Rules. The target is to pay 95% of invoices within 30 calendar days of receipt of a valid invoice, or the goods and services, whichever is the latter. A further regional target to pay 70% (increased from 60%) of invoices within 10 working days (14 calendar days) has also been set.

NIAS Prompt Pay Performance 2025-26

	Final													
Number	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD Cum	Target
Total bills paid	3,483	2,955	2,926										9,364	
Total bills paid within 30 calendar days of receipt of undisputed invoice	3,396	2,876	2,863										9,135	
% bills paid on time 30 days	97.5%	97.3%	97.8%										97.6%	>95%
Total bills paid within 10 working days (14 calendar days)	2,653	2,240	2,373										7,266	
% bills paid on time 10 days	76.2	75.8%	81.1%										77.6%	>70%
Targets														
30 days	>95%	>90%	<90%											
10 days	>70%	>65%	<65%											

Statutory financial performance targets The position outlined in this report, and the associated RAG status, is subject to several assumptions.	RAG status
Manage within allocated Revenue Resource Limit (RRL) / Achieve financial break-even	

For period ending June 2025, the Trust is reporting YTD expenditure of £33.280m. At this early stage of the year, NIAS is forecasting to break even at the end of the year.

Manage within allocated Capital Resource Limit (CRL)	

The Trust has received a Capital Resource Limit (CRL) allocation of £6.135m. At this early stage of the year, NIAS is forecasting to break even at the end of the year.

Savings target	

The Trust has to achieve £3.675m of savings in 2025-26. This savings target has been included within the current 2025-26 financial plan as follows.

Savings Plan 2025/26	Plan £m	YTD Actual £m	Full Year Forecast	Variance
Non-Frontline Vacancy Management	1.000	0.251	1.000	0.00
Frontline savings due to vacancies	0.500	0.157	0.500	0.00
Uniforms	0.150	0.057	0.150	0.00
Travel and Expenses	0.100	0.016	0.100	0.00
TOTAL ALLOCATED	1.750	0.481	1.750	0.00
Savings required for Employers NIC Increases	1.200	0.300	1.200	0.00
Sale of End-of-Life Vehicle	0.200	0.002	0.200	0.00
Income	0.300	0.075	0.300	0.00
TBC	0.225	0.056	0.225	0.00
TOTAL UNALLOCATED	1.925	0.433	1.925	0.00
TOTAL	3.675	0.914	3.675	0.000

The unallocated savings above have not yet been uploaded to CP to a specific cost code.

Prompt payment target - 95% of suppliers within 30 days	

Cumulative performance is 97.6% for the period ended 30 June 2025.

End of Report

Northern Ireland Ambulance Service
Health and Social Care Trust

NIAS Trust Board

PRESENTATION OF PAPER

Title of paper:	**NIAS Safety and Quality Level Two Programme Update for Trust Board**
Brief summary:	**This paper is to provide an update to Trust Board regarding the delivery and progress of the NIAS Safety and Quality Level 2 programme.**
Recommendation:	**For Approval** ☐ **For Noting** ☒
Previous forum:	
Prepared and presented by:	Seán Maguire Lynne Charlton
Date:	14th August 2025

Northern Ireland Ambulance Service
Health and Social Care Trust

Executive Summary:

NIAS staff have benefitted from participation on SET Quality4U programme for many years. As the Quality, Safety and Improvement directorate has grown and with the appointment of Quality and Service Improvement Leads in 2021 it was felt that NIAs should develop and deliver its own in house level two programme.

In October 2024 a cohort of 13 staff with 11 projects commence on the first ever Safety and Quality Level 2 programme in NIAS.

Following successful completion of the programme a graduation event was held to celebrate the successes of the participants, their projects and the organisation on the programme.

Each project is to be further supported in a presentation to the respective directorate, executive sponsor and team to identify key learning points and to ascertain their suitability and maturity for scaling up and spreading throughout the organisation.

Cohort two of SQ2 is currently open to recruitment and nominations are encouraged from those directorates and departments where their quality improvement journeys have yet to begin.

Whilst level two capacity increases so to does the level three with staff recently graduating from Scottish Quality and Safety Fellowship (SQSF), Scottish Improvement Leaders (ScIL) and also enrolling in this coming year's programmes. Additionally a place has been secured with Set on their Safety Fellowship programme and also two places secured on an all – island QI coaching programme facilitated by HSCQI NI and HSE. This additionality will support the development faculty and build capacity and capability within NIAS.

Northern Ireland Ambulance Service
Health and Social Care Trust

Background:

In 2017 a partnership with the South Eastern Trust (SET) led to the provision of Quality Improvement (QI)level two programmes for NIAS staff through their Safety Quality and Experience Level two programme, more recently known as Quality4U. In the period up to 2024 NIAS were in a position to support 38 staff on their improvement journey with SET. As the QI team in NIAS has evolved and developed over the past few years it has always been the intent to develop and deliver a level two QI programme for NIAS staff delivered by NIAS staff. In October 2024 we successfully launched the NIAS Safety and Quality 2 (NIAS SQ2) programme. This milestone realised the strategic priority identified through "Caring Today, planning for tomorrow- Our Strategy to Transform 2020-2026" of QI as a priority area for transformation. The launch of SQ2 will serve to improve and develop QI knowledge and skills for staff across the organisation and be key to achieving this strategic priority.

Programme Development:

In developing NIAS SQ2 it was important to ensure that the key elements outlined in Q2020 – Attributes skills framework, for a level two QI programme were followed, but it was equally important that we use a familiar format which had a proven track record. As SET had been the programme most familiar to NIAS it was decided to employ a similar model of delivery to theirs. Whilst this has changed over many years it was considered that the current model of short modules (3-4 hours) spread across eight months would meet our current needs.

Programme Launch

In October 2024 the NIAS Quality and Service Improvement Leads launched the first in house quality and safety improvement programme (SQ2) for NIAS staff. A cohort of 13 staff were inducted and 11 projects (Appendix 1.) were agreed.

The programme was delivered in short modules as learning sets. In addition to the learning sets, the faculty supported participants with QI clinics and feedback including that of their peers.

The programme concluded in April 2025 with final presentations and poster presentations being delivered to colleagues, peers and senior managers at a celebration event in June 2025.

Course resources were hosted on Canvas which is the NIAS virtual learning environment used predominantly by the clinical education team.

Celebration Event:

To mark the achievement of the participants and also of the Trust on the completion and graduation of our first cohort a small celebration event was held. There was a mixed audience from the Chief Executive, senior sponsors of the projects, peers and colleagues from the HSCQI Alliance. All project posters were displayed and time was set aside for guests to view and discuss with the project leads. All participants were awarded certificates and three projects (Appendix 1 marked with), and three posters (Appendix 1 marked with) were selected for additional awards. The top three projects were presented formally to the audience with an opportunity for further comments being provided. Staff who undertook the programme have commented on how beneficial it was – how much they learnt and how they have appreciated the opportunity to lead a project of small change in their area of work.

Post Course follow up:

It is important to recognise the success and potential impact that the projects could have in a greater organisational setting. As such each project lead was asked to present their project work to their own team and directorate, not only with a view to continuing the work beyond the project but to assess if there is any learning or improvement ideas that can be scaled up and spread across the organisation. These have been well received to date.

Northern Ireland Ambulance Service
Health and Social Care Trust

Capacity and Capability:

Developing capacity and capability for QI is a key strategic priority in our NIAS Quality Strategy. In order to promote a spread of QI knowledge across each directorate, nominations were sought to ensure there was a good representation. It is vital that candidates attaining a level two qualification can implement and use QI methodology to drive improvement in their area of work and also contribute to other QI projects as required. This will ensure that the foundations for QI, capacity and capability are built within individual teams and spread across NIAS. It is noted that some teams and directorates have limited QI capacity and this will be a focus for the QSI team in the coming year and during the current recruitment to cohort two of NIAS SQ2. Charts 1a& 1b below shows a breakdown of capacity across each directorate.

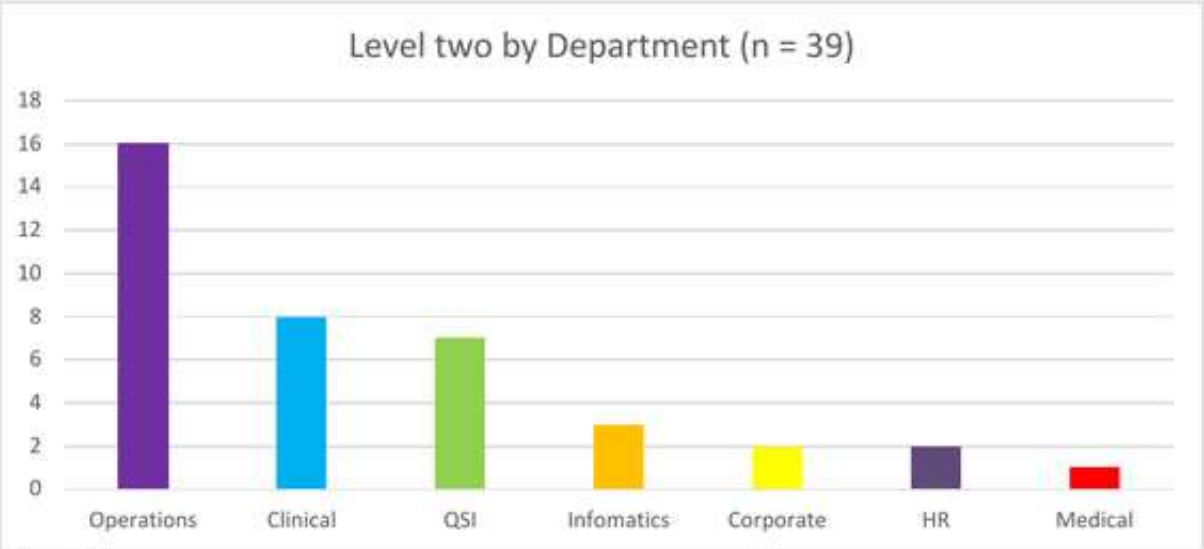


Chart1a

Northern Ireland Ambulance Service
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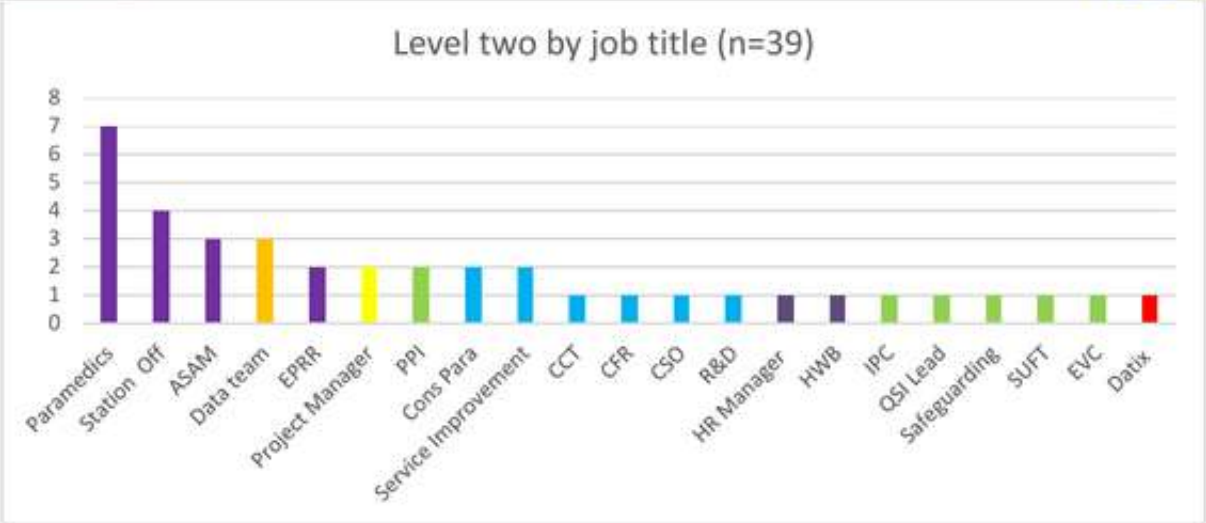

Chart1b.

Chart 2 below gives an indication of what the QI level two growth looks like over the past 7 years.

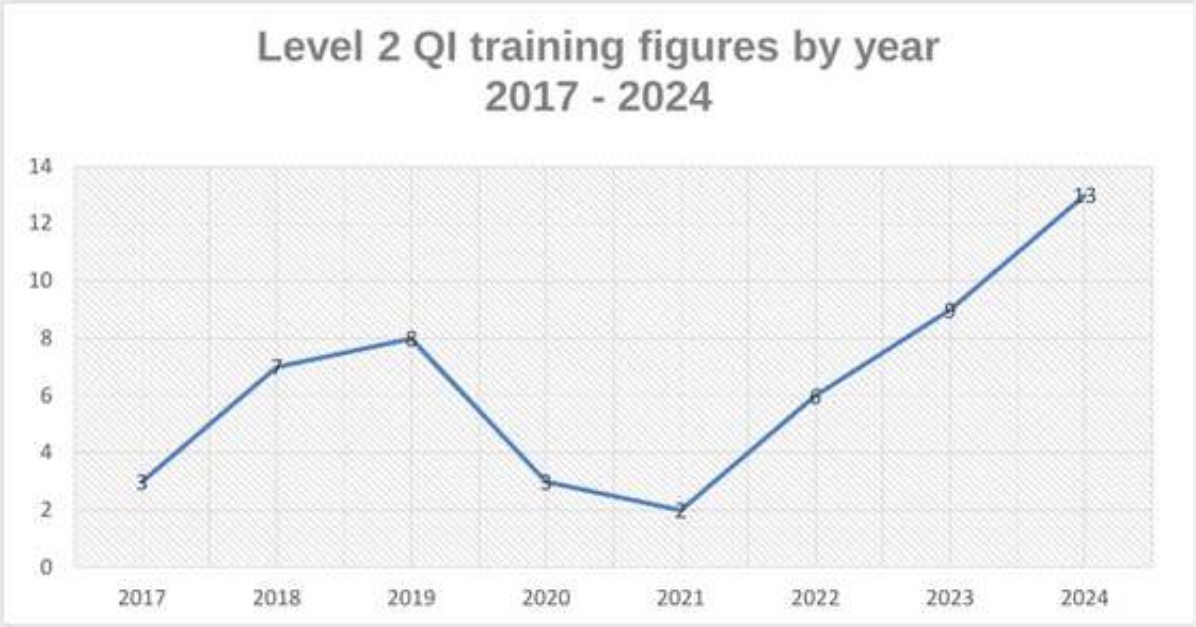

Chart 2.

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Next Steps:

As mentioned previously several departments have yet to start their journey to develop their capacity and capability for QI. This will be addressed through the current recruitment to the 2025/ 2026 programme for cohort two.

QI training and development reaches beyond level two and we are pleased to also report that the level three capacity continues to grow with an additional three staff being enrolled in a number of different level three programmes –and SET Safety Fellowship.

NIAS have also been awarded two places on a QI coaching programme which is being co facilitated by HSCQI (NI) and the HSE as part of an all-island initiative.

Faculty development is central to the future delivery of the programme and creating a culture for QI within NIAS. It is anticipated to invite graduates of NIAS SQ2, SQSF, ScIL and QI coaching programmes to become shadow faculty with a view to contributing to future programme delivery.

Northern Ireland Ambulance Service
Health and Social Care Trust

Appendix 1.

Name	Position	Project title
Ann Marie Mc Stocker	Health and Wellbeing Project Officer	Journey Towards Trauma Informed – Improving Access and Uptake of Immediate Post Incident Psychological, Critical Incident Support.
Eileen Lyttle	Lead Data Analyst	Information Governance Training Improvement Project.
Laura Duncan	Information Governance Officer	
Hannah McGeoch	Clinical Pathways Lead	Increasing Referrals from NIAS ambulance crews to the Northern Sector of Hospital at Home for the Western Trust.
Helena Blair	Assistant Programme Manager	Mobilisation Times at Bridge End Station
Joanne Maguire	Station Officer (SE Division)	Increasing Taxi pathway usage within SE division.
Maggie Hamilton	Experience and Involvement Officer	Improving Care Opinion story generation via CFRs.
Neil Gillan	Co-production Partnership Lead	
Paul Cushnan	Station Officer (SE Division)	Increasing physical activity levels for frontline staff within NIAS.
Robert Bailie	Paramedic Station Supervisor	Time is Tissue – Improving Fast Positive patients' outcomes.
Robert Millar	Station Officer (Belfast)	Increasing FIT Testing Compliance for NIAS Operational Staff.
Robert Murphy	HART Manager	Increasing NIAS Commander Confidence Using Body Worn Camera
Stacey Chambers	Safeguarding Manager	Increasing Safeguarding Referral Rates.

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

PRESENTATION OF PAPER

Date of Trust Board:	28 August 2025
Title of paper:	Safeguarding annual position report 24/25
Brief summary:	The Annual Safeguarding Position Report is considered an important overview and governance tool for all organisations and groups supporting adults and children at risk or in need of protection. As such, it contains significant information for an organisation's committees and Trust Board. There is an expectation that the Position Report should be made available for any external audit purposes. The Annual Position Report is key in demonstrating organisational levels of compliance with the Adult Safeguarding: Prevention and Protection in Partnership (July 2015) Policy, and Co-operating to Safeguard Children and Young People in Northern Ireland 2017. In addition, this report will also reflect progress on recommendations which followed a National Ambulance Safeguarding Advisory Group (NASAG) peer review carried out in March 2023. This paper will provide an update to the SQPE committee in relation to: ➢ NASAG Peer Review position summary against key improvement areas ➢ Safeguarding Referral Data ➢ NIAS Engagement with other Safeguarding Agencies ➢ Domestic Homicide Reviews ➢ Adult Protection Bill (NI) ➢ Staff Safeguarding Allegations ➢ REACH utilisation and impact. Key achievements during 24/25 will be presented including in relation to: ➢ Policy development, launch and embedding ➢ Increasing rates of safeguarding/welfare referrals, 25% more in 24/25 (n= 1391), compared to 23/24 ➢ Increasing numbers of NIAS frontline staff trained to level 3, (n=586) ➢ Increased engagement with external partner agencies. Areas of focus for 25/26 will be detailed and will include:

	➢ Ongoing training activity ➢ Contribution to NIAS Culture Review and ensuing programmes of work/ work streams, particularly in relation to sexual safety ➢ Embedding of Safeguarding Allegations and Chaperone policies ➢ Work in relation to utilisation of REACH technology and Safeguarding Dashboard. ➢ Cross directorate working in relation to confidential pathways for referral to partnership agencies and Disclosure and Barring Service
Recommendation:	**For Approval** ☒ **For Noting** ☒
Previous forum:	SQPE 24/04/2025
Prepared and presented by: **Date:**	Des Flannagan Lynne Charlton 20.08.2025

Position Report on NIAS Safeguarding

Safety, Quality, Patient Experience and Performance Committee
April 2025

Compiled by:

Des Flannagan – Head of Safeguarding

Ruth Finn – ADQSI

Lynne Charlton - DQSI

Contents

1.Executive Summary

The Annual Safeguarding Position Report is considered an important overview and governance tool for all organisations and groups supporting adults and children at risk or in need of protection. As such, it contains significant information for an organisation's Committees and Trust Board.

There is an expectation that the Position Report should be made available for any external audit purposes. The Annual Position Report is key in demonstrating organisational levels of compliance with the RQIA Safeguarding Quality Improvement Plan issued in December 2019, the Adult Safeguarding: Prevention and Protection in Partnership (July 2015) Policy, and Co-operating to Safeguard Children and Young People in Northern Ireland 2017. In addition, this report will also reflect progress on recommendations which followed a National Ambulance Safeguarding Advisory Group (NASAG) peer review carried out in March 2023.

Key updates:

Safeguarding Policy and Procedure

The Trust has introduced two new polices to enhance safeguarding in 2024/25. These include Managing Allegations against People Who Work with Children, Young People or Adults at Risk, and a Chaperone Policy which aims to ensure that the patient's safety, privacy and dignity are protected during intimate examinations/procedures.

Staff Education and Sexual Safety

A three-year plan was developed to provide all staff delivering direct patient care with Level 3 face to face safeguarding education. The current number of staff trained to level 3 is now 586 which represents in excess of 60% of staff delivering patient care. The training incorporates scenario-based learning specific to the role of Ambulance clinicians and includes wider learning from domestic abuse and safeguarding for our workforce particularly in respect of sexual safety. Staff are invited to complete an evaluation of the course which has been positive to date. Staff are also encouraged to feel safe to raise concerns throughout the session. A number of staff have approached the safeguarding team following the session describing a hesitation to report incidents, often due to a fear of their concerns not being taken seriously or facing repercussions or inaction. There were also specific examples of staff, many of them female, who reported concerns regarding the level of confidence and trust in the current reporting mechanism or supports offered by the Trust.

These interactions, the majority of whom were female, resonate with the cultural issues related to sexual safety identified within the AACE Reducing Misogyny and Improving Sexual Safety in the Ambulance Service (October 23) and NHS England Culture review in Ambulance Services (Feb 24) They also strengthen the need for the current cultural review and sexual safety programme within NIAS.

It is recognised that an organisational culture programme has been established; with a cross-directorate workshop taking place in March 25 and that the Trust has secured dedicated capacity from the national ambulance sexual safety lead who will be in post to provide leadership to this programme from April 25. There is, however,

also likely to be a case for further capacity within the organisation to ensure we have the level of support needed for our staff, provided by individuals with the essential skills and knowledge.

Safeguarding Case Monitoring

In the context of significant increase in referrals and in recognition of the current capacity in terms of the safeguarding team, the weekly review processes in place for safeguarding cases has now been amended to focus on specific case discussions for more complex cases. The Safeguarding Manager has established an allocation dashboard and has regular contact with the Safeguarding practitioners to support more complex cases.

Safeguarding Referral Data

From 01 April 2024 to 31 March 2025, 1391 safeguarding incidents were reported by NIAS staff, a 25% increase on the same period last year and a 50% increase on referral for the period 22/23. The significant increase in safeguarding incidents reported by NIAS staff reflects a stronger culture of awareness and vigilance, along with improvements in reporting mechanisms. It is also encouraging to see that staff who have completed Safeguarding Level 3 are demonstrating greater awareness and providing high quality reports that advocate for vulnerable patients.

Engagement with Safeguarding Agencies

NIAS actively collaborates with the Strategic Planning and Performance Group (SPPG) and the Head of Safeguarding meets with the leads of the Interim Adult Protection Board every 3 months to review activity and discuss themes related to adult protection. Meetings with Hospital Social work teams continue alongside community teams to address interface issues. NIAS remains involved with the new Adult Protection Bill (Northern Ireland), which continues to be in draft awaiting legislative changes. NIAS has representation on the Safeguarding Board for NI and attends the Belfast Panel every quarter. Further work is required to take forward a recommendation arising from a previous Domestic Homicide Review relating to consideration of NIAS becoming a member of the Multi Agency Risk Assessment Conference (MARAC), a meeting where organisations discuss the risk of future harm to individuals experiencing domestic abuse and violence, in order to discuss an action plan to manage the risk. The Head of Safeguarding is engaging with regional colleagues in relation to this consideration.

Staff Safeguarding Allegations

The new Safeguarding Allegations policy has been promoted at meetings with senior operational staff who are often the first to respond when allegations become known. It is anticipated that similar information sessions will be delivered to Human Resource staff to establish implementation of the policy and procedures into the organisational culture.

Implementation of REACH Software and EPRF Platform

The REACH platform is now live, providing improved digital tools for staff to report safeguarding concerns. However, issues with data transfer and case management integration remain. NIAS continues to manage referrals through Datix pending

further upgrades to REACH, which will streamline referral tracking and enhance interagency collaboration.

Progress with NIAS Safeguarding Peer Review (March 2023- Published August 2023)

NIAS invite a peer review in March 2023 carried out by the National Ambulance Safeguarding Group (NASAG) led by the Head of Safeguarding for London Ambulance and the Welsh Ambulance Service. The table below represents progress with the 13 recommendations, 9 (69%) of which are complete with 4 (31%) partially complete.

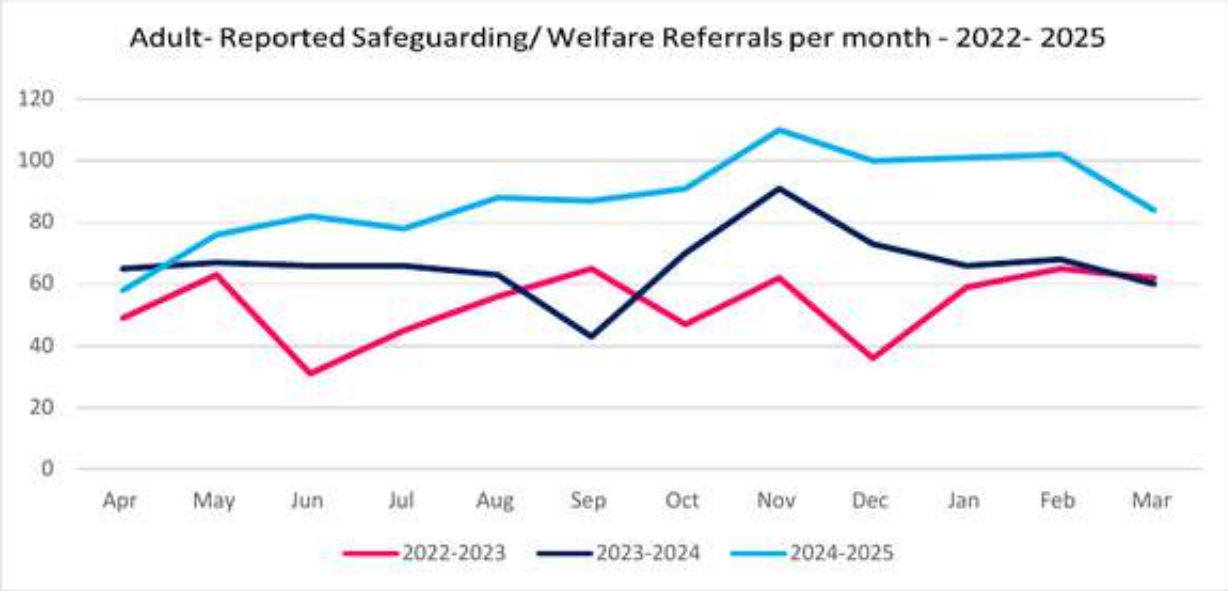
	REFERRAL PROCESS	RAG status
1	In addition to the current Belfast pilot the trust should consider promptly making the referral process simpler for all staff by removing the direct notification to duty teams in most circumstances and the safeguarding team making the referrals. This would be in line with other UK Ambulance Trusts. However, it is recognised there is no substantive safeguarding team therefore additional resources are required.	**Complete** Pathway altered for safeguarding/welfare referral September 2023 removing the need for crews to telephone social care agencies.
	TRAINING	
2	The trust should take urgent action to establish the quality and quantity of safeguarding training and update its strategy as it is key to staff understanding and protecting vulnerable patients and trust statutory requirements.	**Complete** The review of the Training and Education Strategy is now complete with a new level 3 in person course being delivered. In excess of 60% of the workforce involved in direct patient care have been trained to level 3 as of 31 March 2025.
3	The trust should conduct an organisational training needs analysis to determine training levels required, mode of delivery and trajectory for monitoring compliance.	**Completed** Undertaken in partnership with the Education Team and reflected in the review of the Safeguarding Training Strategy
4	The trust should review the current e-learning package to ensure it meets level 2 requirements, decide if it is level 1 or 2 and if level 1 should introduce a level 2 package that is tailored/bespoke to ambulance service and or call taking.	**Partially complete** The introduction of Level 1 and implementation of a review of Level 2 is being progressed with support from learning and organisational development lead as both will be hosted online. The content of both course has been developed and it is anticipated both of these course will be hosted on online by July 2025.

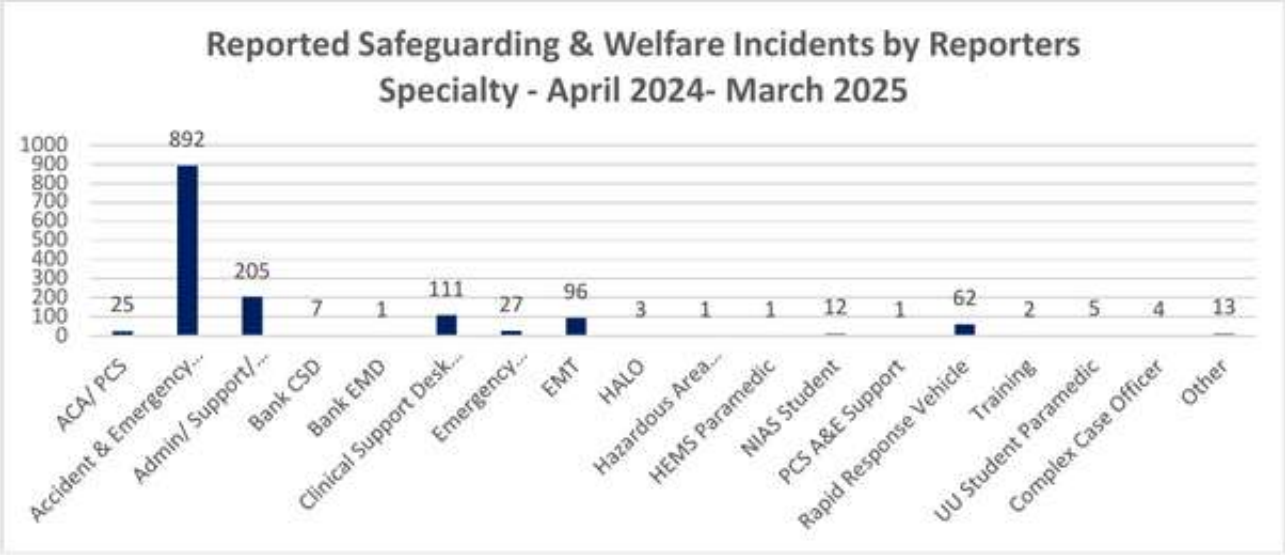
5	The trust should develop a level 3 package and objectives. This could be fully face to face or blended.	**Complete** Established from October 2023
6	The trust will need to resource further safeguarding specialists in the team to deliver the training as it is not appropriate or sustainable for the Head of Safeguarding to be delivering all the training. The Head of Safeguarding role is strategic and the role is currently compromised by training and operational duties.	**Complete** B7 Safeguarding Manager in Post from May 2024 B4 Safeguarding referral navigation administrative support in post from July 2024
7	The trust should review its reporting databases so that accurate figures and percentages of training compliance are available to Safeguarding team and operational management.	**Complete** Data base in place from Aug 2024 managed by new admin position in partnership with training team admin support
	GOVERNANCE & ASSURANCE	
8	Draft allegations policy to be adopted.	**Complete** The Safeguarding Allegations Policy is now operational, and information and support sessions are being delivered to operational staff involved in the supervision of the workforce. In addition, a Chaperone Policy has been developed & approved with a plan for joint promotion of the policy involving the head of professional practice.
9	Consider implementing risk assessment panel for all allegations that consists of key senior managers, HR, safeguarding, operations etc.	**Complete** Procedures within the Trust Safeguarding Allegations Policy, include a risk assessment panel for all allegations including key senior managers, HR, safeguarding, operations. There are further plans to have a cross directorate safeguarding oversight group to review Safeguarding related organisational themes/issues.
10	Ensure clear guidance is provided on who and when to notify the Disclosure and Barring Service (DBS) (adopting 2 stage test).	**Partially Completed** The Head of Safeguarding and Safeguarding Manager have now undertaken training and met directly with the lead for DBS in Northern Ireland.

		Further engagement with Trust Human Resources colleagues required to agree organisational guidance.
11	Ensure clear guidance on who and when to inform professional bodies, HCPC, NMC, GMC etc.	**Complete** Procedures within the Trust Safeguarding Allegations Policy, include consideration of requirement to inform professional bodies. The Trust Professional Standards Lead is key to the meetings undertaken to consider allegations.
12	Develop confidential pathways with HSCB and Police for informing them of safeguarding allegations against staff and the process of working in conjunction with them.	**Partially Complete** The Head of Safeguarding/Safeguarding Manager work with Adult Protection Teams and Trust Designated Adult/Child Protection Teams in allegation cases. The Head of Safeguarding also meeting every 3 months with the SPPG leads of the Interim Adult Protection Board and the SBNI multi agency panel for child protection which includes representation from PSNI. Whilst confidential engagements take place with PSNI, further cross directorate work is required to ensure confidential pathways are explored with each agency and formally established within the organisation. Expected date for completion Sept 2025
13	Trust should consider introducing a sexual safety charter or policy that links to their cultural improvement plan and provides clear advice and guidance for staff instilling confidence for staff to be able to report concerns, knowing that they will be handled sensitively and appropriately and not dismissed.	**Partially complete** An organisational culture programme has been established; with a cross-directorate workshop taking place in March 25 and that the Trust has secured dedicated capacity from the national ambulance sexual safety lead who will be in post to provide leadership to this programme from April 25.

Safeguarding Referral Data

From 1 April 2024 until 31 March 2025 there have been a total of 1391 adult/children safeguarding/ welfare incidents reported by NIAS staff. **This is an increase of 25%** on the same period 2023/24 and an **increase of 51%** on the reporting period 2022/23.





It is noted that there is a low volume of referrals received from our ACA staff group. Although the two cohorts of recently recruited ACA students have completed the level 3 training, the extant ACS staff group has not yet attended the safeguarding training. Discussions are ongoing with the education and operational team in relation to providing education to this group. The next series of targeted Level 3 training will begin in June 2025.

Other updates

Domestic Homicide Reviews

NIAS has contributed to 3 DHRs in 2024/25. Following the publishing of the Marcella DHR NIAS has continued to progress the recommendations including the training of our workforce particularly in EAC and have made significant efforts to take forward a recommendation in relation to consideration of NIAS representation on the MARAC (Multi Agency Risk Assessment Conference). The safeguarding manager has brought 1 case to MARAC in the past 6 months in order to safeguard a particularly high-risk patient who disclosed a history of domestic abuse to a NIAS clinician. There is 1 current individual agency review which requested in March 2025 in relation to homicide which took place in 2024.

Adult Protection Bill (NI)

NIAS is represented by the head of safeguarding in working groups related to the implementation of the adult protection bill which remains in draft. The Bill will see the introduction of new offences relating to ill treatment and wilful neglect. It will also introduce additional powers and duties to strengthen and improve the adult protection process and bring Northern Ireland into line with other parts of the UK. The bill is in a final draft although yet to be approved.

Staff Safeguarding Allegations

The Safeguarding Team has been involved in 7 staff cases, with significant input from Safeguarding manager and Head of Safeguarding into 2 cases that required investigation which included co-operation from other agencies. 2 Cases have recommendations for referral to Disclosure and Baring Service (DBS). There is significant learning from one specific case in relation to identifying and responding to patterns of concerning behaviour towards female staff.

Conclusion

Following considerable investment in staff education, NIAS has experienced an expected increase in safeguarding referrals. The organisation has appointed a Safeguarding Manager who has developed a number of partnerships with safeguarding agencies and Trust teams to improve interface working.

NIAS have been identified nationally as an ambulance service organisation with an outlying low safeguarding referral rate for safeguarding, 0.25% when the RQIA report highlighted concerns in 2019. This increased to 0.5% in 23/24. Whilst the volume of referrals has increased in 24/25 by 25% overall our referral rate remains lower than the 4% reported nationally across other UK ambulance services, there is however further work to be done to determine if all services follow the same operational definition to determine referral rate.

Managing this ongoing increase of referrals, training demands, alongside demands from partner agencies who are now more engaged with NIAS has placed pressure on what is a relatively small team, with little resilience, this was particularly evident in early 2025 when a member of staff was on sick leave and the were significantly challenged in the management of referrals, whilst simultaneously delivering an ambitious training programme). In recognition of this SMT have approved the appointment of an additional Band 5 Safeguarding Officer, however this is on a temporary basis, the service will require a stable and experienced workforce to manage what are likely to be increased referral rates as we continue to support clinicians to recognise and report safeguarding concern.

Key areas of focus during the remainder of 25/26 are:

1. Continue progressing Level 3 training, with an aim that all staff involved in the delivery of direct patient care will be trained by March 2026.
2. Address REACH software issues to ensure seamless case management and accurate data reporting.
3. Continue to monitor and report on the increasing rates of referrals and demands this places on safeguarding workforce.
4. Promote the safeguarding allegations and chaperone policy and procedures to ensure joint working and appropriate levels risk assessment and shared decision making.
5. Progress internal collaboration to develop clear guidance clear guidance is provided on who and when to notify the DBS.
6. Progress cross directorate work required to ensure confidential pathways are explored with relevant external agencies and formally established within the organisation.
7. Engage and contribute to the organisation culture and sexual safety programmes ensuring a strong safeguarding influence.

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

PRESENTATION OF PAPER

Date of Trust Board:	28.08.2025
Title of paper:	Infection Prevention and Control Annual Report for 2024/2025
Brief summary:	The paper updates on the Trust performance in relation to: • Hand Hygiene compliance • PPE compliance • Environmental Cleanliness auditing • Management of alert organisms and outbreaks • IPC E-learning
Recommendation:	**For Approval** ☐ **For Noting** ☒
Previous forum:	SQEP: 05.06.2025
Prepared and presented by: **Date:**	Ruth Robb IPC Lead 21.08.2025

Northern Ireland Ambulance Service
Health and Social Care Trust

Infection, Prevention and Control Annual Report

2024-2025

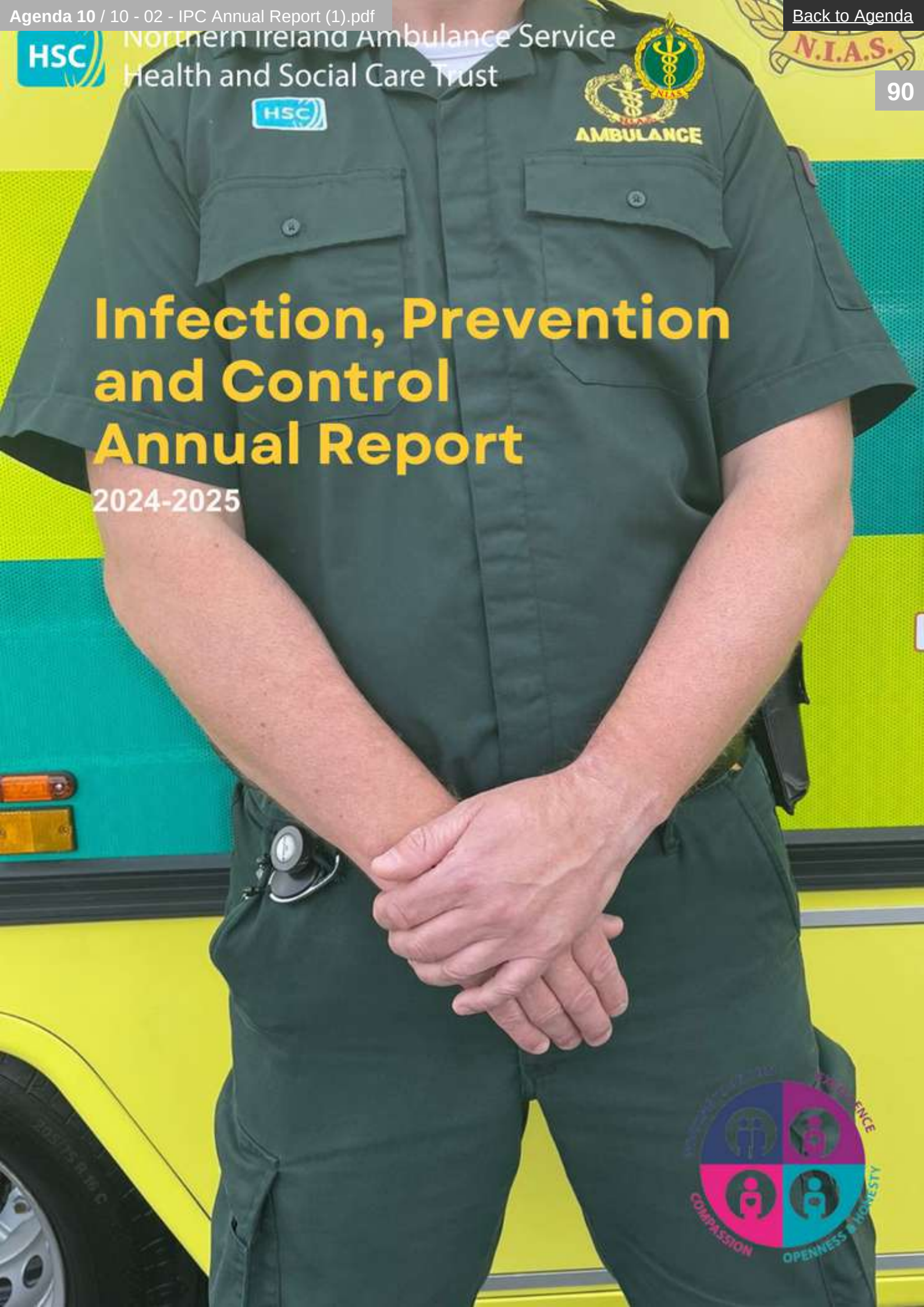


Table of Contents

Director of Quality, Safety and Improvement Foreword

This report recognises both the challenges faced and progress made in relation to Infection Prevention and Control (IPC) within the Northern Ireland Ambulance Service (NIAS) during the period 1st of April 2023 to 31st of March 2024.

The year has been marked by continued dedication, innovation and adaptability in responding to emerging risks and ensuring the highest standards for patients, staff and the wider community.

The re-emergence of measles and the new threat of Clade 1 Mpox cases demonstrated the success of a multidisciplinary approach to IPC risks faced by the ambulance service. While the pressure on the health system as a whole remained unchanged, as an organisation we were able to adapt and to ensure safe systems of work were established and risks mitigated as far as possible in this challenging service delivery context.

During this year we continued to work with internal and external stakeholders to ensure a robust and responsive IPC service tailored to the needs of the pre-hospital setting and all its unique challenges.

As we move forward, we remain focused on improving our culture of IPC and fostering a spirit of continuous learning and improvement.

I would like to take this opportunity to thank our NIAS IPC team for their hard work, dedication and commitment during this year, I am very proud of all that this small team have achieved. I would too like to acknowledge the role of our Operational Crews, of our NIAS Educators and of our Service Managers in delivering and supporting with all IPC efforts this year, and in championing a culture where IPC is foundational and part of our core business.

Lynne Charlton

Lynne Charlton
Director of Quality, Safety, and Improvement

The Northern Ireland Ambulance Service Health and Social Care Trust

Background Information

The Northern Ireland Ambulance Service (NIAS) provides high quality urgent and emergency care and treatment, as well as scheduled non-emergency patient transport services for all the 1.9 million population in Northern Ireland (NI). We provide these services across 5,500 square miles and five divisions – Belfast Division, Northern Division, South-Eastern Division, Southern Division and Western Division. NIAS dispatch vehicles from a range of 59 stations and deployment points across the region and our Trust headquarters are based in Knockbracken Healthcare Park, Belfast.

There are circa 1,400 staff employed by NIAS at any given time with 250 volunteer first responders and 100 voluntary car drivers also supporting service delivery. The table below provides a breakdown of the NIAS permanent workforce at 31st of March 2024:

Staff Group	Number of staff
ACA	237
EMT	273
Paramedics	433
Other	525
Total	1468

Within the service there are 116 frontline double crewed emergency ambulances, 43 rapid response cars and 115 non-emergency ambulance vehicles coordinated by one Emergency Control Room and one Non-Emergency Control Room. In addition, the NIAS Hazardous Area Response Team (HART) work with other emergency services to treat individuals and support the management of major incidents.

The NIAS Infection Prevention and Control (IPC) and Environmental and Vehicle Cleanliness (EVC) Teams are key contributors to the quality, safety and patient experience agenda of the organization. As set out in "Caring Today, Planning for Tomorrow- Our Strategy to Transform: 2020-2026", the NIAS as a whole and the IPC & EVC teams are committed to providing high quality, evidence-based services and consistently showing compassion, professionalism and respect to the patients that we care for. We do this by ensuring that:

- Our patients feel professionally cared for, always with compassion and respect
- Our staff will feel positive and proud to work for NIAS
- Our stakeholders and partners will have confidence in us as a reliable provider at the center of urgent and emergency care
- Our communities will continue to value and trust us.

The NIAS in line with other Health and Social Care providers across NI continue to face significant challenges and issues. These include the need to deliver safe, high quality care, improved response times and service modernisation in the context of a constrained financial environment. The Trust's frontline challenges are those that are also faced by ambulance services across the rest of the United Kingdom (UK) and the broader Health and Social Care Sector in Northern Ireland, as documented in the GIRFT review of Emergency Medicine In Northern Ireland (2024) and the Northern Ireland Audit Office review of Ambulance Handovers in Northern Ireland (2025).

Introduction

The purpose of this report is to provide a comprehensive overview of the IPC activity which has taken place in NIAS from 1st April 2024 to 31st March 2025.
It will demonstrate how NIAS has achieved compliance with the NI extant strategic regional action plan for the prevention and control of Health Care Associated Infections (HCAI) 'Changing the Culture' (2010).

The overarching strategic aim of 'Changing the Culture' is to eliminate the occurrence of preventable healthcare-associated infections in all health and social care settings, and promote, strengthen and maintain public confidence and understanding.
In addition, this report will present performance against the agreed Key Performance Indicators (KPIs) of NIAS which are used to provide assurance of, monitoring of and to promote improvements in IPC and EVC.

Organisational Structure

The IPC service within NIAS was formally commenced in November 2019 and sits within the newly formed Quality Service and Improvement Directorate (QSI) see organisational chart below:

Assurance and Governance

Robust processes are in place within NIAS in relation to IPC governance and assurance utilising the three lines of defence model and including first line -operational management, second line- corporate oversight and third line- independent assurance.

The following internal processes are in place to support the first and second lines:

- Undertaking of independent Hand Hygiene (HH), Personal Protective Equipment (PPE), Station and Vehicle Audits.
- Reporting of audit results and KPI performance through to NIAS IPC and EVC quarterly improvement group. IPC KPIs reported include HH, PPE, E-Learning and ANTT
- Reporting of audit results, improvements and KPI performance through to the NIAS Safety, Quality, Patient Experience and Committee (SQPE) quarterly
- KPI monitoring, action planning and improvement by the IPC team
- IAS framework monitoring and audit
- Reporting back any key learning, actions or achievements to the Learning and Development Outcomes group.

Additional process that are in place to strengthen governance and assurance include in relation to the third line:

1. Regulation and Quality Improvement Authority (RQIA) inspection and regulation
2. IPC Peer reviews with AACE colleagues.

Governance and assurance process within NIAS are additionally supported through the use of risk registers and appropriate risk reduction strategies, action plans and mitigations.

RQIA Inspection and Regulation

There were no unannounced or announced inspection by the regulator, RQIA, undertaken within NIAS during this period.

We continue to utilise the 'RQIA bespoke Ambulance Audit tool' to undertake 'mock' RQIA inspections. This process is utilised for general audit, for improvement and to support areas to know and understand the standards required and their roles/responsibilities in relation to this.

AACE Peer Review

The programme was developed and delivered through the NASIPCG and tasked an identified expert individual from one ambulance trust, to visit colleagues in another trust to undertake a standardised assessment of IPC. The assessment aspect of this looked at core competencies and CQC/ RQIA criteria. Any feedback from the reviewer was sent back to the host trust formally which will reflect areas of good practice and areas which could provide additional learning or review. This program of work has been paused since April 2024 due to service pressures in the UK Ambulance Sector.

Risk Register

All previous Corporate and QSI Directorate risks relating to COVID-19 response and IPC service development have been closed.

Risks 761 on the corporate risk register, rated as high risk, relates to operational capacity of the Hazard Area Response Team (HART). Risk 833, rated as medium risk, relates to the ability of NIAS to respond to a High Consequence Infectious Disease (HCID). Although these risks are outwith the IPC Team (IPCT), they do impact on how HCIDs are responded to by the service. The IPCT have worked with the Emergency Preparedness, Resilience and Response Team and across specific Incident Control structures (for example MPox, Clade 1) that have been stood up to operationally manage response to HCID, to support safe systems of work and to mitigate risk. Risk mitigate actions taken include direct provision of specific NIAS bespoke guidance documents that detail how to manage HCID within the operational context of NIAS and HSC, and extensive training of operational crews in relation to HCID Personal Protective Equipment (PPE).

Infection Prevention and Control Team

The IPC Team comprises of:
1 WTE Band 8A IPC Lead
1 WTE Band 7 Senior IPC Practitioner (post created October 2022)
1 WTE Band 6 IPC Practitioner (post created in 2020)
Service pressures have arisen in year as a result of absence.

The Team structure is as outlined below.

Post	Band	Date of Appointment	Incumbant
Director of Quality, Safety and Improvement and Director of Infection Prevention and Control (DIPC)	Director	2019	Ms Lynne Charlton
Assistant Director of Quality, Safety and Improvement and Deputy Director of Infection Prevention and Control (DDIPC)	Assistant Director	2022	Ms Ruth Finn
Infection Prevention and Control Lead	8A	April 2023	Ms Ruth Robb
Infection Prevention and Control Practitioner	7	October 2022	Ms Claire Fitzsimons
Infection Prevention and Control Practitioner	6	December 2020	Mr Paul McMillan

There will be some change in post holders in this incoming financial year as a staff member has recently left the service to pursue a promotional opportunity. This vacant post has been successfully appointed to, with a new staff member expected to join the team in August 2025.

Key Service Achievements IPC April 2024 to March 2025

The NIAS IPCT have worked during this period to ensure that the service delivered and the key achievements of the team were aligned to the NIAS 'Strategy to Transform (2020-2026) – Caring Today, Planning for Tomorrow'. Work streams were planned in relation to the 7 priority areas for transformation laid out in the strategy:

Areas for Transformation	What has been achieved by the IPCT
Delivering care IPCT have ensured delivery of a high quality, evidence based IPC service in line with agreed key performance indicators (KPIs)	• Development of, agreement of, monitoring of key performance indicators related to IPC. KPIs related to Hand Hygiene (HH), e-Learning and ANTT are subject to the above processes and are reported to NIAS IPC/ EVC Group, NIAS SQEP Committee and as appropriate to NIAS SMT and Trust Board • Development and cascade of a NIAS bespoke HH policy including the updated HH Audit Tool. • Development and cascade of a NIAS bespoke ANTT policy • Development of a monthly HH and PPE audit report for the organisation
Our workforce The IPCT has and will continue to develop an IPC workforce fit to deliver a high quality, evidence based IPC service for NIAS	• Support of the development of IPC Practitioners utilising professional development framework of Infection Prevention Society • Support of IPC practitioners to undertake role specific training and professional development by attending IPC Conferences, attending IPC webinars, undertaking Level 2 Quality Improvement, undertaking teaching qualifications and spending time with members of the MDT in other trusts relevant to the IPC role • Participated in a Peer review with members of AACE to ensure the best evidence based service is provided
Organisational development The IPCT have contributed to QSI Directorate development and the NIAS 'Strategy to Transform 2020-2026'	• The IPCT have advised on operational service delivery in respect of IPC related matters, for example management of patients with infectious organisms • Participating in development of directorate through attendance at team meetings, inputting into REAP Actions, inputting into developing business continuity plan for the directorate • Input into developing, maintaining and updating IPC risks for NIAS risk register (corporate and divisional) where appropriate (nil at present) • Input into NIAS Fleet Strategy in respect of IPC related matters • Support and input into monitoring framework development for PAS/ VAS/ IAS, development of and participation in unannounced audit programme for same • Support with and input into REAP 4 planning and actions • Undertaking and providing specialised advice in relation to audit and action planning • The IPC team have worked with National and Regional colleagues to ensure the best evidence based practice is in place and to raise the profile of NIAS IPC • The IPC team have liaised with Estates and Operational colleagues in the development of new building developments with NIAS.

Quality improvement IPCT have begun to build QI capacity within own service and are utilising QI methodology when undertaking service improvement projects	• Band 6 IPC Practitioner has undertaken Process Mapping training and plans in place for Band 7 Senior IPC Practitioner to complete same when they join the service • IPC Practitioner and Senior IPC Practitioner have undertaken level 2 SQE training programme • IPCT members have been supported with QI Mentorship for SQE projects as required • The IPCT have secured funding from the Infection Prevention Society for a QI project in relation to Bare Below the Elbow (BBE) • The IPCT have inputted into Contract Awards for FFP3 masks, Hand Hygiene Consumables, Gloves and Face Shields • The IPCT Launched a new IPC resource in November 2023 to allow staff easy access to IPC advice and information regarding Health Care Associated Infections. The project was presented at the 2024 UK IPS conference to raise the profile of NIAS at a national level. • The IPCT have supported with the review and implementation of new IT devices including the Toughbook to aid operational staff.
Digital enablers The IPCT has developed the NIAS IPCservice offer by utilising digital enablers	• All members of the IPCT have been given access to IT equipment such as tablets, laptops, Citrix fobs, smart phones to promote flexible and mobile working and efficient service delivery • The IPCT have worked with EVC and key stakeholders to purchase, build and embed a new electronic audit system - including the set up and training of key staff throughout the organisation.
Our infrastructure IPCT will ensure that the team is properly constituted, adequately funded and has appropriate governance arrangements in place	• The NIAS IPCT have been allocated permanent suitable office accommodation which meets all of its needs • The IPCT has source and procured all required resources for training such as glo –torches, pop-up signage, supplies of consumables • All IPCT team members have annual PDP and 1:1 meetings with line manager • The IPCT has developed a clear annual work plan and associated SMART objectives and actions • The NIAS IPCT has put in place all the resources it requires at present to deliver service. • There is an IPC/ EVC Group and an identified committee for governance and assurance.

Communication and engagement IPC has increased awareness of, profile of and access to IPCT	• The IPCT take a lead role in organising and participate in Divisional EVC and IPC meetings • The IPCT present KPI data and assessment of same to NIAS SQPE committee • The IPCT have utilised many different media channels within NIAS to communicate with staff such as What's App, Share point, Email and MDT • The NIAS IPCT have developed and cascade a bespoke monthly report for HH and PPE • The NIAS IPCT have developed a Newsletter for NIAS in relation to IPC 'IPC Matters', from April 2024 to March 2025, 12 different newsletters in relation to current IPC alerts and concerns have been issued • Each year in May the IPCT deliver a week of engagement in relation to hand hygiene for World HH day • The NIAS IPCT team have delivered face to face training and this is currently being reviewed to enable more face to face training to be undertaken • The IPC team have worked with Continuing Clinical Education Team to update AAP and ACA training in line with guidance • The IPCT are a core and active member of the AACE National Ambulance Sector IPC group • The NIAS IPC team have been involved in Regional Infection Prevention Society meetings and conference planning to raise NIAS IPC profile and to promote NIAS achievements • The NIAS IPC Lead is the current chair of the Regional IPC Lead Group, an influential group of Senior NI IPC leaders who influence NI IPC strategic direction and policy.


HSC
AMBULANCE

Audit and Monitoring

The IPCT are responsible for undertaking independent audit of hand hygiene (HH) the use of Personal Protective Equipment (PPE) and RQIA style inspections related to IPC and EVC.

A digital auditing system has been employed by NIAS for some years, in April 2024 the contract for the system was reviewed. After a period of consultation with all users a new system, MEG, was selected. The transition to MEG required a period of product build where the structure of stations, divisions, staff and vehicles was created to provide a reporting structure. Each individual audit was built and tested before it could be released. There was a significant training requirement which were provide initially by the company but then revert to the responsibility of the NIAS IPC/ EVC team for same.

All IPC audits are reported firstly to the station officers and area managers as appropriate. This sharing has two functions, firstly to provide service managers with an understanding of performance and secondly to provide information to support them to drive improvement. We advise station officers to share these with staff and include discussion of them in routine divisional meetings. Results are shared and discussed at the IPC/EVC group and the Safety, Quality and Patient Experience Committee (SQPE).

During year 2024-2025 auditing by the IPC team was paused in November, December and January 2025 as Mpox preparedness and training in relation to Personal Protective Equipment (PPE) had to be prioritised.

Audit performance is outlined in the following sections.

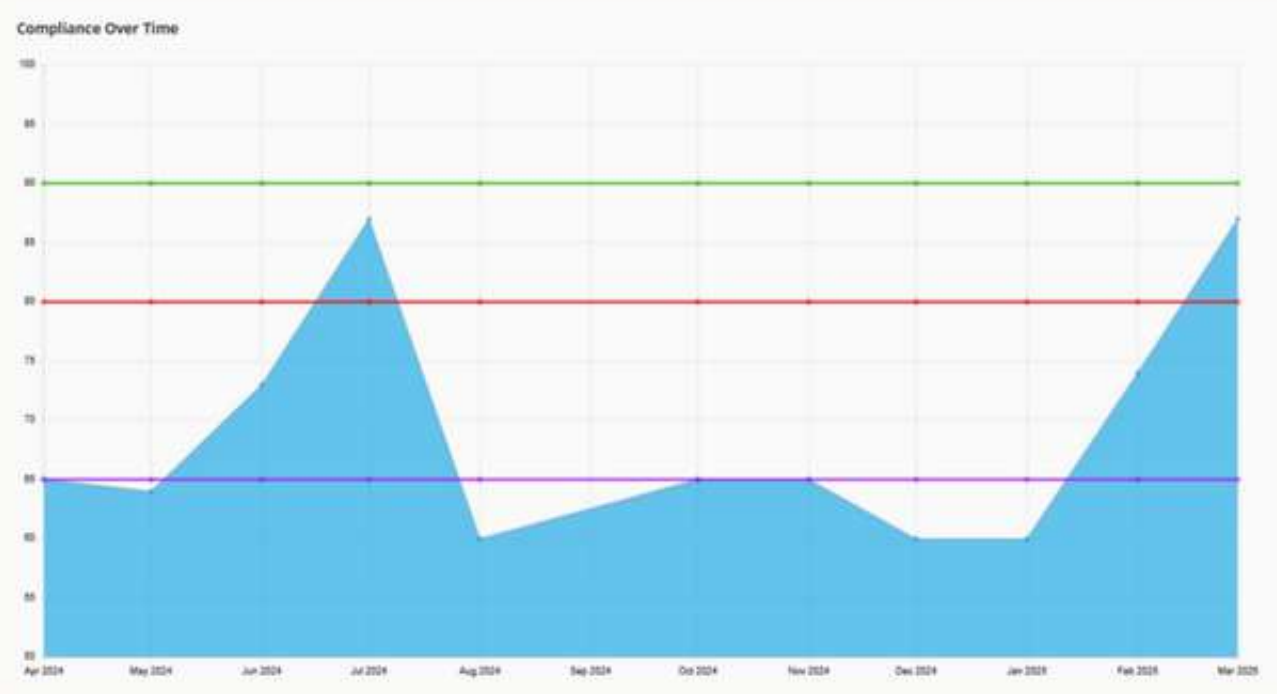
Hand Hygiene

Hand hygiene (HH) auditing is carried out monthly by the IPCT at 6 major Emergency Departments (EDs) within NI, with the KPI set at 90% compliance.

Operational NIAS staff are audited against the standards of the NIAS 'Hand Hygiene Policy', the World Health Organisation (WHO) '5 Moments of Hand Hygiene' (2009) and the '7 Step Technique'. This 'on the ground' engagement is an excellent opportunity for the IPCT to be highly visible to support and advise operational staff on any HH related queries they may have and to build good and effective working partnerships.

It is important to acknowledge that ED performance levels do not just represent the performance of crews from the Division that the ED is located in as crews from other Divisions may frequent various EDs, for example crews from North Division may convey to the Mater Hospital, from South East may convey to the RVH and vice versa.

The following graph (SPC with upper control, lower control and median lines) shows the Trust average for HH compliance between 1st April 2024 to 31st March 2025. The target is 90%.



The table below breaks this data down by ED and by audit question:

	Overall Compliance	Altnagelvin Hospital ED - NIAS - Emergency Department ^	Antrim Area Hospital ED - NIAS - Emergency Department ^	Craigavon Area Hospital ED - NIAS - Emergency Department ^	Royal Victoria Hospital ED - NIAS - Emergency Department ^	South West Regional Acute Hospital ED - NIAS - Emergency Department ^	Ulster Hospital Dundonal ED - NIAS - Emergency Department ^
	Overall Compliance	Altnagelvin Hospital ED	Antrim Area Hospital ED	Craigavon Area Hospital ED	Royal Victoria Hospital ED	South West Regional Acute Hospital ED	Ulster Hospital Dundonal ED
Overall Compliance	83.7% (1449/1728)	77.5% (217/280)	83.4% (267/320)	88.6% (248/280)	84.4% (341/404)	86.6% (142/164)	80.7% (226/280)
Was the opportunity for HH taken?	92.6% (400/432)	85.7% (60/70)	93.8% (75/80)	94.3% (66/70)	92.1% (93/101)	92.7% (38/41)	97.1% (68/70)
Was Seven Step Technique undertaken?	92.6% (400/432)	85.7% (60/70)	92.5% (74/80)	95.7% (67/70)	92.1% (93/101)	92.7% (38/41)	97.1% (68/70)
Was staff member bare below the elbow when undertaking hand hygiene?	76.4% (330/432)	71.4% (50/70)	75.0% (60/80)	84.3% (59/70)	79.2% (80/101)	87.8% (36/41)	64.3% (45/70)
Is this a compliant observation?	73.1% (316/432)	67.1% (46/70)	72.5% (58/80)	82.9% (58/70)	74.3% (75/101)	85.4% (35/41)	64.3% (45/70)

The audit demonstrates that staff often carry out HH with good practice noted in relation to HH technique when it is undertaken, however staff are often not “Bare below the elbow (BBE)” resulting in a non-compliance.

Wrist watches are the most commonly seen cause of non- compliance with BBE followed by false nails or gel nails being worn.

The HH audit results are often affected by the overuse of gloves which can lead to missed moments of HH.

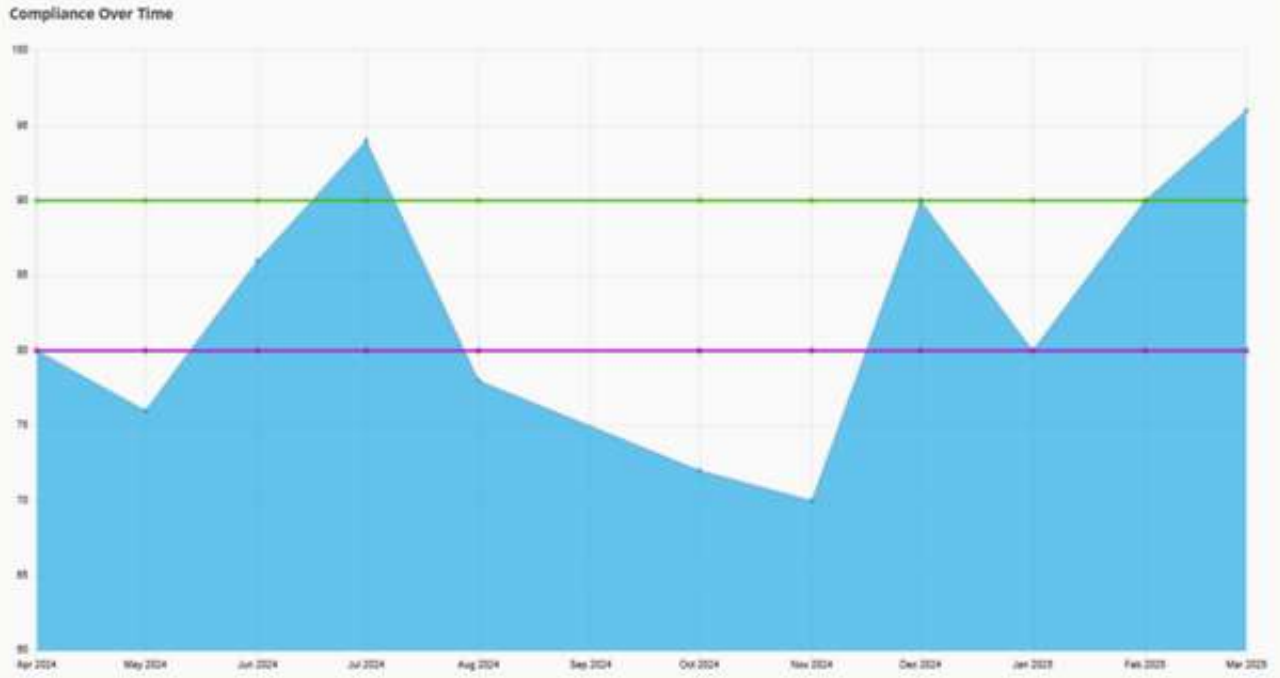
A number of actions have been taken by the IPCT and the IPC and EVC Group to date in relation to HH audits including:

- Face to face engagement with staff at EDs around identified issues, with respectful challenge and education by the IPCT
- Provision of staff member details to Area Managers where non-compliance was observed for identification of trends and addressing of same where issues arise
- NIAS bespoke HH leaflet developed and shared with staff
- Circulation of AACE statements and resources to staff regarding BBE and the development of a BBE QI project
- Circulation of HH newsletter and HH policy to staff.
- On-going education with staff at all levels, including students, and the promotion of World Hand Hygiene day at the main ED sites
- Training sessions held with CSOs from each division covering expectations of compliance for HH, PPE and ANTT
- HH for managers training sessions held over teams throughout May 2024.

Personal Protective Equipment (PPE)

Operational staff are audited on whether they are wearing the appropriate PPE with the KPI set at 90% compliance.

The following graphs show the Trust average for compliance between 1st April 2024 to 31st March 2025.



The table below demonstrates the audit results broken down by ED. There have been times where it has not been possible to complete a PPE audit as staff observed were not utilising PPE at the time of the audit (appropriately), this is most common in the West division.

Audit Score

	April 2024		May 2024		June 2024		July 2024		August 2024		October 2024		November 2024		December 2024		January 2025		February
Location	Compliance	Count	Compliance	Count	Compliance	Count	Compliance	Count	Compliance	Count	Compliance	Count	Compliance	Count	Compliance	Count	Compliance	Count	Compli
Altnagelvin Hospital ED	100.0%	1	60.0%	10	90.0%	10	-	0	60.0%	10	-	0	80.0%	10	90.0%	1	-	0	100.0%
Antrim Area Hospital ED	80.0%	1	70.0%	10	80.0%	10	100.0%	10	80.0%	10	50.0%	10	60.0%	10	-	0	-	0	100.0%
Craigavon Area Hospital ED	90.0%	1	80.0%	10	100.0%	10	100.0%	10	-	0	80.0%	10	-	0	-	0	-	0	90.0%
Royal Victoria Hospital ED	70.0%	1	80.0%	20	70.0%	10	85.0%	20	80.0%	10	60.0%	10	-	0	-	0	80.0%	10	80.0%
South West Regional Acute Hospital ED	70.0%	1	80.0%	10	-	0	100.0%	2	-	0	-	0	-	0	-	0	-	0	-
Ulster Hospital Dundonal ED	70.0%	1	80.0%	10	90.0%	10	100.0%	10	90.0%	10	100.0%	10	-	0	-	0	-	0	80.0%
Average Score	80.0%	6	75.0%	70	86.0%	50	97.0%	52	77.5%	40	72.5%	40	70.0%	20	90.0%	1	80.0%	10	90.0%

Compliance with PPE is closer to the KPI of 90% than HH. The most used item of PPE is gloves, often with staff wearing gloves with every patient, (not seen as commonly in the West Division). This overuse of gloves can lead to missed moments of HH where gloves are donned to early or removed too late which also affects the HH audit results.

A number of actions have been taken by the IPCT and the IPC and EVC Group to date in relation to PPE audits including (there is cross over with the actions in relation to HH)

- Face to face engagement with staff at EDs around identified issues, with respectful challenge and education by the IPCT
- Provision of staff member details to Area Manager where non-compliance was observed for identification of trends and addressing of same where issues arise
- Encouraging staff to risk assess PPE and providing communications surrounding transmission based precautions
- Completion of a glove improvement Quality Improvement project at UHD
- Circulation of PPE/glove newsletter
- Training sessions held with CSOs from each division covering expectations of compliance for HH, PPE and ANTT.

RQIA style environmental cleanliness auditing

All RQIA style audits carried out by the IPC team are unannounced. The station environment, vehicle cleanliness and staff knowledge are reviewed. An audit is considered compliant if it achieved an overall score of 85% and above. Scores of 76%-84% are considered partially compliant while scores under 75% are non-compliant.

In this reporting period the IPC team completed 1 RQIA style environmental audit in Ballymena station, which was compliant. It was noted that it was difficult to be able to ask the 'staff question' set to staff as they were not available due to call attendance.
The complexity and length of the RQIA style audit was particularly challenging to build into the MEG system, which resulted in the delay of returning to this work stream. In 2025-2026 the team plan to return to completing this in 1 station per month.


AMBULANCE
18

Training and Education

IPC mandatory E- Learning

IPC mandatory training is provided through the Leaning Management System (LMS) using the NI regional training package. Two levels of training are available:

- Tier 1: for staff who do not provide patient care
- Tier 2: for staff who do provide patient care

Additionally, ANTT E-Learning is provided for all clinical staff who undertake ANTT procedures (e.g. venepuncture, cannulation, wound dressings)

For example, an office based 'Personal Assistant' would undertake Tier 1. All patient facing staff (regardless of role, ACA, paramedic etc.) would undertake Tier 2. Those patient facing staff who undertake ANTT procedures such as canulation, or wound dressing will also complete ANTT E-Learning.

The table below demonstrates performance in relation to this for this reporting period (figures provided by the Learning and development team).

Course	No. of staff certified	Overall staff percentage
IPC Level 1 Training (mandatory)	125	52%
IPC Level 2 Training (mandatory)	113	7.3%
ANTT (Antiseptic Non-Touch Technique)	161	10%

Uptake of IPC mandatory training is poor. Unfortunately, while IPC training is mandatory to complete every 3 years it was not included in the core 10 activities identified for Trust focus in year, this has been addressed and it has been requested and agreed that risk be an active consideration when prioritising training going forward. While the IPC team encourage and advise all staff to complete this, front-line staff often struggle to find the time in which to complete this.

The regional learning package is currently under review by the IPC Lead Nurse Forum, the updated version is expected to be available in the summer of 2025. The NIAS IPC team have been working with this group to ensure the package reflects the needs of the ambulance service.

Other IPC training education

The IPC team continued to provide non-mandatory training in this reporting period and the team delivered education to 673 NIAS staff members. The main areas of training delivery have been full training days for AAP course and induction courses for paramedics who have transferred from other trusts, CSOs and new station officers.

The IPCT committed to providing weekly Mpox update / PPE training sessions as part of the trust preparedness planning for this HCID (now derogated as a HCID).

This year additional focus was placed on HH, PPE and ANTT with bespoke educational sessions held for line managers highlighting their roles and responsibilities in management and improvement of this.

The team also provided training to CSOs in all divisions to support them when undertaking observational shifts with front line staff. This training included each CSO completing their ANTT assessor training so they could carry out these assessments as part of their role. The team were able to work with the CCE Team to build ANTT assessments into the NQP, AAP and ACA courses meaning these staff were able to go into the workforce fully compliant with all IPC training. This will also negate the need for further training for these staff cohorts for 2 years.

This year the team were included in the University of Ulster second years Paramedic course providing an IPC update on HH, PPE and ANTT in preparation for them going on placement. This is flet to be a very positive addition to our training calendar as it helps to develop relationships with students and potential employees at an early point in their career journey. It helps us to share the message about the culture of IPC in the organisation and helps to share the standards required and the behaviours expected. It also serves to connect to ensure that the IPCT are connected into the education system and encourages the team to ensure that they are working from a place of knowledge of best practice, new developments and innovation.

A breakdown of the main training courses provided is outlined below:

Course	No. of attendees
Hand Hygiene for Managers	34
RRV day	21
AAP days	19
CSO update including ANTT assessor training	28
IPC update for 2nd year paramedic students	50
NQP induction	51
VCS	21
NQP ANTT assessments	48
ACA days	44
ERPP days (Mpox updates)	223
Station Officer Induction	6

The team again provided informal education for World Hand Hygiene Day 2024, engaging with staff at ED and providing some educational materials. The follow photographs demonstrate some of the staff engagement undertaken by the team. The team recognise the importance of sugary snacks to our operational staff and went to extreme lengths with the IPC compliant cupcakes!

Incidents, outbreaks, and management of organisms

An outbreak is defined as two or more cases of an infection or alert organism linked by time and place. An outbreak in a station or in a control room can be devastating to service provision so it is vital that every suspected outbreak is carefully risk assessed and appropriate measures put in place to prevent further transmission. In this reporting period there were 0 outbreaks declared.

During this period the IPC provided advice or contact tracing on the following organisms (suspected and confirmed):

Organisms	
Invasive Group A Streptococcus (iGAS)	14
Measles	3
Meningitis	6
Tuberculosis	5
Pertussis	3
Varicella Zoster (chickenpox or shingles)	2

Each of these cases requires the team to review the patient information and locate the crew or crews involved in the patient's care. An assessment of the level of risk or exposure will be carried out and if required staff are referred to Occupational Health team for further support and follow up. The key challenge for the IPCT is access to information in a timely way as some of these organisms require to actioned very quickly to mitigate risk. The team have been working across all levels of the organization and have developed systems and process to support timely access to information. The team ensure that any learning from outbreaks or incidents is shared with relevant teams within the organization and across HSC where intertrust / interface incidents occur.

Quality Improvement Projects

This year the team were able to share learning from QI work undertaken, on a national stage at the 2024 Infection Prevention Society (IPS) Conference, with two projects accepted for poster submission, one of which was also selected for a poster talk. These Quality Improvement projects were carried out in 2023/4 one on the creation of the IPC Resource and the other the Glove reduction project. This was an achievement which the team was very proud of and going forward hope to continue to showcase learning from the Ambulance Service across all IPC fora.

The team successfully applied for funding from the UK Infection Prevention Society (IPS) for a further innovative QI project to be undertaken in 2025/6, focusing on improving compliance with BBE.

Preparedness Work

In this reporting period the team supported the organization in preparedness work for new and emerging threats. In response to a large and sustained outbreak of Measles in England NIAS joined the other local HSC and national Ambulance Service Trusts to ensure that it was prepared to recognize and manage cases of Measles among the general population, patients and potentially among staff members.

Actions included:

- A Measles preparedness group was formed in February 2024.
- There was engagement across all level of NIAS Operational Management in relation to this.
- The IPC team continue to liaise with Regional colleagues regarding Measles cases.
- Education sessions were planned for NIAS staff over Teams on 3 occasions.
- Newsletters and guidance sent out via daily bulletin and circulated to all staff.
- The IPC resource has a section dedicated to Measles.
- PPE supply confirmed.
- Assistance and advice given to the team who are responsible for Fit testing.
- The IPC team (2 staff members) have participated in an on-call rota to provide out of hours support over the weekend and during bank holidays which ceased in July 2024 (on the basis of assessment of need). 0 calls were taken during this on call period.
- Resources were created to support staff in the event of a positive case.
- Liaised with OH and HR to encourage staff to participate in a mop of vaccination programme.
- Reviewed NIAS risk where positive cases identified.
- The measles preparation IMT has now been stood down as the number of new cases nationally has abated.

IIn August 2024 the World Health Organization (WHO) declared a situation of internal concern regarding Clade 1 Mpox as cases had been reported in countries outside of Africa. Clade 1 Mpox was initially considered a High Consequence Infectious Disease (HCID) before this derogated in March 2025.

Actions taken to prepare included:

- NIAS Incident Management Team (IMT) established in August 2024
- Attended a regional tabletop exercise arranged and chaired by the PHA in January.
- Developed resources for staff including new PPE donning and Doffing posters.
- Guidance document for frontline staff developed and circulated based on the AACE Guidance on MPox.
- IPC team provided weekly Mpox awareness session at the EPRR days.
- Trust risk assessment in relation to HCID and Mpox developed.
- Supported the fit testing service.
- PPE stock levels reviewed.
- NIAS are now working in partnership with HSC, Dept of Health and the Public Health Agency to ensure that this is effectively planned for across NIAS and NI. It is noted that preparedness for HCID is cross cutting across a number of Directorates within NIAS and thus preparedness is being addressed through a cross Directorate IMT. Additionally, there is an impact in terms of Emergency Planning, Preparedness and Resilience (EPPR) through the Hazard Area Response Area Team (HART) and it is recognised that there is ongoing regional work with the Dept. of Health in relation to HART capacity.

While Clade 1 Mpox was derogated and no longer considered a HCID the IPC team will continue to work with HART and the wider MDT to ensure NIAS has an adequate HCID response.

Conclusion

2024/5 proved to be another challenging year for NIAS Operationally with most of the year spent in REAP 3 and 4. The IPC service worked hard to keep themselves up to date with changes to policy and guidelines and ensured these were considered and shared with organization and staff. This year has demonstrated that despite the continued pressure on the system there is a continued need to prepare for future IPC concerns in the form of HCID and to ensure that fundamental IPC practices are embedded into every day practice.

References:

GIRFT (2024) - Getting It Right First Time Review (GIRFT) of Emergency Medicine in Northern Ireland | Department of Health

NIAO (2025) -Ambulance Handovers in Northern Ireland | Northern Ireland Audit Office

Northern Ireland Ambulance Service
Health and Social Care Trust

TRUST BOARD

PRESENTATION OF PAPER

Date of Trust Board:	28 August 2025
Title of paper:	Board Assurance Framework
Brief summary:	The Board Assurance Framework (BAF) is presented at Trust Board, further to its consideration at GARAC. A series of recommendations are made to strengthen internal controls and assurance on pages 5 to 7, with a progress update. Following feedback from GARAC, the assurance rating and risk score for Strategic 6 have been changed to "Limited" and "High" respectively.
Recommendation:	**For Approval** ☒ **For Noting** ☐
Previous forum:	SMT – 19 August 2025 GARAC – 24 June 2025
Prepared and presented by: **Date:**	Seamus Mullen, Interim Director of Planning, Performance and Corporate Services 20 August 2025

Version 1.0: August 2025

Northern Ireland Ambulance Service Health and Social Care Trust

Board Assurance Framework

Overview

The Board Assurance Framework (BAF) forms part of the Trust's corporate governance system and allows the Board to maintain oversight of the principal risks to delivery of the Trust's strategic objectives.

The BAF:

1. Identifies the strategic risks which might threaten NIAS's priorities.
2. Summarises the controls which are in place to mitigate the strategic risks.
3. Assesses the effectiveness of the controls and the quality of assurance which is currently available to Trust Board.

Benefits of the BAF

The BAF is designed to support decision-making and prioritisation by the Senior Management Team (SMT) and Trust Board by bringing together in one place all the relevant information on the strategic risks to the organisation's objectives.

Specific benefits include:

- Providing a comprehensive overview of the extant controls and sources of available assurance, and an assessment as to whether they are sufficient and effective.
- Identifying areas where controls and assurance could be strengthened.
- Identifying areas where assurance is duplicated and/or is disproportionate to the level of risk; and
- Providing an evidence base to assist the organisation in the preparation of its annual governance statement.

Development of the BAF

Following Trust Board's October 2024 workshop, the risk and governance team has engaged with all Directorates at NIAS to map out the key management controls which they have in place to support delivery of their core functions.

This information, alongside benchmarking of BAFs used elsewhere in HSC, the NHS and other ambulance services, has been used to inform the development of NIAS's BAF.

Strategic vs. Corporate Risks

The BAF is orientated to the strategic risks facing the organisation. While there is some overlap between strategic risks and risks on the corporate risk register, they are distinct in that:

- **Strategic Risks** are those that might threaten an organisation's desired objectives and are often, but not always, outside of the organisation's direct control and/or influence.

- **Risks on the Corporate Risk Register** are the most potentially serious operational risks that might threaten the Trust's day-to-day activities and service delivery.

Three Lines Model

The three lines model is a framework which defines sources of assurance which are available to an organisation:

- **1st Line Assurance** is derived from activities carried out at a departmental or service level. This could range from management meetings, data analysis and implementation of standard operating procedures to carrying out internal audits or spot checks.

- **2nd Line Assurance** is provided by internal functions which have a degree of independence from frontline services such as Board/Committee oversight, Health & Safety, Infection Prevention and Control and corporate risk management. It may also be derived from specific accountability and reporting mechanisms commissioned by senior management.

- **3rd Line Assurance** comes from sources external to the organisation. This might include Internal Audit reports or inspections by regulatory bodies, such as the Regulation and Quality Improvement Authority or the Northern Ireland Audit Office.

BAF Structure

The strategic risks to NIAS's 2024-26 strategic objectives are set out below. For each strategic risk, the BAF presents key information including:

- Initial, Current and Target scoring using the HSC Regional Matrix. The Target score is derived from the Trust's Risk Appetite Statement as set out in the Risk Management Policy.

- Relevant operational risks on the Corporate Risk Register or Directorate risk registers are cross-referenced.

- In-year commitments to support delivery of the strategic objective.
- A summary of controls currently in place at NIAS to mitigate the risk.
- The sources of available assurance across 1st, 2nd and 3rd lines.
- Gaps in the existing controls and available assurance are highlighted.
- An aggregated assessment of current assurance using the following framework:

NONE	There is no available assurance about the effectiveness of existing controls. **Urgent action is required** to strengthen controls and assurance mechanisms.
LIMITED	The available assurance provides only a low-level of confidence about the effectiveness of the controls. Actions **are required** to strengthen controls and assurance.
ADEQUATE	The available assurance provides a moderate level of confidence about the effectiveness of the controls. Actions **should be** taken to strengthen controls and assurance.
SUBSTANTIAL	The available assurance provides a good degree of confidence about the effectiveness of the controls.

How the BAF will be reviewed

As a formal governance document, the BAF will be reviewed regularly by SMT. This review will consider:

- Any changes in the operating environment that might impact on the likelihood or impact of the strategic risks;
- A review of existing controls and assurance mechanisms to identify if they are still in place and remain fit for purpose; and
- Updates of any actions to address gaps in controls or assurance.

Due to its cross-cutting nature, the BAF will be reviewed regularly by Trust Board and its Committees, with any key highlights drawn out related to each Committee's remit, alongside the relevant risks on the Corporate Risk Register.

BAF SUMMARY DASHBOARD	Assurance Rating	Risk Score
Strategic Risk 1: We fail to provide safe and compassionate care for our patients on all occasions.	ADEQUATE	MEDIUM
Strategic Risk 2: We do not provide a timely and effective response to service users.	LIMITED	HIGH
Strategic Risk 3: We fail to transform how we deliver services to meet patient need across all care settings.	LIMITED	HIGH
Strategic Risk 4: We are unable to recruit and retain the people we need to deliver our services and strategic priorities.	ADEQUATE	MEDIUM
Strategic Risk 5: Our staff do not feel safe, supported or engaged in the workplace.	LIMITED	HIGH
Strategic Risk 6: We are unable to respond appropriately to unexpected events and external threats.	LIMITED	HIGH
Strategic Risk 7: Our critical infrastructure – estates, fleet and ICT- does not support effective operations and delivery of high-quality, safe care.	LIMITED	MEDIUM
Strategic Risk 8: We fail to manage our finances effectively within our annual budget allocation.	SUBSTANTIAL	MEDIUM

	RECOMMENDATIONS TO STRENGTHEN CONTROLS AND ASSURANCE (1 of 3)	Priority	Update August 2025
Governance Structure	**1.** Several management groups should be established at 1st line level to ensure that key areas of activity are being monitored effectively, focussing on: • Cyber Security and Information Governance management and performance. • Vehicle and Driving Management Group: to oversee NIAS's vehicle fleet and driving activity. • Estates Management Group: Management and maintenance of the Trust's estate to include review of health and safety, fire, security and other accommodation issues. • Performance Management Group: to monitor operational performance, highlight areas of escalation to SMT/Trust Board, identify and monitor impact of improvement work. • Strategic Workforce Group: focussing on, for example, workforce planning and expansion, training, recruitment processes and policy development, staff well-being initiatives. • Strategy Delivery Group: Implementation and progress against the Trust's corporate priorities. • Digital Priorities: management of critical digital enabling technologies and appraisal of potential new systems/projects to ensure they align with NIAS's strategic objectives. It is recommended that these groups meet quarterly and that the frequency of the AD Forum, which currently meets weekly, should be significantly reduced to release capacity to form and establish these management groups.	HIGH	• Digital Priorities Group has had first meeting. • Cyber Security/IG Group planned for September. • Discussions with Estates about standing up Estates Management Group in October.
	2. The groups noted above, and other management groups, should be supported with a model Terms of Reference and agenda and a Governance Highlight Report template which will be sent to SMT after each meeting. Each group should specify standing items which should include monitoring of KPIs and relevant mandatory training and review of policies within its remit.	MEDIUM	• Model ToRs, Agenda and Reporting templated disseminated to Assistant Directors.
	3. A mechanism should be put in place to ensure that key organisational documents including policies and procedures are reviewed and updated regularly, aligned with national standards and regulatory requirements and are easily accessible for staff.	HIGH	• Digital platforms being trialled by multi-professional group.
	4. The frequency of meetings and attendance, e.g., in respect of programme/project management, should be reviewed to ensure that they are proportionate and value-adding. Teams should be encouraged to review their current meeting structure to identify where meetings and/or attendance of personnel could be rationalised or improved.	MEDIUM	• Model ToRs suggests representative from each Directorate, as opposed multiple attendees.

	RECOMMENDATIONS TO STRENGTHEN CONTROLS AND ASSURANCE (2 of 3)	Priority	Update August 2025
Safety	**5.** Plans should be put in place to significantly strengthen the clinical audit capacity in the Trust, with a view to establishing key parameters that will be routinely captured and reported on to SMT and to Trust Board/Committees.	HIGH	• Discussed with Deputy Clinical Director – added to Directorate Risk Register.
	6. NIAS should review the clinical KPIs, and outcome measures reported on by other ambulance services and develop a roadmap to replicate this reporting and analysis locally.	HIGH	• Action to be taken forward by Clinical Governance Group.
	7. The Trust should benchmark its ability to abstract operational staff to undertake refresher training in clinical and core skills and should work towards delivering the same level of refresher training as peer Trusts. Where possible, release of staff to undertake statutory and mandatory training, should be prioritised.	HIGH	• Incorporated as part of ORH benchmarking. • Business plan for release of staff to undertake refresher moving people/CRT training in development.
	8. Steps should be taken to ensure that adverse incidents, which do not meet the threshold of an SAI, are regularly reviewed and analysed for learning, and are reported to relevant management groups.	MEDIUM	• Quarterly adverse incident theming report developed and presented at LORG.
	9. A process should be put in place to capture learning arising from major/critical incident debriefs and to ensure that this is disseminated across the organisation.	MEDIUM	• Process discussed and agreed with EPRR.
Performance	**10.** Performance reports which are sent to SMT and Trust Board/Committees should be reviewed, and expanded, to ensure that key metrics captured at 1st line, e.g., call answer KPIs and PCS performance, are reviewed at 2nd line level.	MEDIUM	• No update.
	11. SMT should strengthen its oversight and its accountability mechanisms for operational and organisational performance by, for example, having dedicated meetings focussing on performance across the patient pathway or undertaking "deep dives" on specific aspects of performance.	HIGH	• No update.

	RECOMMENDATIONS TO STRENGTHEN CONTROLS AND ASSURANCE (3 of 3)	Priority	Update August 2025
Accountability Processes	**12.** The agenda of the Directorate Accountability Meetings, which take place three times a year, should be broadened to include outstanding responses to safety alerts, compliance with mandatory training, outstanding SAI/complaint recommendations and policies/procedures overdue for review.	LOW	• Agenda of Accountability Meetings amended to include these items.
	13. Mechanisms to enhance accountability reporting at Divisional level and to escalate barriers to performance should be explored.	MEDIUM	• No update.
	14. The procedure for responding to Assembly Questions and Departmental returns should be reviewed and updated.	LOW	• No update.
	15. Where the Trust is required to provide a self-return to the Department or other body in respect of implementing substantive recommendations or service changes, SMT should consider the option of seeking independent assurance, either internally or externally from peers, on its compliance.	LOW	• No update.

Strategic Risk 1: We fail to provide safe and compassionate care for our patients on all occasions.

Risk Appetite	**Averse**	**Strategic Objective(s)**	We will identify the most appropriate clinical response for our patients.
Risk Score		**2025-26 Commitments**	Deliver refocussed clinical supervision
Initial	**High**		
Current	**Medium**	**Linked Corporate and Directorate risks**	816: Hospital Handovers; 531: Oversight of Independent Sector; 727: Response to Mental Health Calls; 830: Delayed response because of Late Finishes; 712: Medicines Management.
Target	**Low**		

Gaps in Controls	Gaps in Assurance
• Limited clinical audit and reporting capacity. Range of indicators not assessed routinely e.g., accuracy and completion of NEWS, Pain Score. • Limited ability to abstract operational staff to undertake clinical training to maintain skills and knowledge. • Extant policies and procedures not routinely updated – some key documents significantly beyond review date. • Lack of process to oversee and monitor policy/procedure review. • Policies/procedures difficult to access. • Lack of Divisional accountability and performance management structure.	• Limited reporting and tracking of adverse incidents which are not SAIs. • Limited reporting from 1st line management groups e.g. medical devices group, UCOG upwards to SMT/Board Committee. • Mandatory training not reviewed, or performance managed, regularly at 1st line groups. • QI activity is not routinely reported at 1st or 2nd line level and gap in alignment between QI work and strategic and clinical priorities. • Lack of mechanism to track responses to safety alerts issued by the DOH and other regulators. • Progress against SAI recommendations not routinely reported to SMT.

Controls and Assurances

Controls [systems to manage impact/likelihood of risk]	Available Assurance [evidence that controls are effective]		
For Strategic Risk 1: We fail to provide safe and compassionate care for our patients on all occasions	**First Line** [Service-level/day-day management]	**Second Line** [Internal oversight]	**Third Line** [Independent challenge]

• Clinical education and training for frontline staff including annual CCE days.
• BSc Hons. Degree at UU for NQPs.
• EMD training and sign-off process for call handling.
• Mandatory training in IPC, ANTT, Safeguarding and QI.
• Integrated Care Hub: SOPs and guidelines for management of calls; training for ICH clinicians in Manchester Triage System.
• Policies for appropriate management of patients via Hear and Treat/See and Treat.
• JRCALC clinical practice guidelines available to all operational staff via app.
• Policies for the reporting and management of adverse incidents, SAIs and complaints.
• Inter-trust adverse incidents reported by other HSC Trusts.
• Medical devices deployed as per Trust Policy.
• IPC quality assurance framework.
• IPC policies and procedures including hand hygiene, PPE and environmental cleanliness.
• EVC team clean vehicles as per schedule.
• QI initiatives and projects.
• Complaints policy and procedure.
• Learning Outcomes Review Group meets quarterly to share learning arising from incidents, complaints etc.
	• SAI, complaints, adverse incident data and IPC performance cascaded through Operations management structure.
	• High risk incidents, complaints and query SAIs reviewed weekly at RRG.
	• Clinical supervision: frontline staff have 2 x clinically supervised shifts per year.
	• ICH clinicians have 2 calls peer reviewed on monthly basis: supported by BI dashboard.
	• Monthly DRC meeting to review appropriateness of call management.
	• 3% of all EOC call volume audited.
	• Additional clinical/call handling training for staff as required.
	• Professional Standards monthly meeting.
	• Monthly Urgent Care Oversight Group monitors H&T/S&T.
	• Monthly medical devices group monitors incidents, training etc.
		• Notified SAIs and complaints reported to SMT.
		• PEQS Committee receives reports on complaints and SAIs.
		• Patient feedback reported to SMT and PEQS.
		• Clinical education activity reported to PEQS.
		• IPC and EVC KPIs reported to SMT and PEQS.
		• Care Opinion reports weekly to SMT.
		• QI activity reported to PEQS.
		• IAS framework and assurance reported to PEQS.
		• Medicines management reported to PEQS.
		• Annual Quality Report published.
			• SAIs notified to SPPG and monitored.
			• Potential review/inspection from RQIA.
			• Internal Audit Reports:
			  • Clinical Governance (21/22) – Limited
			  • Patient Pathways (23/24) – Limited
			  • Risk Management (24/25) – Satisfactory
			  • Complaints and SAIs (24/25) – Satisfactory
			  • Management of Medical Devices (21/22) – Limited

• Framework contract for IAS providers. • Medicines management policies and procedures. • Safety, medical device and other alerts received from statutory/regulatory partners. • MOU with NIFRS for response to bariatric patients. • Operations quarterly meetings with NISTAR on management of critical care transfers. • Risk Management Policy and risk register review.	• Monthly dip sample of paper PRFs by CSOs. • Monthly IPC/EVC group with Operations and QSI. • Quarterly assurance meetings with IAS providers and twice-yearly inspection by NIAS. • Regular medicines and CD audits at station level. • Safety alerts disseminated to appropriate Directorate for response and implementation.		
	Assurance Level: ADEQUATE		

Strategic Risk 2: We do not provide a timely and effective response to service users.

Risk Appetite	**Minimal**	**Strategic Objective(s)**	We will identify the most appropriate clinical response for our patients. We will work collaboratively with our HSC partners to maximise the use of available care pathways for our patients.
Risk Score		**2025-26 Commitments**	Develop clinical effectiveness measures with ePCR data; Roll out targeted education programmes;
Initial	**Catastrophic**		
Current	**High**	**Linked Corporate and Directorate risks**	816: Hospital Handovers; 830: Delayed response because of Late Finishes; 825 PCS Capacity; 372: Operations Management Structure; 835: CFR Call Management; 149: Delayed call response caused by shift design; 411: Impact of Duplicate Calls.
Target	**Low**		

Gaps in Controls	Gaps in Assurance
• Clinical indicators measured in other ambulance services not routinely captured e.g. time to call; time from STEMI to catheter insertion, STEMI patients receiving appropriate care bundle. • Some aspects of performance, e.g. ambulance dispatch not regularly reported on/audited. • Process for responses to Departmental requests and Assembly Questions is out of date. • Extant policies and procedures not routinely updated – some key documents significantly beyond review date. • Lack of process to oversee and monitor policy/procedure review.	• Priority of operational performance review at 2nd Line. • Productive hours lost and contributory factors, e.g. compensatory rest not routinely reported to 2nd Line groups. • PCS operational performance not routinely reported at 1st or 2nd Line. • Full scope of ICH KPIs not regularly reported upwards to 2nd Line groups. • EOC performance reports not routinely tabled at SMT or Board/Committee level. • Other aspects of performance e.g. FOI/SAR turnaround not included in Trust performance report. • VCS and CFR activity not routinely reported upwards via Trust's governance framework.

Controls and Assurances

Controls [systems to manage impact/likelihood of risk] **For Strategic Risk 2: We do not provide a timely and effective response to service users.**	Available Assurance [evidence that controls are effective]		
	First Line [Service-level/day-day management]	**Second Line** [Internal oversight]	**Third Line** [Independent challenge]
• Daily operations huddle to manage capacity, demand and pressures. • Calls categorised via AMPDS algorithms. • SOP for ambulance dispatch. • ICH clinicians monitor and assess waiting calls. • H&T and S&T pathways. • RRVs deployed to provide timely clinical assessment. • Engagement with DOH/HSC Trusts on ED handovers. • Failed Category 1 release SOP. • Regional Coordination Centre to manage demand/pressures across the HSC system. • Community First Responders (CFRs) can provide initial response in advance of ambulance arrival. • Hospital Emergency Medicine Service (HEMS) provides specialist response to suitable calls. • REAP and CSP protocols to align capacity to demand. • Clinical outcome indicators for OOCA arrest. • Implementation of ePCR. • Monthly HSC Directors of Performance meeting. • Intelligent Routing Protocol – waiting calls diverted to available EOC capacity in UK.	• Operational performance captured and reviewed via dashboards. • Operations report on productive hours lost, compensatory rest, Cat 1 performance. • Monthly H&T and S&T Group meetings review activity levels. • All OOCA calls reviewed and performance monitored by bi-monthly OOCA Steering Group. • Recontact rates and time to ICH assessment reviewed at H&T and S&T groups. • REAP assessment undertaken weekly and circulated to all staff. • Bi-weekly PCS service and performance meeting. • Quarterly meeting with AMPDS to review clinical cases and call coding practice. • Review of use and of care pathways, e.g. falls management.	• Clinical Governance Group meets quarterly to assess assurance in respect of clinical outcomes and KPIs – reports to PEQS. • Trust Performance report sent to SMT and Board Committees and captures: ▪ Out of Hospital Cardiac Arrest 30-Day Survival ▪ ROSC % for shockable rhythm ▪ ROSC % for workable OOCA ▪ Monthly Hear and Treat Rate ▪ Monthly See and Treat Rate ▪ ePCR use	• DOH/SPPG accountability meetings. • Assembly Questions and DOH requests. • DOH bi-monthly Support & Implementation Framework – (oversight by PTEB). • Potential inspection from RQIA. • NIAO March 2025 Hospital Handover Report. • EOC International Academies of Emergency Dispatch Accredited Centre of Excellence (reassessed in 2026). • Internal Audit Reports: • Clinical Governance in respect of Cardiac Arrests (24/25) – Limited
	Assurance Level: LIMITED		

Strategic Risk 3: We fail to transform how we deliver services to meet patient need across all care settings.

Risk Appetite	**Cautious**	**Strategic Objective(s)**	We will work with partners to ensure the appropriate resources are deployed to meet our patients' needs. We will support regional initiatives that aim to drive improved health outcomes for the population of Northern Ireland.
Risk Score		**2025-26 Commitments**	Work with HSC partners to transform NIAS's contribution to healthcare; Engage our patients, partners and people in drafting a new NIAS Strategic Plan for post-2026; Use NIAS data, insight and evidence to better understand health inequalities and plan services.
Initial	**High**		
Current	**High**	**Linked Corporate and Directorate risks**	848: Recruitment and retention to senior roles; 486: Lack of engagement about HSC service changes.
Target	**Medium**		

Gaps in Controls	Gaps in Assurance
• Lack of integrated planning to align Directorate/team priorities with Trust's strategic objectives. • High meeting demand, and duplication, for programme and project delivery.	• Limited 1st Line mechanisms to ensure cross-Directorate progress against strategic plans and modernisation initiatives.

Controls and Assurances

Controls [systems to manage impact/likelihood of risk] **For Strategic Risk 3: We fail to transform how we deliver services to meet patient need across all care settings.**	Available Assurance [evidence that controls are effective]		
	First Line [Service-level/day-day management]	**Second Line** [Internal oversight]	**Third Line** [Independent challenge]
• 2024-26 Corporate Plan and annual priorities. • Trust and system-wide business planning processes. • Programme and project boards. • Development of fleet, estates and sustainability strategy. • Timetable for development of new NIAS strategy underway. • SRO training provided to project/programme leads. • Appointment of public health researcher to inform new strategic plan and priorities.	• Programme Boards to manage specific projects and initiatives e.g. Delivering Value Programme. • Clinical strategy development group meets weekly.	• Reports to SPF Committee on: ▪ Major areas of transformation. ▪ Progress against the corporate plan. ▪ New strategy development. • Mid-Year and End-Year reports to Trust Board on delivery of corporate plan. • Delivery against corporate plan standing item on Directorate Accountability meetings. • Strategy Development Steering Group established to facilitate new corporate strategy.	
			Assurance Level: LIMITED

Strategic Risk 4: We are unable to recruit and retain the people we need to deliver our services and strategic priorities.

Risk Appetite	**Minimal**	**Strategic Objective(s)**	We will work with partners to ensure the appropriate resources are deployed to meet our patients' needs. We will optimise organisational resilience to respond to patients' needs.
Risk Score		**2025-26 Commitments**	Create clear clinical development framework for staff; Mainstream Equality, Rural Proofing and Human Rights considerations in Trust policy and service delivery.
Initial	**High**		
Current	**Medium**	**Linked Corporate and Directorate risks**	559: Organisational Cultural Improvement; 403: Sickness Absence; 372: Operational Management Structure.
Target	**Low**		

Gaps in Controls	Gaps in Assurance
• High meeting demand, and duplication, in respect of absence management, particularly for Operations staff. • Extant policies and procedures not routinely updated – some key documents significantly beyond review date. • Lack of process to oversee and monitor policy/procedure review. • HR/OD scorecard metrics are overdue for review. • Internal access to management and leadership training is limited. • Limited workforce planning activities across Directorates.	• Lack of 1st line mechanism to review strategic workforce planning, policy and delivery.

Controls and Assurances

Controls [systems to manage impact/likelihood of risk] **For Strategic Risk 4: We are unable to recruit and retain the people we need to deliver our services and strategic priorities.**	Available Assurance [evidence that controls are effective]		
	First Line [Service-level/day-day management]	**Second Line** [Internal oversight]	**Third Line** [Independent challenge]
• Regional recruitment processes. • Annual budget for staffing. • HR Business Partners in place to support Directorates on workforce matters. • Weekly and monthly absence management meetings with HR and Operations (including complex and employee relations cases). • Associate Ambulance Practitioner (AAP) programme. • BSC Hons. Programme at UU with annual cohort of NQPs. • Advanced Paramedic Critical Care programme. • Workforce planning/benchmarking exercise for operational staff carried out by ORH (June 2025). • Business cases in development for additional operational crews, Advanced Paramedics and ICH expansion. • Continuing Professional Development (CPD) and assistance to study opportunities. • Access to courses and programmes via HSC Leadership Centre • Bespoke training for certain roles and specialist posts e.g. EMD call handling and HART. • HR provide training to managers on recruitment and selection/disciplinary procedure investigations. • Regional HR meetings on HR specialisms.	• Workforce levels including vacancies managed at Directorate level. • Monthly staff in post return from each Directorate. • Absence management data and KPIs cascaded through Operations management structure. • Uptake of mandatory e-learning across Directorates emailed to managers on monthly basis. • SLA with HSC Leadership Centre managed by HR. • Application to Study Panel reviews proposals for staff learning.	• SPF Committee monitors finance reports to include vacancies and cost pressures. • HR/OD Scorecard covering workforce KPIs reported to People, Culture and Organisational Development Committee– prioritised reporting in respect of absence. • PCOD receives reports on uptake of mandatory e-learning.	• Internal Audit Reports: ▪ Absence Management (22/23) – Limited
			Assurance Level: LIMITED

Strategic Risk 5: Our staff do not feel safe, supported or engaged in the workplace.

Risk Appetite	**Minimal**	**Strategic Objective(s)**	We will protect the wellbeing of our staff by mainstreaming this within work programmes across the organisation and making it the driver of operational changes.
Risk Score		**2025-26 Commitments**	Deliver on 3-year plan to improve organisational culture; Agree on a statement of culture that embeds respect for equality and diversity;
Initial	**High**		
Current	**High**	**Linked Corporate and Directorate risks**	372: Operations Management Structure; 395: Violence and Aggression; 559: Organisational Cultural Improvement; 403: Sickness Absence; 837: Lack of Partnership Agreement.
Target	**Low**		

Gaps in Controls	Gaps in Assurance
• Limited ability to abstract operational staff to undertake refresher training in manual handling and conflict resolution (and other aspects of statutory training). • Extant policies and procedures not routinely updated – some key documents significantly beyond review date. • Lack of process to oversee and monitor policy/procedure review. • Specialist functions, e.g. Health and Safety and Violence Reduction reliant on small or single-handed teams. • Lack of Partnership Agreement framework for engagement with TUs. • Access to clinical professional support/supervisor for Peer Support Team.	• Limited 2nd line reporting on incidents of violence and aggression and health and safety. • Lack of 1st line mechanism to review driving assessment activity and quality of driving. • Limited 2nd line reporting on driving training and compliance. • Mandatory training not reviewed or performance managed regularly at 1st line groups. • Data on peer support/other well-being initiatives and Occupational Health performance not routinely reported to 2nd line level.

Controls and Assurances

Controls [systems to manage impact/likelihood of risk] **For Strategic Risk 5: Our staff do not feel safe, supported or engaged in the workplace.**	Available Assurance [evidence that controls are effective]		
	First Line [Service-level/day-day management]	**Second Line** [Internal oversight]	**Third Line** [Independent challenge]
• Mandatory health and safety and moving and handling e-learning. • Operational crews provided with training on induction on conflict resolution and moving and handling. • Violence and aggression reduction strategies including provision of body-worn video cameras. • Policy and processes for the reporting of adverse incidents. • Health and Safety risk assessments and advice. • NIAS Healthy People, Healthy Place Strategy. • Organisational Culture Review launched in 2025. • Health, Well-Being and Support roles; referral to peer support available for all operational staff. • Critical Incident Stress Management support. • Health and well-being initiatives. • Internal communication channels. • Policy for the management of violence and aggression in the work place. • Driving training and familiarisation on new vehicles. • Driving and Occupational Road Health and Safety policies. • Framework of meetings between Operations, HR and staff side via JCG sub-groups. • Compensatory rest and missed meal break procedures.	• Manual handling incidents reported to Health and Safety Committee quarterly. • Violence and aggression incidents reported to Violence and Aggression Prevention Group. • Uptake of e-learning packages reviewed at H&S Committee. • Participation in AACEs sub-groups on H&S, violence and aggression and driving training. • Whistleblowing and Complaints Oversight Group to monitor cases which come through Whistleblowing Procedure. • Occupational Health and Peer Support activity monitored at management level.	• Driving training and familiarisation activities reported to PEQS Committee on ad hoc basis. • Number of missed meal break and late finish adverse incidents reported to SMT.	• Annual Fair Employment Monitoring report sent to Equality Commission. • Internal Audit Reports: • Absence Management (22/23) – Limited
	Assurance Level: LIMITED		

Strategic Risk 6: We are unable to respond appropriately to unexpected events and external threats.

Risk Appetite	**Minimal**	**Strategic Objective(s)**	We will optimise organisational resilience to respond to patients' needs.
Risk Score		**2025-26 Commitments**	Explore innovative technology to optimise allocation of resources including personnel and response vehicles.
Initial	**High**		
Current	**High**	**Linked Corporate and Directorate risks**	311: Cyber Security; 486: Lack of engagement about HSC service changes; 761: HART Capacity; 744: CBRN Capability; 824: HART Facilities.
Target	**Low**		

Gaps in Controls	Gaps in Assurance
• Lack of process to document, track and implement learning arising from a major/critical incident debrief.	• Limited 1st and 2nd line mechanisms to monitor performance/activity in respect of Cyber Security and Information Governance.
• Extant policies and procedures not routinely updated – some key documents significantly beyond review date.	• Mandatory training not reviewed, or performance managed, regularly at 1st line groups.
• Lack of process to oversee and monitor policy/procedure review.	• Lack of mechanism to track responses to Joint Operational Learning alerts.
• Limited routine KPIs in place for EPRR/HART activity.	• Limited 2nd line assurance and inquiry into effectiveness of actions put in place to respond to recommendations regarding specialist response capability (from AACEs reports and MAI recommendations).
• BCPs not in place across all Directorates.	

Controls and Assurances

Controls [systems to manage impact/likelihood of risk] **For Strategic Risk 6: We are unable to respond appropriately to unexpected events and external threats.**	Available Assurance [evidence that controls are effective]		
	First Line [Service-level/day-day management]	**Second Line** [Internal oversight]	**Third Line** [Independent challenge]

• Business Continuity Plans for each Directorate.
• Incident Response Plan (IRP) sets out the process, framework and actions for dealing with major, unexpected events.
• EPRR training for operational staff 2025-26.
• EPRR framework including training for tactical, operational and strategic commanders.
• Hazardous Area Response Team (HART) available to provide specialist response.
• Information security and data protection policies and procedures.
• Cyber Security Controls Assurance Framework.
• Mandatory cyber security e-learning and cyber awareness session provided on induction.
• Regional and national meetings on Cyber Security management.
• HSCNI Monthly Cyber Security Awareness Training.
• EPRR/operations attendance at NI operational, tactical and strategic civil contingencies/emergency planning meetings.
• EPRR attendance at Blue Light Forum and sub-groups.
• EPRR attendance at JESIP meetings.
• Joint operational learning alerts (from JESIP).
	• EPRR governance group with cross-Directorate representation.
	• Business continuity exercises (tabletop and practical) – e.g., monthly decant of EOC operations to Site 5.
	• Backup and resilience arrangements for critical systems managed via SLAs with suppliers.
	• EPRR attendance at national emergency planning meetings (via AACEs).
	• Contract for maintenance of specialist HART equipment.
	• EPRR/HART assess compliance with HSC Core Standards for Emergency Planning and return to DOH.
	• Updates sent to DOJ and AACEs on implementation of Manchester Arena Inquiry recommendations.
		• PEQS priority reporting on EPRR and HART capacity.
		
		• Updates sent to SMT on implementation of AACEs EPRR and MAI recommendations.
			• Maintenance of HART equipment assessed independently by 3rd party.
			
			• 2-yearly assessment of cyber and information security as per Network and Information Systems (NIS) Regulations.
			
			• 2024 National Security Cyber Assessment carried out obo AACEs - NIAS score of 69% for cyber maturity.
			
			• AACEs peer assessment of implementation of recommendations from Reports 1 and 2 on HART service.
			
			• Internal Audit Reports:
			  • Cyber Security (23/24) – Limited
			  • Business Continuity (24/25) - Limited/Satisfactory

• Cross-border resilience and emergency response groups. • MOU with partner agencies, including NIFRS, for response to major, complex event. • Policies and procedures for HART activity. • AACES Reports 1 and 2 on NIAS HART service. • EPRR/Operations involvement in planning for specific events, e.g. NW200, the Open Championship.	**Assurance Level: LIMITED**

Strategic Risk 7: Our critical infrastructure – estates, fleet and ICT- does not support effective operations and delivery of high-quality, safe care.

Risk Appetite	**Minimal**	**Strategic Objective(s)**	We will optimise organisational resilience to respond to patients' needs.
Risk Score		**2025-26 Commitments**	Explore innovative technology to optimise allocation of resources;
Initial	**High**		
Current	**Medium**	**Linked Corporate and Directorate risks**	851: Belfast Divisions fitness for purposes; 704: Inappropriate Accommodation for EOC.
Target	**Low**		

Gaps in Controls	Gaps in Assurance
• No water safety policy/framework in place at NIAS. • Lack of NIAS estates and fleet strategy to support modernisation agenda. • NIAS estates team heavily dependent on agency. • Duplication/overlap in station inspections undertaken by H&S and estates. • Extant policies and procedures not routinely updated – some key documents significantly beyond review date. • Lack of process to oversee and monitor policy/procedure review.	• Estates KPIs and activity not routinely reported to SMT or to Board/Committee level. • Sustainability metrics not reported to SMT or to Board/Committee level. • Audits/inspections of stations not routinely reported upwards and lack of framework to monitor actions. • Limited 1st and 2nd line mechanisms to ensure that Fleet, ICT and Estates needs are included in strategic plans. • Limited 1st and 2nd line assurance on management of fleet including road traffic accidents, volume of repairs and cost etc. • Routine ICT KPIs not reported to SMT or Board/Committee level.

Controls and Assurances

Controls [systems to manage impact/likelihood of risk] **For Strategic Risk 7: Our critical infrastructure – estates, fleet and ICT- does not support effective operations and delivery of high-quality, safe care.**	Available Assurance [evidence that controls are effective]		
	First Line [Service-level/day-day management]	**Second Line** [Internal oversight]	**Third Line** [Independent challenge]

• Estates manage contracts for range of statutory requirements including legionella sampling, electrical testing, fire alarms and waste removal.
• H&S, Fire and Security policies.
• Estates regional and national meetings to share best-practice and align processes.
• Annual capital planning and prioritisation processes – managed in line with extant strategies.
• Estates attend Strategic Investment Group with SPPG.
• MOUs with NIFRS and other HSC Trusts outlining roles and responsibilities for shared accommodation.
• Contract with RLB to facilitate NIAS's sustainability reporting requirements on climate change mitigation and adaptation.
• Ad hoc meetings for specific estates projects.
• Vehicle replacement programme for fleet, supported by business case development.
• Fleet monitor vehicle repair schedule on weekly basis.
• Vehicle maintenance schedule in line with DVSA guidance and manufacturer requirements.
• Maintenance of equipment in line with manufacturer servicing schedule.
• Trained motor mechanics in-house.
	• Monthly meetings with Estates, Fleet and Operations to monitor and progress priority works.
	• Estates monitor performance of job requests.
	• Planned Preventative Maintenance (PPM) activity monitored.
	• Quarterly report of station sustainability and condition of estate.
	• All stations subject to annual fire/H&S inspection each year.
	• Contract management of key 3rd party arrangements.
	• Estates audit of work carried out by contractors.
	• Fleet quarterly contract meetings with suppliers providing maintenance services.
	• ICT KPIs for management of requests.
	• Contract management meetings with suppliers of critical systems – radio, telephony and CAD.
		• Vehicle MOT and Service Rates reported to SMT.
		
		• Estates PPM activity included in Performance Report to SMT.
			• RQIA can inspect quality/safety of NIAS accommodation.
			
			• Health & Safety Executive inspections.
			
			• Independent inspections of lifting equipment on vehicles.
			
			• 15% of vehicle maintenance activity inspected by 3rd party.
			
			• Internal Audit Reports:
			  • Management of Fleet and Fuel (23/24) – Limited/Satisfactory
			  • Fire Safety (21/22) – Satisfactory

• Arrangements with 3rd parties to carry out vehicle maintenance and servicing of vehicle equipment. • ICT policies and procedures for maintenance of systems and request management. • Range of ICT working groups locally and nationally to discuss best and emerging practice, and planning. • Programme infrastructure around critical systems including ePCR, telephony, CAD etc.	• Monthly spot-checks of management of ICT helpdesk requests.		
			Assurance Level: LIMITED

Strategic Risk 8: We fail to manage our finances effectively within our annual budget allocation.

Risk Appetite	**Cautious**	**Strategic Objective(s)**	We will work with partners to ensure the appropriate resources are deployed to meet our patients' needs.
Risk Score		**2025-26 Commitments**	Explore innovative technology to optimise allocation of resources including personnel and response vehicles.
Initial	**High**		
Current	**Medium**	**Linked Corporate and Directorate risks**	820: Financial Stability 2025-26; 276: Contract Management.
Target	**Low**		

Gaps in Controls	Gaps in Assurance
• Extant policies and procedures not routinely updated – some key documents significantly beyond review date. • Lack of process to oversee and monitor policy/procedure review. • Lack of procedure for use of bank staff. • Management of late finishes and accrual of both additional payments and compensatory rest.	• Mandatory training not reviewed, or performance managed, regularly at 1st line groups.

Controls and Assurances

Controls [systems to manage impact/likelihood of risk] **For Strategic Risk 8: We fail to manage our finances effectively within our annual budget allocation**	Available Assurance [evidence that controls are effective]		
	First Line [Service-level/day-day management]	**Second Line** [Internal oversight]	**Third Line** [Independent challenge]

• Annual budget planning for pay and non-pay.
• Capital planning and prioritisation.
• Budget management training offered to all budget holders (on CP).
• Financial approval limit framework.
• Regional HSC systems and procedures for core finance functions including procurement and payroll.
• Mandatory fraud e-learning training for staff.
• Delegated budget management.
• DAC/Contract management and business case development training available via BSO.
• Monthly finance report generation and variance monitoring.
• Finance policies and procedures for core functions including invoice payment, contractual management, travel and subsistence etc.
• Internal approval processes for discretionary expenditure e.g. assistance to study, travel.
• Business case development and approval framework.
• Charitable Trust Funds procedures.
• Fraud Risk Assessments.
• Counter Fraud reporting and investigations facilitated by BSO.
	• Fleet audit use of fuel cards and fuel transactions.
	• Monthly meetings with Directorates to review pay/non-pay expenditure against allocated budget.
	• Monthly capital meeting with relevant teams to review plans and progress against anticipated spend.
	• SLA meetings with BSO for financial activities.
	• Monthly staff in post return from each Directorate.
	• Scrutiny Panel approval for any proposed staffing expenditure.
		•Monthly finance and variance report considered by SMT.
		•Finance report reviewed at all SPF Committee meetings.
		•GARAC internal assurance and controls on financial management.
		•Directorate Accountability Meetings held 3 times a year, chaired by Finance and PPCS – financial performance and contract management standing items.
		•Monthly finance meeting with SPPG to monitor spend and forecasts.
		•Monitoring return sent to SPPG monthly.
		•Annual Report and Accounts published.
			• Statutory external audit of financial accounts.
			
			• Mid and End of Year Accountability Statements to DOH.
			
			• NIAO value for money assessments.
			
			• Annual Internal Audit workplan.
			
			• Internal Audit Reports:
			  • Procurement and Contract Management (19/20) – Limited
			  • Resource and Rota Management (24/25) – Limited
			  • Financial Review (23/24) – Limited & Satisfactory

	Assurance Level: SUBSTANTIAL		

NIAS C'TTEE ITEMS JUNE 2025

SPF – 19 June	PEQS – 5 June	PCOD – 12 June	GARAC – 24 June
• Trust budget report and year-end forecast. • Detailed Directorate budget report. • 2025-26 Opening Budget Allocation • Performance Report • Deep Dive on Cat 1 and Cat 2 performance. • Focus on Strategic Plan Development. • Business Case Update	• Quality Strategy 22-26 • IPC Report • Pharmacy bi-annual report • NIAS Hand Hygiene Policy • SUF & Complaints Report • EVC Update • HART capacity update • IAS Assurance & Governance Update • EPRR Update • Discussion on de-escalation of corporate risk 833. • Controlled Drugs Policy • Medicines Policy	• Management of violence & aggression Update • Sexual Safety Workstream • Org culture Update • Mthly workforce Info & strategic HR Report • Absence Management Update • HROD Restructure / 25/26 planning • Ops Restructure Update • Media and Comms Overview • AOB – Internal audit reccs	• DAC Register • Fraud Update • IA Progress Report • HIA HSC General Annual Report 25/26 • Updated Internal Audit annual plan 25/26 • External Audit Draft Report to those charged with governance. • Annual Report & Accounts • GARAC Annual Report • Board assurance Framework
		Extraordinary Meeting on 11 August re: Sexual Safety Improvement.	
Next Meetings			
18 Sep	11 Sep	25 Sep	9 October 2025

15.8.2025

Trust Board and Committee Forward Work Plan 2025-26

Trust Board

Meeting	15 May 2025	26 June 2025	28 August 2025	23 October 2025	11 December 2025	19 February 2026	26 March 2026
Agenda Items	/	• AACES Presentation on Violence & Aggression • Performance Update • Finance Update • Final Annual Report and Accounts • Corporate Risk Register • Board Assurance Framework	• Board Assurance Framework • Cyber Board Training • Safeguarding Annual Report • Presentation – QI Programme • EPRR Core Standards. • ORH Presentation • Performance Report • Finance Report	• Corporate Plan Mid-Year Progress Report • Board Governance Self-Assessment Tool. • Performance Update (Report) • Finance Update (Report) • Locality/winter planning • [ORH presentation] • TB/Committee business case approval threshold TBC LD • Fleet Business Case (TBC) SM • Sexual Safety – mgt response	• Safeguarding Annual Position Report • Annual Quality Report • [Staff Survey Results presentation] • [Cyber Security/NIS Presentation] • Finance Update (Report) • Performance Update (Report)	• Corporate Risk Register • Performance Update (Report) • Finance Update (Report)	• Corporate Plan End Year Progress Report • Board Assurance Framework • Performance Update (Report) • Finance Update (Report)

15.8.2025

Governance, Audit and Risk Assurance Committee (GARAC)

Meeting	12 May 2025	24 June 2025	9 October 2025	9 December 2025	30 January 2026	Feb Date TBC	12 March 2026

Agenda Items	• Corporate Risk Register
	• Corporate Governance Code of Good Practice NI (2025)
	• Draft Annual Report and Accounts
	• Draft Charitable Trust Funds Trustees Annual Report
	• DAC Register
	• Fraud Update
	• Internal Audit
	  • Progress report
	  • Recommendation f/up
	  • Shared Service note
	  • HIA Annual Report
	  • IA Strategy and 25/26 plan
	• External Audit
	  • NIAO Handover Report
		• Focus on Final Annual Report and Accounts
		• [Draft RTTCWG report]
		• [DAC Register]
		• [Fraud Update]
		• [Internal Audit]
		• [External Audit]
		• Update on Unsocial Hours IA progress.
		• 2024-25 GARAC Annual Report.
			• IGG and Cyber Security Update
			• Board Governance Self-Assessment Tool.
			• NIAO ARAC checklist.
			• DAC Register
			• Fraud Update
			• Mid-Year Assurance Statement.
			• Focus on any relevant risks on CRR.
			• Internal Audit
			• External Audit
			• Update on Unsocial Hours IA progress.
			• Resource and Rota Management (HR to attend) (notes 24-6-25)
				• Focus on Internal Audit recommendations	• Corporate Risk Register
					• DAC Register
					• Fraud Update
					• TORs review
					• Internal Audit
					• External Audit
					• Risk Appetite Statement Review
					• Review of SFIs
					• Review of Standing Orders
					• Update on Unsocial Hours IA progress.
						Extra meeting requested as per notes 24-6-25 regarding Progress on IA	• IGG and Cyber Security Update
							• DAC Register
							• Fraud Update
							• Internal Audit
							• External Audit
							• Update on Unsocial Hours IA progress.

15.8.2025

People, Culture and Organisational Development Committee (PCOD)

Meeting	3 April 2025	12 June 2025	11 August 2025	25 September 2025	4 December 2025	12 February 2026
Agenda Items	/	• Performance Report (on absence) • Trust Communications Activities Overview. • HR/OD Balance Scorecard • Organisational Cultural Improvement Update incl. sexual safety • Operations Restructure Update • Discussion about Unsocial Hours Payment IA assurance. • Violence and Aggression briefing	Extraordinary Meeting re: Sexual Safety Improvement Update	• Performance Report (on absence) • HR/OD Balance Scorecard • Maximising Attendance Update • Organisational Cultural Improvement Update inc. sexual safety • Vaccinations Briefing • Partnership Framework • Assistance to study • Workforce Health and Well being • Sexual Safety (Management Response)	• Performance Report (on absence) • HR/OD Balance Scorecard • Organisational Cultural Improvement Update • Operations Restructure Update • Focus on any relevant risks on CRR. • Workforce profile and Recruitment Programme • Learning and Development • [Violence and Aggression briefing] • [Staff Survey Results presentation]	• Performance Report (on absence) • TORs review • HR/OD Balance Scorecard • Maximising Attendance Update • Organisational Cultural Improvement Update • Employment Law Case annual Update • Equality, Diversity and Inclusion Report • Safeguarding Employment Update

15.8.2025

Patient Experience, Quality and Safety Committee (PEQS)

Meeting	24 April 2025	5 June 2025	11 September 2025	20 November 2025	22 January 2026
Agenda Items		• Performance Report (on SAIs, complaints etc./clinical KPIS) • IPC Report • Pharmacy bi-annual report • SAI Report • OOCA improvement • HART capacity update • Discussion on de-escalation of corporate risk 833. • IAS report • EVC report Quality and Service Improvement – Quality Strategy update	• Complaints Annual Report (notes 4-6-25) • Performance Report (on SAIs, complaints etc./clinical KPIs) Safeguarding Report • Co Production and Partnership • Focus on any relevant risks on CRR. • Training Update (every 6 months) • OOCA improvement • Delayed Response Thematic Review • EPRR (notes 4-6-25)	• Performance Report (on SAIs, complaints etc./clinical KPIs) • Update on SAI Redesign (not full SAI report) • Quality and Service Improvement - Annual Quality Report update • Adverse Incident management report • IAS Assurance • EPRR update • EVC Report. • IPC report	• Performance Report (on SAIs, complaints etc./clinical KPIs) • Pharmacy bi-annual report. • TORs review • OOCA improvement • HART capacity update • SAI Report • Service User Feedback Report • Co-Production and Partnership

15.8.2025

Strategic Performance and Finance Committee (SPF Committee)

Meeting	10 April 2025	19 June 2025	18 September 2025	27 November 2025	5 February 2026
Agenda Items	/	• Trust budget report and year-end forecast. • Detailed Directorate budget report. • 2025-26 Opening Budget Allocation • Performance Report • Deep Dive on Cat 1 and Cat 2 performance. • Focus on Strategic Plan Development.	• Trust budget report and year-end forecast. • Detailed Directorate budget report. • Capital budget, expenditure and forecast. • Overtime budget and expenditure • Focus on Service Delivery Model. • Performance Report. • Corporate Plan Mid-Year Progress Report • Strategy Development Update. • [ORH update] • Fleet Business Case (TBC)	• Trust budget report and year-end forecast. • Detailed Directorate budget report. • Overview of Fleet and Estates. • Fleet Expenditure. • Budget and expenditure on IAS, Taxis and Voluntary Drivers • Focus on delivering value (efficiencies). • Performance Report. • Strategy Development Update.	• Trust budget report and year-end forecast. • Detailed Directorate budget report. • Capital budget, expenditure and forecast. • 2026-27 Draft Financial Plan • Overview of Sustainability • Focus on Corporate Plan Implementation. • Performance Report. • Corporate Plan End Year Progress Report • Strategy Development Update. • TORs review

15.8.2025

Actions from last meeting		• Proposal on appropriate threshold of business case approval.			

Northern Ireland Ambulance Service
Health and Social Care Trust

MINUTES OF THE GOVERNANCE, AUDIT AND RISK ASSURANCE COMMITTEE HELD AT 9:30AM ON MONDAY 12 MAY 2025 IN THE BOARDROOM, NIAS HQ

PRESENT:	Dr P Graham	Committee Chair
	Mr D Ashford	Non-Executive Director
	Dr P Corrigan	Non-Executive Director
IN ATTENDANCE:	Mr S Mullen	Interim Director of Planning, Performance and Corporate Services
	Mr N Sinclair	Interim Director of Operations and Chief Paramedic Officer
	Ms L Donnelly	Interim Director of Finance
	Dr N Ruddell	Medical Director
	Ms B McCauley	Assistant Director of Finance
	Mr M Smyth	Temporary Assistant Director of Finance
	Mr N Henry	Assistant Director Governance
	Ms L Hill	Risk Management Co-ordinator
	Mr D Charles	Internal Audit, BSO
	Ms C McKeown	Internal Audit, BSO
	Ms C Hagan	ASM
	Mr P O'Sullivan	Northern Ireland Audit Office
	Ms H Rob	Senior Secretary
APOLOGIES:	None	

1. Apologies & Opening Remarks

There were no apologies noted.

The Chair welcomed members to today's meeting.

2. Procedure

2.1 Declaration of Potential Conflict of Interest

No declarations were made.

2.2 Quorum

The Chair confirmed that the Committee was quorate.

2.3 Confidentiality of Information

The Chair confirmed and emphasised the confidentiality of information.

3. Previous Minutes

The minutes of the previous meeting were **APPROVED**, subject to the following amendment: Mr David Charles should be noted as an attendee, instead of Ms Catherine McKeown.

ACTION: Ms Beggs

4. Matters Arising

The actions arising from the previous meeting were **NOTED** as having been progressed.

5. Chair's Business

The were no items of business discussed by the Chair.

6. Standing Items

6.1 NIAS Direct Award Contract Register

Ms Donnelly advised that NIAS has authorised 3 new DACs since the last meeting including Maintenance and Support for the Global Rostering System, Maintenance and Calibration of Fit Test Machines and the extension of the Vodafone contract. Ms Donnelly noted that there are two DACs pending relating to a Paperless Fleet Approval and Authorisation Platform (with a value of £26,000) and the Servicing, Maintenance and

Replacement of Suction Units (with a value of £400,000). Ms Donnelly explained that the latter covers a period of 7 years.

The Committee **NOTED** the update.

6.2 Fraud Update

Ms McAuley advised that there have been no new fraud allegations received. The two open cases which were discussed at the last Committee meeting remain under investigation.

The Committee **NOTED** the update.

6.3 Counter Fraud End of Year Report 2024-25

Ms McAuley provided a summary update on the HSC-wide Counter Fraud End of Year report 2024-25 provided by BSO. The Committee discussed the timeliness of Counter Fraud investigations and associated timescales. Ms McCauley advised that the Counter Fraud service is performing as expected in this regard.

The Committee **NOTED** the update.

7. Internal Audit

7.1 Progress Report

Ms McKeown discussed the Internal Audit progress report and advised that the 2024-25 audit work is now complete. Internal Audit are providing a Satisfactory Assurance on all financial reviews carried out with the exception of the review into the Management of Unsocial Payments which is of Limited Assurance.

Ms McKeown noted that one significant finding from the 2023-24 review into the Management of Unsocial Hours Payments remains outstanding, despite the significant progress which has been made by management to address the recommendations. Ms McKeown noted that the four key findings in the 2024-25 report have been accepted by NIAS management.

Mr Corrigan sought clarity on why the significant finding from the 2023-24 report remains outstanding and sought assurance in this regard. Ms McCauley explained the work that has been undertaken to investigate the issue, involving review of over 200 rotas and triangulation of all potential over and under payments. Ms McCauley advised that some aspects of the finding necessitate engagement with Trade Union colleagues and explained the significant amount of work involved in undertaking the review.

Mr Corrigan stressed the importance of maintaining a focus in this area and to ensure that reviews are carried out in a timely fashion and noted that the timeframe for completion has been delayed to the end of March 2026.

The Committee **AGREED** to include a progress report on the Management of Unsocial Hours Payments as a standing item for upcoming meetings.

ACTION: Mr Henry

Ms McKeown advised that Internal Audit were providing Limited Assurance in respect of the recently completed review of Resource and Rota Management and noted three key findings regarding the age of the rotas used within NIAS, the lack of documented process for the use of Bank and the management of requested annual leave.

The Chair noted that there is a significant amount of activity underway with regards to rota restructure. Mr Sinclair advised that rota management is an important priority and the way forward on this will be informed by the upcoming capacity and workforce review exercise being carried out by ORH which is due to report in June. Any rota redesign will have to be informed by the needs of the service, as well as ensuring staff are receiving meal/rest breaks and are provided with sufficient education and training days throughout the year.

Mr Sinclair noted that discussions on rota redesign will have to be taken forward with Trade Union colleagues. Mr Corrigan queried whether new recruits could be commenced on new, more flexible rotas. Mr Sinclair advised that this has been

explored but it is challenging because newly qualified staff need to be paired with more experienced staff who will be on a fixed rota pattern.

Mr Ashford highlighted concern regarding the 10% absence rate and that reducing this would support reduced reliance on bank/overtime to cover shift gaps. Mr Sinclair advised that a draft SOP had been prepared regarding the utilisation of bank, but there is a need to revisit this and to have input from HR to formalise and embed this.

The Committee discussed the importance of monitoring where staff are taking sick leave if annual leave is rejected, and that this should be being managed through extant disciplinary processes, and robust absence management.

The Chair suggested that a representative from HR could be invited to attend the next GARAC meeting to discuss this matter and provide assurance in respect of absence management. Mr Corrigan offered to raise the issue at the next People, Culture and Organisational Development Committee. The Committee **AGREED** for Mr Corrigan to raise the issue at PCOD, and for a report to subsequently be provided at the next GARAC meeting.

ACTION: Mr Corrigan

Mr Corrigan highlighted the Internal Audit finding that NIAS is currently paying staff overtime for a late finish in addition to providing compensatory rest and noted the extension in compensatory rest entitlement that has been put in place by NIAS: this is in effect leading to a "double payment."

Mr Corrigan stressed the need to revisit the issue and potentially stand down the compensatory rest entitlement extension. Mr Sinclair advised that this is a complex issue and that measures were put in place historically to try and help manage ASOS, and that reversing those decisions will likely be exceptionally challenging. The prospect of rota design should go some way to address late finishes and mitigating the impacts.

Mr Corrigan acknowledged the difficulties in addressing these issues, and highlighted that the timescale for introducing new rotas, two years, is very lengthy, and there is a need to address these matters before then. Mr Sinclair noted that two years would be the worst case scenario, and that the aspiration would be to have new rotas in place before then.

7.2 Internal Audit follow up of Recommendations

Ms McKeown noted that 92% of Internal Audit recommendations at year end had been implemented by NIAS management which was an excellent result. Ms McKeown highlighted the recommendations which remain outstanding.

The Chair acknowledged the efforts and hard work by all in achieving the result, particularly given the range of demands on the service. The Chair praised all the Directors and their teams who were all an important part in implementing the recommendations.

Mr Corrigan noted the outstanding recommendation in respect of fleet and explained that fleet is one of the areas which has historically not been brought to Committee/Board level, but that the intention is that the Strategic Performance and Finance Committee will start to receive briefings on this.

The Committee **NOTED** the update.

7.3 Shared Services Update

Ms McKeown advised that Internal Audit were providing Satisfactory Assurance in respect of the three Shared Service audits that had been carried out: Business Services Team (BST), Payroll Service Centre and Recruitment Shared Service Centre.

The Committee **NOTED** the update.

7.4 Head of Internal Audit Annual Report 24/25

Ms McKeown spoke to the tabled paper and the Committee acknowledged the progress which has been made but stressed

the importance of a continual focus on implementing Internal Audit recommendations.

The Committee **NOTED** the update.

7.5 Internal Audit Strategy and Annual Plan 2025/26

Ms McKeown presented the Internal Audit plan for 2025-26 which is the final year of the 3-year cycle and sought Committee approval on same.

Mr Ashford highlighted concern at the potential deferral of an Internal Audit on the HART service to 2026-27, as this would be over two years since the concerns regarding the HART service were raised to Committee level. Mr Ashford advised of an upcoming meeting with AACEs regarding their peer assessment of the implementation of recommendations they have made previously regarding NIAS's HART service.

The Committee discussed the prospect of deferring an alternative audit scheduled for 2025-26 to allow the HART review to take place in-year. Mr Ashford and Mr Sinclair agreed to have a discussion about the potential deferral of the HART review in light of the AACE peer assessment.

Following discussion with AACE, Mr Ashford agreed to discuss outcomes of the meeting with the Chair, who in turn would discuss with Internal Audit the potential to keep HART within the 2025-26 programme and reallocate the total Internal Audit days to include it.

The Committee **APPROVED** the Internal Audit plan for 2025-26, subject to confirmation about potential deferral of the HART review.

ACTION: Mr Ashford/Mr Sinclair

7.6 Global Internal Audit Standards

Ms McKeown advised the Committee of the updates to the standards that will be incorporated into the Internal Audit team's work going forward.

The Committee **NOTED** the update.

8. External Audit

8.1 NIAO Handover Report

Ms Hagan provided a brief summary on key issues contained within the NIAO Handover Report. The Committee discussed the process for ensuring there is governance around the implementation of the actions which are relevant to NIAS, and it was agreed that this would be discussed at Trust Board later in the week.

The Committee **NOTED** the update.

9. Draft Annual Report and Accounts 2024-25

Mr Mullen provided a brief overview on the Draft Annual Report narrative, which follows the same format as previous reports. Mr Mullen noted the timescales involved in compiling the report and the need to ensure early forward planning for next year.

Ms Donnelly highlighted the key aspects of the Draft 2024-25 Annual Accounts and discussed the details of the Consolidated Statement of Financial Position as at 31 March 2025. Ms Donnelly explained that the final Annual Report and Accounts will be tabled at Trust Board in June.

The Committee **APPROVED** the Draft Annual Report and Accounts.

10. Draft Charitable Trust Funds Trustees Annual Report 2024-25

Ms McAuley discussed the salient aspects of the Draft Charitable Trust Funds Trustees Annual Report including income and expenditure throughout the year.

Mr Corrigan suggested including reference to the establishment of the Charitable Trust Funds Advisory within the Report. The Committee **APPROVED** the draft report, subject to this addition.

ACTION: Ms McCauley

11. Review of Corporate Risk Register

Mr Henry provided an overview of the updated Corporate Risk Register and proposals to escalate and de-escalate risks.

The Committee agreed that risk 825 pertaining to PCS capacity and risk 455 on Safeguarding were appropriate for de-escalation to the Directorate risk register. The Committee also agreed with the proposed additions to the Corporate Risk Register regarding recruitment and retention of senior roles (848), response to mental health calls (727) and consultation about HSC service changes (486).

Mr Ashford queried the proposal to de-escalate risk 833 regarding the ability to respond to a High Consequence Infectious Disease (HCID), in the context of limited HART capacity at NIAS. Mr Henry noted that the issues pertaining to HART capacity are recorded separately on the Corporate Risk Register and that the proposal to de-escalate 833 was due to the de-classification of Clade II Mpox as an HCID and the agreements put in place with other HSC Trusts to maintain safe systems of work for HART should they respond to a confirmed/probable HCID.

The Committee **APPROVED** the updated Corporate Risk Register, subject to the proposal to de-escalate risk 833 being discussed at the next Patient Experience, Quality and Safety Committee.

12. Corporate Governance Code of Good Practice NI (2025)

Mr Henry highlighted the review which has been undertaken of the revised Corporate Governance Code of Good Practice NI and two proposals which are made in respect of establishing de minimis level of approval for business cases at Committee/Trust Board level and oversight of corporate risks.

The Committee **APPROVED** the proposal in respect of business case approval levels and suggested that this be tabled at the

next Trust Board meeting, and subsequently be reflected in the revised SPF Terms of Reference.

The Chair advised that he is content with the extant arrangements for managing corporate risk and the frequency of discussion of corporate risks at Trust Board. The Committee noted previous discussions about having "deep dives" of Directorate risks at future GARAC meetings.

13. DOH Correspondence

There were no items of correspondence tabled.

14. Date of Next Meeting

24 June 2025, 9.30am, Microsoft Teams

15. Any Other Business

There were no items of business raised.

THIS BEING ALL THE BUSINESS, THE CHAIR DECLARED THE MEETING CLOSED

SIGNED: P. Graham

DATE: **24/06/24**

Northern Ireland Ambulance Service
Health and Social Care Trust

MINUTES OF THE STRATEGIC PERFORMANCE & FINANCE COMMITTEE HELD AT 9.30AM ON THURSDAY 10 APRIL 2025 IN THE BOARDROOM, NIAS HQ

PRESENT:	Mr P Corrigan	Committee Chair
	Mr J Dennison	Non-Executive Director
	Mr P Quinn	Non-Executive Director
IN ATTENDANCE:	Mr N Henry	Assistant Director of Governance, Risk and Assurance
	Ms L Donnelly	Interim Director of Finance
	Ms S Beggs	Manager of Chair and Chief Executive Office
	Mr S Mullen	Interim Director of Planning, Performance and Corporate Services
	Mr N Walker	Head of Performance, Planning and Corporate Services
	Mr W Abernethy	Management Accountant
	Mr N Sinclair	Chief Paramedic Officer

1 Apologies & Opening Remarks

The Chair welcomed members to the meeting.

2 Procedure

2.1 Declaration of Potential Conflicts of Interest

The Chair asked those present to declare any potential conflicts of interest now or as the meeting progressed.

No declarations of conflict of interest were made.

2.2 Quorum

The Chair confirmed the Committee as quorate.

2.3 Confidentiality of Information

The Chair emphasised the confidentiality of information.

2.4 Terms of Reference (ToR)

The Chair referred to section six of the terms of reference and reminded members of the remit of the Committee which is to review the Trust Financial strategy, major strategic initiatives, and financial and operational performance, and provide the Board with a level of assurance.

The Committee discussed its role in terms of the approval of business cases and its responsibility in this regard compared to Trust Board. Mr Corrigan and Mr Dennison noted that there have been conversations about this in the past and that it would be useful to confirm what, if anything, is documented in the Standing Orders. Ms Donnelly suggested that business cases relating to substantive capital expenditure should be brought to the Committee, such as the Fleet Business Case which is being prepared at present.

Mr Quinn suggested the Committee oversee items that are strategically relevant and provide governance oversight for large business cases involving sizeable expenditure.

Mr Corrigan requested a paper at the next meeting outlining the current standing orders for delegated authority, the big investments, and a proposal from the Finance team on how it best works. He suggested that the Committee review the proposal to be considered at Trust Board.

ACTION: Ms Donnelly

The Chair referred to the performance element of the terms of reference and noted that the Committee needs to prioritise its focus on strategic and high-level matters e.g. high level strategic objectives, transformation projects and programmes. It will be important for the Committee to work out how the Committee can provide assurance to Trust Board without duplicating and that the Committee will need to consider the level of detail required at Committee level to raise matters in a meaningful way to Trust Board.

Mr Quinn highlighted that the Committee are reviewing papers and discussing strategy development, but it is ultimately the Board's responsibility to develop transformation. It seems appropriate for the Committee to monitor strategy development, and this may need to be included within the Terms of Reference. Mr Corrigan agreed with the importance of the Committee receiving regular updates on strategy development and noted that the terms of reference will be reviewed annually however, they can be tweaked in advance if required.

2 Performance Report March 2025 (SPF10/04/25/01)

Mr Corrigan noted that the tabled performance report is the same one that was reviewed at Trust Board recently and therefore there is little value in focusing Committee time to it today. Going forward, the Committee will review performance metrics and Trust Board will also be provided with oversight of performance from an assurance perspective, but not to the same level of detail.

Mr Walker gave an overview of the current format of the performance report and the included metrics. The Committee discussed its role and responsibility relevant to other Committees in terms of appraising performance. Mr Henry noted that one of the intended purposes of the Committee was to facilitate sufficient time to scrutinise performance at Committee level, given that performance discussions at Trust Board can be limited to busy agendas. The Committee may wish to escalate particular performance issues to Trust Board after reviewing the performance report in its entirety.
Mr Corrigan added that there has been a disconnect up until now as the performance report has been a monthly report, submitted to SMT and then the most recent one submitted to Trust Board, therefore the Committee need to think through how that would work better.

Mr Sinclair said focus is required on how response times are improved, it's not about hitting targets, its about doing the right thing for patients. Mr Sinclair noted the update at Trust Board needs to be a more succinct executive summary of key highlights, highlighting the synergy between response times and clinical outcomes.

Mr Dennison suggested that the performance report could be amended to have an executive summary setting out the key issues: the main areas of underperformance and any ongoing priority areas to try and improve. The underlying detail is important and provides really rich information, but the Committee might struggle to extract the information they need to focus on. Mr Dennison acknowledged the amount of work that goes into this report and reiterated that the feedback is not in a critical manner, but the report needs to be reviewed in order for NEDs to deliver their duties.

Mr Walker responded that it has been really helpful to have the discussion, to understand what is required.

Mr Mullan noted that the performance report will have to be amended over time to adapt to the new commissioning metrics which NIAS will be held to account for by SPPG as part of the Strategic Outcomes Framework. Mr Mullen confirmed for Mr Corrigan that NIAS are still reporting on the previous framework, but there are regional discussions with SPPG about transitioning into one reporting process but is unsure yet what that key metrics will be. Mr Corrigan suggested realigning this to the NIAS Strategic Plan, which Mr Mullen agreed with.

Mr Dennison said that coming to the end of the strategic plan, and developing the new plan, the Committee need to know what needs progressed longer term in the future and suggested picking out a subject area to focus on at each Committee.

Mr Quinn suggested raising the commissioning plan with Mr Farrar which was discussed at a committee a while ago. Mr Quinn noted that there are system pressures and commented on the poor Category 2 performance and the translation of this into delayed responses and increased patient harm/SAIs being reported. Mr Quinn emphasized that it is important that poor performance and long ED handovers do not become normalized and there is a need to highlight these performance pressures.

Mr Corrigan emphasised that he doesn't want to create extra work in relation to the report, but it is important that it includes the right level of detail required in an Executive summary including narrative with key issues or areas of concerns to be highlighted at Trust Board.

Mr Quinn suggested keeping the report as it is but highlighting a couple of key aspects to focus on i.e. what underpins or underlies what this report tells the Committee. Cat 1 and 2 response times are very important to look at. Mr Dennison added the Executive Summary should bring the items required to their attention.

The Committee **AGREED** that the performance report should be amended to have an Executive Summary upfront highlighting key areas of performance and improvement action, with the underlying detail provided in the papers. The Committee further **AGREED** that it would be useful to focus on particular areas of performance through a "Deep Dive" at each Committee meeting.

ACTION: Mr Mullen/Mr Walker

4 **Finance Report (Month 11) (SPF10/04/25/02)**

Ms Donnelly presented the Month 11 Report (Jan 25) and explained the key highlights.

In relation to RRL, as at Month 11, the Trust was reporting YTD expenditure of £110.396m, with an underspend of £ 0.168m when compared to YTD profiled budgets. (£10.381m monthly spend). The main change from the Month 10 position was the allocation of £5.103m of the pay award funding, increasing the Trust allocation from SPPG from £119.116m to £124.270m. In Month 11, the savings plan to deliver £2.475m of savings was also on track to be achieved in full.
Month 12 expenditure is expected to increase in line with expenditure profiles and for reasons including the 2024-25 pay award. Ms Donnelly noted that, at the time of the Committee meeting, NIAS remains on track to deliver a break-even position at year-end.

The Committee discussed the processes put in place to fund the 2024-25 pay award and whether this would affect the year end position. Ms Donnelly advised that the finance team is actively working on that issue and does not expect this to be a risk.

Ms Donnelly further noted that for financial year 2025-26, NIAS will be reviewing the funding requirement and associated evidence to support the funding position going forward. In addition, the finance

team will be seeking to optimise resources for NIAS's use and will engage with SPPG on any potential shortfalls.

Mr Corrigan highlighted the discrepancy that arose last financial year with investment being provided and misalignment with workforce availability and recruitment timescales, and that it was important to ensure that a similar issue did not arise this year. Mr Corrigan noted the importance of demonstrating credibility to SPPG.

Mr Sinclair said that the clear focus 10 days into the new financial year should be to proactively recruit to vacant and new posts as early as possible. The team are trying to piece together and be on the front foot with lead times and challenges with delays regarding recruitment. Mr Sinclair noted that there is a degree of certainty around cohorts of NQPs coming out of university and there is a need to focus on recruitment activities for Advanced Paramedics and EMTs.

Ms Donnelly advised that plans are developed this year to work with directorates and budget holders to project the financial requirements for next year to ensure there is evidence for next year's funding. Ms Donnelly said there is an indicative allocation of £122 million but this didn't take into account the £5m for the pay award - the actual allocation will be notified at the end of May.
Mr Quinn pointed out there is a revenue consequence due to the restructuring of staff and sought clarification that NIAS are being dynamic with the budget, recognising there is a resource need there. Mr Abernethy responded that they are looking at the position and considering new starts. There is a new cohort of EMT staff in the current month, 48 new staff from university and they are working out the budget number for next year. Ms Donnelly added that they are identifying the contingencies so NIAS can benefit from them.

Ms Donnelly confirmed that there was significant provision for the historic holiday pay dispute, which DoH are leading on. Ms McAuley is leading on this within NIAS and Ms Donnelly agreed to get an update on figures.

ACTION: Ms Donnelly

In relation to CRL, as at Month 11, the Trust has received a CRL of £8.837m. (This includes the additional £1.1m to support pressures.) The year end capital work is progressing well and, the forecast is a break-even position at year-end.

Ms Donnelly advised the Committee that in terms of the indicative budget they are basing this on the rolling initial allocation and the team are reaching out to directorates to see what their funding requirements are.

Ms Donnelly has met with the DoH to discuss the consequences of higher inflationary costs for example for fleet. Ms Donnelly noted that there is anticipated to be significant budgetary constraints within HSC this financial year, but that she will continue to liaise with DoH to communicate any pressures and try to secure any funds that may be available.

Mr Quinn referred to the agenda for change regarding job evaluations and asked if there is a delay in getting jobs evaluated for the Ops Restructure. Mr Quinn is considering raising the issue with Mr Farrar if required, however, Mr Sinclair advised it is an internal process.

5 **Overview of finance reporting & suggested priorities for future SPF Meetings.**

There are five meetings of SPF scheduled for 2025/26: April, June, September, November, and February 2026.
Ms Donnelly outlined the intention to provide the Committee with more granular information, reports, and updates than are currently received by the Trust Board or the previous PFOD Committee. This will give further additional assurance to the Board that there is a satisfactory level of ongoing and detailed scrutiny regarding the Trusts financial position, financial forecasting, and forward financial plans. Ms Donnelly provided the Committee with a table of proposed reports that the Committee will be presented with through the year and welcomed the members feedback on any changes required.

The Chair said that he would like this Committee to have an oversight of the savings plan, which is reported in the current monthly finance report.

ACTION: Ms Donnelly

Mr Corrigan would also like some narrative on Fleet and queried where issues pertaining to Fleet are currently reported. It was confirmed that fleet expenditure would fall under Capital and the Chair requested further detail to be included in relation to Fleet and Ms Donnelly said she would be happy to share this information. Mr

Henry added that it was a recommendation from Internal Audit last year for Committees to have more visibility of fleet matters and it would be built in this year for fleet to come to the SPF Committee in relation to the spend side with an opportunity to have a deep dive into fleet.

ACTION: Ms Donnelly / Mr Mullen

Mr Henry confirmed for Mr Quinn that the sustainability for fleet was another recommendation for this Committee to have sight of. Mr Quinn suggested it would be useful for the Committee to receive more information on this.

ACTION: Mr Mullen

Mr Dennison alluded to reforecasting and Ms Donnelly confirmed she has implemented a more robust process to ensure accurate reforecasting. There is an initial budget allocation for each Directorate and the Finance team meet with teams each month to update their reforecasting profiles, with a formal exercise taking place in October and before Christmas. Mr Corrigan would expect to see a forecast with a degree of accuracy by month four and Ms Donnelly said she would advise the Committee of the plan in due course.

ACTION: Ms Donnelly

6 Overview of strategic transformation initiatives & suggested priorities for future SPF meetings (SPF10/04/25/03)

Mr Mullan presented a paper outlining the proposed meeting structure, schedule and exemplar of papers for the Committee.

He referred to the earlier discussion regarding the performance report and that the team plans to make it easier to digest highlighting the key priorities.

The plan includes a proposal of agreed areas of focus in addition to Ms Donnelly's information so the Committee can see in advance what items are being discussed to ensure papers are ready in advance.

Mr Corrigan said that the plan looks good as a starter and all the main areas are covered. It will be an ongoing developing process and as some meeting dates don't have the CTF Committee after, there will be more time to focus on areas at this Committee.

Mr Corrigan offered Directors to email him papers in advance of the June meeting if it is helpful.

7 NIAS 2026-36 Strategy Development Process (SPF10/04/25/04)

Mr Mullen explained that Trust Board has previously discussed the NIAS Corporate strategy development process and timeline at a meeting in September 2024. It was subsequently agreed that a task and finish steering group be established to oversee the strategy development process and ensure ownership across directorates. Trust Board endorsed this approach and tasked a NED to chair the process, which Mr Quinn has agreed to do.

Mr Mullen noted that two members of staff with public health experience will shortly be joining NIAS to begin the detailed work to establish a draft strategy by the end of this calendar year.

Mr Quinn suggested that due to the work involved, the strategy should be for a period of 10 years, 2026-36 and Mr Mullen said it is within NIAS' gift to decide how long it is. Mr Corrigan agreed it is beneficial to look forward but suspects in terms of getting into the detail, they might only be able to look at two or three years ahead. Mr Quinn said it will be challenging to project far ahead, but they are trying to envision what an ambulance service could look like in five to six years, which he thinks is the approach that needs to be taken. The team have brought in two critical skills sets for data and project management.

Mr Dennison reminded the Committee that initially, a decision was taken to proceed with the strategy development and to not wait on a new Chief Executive. However, he suggested looking at the process again in Autumn after the background work had been undertaken, and review whether or not to proceed if there is no permanent Chief Executive by that stage.

Mr Quinn noted that engagement with service users and stakeholders is a key element and Mr Mullen confirmed that there is already an existing patient forum which Mr Neil Gillan supports and has established strong relationships with. The plan is to ask two members of that forum to join the Strategy Development group.

Mr Corrigan noted in terms of governance that this Committee is the natural place for oversight and progress of the workplan but ultimate

sign off is with the Board. He suggested tabling this as a standing item at each Committee for a progress update, depending on how often the steering group is and doing a deeper dive once a year.

ACTION: Ms Beggs/Mr Mullen

Mr. Quinn discussed the need for a detailed timeline and the importance of having a strategic away day with Mr. Mike Farrar. He mentioned that it can be beneficial to step back from day-to-day duties and work with an experienced facilitator, especially after the team has gathered a variety of perspectives.

8 Any other business

There were no matters discussed.

9 Next meeting:

19 June, 18 September, 27 November and 5 February

THIS BEING ALL THE BUSINESS, THE CHAIR DECLARED THE MEETING CLOSED AT 11:15AM

SIGNED:

DATE: 19/6/25

Northern Ireland Ambulance Service
Health and Social Care Trust

MINUTES OF THE PEOPLE, CULTURE AND ORGANISATIONAL DEVELOPMENT COMMITTEE HELD AT 9.30AM ON THURSDAY 3 APRIL 2025 IN THE BOARDROOM, NIAS HQ

PRESENT:	Mr J Dennison	Committee Chair
	Mr P Corrigan	Non-Executive Director
	Mr P Quinn	Non-Executive Director
IN ATTENDANCE:	Ms M Lemon	Director of HROD
	Ms S Beggs	Manager of Chair and Chief Executive Office
	Ms R Byrne	Director of Operations
	Ms L Turley	Deputy Director HROD

1 Apologies & Opening Remarks

The Chair welcomed members to the meeting.

2 Procedure

2.1 Declaration of Potential Conflicts of Interest

The Chair asked those present to declare any potential conflicts of interest now or as the meeting progressed.

No declarations of conflict of interest were made.

2.2 Quorum

The Chair confirmed the Committee as quorate.

2.3 Confidentiality of Information

The Chair emphasised the confidentiality of information.

3 Previous Minutes – 13/02/2025 (PC03/04/25/01)

The minutes of the previous meeting held on 13 February 2025 were **APPROVED** on a proposal from Mr Quinn and seconded by Mr Corrigan

4 **Matters arising (PC03/04/25/02)**

Vaccinations
Ms Lemon advised that an update will be provided at the next Committee meeting and Ms Ruth Finn has been asked to present on this.

Mr Quinn suggested that it would be useful to update the organisational chart setting out the roles and responsibilities of different teams, and Ms Lemon agreed to progress this with colleagues.

ACTION: Ms Lemon

Culture Workshop
The NIAS Culture Workshop took place on 31 March and was co facilitated by Kings Fund and the Leadership Centre.

The main purpose was to identify key issues, themes, and drivers in advance of the establishment of a Programme Board for the upcoming cultural improvement work. Ms Lemon advised that a comprehensive post workshop brief will be provided in due course.

Mr Quinn noted that while the Workshop had been well facilitated, some key staff groups, such as the Operations and Clinical Directorates, were not well represented. Mr Quinn sought clarity on who has the lead responsibility going forward for the Programme and emphasised that it is important to ensure engagement from all parts of the Trust. Further, Mr Quinn noted that there needs to be buy-in from the Chief Executive and SMT to ensure that the tangible concepts arising from the workshop are addressed and delivered on.

Ms Lemon advised that Michael Riddell will be joining NIAS at the beginning of June and this will enhance senior level Deputy Director HROD capacity within the Trust to deliver the necessary workstreams identified by the Programme Board. Ms Lemon noted the ongoing work being taken forward by Bron Biddle in respect of

sexual safety in the workplace and that this would be aligned with the cultural improvement review.

Mr Corrigan agreed that the workshop went well, and it is important that this piece of work continues. He said that culture is part of the PCOD Committee, however the Programme Board needs to direct the activity and ensure the Committee receives regular assurance updates. Ms Lemon confirmed that the Programme Board will update the PCOD Committee, and the Committee **AGREED** that Culture will be a standing item at future Committee meetings.

ACTION: Ms Beggs

A part of a Culture programme, in terms of shaping the relationship with Trade Unions, we will undertake a Partnership working review. Work will be undertaken to facilitate co-production of a new industrial relations Framework. Moving this into a more strategic, solutions focused place. Enhancing governance and promoting meaningful and true partnership working. This will also improve relationships and lifting levels of engagement with NIAS as part of overall cultural enhancement.

The Committee sought assurance on the anticipated next steps in terms of developing a Partnership Framework and discussed that it would be useful to establish a Strategy and Work Programme, in detail, covering a 3-year period with a timeline for the role of the Board and PCOD members. Mr Dennison asked what the next steps are, and Ms Lemon confirmed there will be a formal de-brief and the first Programme Board Meeting scheduled.

Mr Quinn suggested getting a date scheduled as soon as possible with an update coming to the next meeting on 12 June 2025.

Ops Restructure

Ms Byrne advised there is no further update on the Ops Restructure since the last Trust Board Meeting at the end of March. Ms Lemon has agreed to release a senior HR manager for two days per week, which will increase to full time release, to support the Ops Restructure and a project lead has been identified from within Planning Performance and Corporate Services.

5 HROD Balance Scorecard (PC03/04/25/03)

Ms Turley provided some key highlights from the Balance Scorecard.

The reports show there is a stable workforce currently in terms of headcount, with just over 1,300 members of staff. Turnover is reported at 6.33% on average across the health service, and no specific concerns are highlighted to the Committee in this regard.

Good progress has been made within Whistleblowing cases since the last PFOD meeting: several have been triaged at an early stage and have been addressed with relevant training.

Ms Lemon apologised that the narrative paper was not available for this meeting and noted that the report is still in the format used for PFOD Committees. Ms Lemon sought feedback from the Committee about the usefulness of the information and what other metrics the Committee may wish to be included.

Mr Corrigan advised that it would be useful to pull out key themes and present this as an Executive Summary for the Committee. The underlying detail can be provided, but the salient points need to be provided upfront.

Ms Lemon confirmed that overtime payment pressures will be reported, going forward, at the Strategic Performance and Finance (SPF) Committee.

The Committee made further suggestions as to how the HR/OD Balance Scorecard could be improved with regards to divisional breakdown of metrics, capturing key milestones associated with projects and the use of graphs/charts.

The Committee suggested more information regarding Organisational Health would be useful, for example, joiners and leavers and information on exit interviews, maybe twice a year, to identify any themes, which will tie in with the cultural scheme.

The Committee agreed that succession planning, and talent management should be reflected within the performance report and Ms Lemon said that the new HR AD for workforce planning and succession planning should be at the next meeting.

The Committee discussed the reporting of Mandatory Training compliance. Ms Lemon highlighted that this overlaps several Committees and there is a need to agree and formalise which Board Committee will take ownership of this, with issues pertaining to safeguarding a good example.

Mr Corrigan said that the Safety Committee may be reviewing safeguarding, but potentially under a different scope, and that clinical education, learning and development, continual development, usually falls within the HR remit. Ms Lemon confirmed that training is reported at Safety Committee but within a different 'lens'.

Mr Quinn highlighted the challenges around capacity in the safeguarding team and noted that when establishing objectives for the cultural improvement work, NIAS challenge itself to identify what problems require specific resolutions and the evidence-base from which improvement can be measured.

The Committee **AGREED** the proposed revisions to the HR/OD scorecard and Ms Lemon and Ms Turley agreed to update before the next meeting.

ACTION: Ms Lemon/Ms Turley

The Committee discussed the need to ensure that it, or one of the other Board Committees, is sufficiently sighted on issues including cases where a clinician is practicing despite their professional registration having lapsed, the communications activities in the Trust and relevant strategies and proactive engagement with the public and independent sector.

The Committee agreed that communications should remain as an item under the Committee's remit.

The Committee discussed examples within HCPC i.e. someone practicing whose registration has lapsed, which is an important governance issue, that NIAS have systems in place to identify.

ACTION: Ms Lemon/Ms Turley

Mr Corrigan suggested it may be helpful for the Chair and Chief Executive to review and confirm items are sitting within the appropriate Committee, after the first Committee meetings within the new structure have taken place, as part of a governance restructure review.

Mr Dennison suggested that NIAS periodically liaise with other Organisations not affiliated with NIAS, to learn different things. Ms Byrne advised that they collaborate on an ongoing basis with the PSNI but agreed to consider and discuss with the team.

ACTION: Ms Byrne

6 **Absence Management (PC03/04/25/04)**

Ms Lemon referred to the progress made within absence management and wished to commend all the team who have worked hard to maintain this.

There are a couple of key themes, the main one is mental health and demonstrates the reality of the pressure NIAS staff are working in.

The team have achieved great progress within redeployment and Ms Lemon noted that as staff get older there can be physical limitations in terms of the full range of activities they can undertake. There is ongoing engagement and dialogue with TU colleagues about role adjustment in these circumstances.

The peer support team are heavily engaged on trauma support but are also moving into supporting the health and well-being HSCNI Regional Strategy.

Ms Lemon noted significant challenges regionally with Occupational Health services capacity and waiting times for an appointment. There are KPIs now in place to review the level of service NIAS is receiving, and Ms Ann-Marie McStocker monitors this.

Ms Turley concluded that there are two areas of focus, pre-employment health checks and the gap for professional support for peer support workers. The improvement within occupational health delays will help improve absence. Mr Corrigan is keen that NIAS retain focus on this to ensure NIAS can deliver, as it has been an ongoing barrier.

Mr Corrigan asked to keep Occupational Health Review on the Strategic highlight review Report.

ACTION: Ms Lemon/Ms Turley

Mr Quinn queried whether NIAS asks potential recruits to undergo a psychometric test to determine if their level of resilience is commensurate with the expected roles and activities of their job. Ms Lemon noted that this would be broadly and Ms Turley added that coping skills and resilience would be covered within the induction stage but appreciates it would be beneficial to include this within the recruitment processes.

Mr Quinn sought clarity on whether resilience is captured/assessed as part of clinical supervision and Ms Byrne agreed to check this.

ACTION: Ms Byrne

The Committee discussed that the control room have space to go to after difficult calls, which is a reactive measure but queried what NIAS can do in terms of being more proactive in this respect.

The Committee requested that data relating to staff assaults should be captured at PCOD.

ACTION: Ms Lemon

Mr Quinn referred to the charts in relation to absence within PCS and asked if there is any difference, particularly in the southern division and if it has impacted on absence. It was noted that the PCS absence is reducing. Mr Corrigan acknowledged the significant improvement.

The Committee suggested that once absence is at a more manageable level, NIAS need operational managers to manage other leave as this may result in an increase in annual leave, special leave, or other types of leave. Therefore, NIAS need to ensure all processes and protocols are being strictly adhered to across the board.

Mr Quinn said it is difficult to interpret the graphs and asked HR to consider how Committee members can get the level of information they need from these.

ACTION: Ms Lemon/Ms Turley

Mr Dennison thanked Ms Lemon and Ms Turley for the informative update.

7 Employee Relations (PC03/04/25/05)

The Committee **NOTED** the report which demonstrates there are a number of cases being closed off.

Ms Turley explained that most of these cases should be being resolved at a local level before being escalated. Managers must be more proactive in attempts to resolve issues instead of defaulting to HR. Leadership and Management Development as part of the Ops restructure will help drive this change. Ms Lemon added that skills in resolution and conflict need to be adapted to ensure Managers can deal with certain situations.

The team have closed over 80 cases and section three of the report outlines an overview of what the team are doing.

Mr Corrigan welcomed the update and asked why the update is for the end of January and if a more recent update could have been provided i.e. up to the end of March. Ms Turley advised that some of the cases are cautionary suspensions and perhaps lengthy cases. Ms Turley further noted a small number of suspension cases are sitting with safeguarding and the PSNI. Mr Quinn noted that the way such cases are reported is critical and requested to see the total number and longest duration.

ACTION: Ms Lemon/Ms Turley

8 Partnership Framework

Ms Lemon provided an update on the priority to establish a Partnership Framework in the context of ongoing ASOS, which is presenting challenges in terms of progressing this.

The Committee discussed the on-going ASOS and the recent engagement between the Minister for Health and TU colleagues.

The Committee agreed that it is vital for NIAS to be present at the meeting with the Minister and TUs.

9 PFOD Meetings going forward

The Committee suggested a draft report template is sent to Committee members in advance of the next meeting to ensure they are content with the formulation as per discussions at today's meeting.

ACTION: Ms Lemon/Ms Turley

10 Any other business

The Committee noted that this was Ms Byrne's last meeting and wished her well in her new role. They acknowledged the extreme dedication she has given to NIAS through some very challenging times.

11 Next meeting:

12 June 2025, 9.30am
NIAS Headquarters, Boardroom

THIS BEING ALL THE BUSINESS, THE CHAIR DECLARED THE MEETING CLOSED AT 11.45AM

SIGNED: _____

DATE: _____12/6/25_____

Northern Ireland Ambulance Service
Health and Social Care Trust

MINUTES OF THE PATIENT EXPERIENCE, QUALITY AND SAFETY (PEQS) COMMITTEE HELD AT 9:30AM ON THURSDAY 24 APRIL 2025 IN THE BOARDROOM, NIAS HQ

PRESENT:	Mr D Ashford	Committee Chair
	Mr P Quinn	Non-Executive Director
	Dr P Graham	Non-Executive Director
IN ATTENDANCE:	Ms L Charlton	Director of Quality, Safety & Improvement
	Mr Corns	Consultant Paramedic
	Ms R Byrne	Director of Operations
	Dr N Ruddell	Medical Director
	Ms S Beggs	Temporary Board Secretary
APOLOGIES:	Mr R Sowney	Senior Clinical Advisor
	Mr N Sinclair	Chief Paramedic Officer

1. Apologies & Opening Remarks

The apologies were noted.

The Chair welcomed members to today's meeting.

2. Procedure

2.1 Declaration of Potential Conflict of Interest

No declarations were made.

2.2 Quorum

The Chair confirmed that the Committee was quorate.

2.3 Confidentiality of Information

The Chair confirmed and emphasised the confidentiality of information.

3. Previous Minutes

The minutes of the previous meeting on 30 January 2025 were **APPROVED** on a proposal from Dr Graham and seconded by Mr Quinn.

The Chair asked Ms Beggs to circulate the previous minutes to Committee members, which were approved outside of the meeting by the Committee Chair. Ms Beggs to add these to One Advanced for completeness.

ACTION: Ms Beggs

4. Matters Arising

Committee members **NOTED** the update on Matters Arising.

RQIA Comms: Independent Ambulance Services inspections

Ms Charlton advised that, further to correspondence received from RQIA suggesting that they review the commissioning and oversight of IAS, a response has been approved by HSC Chief Executives and forwarded to RQIA inviting them to meet to discuss further.

Dr Graham advised that he had discussed the matter with Internal Audit who do not plan to proceed with a report in this area. Ms Charlton will issue the letter of response as soon as possible.

ACTION: Ms Charlton

The Committee noted the extant risk on the Corporate Risk Register relating to the oversight of IAS and agreed that this should remain unless there is significant movement from the DoH in respect of a policy/legislative change.

5. Standing Items

(i) Identification of Risk

HSE communication regarding late finishes

The Committee discussed the ongoing, intractable issues regarding the high volume of late finishes and the adverse effect this is having on staff, operational performance, and patient safety.

Ms Charlton advised that a programme of dialogue has commenced with TU colleagues following a case which has been recently covered in the media, with a view to seeking a resolution and derogations from the current ASOS. Ms Charlton advised that the Minister for Health has offered to meet TUs to discuss the ongoing action and a date for this is being arranged.

Mr Quinn sought clarification if Cat 1 and 2 releases will be in the Ministers briefing, and Ms Charlton confirmed that NIAS are anticipating an invite to the meeting, and if so, this could be referred to.

Dr Ruddell advised that an upcoming Coroner's case will likely identify late finishes/ASOS as a contributory factor and there could be more cases in the months ahead.

Ms Charlton reminded the Committee that the risks pertaining to delayed hospital handovers and ASOS are recorded on the Corporate Risk Register. Nick Henry has undertaken a comprehensive risk assessment and an action plan has been developed to put in place measures with an aim to mitigate the risks. A task and finish group will be convened to take this work forward.

At a recent meeting of the National Ambulance Services Medical Directors' Group (NASMeD) there was a communication shared regarding a contravention notice issued by the Health and Safety Executive in England, regarding the psychological impact of late finishes, which suggests the service consider protecting the last hour of shifts. The Committee discussed the prospect of shift redesign, which is being considered as an additional means of reducing the volume of late finishes. Ms Charlton alluded to the outcome of ORH work which was due in June.

The Committee discussed the need to ensure that members of the Health Committee are briefed and are aware of the steps being taken to NIAS to manage the current situation. Ms Charlton advised

that a briefing with the Health Committee is expected in the coming weeks.
Mr Quinn said that Non-Executive Directors have sought clarity regarding the communications function and activity within NIAS. Ms Paterson subsequently organised a meeting with Mr Quinn and Mr John McPoland where they discussed the communication team's capacity and methods of communicating internally and externally. The Committee discussed the need to ensure sufficient capacity and skills are in place to deliver proactive engagement with all key stakeholders, including political representatives.

Dr Graham referred to an article in the Belfast Telegraph recently about the temporary closure of Purdysburn Ambulance Station, which he had followed up with Ms Paterson to ensure the communications team ware aware.

Mr Quinn stated that another risk is the lack of a 24-hour communications service, which might result in delays to issuing response to enquiries/media stories.

6. PEQS Terms of Reference

The Committee **NOTED** the Terms of Reference.

7. EPRR Update

Ms Byrne plans to organise another meeting date with Mr Ashford in regard to EPRR.

Ms Byrne advised the Committee that NIAS's Incident Response Plan went live on 31 March and has been shared with all blue light partners.
Several commander courses have been completed and there are continued education programmes planned.

There are ongoing discussions with the DoH Permanent Secretary regarding the additionality required to provide a comprehensive specialist response service at NIAS. Mr Ashford said this business case is vitally important and the Committee would like to be updated on the progress. Mr Ashford thanked Ms Byrne for all her hard work and dedication in progressing EPRR, as there has been a lot of progress.

8. Events Management Policy

The Chair welcomed Ms Smylie to the meeting.

Ms Smylie presented the NIAS Event Management Policy and explained that NIAS did not previously have a policy in relation to events. The Policy outlines NIAS actions in relation to planned events, a structured process for how NIAS manages risks and protects normal service delivery and roles and responsibilities of each department. Ms Smylie explained that a process will be stood up to determine whether an officer is required to attend an event based on the risks. There will be a Proforma that officers fill in at the event which will create a data collection tool to predict event impact for future event planning.

The Committee agreed this is a very useful policy.

Mr Ashford queried the rationale for NIAS not charging councils/event organisers, and Mr Quinn agreed particularly for large events. Ms Byrne confirmed NIAS will be reimbursed for the Irish Open taking place in July 2025, and this policy is more applicable to events such as concerts.

Mr Quinn suggested making the event organisers aware of the charitable trust fund and Ms Smylie agreed that they can explore this and agreed to discuss and consider the governance arrangements with Ms Heather Sharpe.

The Committee **APPROVED** the Policy.

Mr Ashford thanked Ms Smylie and Ms Byrne and extended his thanks to the wider team.

9. Education Update

Mr Corns presented the six-monthly update which provides the Committee with progress on actions from the agreed education review report. Nine out of 47 recommendations are outstanding and plans to address these in 2025-26 are outlined.

Mr Corns noted the successful partnership working with Ulster University in respect of onboarding NQPs and advised that the

education team are planning to engage other HSC Trusts to implement learning partnerships in specific areas, including managing Deprivation of Liberty under the Mental Capacity Act.

Dr Graham referred to Driver Training and said it is good that NIAS are ahead of the legislation changes which are expected in September 2025.

Mr Quinn referred to the uptake of mandatory training information provided to the PCOD Committee as part of the HROD scorecard and noted that there is a corporate responsibility for safeguarding and quality improvement and impact of this rests well at this Committee, which pertains to certain staff groups. Ms Charlton advised this training is applicable to all staff groups.

Mr Quinn highlighted the need to understand the impact and outcomes associated with clinical supervision and noted a link to the ongoing cultural improvement work.
Mr Quinn suggested that an evaluation would be helpful to inform the content and structure of clinical supervision sessions going forward.

Dr Graham suggested a feedback form to gain a perspective of the recipient of clinical supervision and experience. Ms Charlton advised that the Safeguarding team are reviewing incidents every week and are exposed to difficult information and are engaging with the Health and Wellbeing team for interjects with the inspire team. Linked to this, Ms Charlton advised there is an ongoing PDR review, which is a really critical corporate responsibility for the education team to consider.

Mr Quinn suggested a competency framework would be helpful for the organisation and would form a backdrop to an appraisal conversation and career progression. Mr Corns added that this may require a different lens to look at supervision as the clinical supervisor is not the staff member's line manager and will therefore not be linking PDRs to clinical supervision.

Mr Ashford noted the intention to increase CCE days. While the service has been struggling to meet 3 days per person this year, there is a clear intention in the education strategy to move to 5 days per person. Given the difficulties in moving to 3 days, it is

unclear how NIAS would achieve 5 days, and this could represent a significant risk if not achieved. Mr Ashford said that we would need to look at this subject again to see if there is any improvement at the next update. Mr Corns explained that this has been explored but that there are capacity and prioritisation challenges which limit the ability to release staff currently.
Ms Charlton suggested it might be something to consider with rota changes within the ORH review.

The Committee **APPROVED** the update and plans for 25/26 and thanked Mr Corns for the informative report.

10. Involvement and Co-Production Update

The Committee **NOTED** the update and Ms Charlton explained that there is a requirement for the Committee Chair to sign the assurance document.

The team has simplified the report as much as possible. One appendix demonstrates where NIAS are with committed activities, which are not time bound, so a rag status has been used. Ms Charlton outlined the current funding arrangements for PPI Officers within geographical HSC Trusts have not been allocated within NIAS despite approaches to seek same. She therefore explained that PHA had suggested that NIAS would not be required to report on this activity, however given NIAS commitment to PPI a return will be provided to ensure best practice and reflect progress.

Mr Quinn noted the significant progress and noted the linkage to the previous discussion on communications capacity and strategy i.e. digital communication and the Trust communicating proactively.
Ms Charlton advised that Mr Neil Gillan is part of the strategy development work that has commenced which will create opportunities for engagement with service users over the next 12 months.
The Committee **APPROVED** the report and Mr Ashford agreed to sign the required document.

11. PCS Update

Ms Charlton advised that following the replacement of the non-emergency CAD there had been a software issue which had

resulted in inaccuracies in the current performance data and therefore a PCS paper had not been included, a software upgrade is expected which will hopefully resolve the data issues by 15 May 2025.

Ms Charlton advised that she would provide a PCS update for the next Committee.

12. Safeguarding Position Report

The Chair welcomed Mr Flannagan to the meeting.

Mr Flannagan presented the position report to the Committee and explained the focus over the past year in relation to delivery of Level 3 face to face safeguarding education as per the safeguarding education and training strategy: the original improvement trajectory had been to provide to all staff delivering direct patient care over a three-year period. Mr Flannagan reported that progress to date had exceeded this trajectory, with currently in excess of 60% of staff completing level 3 training.

Mr Flannagan highlighted a significant increase in safeguarding referrals in the last two years. He referred to the correlation of increased referrals with increased education and also to one factor leading to the increase being due to streamlining the referral process for welfare referrals. He referenced quality of information and documentation provided which allows partnership agencies to follow up efficiently.

Mr Flannagan explained that the development and delivery of safeguarding training has been complex and challenging and has brought with it moral stress and the emergence of difficult conversations. A number of staff have highlighted that they feel the organisation has failed them after a traumatic incident in the past. Through the training it is clear that some staff do not wish to raise these concerns and/or don't feel safe or supported in doing so. Mr Flannagan added that this isn't unique to ambulance services, and he has seen this occur within other blue light services. The team's role is to create an environment that disrupts behaviours that are damaging.

Mr Flannagan noted the emotional toll such episodes have on staff and victims, and the training is intended to support staff to recognise such situations and equip them with skills to challenge and investigate them appropriately.

The Committee noted that Bron Biddle is working with NIAS for a short time in relation to the culture perspective, and the need to ensure individuals with the right skills and knowledge are available to deal with these allegations appropriately, which is capacity beyond the safeguarding team.

Mr Quinn has spoken to Mr Flannagan previously regarding the stark reality of safeguarding issues and noted the impact of legacy issues which have happened historically in the organisation.

As referrals have increased so significantly, Mr Flannagan and Ms Chambers are devoting their time to support staff but there is a big challenge to manage business as usual. A temporary Band 5 role has been added to the team to help support them with referrals. Mr Quinn suggested the banding could be reviewed to reflect the area of expertise required.

Mr Quinn highlighted that management capacity is required to recognise the challenges with perpetrator behaviours and NIAS has a duty as an organisation to ensure management and staff are aware of the concerns and are empowered to address them effectively.

The report was **APPROVED** to go to Trust Board on a proposal from Mr Quinn and seconded by Dr Graham.

The Committee thanked Mr Flannagan for the comprehensive report and the team's commitment and professionalism in dealing with very challenging situations.

13. Update on process, governance and assurance: CAT 1 release

The Committee **NOTED** the briefing which has been compiled at the request of the PEQS committee following a discussion at the Committee meeting on 30 January 2025, where this was raised as a concern.

The paper outlines the operational arrangements that are in place for requesting and managing a CAT 1 release from an Emergency Department.

Ms Charlton advised that there has been an improvement since a SOP was introduced in December 2024 for management of a CAT 1 release. However, challenges remain, particularly at the NHSCT where there have been several failed CAT 1 releases.

Ms Charlton explained that should there be a failed CAT 1 release which contributed to significant harm, the Trust will typically raise it as an Interface Incident, although this is rare. Ms Charlton noted that in the patient deaths noted in the report, a failed CAT 1 release may not be a contributory factor.

The Committee noted that this process was due to be reviewed again in March 2025.

Ms Charlton advised the Committee that work continues regionally with colleagues about Category 2 calls and Interhospital Transfers and that Ms Byrne had reached out to other Trusts to make arrangements for NIAS to be represented at appropriate governance meetings to highlight and share learning re SAIs and Cat 1 releases as appropriate.

14. Date of Next Meeting

5 June 2025, 9.30am, NIAS HQ

15. Any Other Business

Ms Byrne made Committee members aware that NIAS have a KPI of answering 999 calls within 5 seconds 90% of the time and EMD Supervisors record the data every hour. This is then reported every morning at the NIAS Regional Huddle and within the Trust annual reports. For the first time ever, NIAS have achieved over a 90% call answering rate for the entire year.

The Committee agreed this is a really positive achievement and to pass on their congratulations to the wider team.

THIS BEING ALL THE BUSINESS, THE CHAIR DECLARED THE MEETING CLOSED AT 11.35 AM

SIGNED: _____

DATE: **4/6/25**