

Agenda

1 Welcome, Apologies & Declarations of Conflict of Interest

For Information

Heather Sharpe attending in Neil Sinclair's absence

2 Minutes of the previous meeting held on 28 May 2026

For Approval

Attachment: 2 - 01 - DRAFT NIAS TB PUBLIC CTEE MINS 28-5-26.pdf

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3 Matters Arising

For Noting

Attachment: 3 - Public Trust Board action list 25-6-26.pdf

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4 Chair's Update

For Noting

Verbal Update

5 Chief Executive's Update

For Noting

Verbal Update

ITEMS FOR APPROVAL

6 Trust Annual Safeguarding Report

For Approval

Attachment: 6 - 01 - Safeguarding Annual Position Report Cover P TB.pdf

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Attachment: 6 - 02 - Annual Position Report on NIAS Safeguarding.pdf

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7 Response to SPPG Strategic and Operational Planning Guidance 2026-27

For Approval

To Follow

ITEMS FOR NOTING

8 Infection Prevention and Control Annual Report

For Noting

Attachment: 8 - 01 - IPC Annual Report Cover Paper & Executive Summary TB.pdf

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Attachment: 8 - 02 - Infection Prevention and control annual report 2025.pdf

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9 CiC Update

For Noting

Verbal Update - meeting taking place on 23 June

10 Committee Business:

For Information

10.1 Committee Chair Updates

For Noting

Verbal Updates from Committee Chairs, if required

10.2 Committee Approved Minutes

For Noting

Committee Minutes approved since the last Trust Board Meeting on 28 May 2026

Attachment: 10 - 01 - Final signed PEQS Minutes 9-4-26.pdf

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Attachment: 10 - 02 - Final signed PEQS Minutes 16-4-26.pdf

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Attachment: 10 - 03 - Final Signed SPF Meeting Minutes 2-4-26-26.pdf

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10.3 Committee forward Workplan

For Noting

Attachment: 26 - 27Trust Board and Committee Forward Work Plan.pdf

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11 Any Other Business

12 Date & venue of next meeting:

For Noting

24 September 2026 at 9.30am, Strabane

Invitees

Stacey Beggs

Ms. Lynne Charlton

Mr. Paul Corrigan

Mr. Jim Dennison

Ms. Leahann Donnelly

Dr. Philip Graham

Ms. Michele Larmour

Ms. Michelle Lemon

Mr. John McPoland

Mr. Seamus Mullen

Ms. Maxine Paterson

Mr. Phelim Quinn

Dr. Nigel Ruddell

Ms. Heather Sharpe

Mr. Neil Sinclair



Northern Ireland Ambulance Service Health and Social Care Trust



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NIAS Trust Board Public Meeting

Date: 28 May 2026
Time: 10.45 am
Location: Board Room, NIAS HQ

Attendance		
Chair:	Ms M Larmour	
Attendees:	Mr P Corrigan Mr N Sinclair Ms L Donnelly Dr N Ruddell Dr P Graham Ms M Lemon Mr J Dennison	Non-Executive Director Director of Operations (Interim) Director of Finance (Interim) Medical Director Non-Executive Director Director of HR & OD Non-Executive Director
In Attendance:	Ms L Charlton Mr S Mullen Mr J McPoland Ms S Beggs Mr N Henry Mr J Cox	Director of Quality, Safety QSI Director of PPCS (Interim) Comms Manager Board Secretary (Temporary) Assistant Director, Risk & Governance Kings Fund Lead Consultant (Observer)
Apologies:	Ms M Paterson Mr P Quinn	Interim Chief Executive Non-Executive Director

Minutes of Meeting		
Agenda Item	Summary of the discussion	Actions Agreed
1.	<u>Welcome, Introduction & Apologies</u> The Chair opened the Trust Board in public session and welcomed members, officers and attendees. A particular welcome was extended to Jeremy Cox, Lead Consultant, King's Fund, who was attending as an observer in connection with ongoing organisational culture work. Apologies were noted as recorded in the draft attendance sheet. No conflicts of interest were declared.	
2.	<u>Previous Notes</u> The minutes of the previous Public Trust Board meeting held on 30 March 2026 were approved as an accurate	



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	record on the proposal of Dr Graham, seconded by Mr Corrigan.	
3.	<u>Matters Arising</u> The Board noted the updates provided under matters arising. Members were advised that an internal programme board had now been established to support EQUIP implementation; that this was a significant organisational programme spanning HR, finance and systems; and that reporting would be channelled through the appropriate committee structures, including GARAC and PCOD as relevant. It was also noted that work on the organisational structure / organogram was nearing completion and would be brought through the relevant internal routes before finalisation.	
4.	<u>Chair's Update</u> The Chair delivered a detailed update covering recruitment, regional engagement and governance matters. She advised that the Chief Executive recruitment process had concluded that four candidates had been interviewed, and that a preferred candidate had been identified and was progressing through the remaining formal processes. The Director of Finance recruitment was also moving forward, with interviews expected in June, and NED recruitment was progressing to interview stage. The Chair recorded appreciation for the support provided through the process, particularly from HR colleagues and external recruitment support. The Chair also updated members on broader system-level engagement regarding the difficult financial context, including attendance at a finance summit and ongoing discussions on the level of efficiencies expected across HSC and the associated risks. She further highlighted the early positive impact of Release to Rescue, noting the role played by NIAS leadership and the wider HSC Chairs in securing cross-system commitment to improved ambulance handover practice. She stressed that the priority was now to maintain consistency and sustainability.	



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	The Board noted progress in the Committee in Common (CiC) arrangements across the six Trusts, with the Chair explaining that this forum was now moving from strategic principles into more detailed consideration of system priorities, patient flow, pathways and interdependencies. She also noted completion of one-to-one NED appraisals and the value of these discussions in shaping the ten-year corporate planning horizon. Finally, she reflected positively on a range of staff engagement activity, including podcasts involving NEDs, meetings with staff leading patient-centred and digital transformation work, and her forthcoming appointment as Chair of the Public Sector Chairs' Forum.	
5.	<u>Chief Executive's Update</u> Dr Ruddell presented the Chief Executive's report on behalf of Ms Paterson. He updated members on the current financial planning position, advising that all Trusts had been asked to identify potential efficiency contributions. He emphasised that NIAS had fewer opportunities than other Trusts to secure savings without direct service impact and that the Trust had therefore been careful to highlight the likely service and patient safety implications. He further advised that the revised risk-based planning response remained the Trust's preferred position, although there was uncertainty as to which version SPPG was using during Departmental discussion. The Board discussed the challenge of balancing early preparatory work with the fact that the Board had not yet agreed any formal service change proposals. It was agreed that the Board should continue to receive updates on the evolving planning and consultation timetable. Executive team to continue keeping the Board updated on evolving planning guidance / SPPG engagement and any related consultation requirements. Dr Ruddell then provided a detailed update on Release to Rescue, confirming that from 27 April 2026 all Trusts had committed to no patient waiting more than two hours outside Emergency Departments. He advised that NIAS had already seen substantial and sustained improvements in ambulance handover times, improved end-of-shift performance, improved compensatory rest arrangements for staff, and some positive effect on	Executive Team



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	response stability each morning. He noted that this was a significant patient safety improvement, although NIAS remained behind the wider UK position on ambulance response standards and could not be complacent. Members discussed the key issue of sustainability. It was noted that some Trusts had voiced concern about pressure elsewhere in the system, particularly flow, discharge and downstream capacity, and that NIAS was monitoring any unintended consequences including conveyance patterns. Management explained that some increased conveyance could reflect previously "latent demand" now being seen through the system rather than self transport or cancellation. The Board also discussed the benefit of maintaining structured leadership oversight, use of data-rich monitoring meetings, and continued liaison with system partners and the Patient and Client Council regarding public messaging. The Chair noted that the Minister had agreed to meet in June and that ambulance handover performance and patient safety would be central to that discussion. Management to continue monitoring the sustainability of Release to Rescue and to maintain data-led engagement with partners and PCC on public messaging. Mr Cox exited the meeting during this item of the meeting.	Executive Team
ITEMS FOR APPROVAL		
6.	<u>Corporate Risk Register</u> The Board considered the Corporate Risk Register, as reviewed by GARAC on 14 May 2026. Members were advised that there were no major changes other than the proposal to de-escalate two risks: the long-standing risk relating to HART premises, given that alternative premises had now been secured; and the risk relating to senior recruitment, in light of recent progress. It was also noted that risks associated with ambulance handover delays remained under close review and would not yet be de-escalated given the early stage of the Release to Rescue improvement period. Members discussed the broader issue of risk appetite, particularly whether some target scores may be unrealistically low given the nature of ambulance service	



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	risk. It was agreed that this would benefit from a dedicated discussion, ideally aligned with future strategic and budgetary planning. The Board approved the Corporate Risk Register as presented. Mr Henry to facilitate a future Board discussion/workshop on risk appetite, aligned where possible with strategy and budget timelines.	Mr Henry
7.	<u>Approved Call Segmentation Approach</u> The Board considered the proposed call segmentation approach for certain Category 2 and Category 3 calls, previously reviewed at Safety Committee. Mr Sinclair explained that this represented a carefully controlled technical and clinical development intended to optimise the Trust's "hear and treat" capability, allowing certain identified lower-acuity calls to be routed temporarily for additional clinical oversight before dispatch where appropriate. This would create further opportunity for safe alternative pathways and would support the wider ambitions of both demand management and Release to Rescue. Dr Ruddell advised that substantial work had already gone into defining which call types were appropriate for this approach, with technical failsafe's built in to ensure no patient could be "lost" in the system and that calls would return to the active dispatch stack if not clinically reviewed within a safe time. Members welcomed the structured and phased approach, the evidence of piloting and benchmarking, and the assurance provided around staff training, governance and clinical safety. The Board approved the proposal.	
8.	<u>Business Cases</u> <u>ICT Hardware</u> The Board noted that the ICT Hardware business case related to a low-value capital item and had already been approved by correspondence as a business-as-usual replacement. As the expenditure fell within capital governance requirements, formal Board approval was nevertheless required and was granted.	
ITEMS FOR NOTING		
9.	<u>Performance Report</u>	



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	The Board noted the revised, more integrated performance and assurance report format. Members commented that the new format was more strategic and better aligned key narrative points — particularly ambulance handovers — with the supporting charts, owners and leads. It was recognised that the report would take some adjustment for members and that a briefing or workshop may be helpful. Members also discussed the importance of maintaining grip on staff absence and the helpful deep dive work already undertaken through committee structures.	
10.	<u>Finance Report</u> Ms Donnelly reported that the draft capital underspend figure had altered since drafting. Members discussed the challenge of operating into the new financial year without confirmed budget allocations and the practical difficulties this created for directorate budget setting. Management confirmed that, despite this uncertainty, directors had been advised to maintain strict spending control, minimise non-essential expenditure and continue working with finance business partners to identify savings opportunities while protecting patient safety. It was acknowledged that formal month one figures were not yet available due to year-end account closure processes. Ms Donnelly undertook to share figures with SPF as soon as they became available, in advance of the next Trust Board where possible.	Ms Donnelly
11.	<u>CiC Update</u> The Board noted the papers arising from the Committee in Common meeting of 21 April. It was recognised that, although ambulance handovers had not always appeared as a distinct agenda item, the issue had informed wider system discussions around patient flow, alternatives to conveyance, transport pathways and consistency across Trusts. Members welcomed CiC as an important forum for data-driven system improvement and cross-organisational alignment.	
12.	<u>Corporate Strategy Update</u> The Board noted the update on the developing Corporate Strategy. Members were advised that stakeholder engagement and consultation had helped refine the articulation of NIAS's role, although the core	



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	strategic direction remained unchanged. The Board agreed that this work was now on a firmer footing and could be further refined with the incoming Chief Executive prior to formal public consultation and launch.	
13.	<u>Committee Business</u> Committee Chairs provided updates, largely reflecting matters already discussed during the meeting. The Chair specifically noted disappointment at the limited internal audit opinion and confirmed that GARAC would continue to monitor this closely. Dr Graham acknowledged the challenges associated with the Limited Internal Audit opinion, particularly in the context of the significant progress made by the Trust to implement outstanding Internal Audit recommendations last financial year. Members also noted committee-approved minutes and forward work plans.	
14.	<u>Any Other Business</u> The Chair thanked Non-Executive and Executive colleagues for their work and contribution over the previous year and expressed appreciation for the commitment shown in a particularly challenging operational and financial context.	
15.	<u>Date and venue of next meeting:</u> 25 June 2026 at 9.30am	
Summary of Actions		
	1. Mr Henry to facilitate a future Board discussion/workshop on risk appetite, aligned where possible with strategy and budget timelines. 2. Ms Donnelly to provide available month one finance information to SPF in advance of the next Trust Board meeting where possible. 3. Executive team to continue keeping the Board updated on evolving planning guidance / SPPG engagement and any related consultation requirements. 4. Management to continue monitoring the sustainability of Release to Rescue and to maintain data-led engagement with partners and PCC on public messaging.	Mr Henry Ms Donnelly Executive Team Executive Team



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TRUST BOARD – 28 May 2026

		INDIVIDUAL ACTIONING	UPDATE
	PUBLIC		
1	Mr Henry to facilitate a future Board discussion/workshop on risk appetite, aligned where possible with strategy and budget timelines.	Mr Henry	To be scheduled in Autumn
2	Ms Donnelly to provide available month one finance information to SPF in advance of the next Trust Board meeting where possible.	Ms Donnelly	Verbal Update
3	Executive team to continue keeping the Board updated on evolving planning guidance / SPPG engagement and any related consultation requirements.	Executive Team	Discussed at SPF on 18 June and update on today's agenda
4	Management to continue monitoring the sustainability of Release to Rescue and to maintain data-led engagement with partners and PCC on public messaging.	Executive Team	Being monitored through our extant performance management framework – update on today's agenda



Northern Ireland Ambulance Service
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MEETING PAPER COVER SHEET

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Paper Title:	Annual Safeguarding Position report for 2025/26		
Paper For:	Trust Board	Link to Strategic Objectives:	
Meeting Date:	25/06/2026	Most appropriate clinical response	☐
Author:	Des Flannagan	Work collaboratively with HSC partners	☒
Responsible Director:	Lynne Charlton	Deploy resources to meet patient needs	☒
Action Required:	TO APPROVE	Support improved health outcomes	☒
Resource Implications:	No	Optimise organisational resilience	☒
Paper History:	SLT		

Executive Summary and Key Messages

This report provides an overview of safeguarding activity, performance and emerging risks within NIAS during the 2025/26 reporting period. It reflects continued alignment with national guidance, including recommendations from the NASAG Peer Review (2023), and organisational priorities relating to safeguarding governance and workforce capability.

There has been a significant increase in safeguarding referrals, rising by 39.5%, alongside the delivery of Level 3 safeguarding training to 86% of patient-facing staff. This demonstrates an increasingly vigilant workforce and improved identification of patient vulnerability. The report highlights key themes including domestic abuse, safeguarding allegations involving staff, inter-agency working, and improvements in data capture through the Datix system.

The report also outlines ongoing challenges, including cultural behaviours associated with safeguarding reporting and system limitations. A programme of improvement is underway, including strengthening governance through the introduction of the Safeguarding Assurance Group (SAG), enhancing workforce training, and improving data quality and partnership working. The report provides assurance to the Committee that safeguarding arrangements are continuing to mature and align with statutory and regional expectations.

Recommendation

The Committee is asked to:

- **Approve** the Annual Safeguarding Position Report for 2025/26
- **Note** safeguarding activity, performance and governance arrangements within NIAS
- **Note** key areas of risk and emerging safeguarding themes
- **Support** the proposed development priorities for 2026–27, including the introduction of the Safeguarding Assurance Group (SAG)



Annual Position Report on NIAS Safeguarding

**Safety, Quality, Patient Experience and Performance Committee
May 2026**

Compiled by:

Des Flannagan – Head of
Safeguarding

Stacey Chambers – Safeguarding
Manager

Ruth Finn – ADQSI

Lynne Charlton - DQSI

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- 7. Adult Protection Bill (NI)**
- 8. Staff Safeguarding Allegations**
- 9. Technological Improvements/Data Management**
- 10. Conclusion**

1.Executive Summary

The focus on this report will continue to reflect the recommendations outlined in the National Ambulance Safeguarding Adult Group (NASAG) Peer Review which took place in 2023. The report will also provide an overview of safeguarding referral data, engagement with partner safeguarding agencies, and safeguarding allegations related to the NIAS workforce. In addition, the report will highlight the emerging safeguarding themes which are emerging when exploring the data.

As the Level 3 safeguarding training programme has now been completed with just over 80% of the patient facing workforce, the focus has now shifted to introducing Level 1 and improving the current Level 2 online offering, alongside renewal of Level 3 starting in 2027.

The growth of safeguarding referrals continues at a significant rate, and work has commenced to review our data and explore opportunities to better understand what we are capturing and how it aligns to strategic safeguard priorities with SBNI and the Interim Adult Protection Board.

Key updates included in this report are:

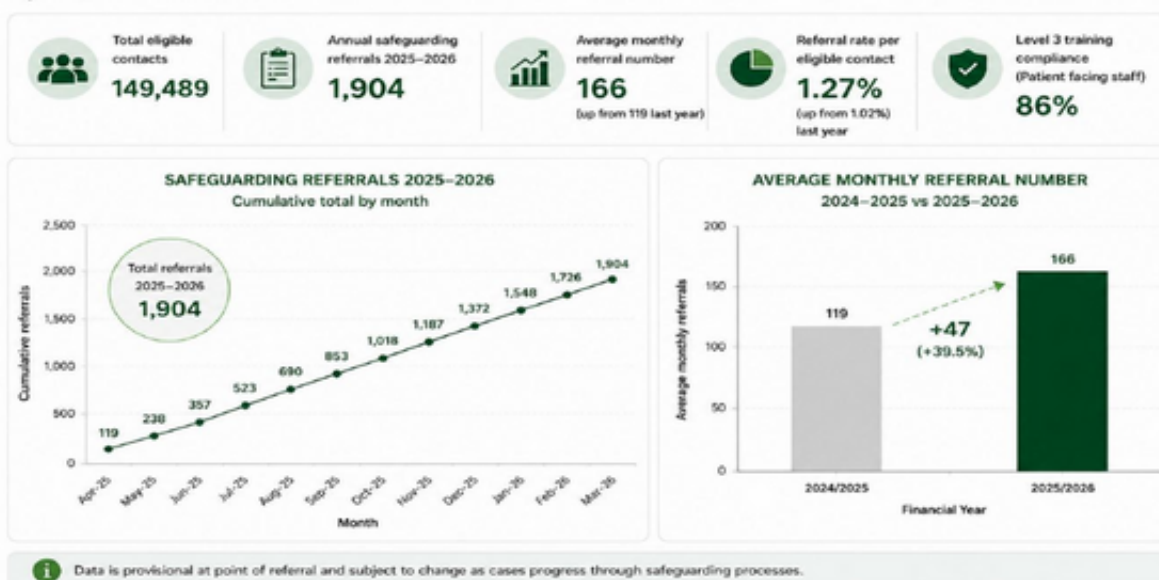
- **Safeguarding Policy Update:** Following the recent introduction of the new policy on Managing safeguarding allegations against staff, there has been some learning identified in the operational management of these cases. Consequently, the policy is currently being reviewed in partnership with colleagues in Human Resources to ensure this learning is applied to the policy and operational processes.
- **Staff Training Progress:** Ongoing progress has been achieved in addressing the aim of providing Level 3 Safeguarding education to all patient facing staff. Level 3 Safeguarding Training has been delivered to **86%** of the workforce who have contact with patients.
- **Increased Safeguarding Referrals:** We have seen a continued increase of safeguarding referrals in reporting period 25/26. By 31 March 2026, the number of **safeguarding referrals increased by 39.5%**.
- **Agency Collaboration:** Alongside contributions to domestic homicide reviews and the draft Adult Protection Bill, NIAS holds partner membership on the SBNI and Interim Adult Protection Board (IAPB). Current panel representation in the Northern and Belfast areas, alongside recent appointments to the South Eastern and Southern Domestic & Sexual Violence & Abuse Partnerships, will soon expand to all remaining Trust areas following the recruitment of a senior safeguarding professional. This cross-agency participation enables NIAS to pool expertise, drive informed policymaking, and deliver a unified, coordinated response that improves outcomes for vulnerable individuals.
- **Technological Improvements/Data Management:** Following integration barriers on the Ortivis platform, the Safeguarding Referral pathway will remain on Datix. To address this, we focused on upgrading the Datix user interface. This work has significantly improved both user experience and data capture quality, directly enhancing our ability to track emerging themes and report safeguarding activity accurately.

2. Safeguarding Referral Data:

From 1 April 2025 until 31 March 2026 there have been a total of 1904 adult/children safeguarding/ welfare incidents reported by NIAS staff. This is an increase of 39.5% on the same period 2024/25. This increase follows on from the 34% increase on the previous reporting period of 23/24.

SAFEGUARDING ACTIVITY SUMMARY

April 2025 – March 2026



Referral Themes

Considerable work has been undertaken to understand and improve the safeguarding data we are capturing, particularly in relation to safeguarding themes that are emerging for our patients. Safeguarding can be complicated due to the overlap of concerns and factors affecting people and organizations. Nevertheless, we have identified some commonly identified themes for adults and children alike.

REFERRAL THEMES AND EMERGING VULNERABILITIES

Understanding the Context Behind the Data

Our data shows that safeguarding concerns are rarely standalone. They sit within the context of multiple, interconnected vulnerabilities.

The themes below highlight the most frequently recorded safeguarding concerns during 2025–2026. Many referrals involve overlapping factors and cumulative harm.



KEY INSIGHT

Current categorisation captures the primary presenting concern; however, many referrals involve overlapping vulnerabilities and interconnected safeguarding risks.

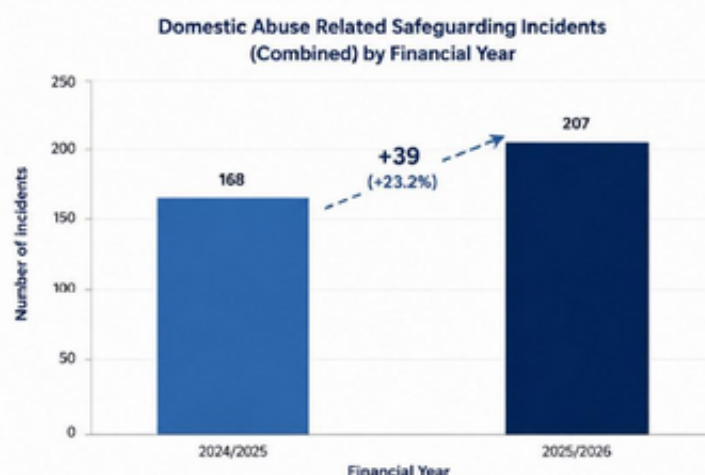
ADULT SAFEGUARDING & WELFARE		CHILD & FAMILY SAFEGUARDING	
Complex community vulnerability and unmet care need		Cumulative household adversity and contextual vulnerability	
Home Care Assessment	Elderly or vulnerable adults requiring assessments, equipment or care packages to remain safe and independent at home. Often following falls, deterioration or welfare concerns.	Carer Mental Health	Impacting parental capacity, emotional availability, stability and ability to meet children's needs.
Adult Mental Health Issues	Significant impact on wellbeing, safety, functioning and ability to cope. Often linked to isolation, crisis and repeat attendance.	Carer Substance Misuse	Frequently associated with neglect, instability, domestic harm and cumulative harm.
Adult Self-Neglect / Unsuitable Living Conditions	Linked to deteriorating health, isolation, reduced capacity to maintain accommodation and unmet care needs. Often a hidden safeguarding concern.	Children in Care	Care-experienced children remain disproportionately vulnerable and often present with complex needs.
Wider Vulnerability Factors	Frailty, cognitive decline, social isolation, unmet care need and financial hardship can all increase risk and reduce resilience.	Child Mental Health	Increasing recognition of emotional distress, trauma, anxiety and self-harm related concerns.
		Children Alcohol and Drugs	Often linked to exploitation, risk taking behaviour, trauma and wider contextual safeguarding concerns.
COMMON UNDERLYING DRIVERS			
Mental ill health and trauma	Poverty and financial stress	Social isolation and lack of support	Substance misuse and addiction
		Housing instability and poor living conditions	Domestic abuse and coercive control
			Reduced resilience and cumulative adversity
Safeguarding activity increasingly reflects contextual and cumulative vulnerability rather than isolated incidents alone.			

3. Domestic Abuse

Domestic abuse safeguarding referrals have increased, but a key operational challenge remains. Staff frequently assume that safeguarding follow-ups are unnecessary if police are present, believing law enforcement will handle the process. Although training has explicitly addressed this misconception, altering established workplace habits will take time. We will continue to reinforce the mandatory requirement to report all cases regardless of police involvement, and this key learning point will be integrated into the 2027 Level 3 refresher training.

DOMESTIC ABUSE RELATED SAFEGUARDING INCIDENTS

Provisional at point of referral | Financial year comparison



KEY MESSAGE
A total of 207 domestic abuse related safeguarding incidents were recorded in 2025/2026, an increase of 39 incidents (+23.2%) compared with 2024/2025.

WHAT'S INCLUDED
This total combines:

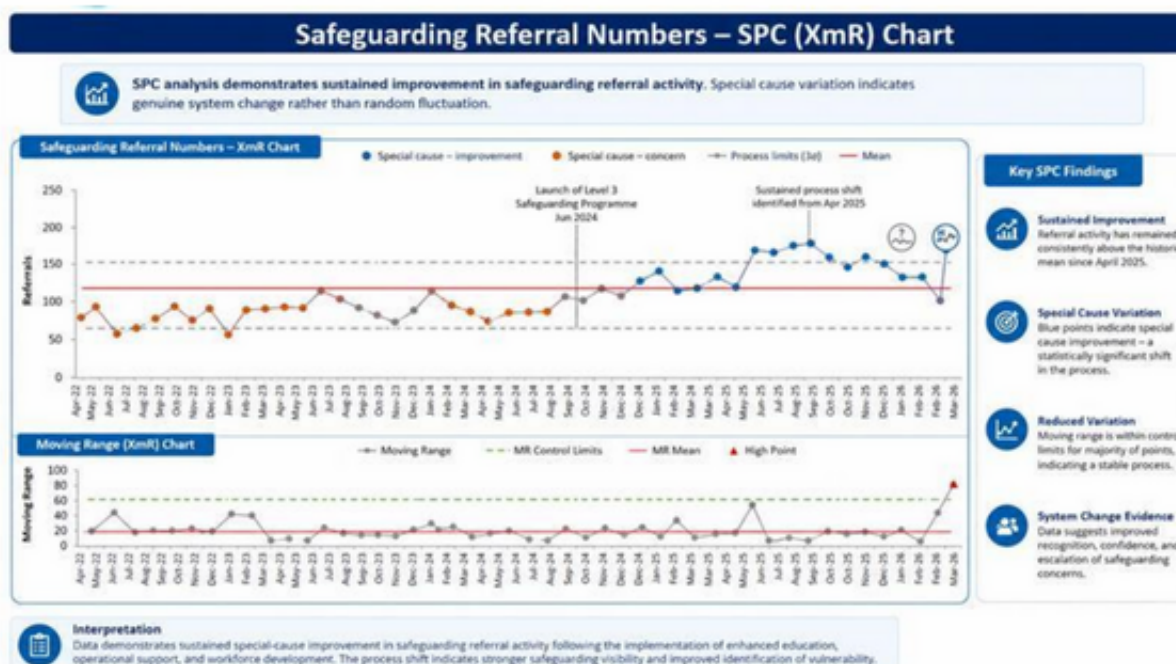
- Adult: Domestic Abuse/Violence
- Children: Carer – Domestic Abuse

YEAR ON YEAR CHANGE
+39 incidents
(+23.2% increase)

 Data is provisional at point of referral and subject to change as cases progress through safeguarding processes.

4. Safeguarding Education and Training

Training our workforce to recognise and respond to safeguarding concerns was a key recommendation of the RQIA improvement plan in 2019. This was also noted in the National Ambulance Safeguarding Advisory Group (NASAG) Peer review commissioned in 2023. There is clear evidence that the targeted education for our workforce correlates with the substantial rise in safeguarding referrals over the past 24 months. Safeguarding Referrals from the Integrated Care Hub (ICH) have notably increased. There has been some targeted Level 3 Safeguarding training for this specific cohort, however the calibre of incoming referrals highlights an embedded culture of professional vigilance. The workforce is to be highly commended for their rigorous approach to identifying and documenting patient vulnerability. The focus in 2026 will be improving the online options for level 1 and 2 alongside the delivery of 3-year renewal training for those who completed Level 3 in 2024.



Integrated Care Hub (ICH) – Increased Safeguarding Referrals



5. NIAS Engagement with other Safeguarding Agencies.

NIAS actively engages with Health and Social Care (HSC) Trusts and other safeguarding bodies, contributing to policy discussions, domestic homicide reviews, and the draft Adult Protection Bill. NIAS is a partner member of the Safeguarding Board N Ireland (SBNI) and Interim Adult Protection Board (IAPB) and currently sit on the Northern and Belfast Safeguarding Board Panels although it is anticipated our representation in other Trust areas will expand with the introduction of a new member of staff. Over the past year NIAS now has representation on two Domestic & Sexual Violence & Abuse Partnerships in the Southeastern and Southern Trust areas. Similarly, this will be expanded to other Trusts areas with the introduction of a senior member of staff to support safeguarding. By participating in these partnerships, NIAS can share expertise and resources, leading to more informed policy-making and improved outcomes for vulnerable individuals. Additionally, the expansion of representation allows for a more unified and coordinated response to safeguarding challenges.

6. Domestic Homicide Reviews

During 2025/26, NIAS actively contributed to five Domestic Homicide Reviews (DHRs), with the Safeguarding Manager currently sitting on two active DHR panels awaiting final multi-agency recommendations. Inter-agency communication and the understanding of perpetrator behaviours have emerged as prominent regional themes across completed reviews. In response, NIAS was able to report to the DOJ on progress sharing this learning with the workforce through the delivery of updated Level 3 Safeguarding training. Additionally, we have targeted specific training with Emergency Medical Dispatch (EMD) staff to sharpen early recognition and risk assessment.

7. Adult Protection Bill (NI)

The Draft Adult Protection Bill is currently moving through the Northern Ireland Assembly and establishes a formal statutory framework for adult safeguarding across Northern Ireland. NIAS is represented by the head of safeguarding in working groups related to the implementation of the adult protection bill which is currently transitioning from the committee stage to the consideration stage within the Northern Ireland Assembly. 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 impact on our workforce will likely be to ensure we reinforce the learning they have been exposed to in their Level 3 Safeguarding. Key messages for our workforce are in keeping with the learning integrated in Level 3.

Ahead of legislative enactment of the Bill, NIAS Safeguarding will deliver a targeted communications strategy to embed these statutory duties, reinforcing and aligning with existing NIAS safeguarding pathways.

8. Staff Safeguarding Allegations

During the reporting period, the Safeguarding Team managed 20 cases involving safeguarding allegations against staff members. This total includes support for two cases where workforce members were identified as victims of domestic abuse or intimate partner violence. Additionally, significant regulatory oversight was directed toward emerging adult safeguarding concerns within two independent ambulance services. These matters remain under active review, with robust mitigation strategies were implemented to manage and reduce further safeguarding risks.

Analysis of the 20 internal cases highlights sexual safety as the primary concern, accounting for 10 cases (eight reported by staff and two directly by patients/relatives). The remaining casework comprises four cases of domestic abuse (including assault), two cases involving child safeguarding concerns, and four cases relating to professional conduct during contact with vulnerable adults.

9. Technological Improvements/Data Management

Following an attempt to integrate safeguarding referrals and administrative process into the Orvis (REACH) platform, integration and data-management barriers were identified. These system limitations mirrored challenges experienced by peer services, including the Safeguarding Team in the South Western Ambulance Service (SWAS) who also use the Orvis platform. Consequently, the decision was made to retain the

Safeguarding Referral pathway within the established Datix system. Over the past six months, targeted development has focused on optimizing the Datix interface. This work has delivered significant advancements in both user experience and data-capture quality. As a result, there is enhanced capability to analyse emerging trends, and deliver accurate safeguarding activity reports.

10.Conclusion

The 2025/26 reporting period demonstrates a significant transformation in the Trust's safeguarding development, driven by targeted workforce education and enhanced referral pathways. The additional staff to support this improvement have been a key asset to the service, particularly their role in assisting our workforce and offering feedback on referrals. The completion of Level 3 Safeguarding training for 86% of the patient-facing workforce directly correlates with a substantial 39.5% increase in referrals. Alongside this the improvements to the recording on Datix has improved data capture improving the Trust's capacity to identify emerging safeguarding themes.

NIAS has established its role within regional governance networks through contributions to Domestic Homicide Reviews (DHRs) and active participation in the SBNI, IAPB, and Domestic & Sexual Violence & Abuse Partnerships. As the draft Adult Protection Bill progresses toward statutory enactment, NIAS is well-positioned to transition from guidance-based practices to mandatory compliance. Key to this ongoing improvement will be the continued embedding of a safeguarding culture reinforcing the statutory duties to report, addressing cultural operational challenges, and scaling up internal policy structures to ensure a unified, regional response to vulnerability. Key to this ongoing improvement across directorates will be the introduction of the Safeguarding Assurance Group which will have senior representation from directorates.

key areas for development in 2026-27

- Strengthen Safeguarding Governance, with the introduction of the Safeguarding Assurance Group. Providing clear Board-level assurance on safeguarding practice, risk and compliance.
- Review and improve the management of Safeguarding Allegations in partnership with human resource colleagues and consider learning internally and from best practice highlighted in reviews.
- Strengthen safeguarding education and workforce capability, introducing level 1 and 2 online training options and finalize the 3-year Level 3 renewal curriculum for a 2027 launch. Include key learning from CMR/DHR and Adult Safeguarding reviews in the content of the targeted training.
- Continue to improve the management of safeguarding data to track themes and share with internal and external partners ensuring NIAS is aligned with strategic safeguarding priorities.
- Strengthen partnerships with regional safeguarding bodies and HSC Trusts to enhance inter-agency communication, drive strategic safeguarding decisions, and influence regional priority-setting.



Paper Title:	Infection Prevention and Control Annual Report 2025/26	
Paper For:	Trust Board	Link to Strategic Objectives:
Meeting Date:	25/06/2026	Most appropriate clinical response ☐
Author:	Ruth Robb	Work collaboratively with HSC partners ☒
Responsible Director:	Lynne Charlton	Deploy resources to meet patient needs ☐
Action Required:	TO NOTE	Support improved health outcomes ☒
Resource Implications:	No	Optimise organisational resilience ☐

Recommendation: The Committee are asked to approve the Annual IPC report

Executive Summary & Key Messages

Overall Position

The IPC service demonstrated strong resilience and continued strategic development despite sustained operational pressures. The team have maintained delivery of a responsive, evidence-based programme of assurance, audit, education, and incident management. The team has continued to support safe systems of work while contributing to wider organisational priorities, including preparedness planning for emerging infectious disease threats.

Key Achievements

- Strengthened governance through audit, KPI reporting and risk management.
- Workforce development and targeted training programmes.
- Delivery of quality improvement projects, including Bare Below the Elbow compliance work.
- Regional leadership in IPC and preparedness planning.

Performance and Compliance

- Audit findings indicate that while staff generally demonstrate good technique when IPC measures are undertaken, compliance with key standards remains variable. With the greatest challenges seen in relation to Bare Below the Elbows and the overuse of gloves.
- Environmental auditing of station environments has demonstrated that despite the challenges of the physical estate, the majority of stations are compliant. Where stations have been found to be non-compliant the staff are supported to improve by the wider MDT, operational pressures however have impacted on the effectiveness of this arrangement. The related learning has been shared at a series of operational workshops which have taken place early 2026/27, with good attendance from staff from EOC and Area Managers, Station Officers and Station Supervisors.
- There have been challenges with releasing operational staff to complete IPC mandatory training, compliance is therefore poor, this has been recognized and with the support of senior leadership a strategy team plan to address was put place to improve this.

Safety and Risk

- The team continue to undertake contact tracing where staff have been potentially exposed to an infectious condition. In this reporting period outbreak activity has been low with only one norovirus outbreak this year.
- IPC-related risks are actively monitored through both directorate and corporate risk registers, including risks relating to hand hygiene compliance and preparedness for high consequence infectious diseases (HCID). The IPC team continues to work collaboratively with Emergency Preparedness, Resilience and Response (EPRR) colleagues and regional partners to strengthen response capability and ensure alignment with national standards and emerging guidance.

Key Challenges

- Sustained service pressures impacting training and audit activity.
- Inconsistent compliance with IPC standards.
- Behavioural challenges in HH, PPE use and BBE adherence.

Strategic Priorities for 2026/27

- Embed IPC culture and accountability.
- Improve assurance through governance and leadership framework.
- Increase education & training accessibility & compliance levels.
- Utilise digital data to drive improvement.
- Strengthen pandemic and HCID preparedness.

Conclusion: IPC remains a critical enabler of safe care delivery. While progress has been made, consistent compliance with fundamental IPC practices remains a priority area for improvement



Northern Ireland Ambulance Service
Health and Social Care Trust



INFECTION PREVENTION AND CONTROL ANNUAL REPORT 2025/26

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Director of Infection Prevention and Control Foreword

This report outlines the challenges encountered and progress achieved in Infection Prevention and Control (IPC) across the Northern Ireland Ambulance Service (NIAS) during the period 1st April 2025 to 31st March 2026.

Throughout the year, the organisation has demonstrated resilience, adaptability and innovation in responding to evolving IPC risks while maintaining a clear focus on protecting patients, staff and the wider community.

Despite ongoing pressures across the health and social care system, NIAS has continued to adapt to a complex and demanding operational landscape. This has enabled the establishment and maintenance of safe systems of work, ensuring that risks are identified early and mitigated wherever possible.

The IPC service has remained committed to working closely with both internal teams and external partners to deliver a responsive, evidence-based service tailored to the unique challenges of ambulance care. Collaboration across clinical, operational and strategic functions has been central to strengthening IPC practice and promoting continuous improvement.

As we move forward, our focus remains on further embedding a positive IPC culture across the organisation, underpinned by learning, improvement and shared accountability.

I would like to extend my sincere thanks to the NIAS IPC team for their dedication, professionalism and commitment throughout the year. I am extremely proud of what this small but highly effective team has achieved. I also wish to recognise the vital contribution of our operational crews, educators and service managers, whose ongoing support and leadership are essential in ensuring that IPC remains integral to everything we do.



Lynne Charlton

Director of Infection Prevention and Control and Quality, Safety, and Improvement.

1. 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 as of 31st of March 2024:

Staff Group	Number of Staff
ACA (includes Team Leads)	258
EMT	294
Paramedics • Paramedic • RRV • HEMS • HART (includes Team Lead) • ICH (Includes Advanced Paramedic)	441 354 28 10 17 32
Station Supervisor / HALO	60
Other	593
Total	1646

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).

2. 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 2025 to 31st March 2026.

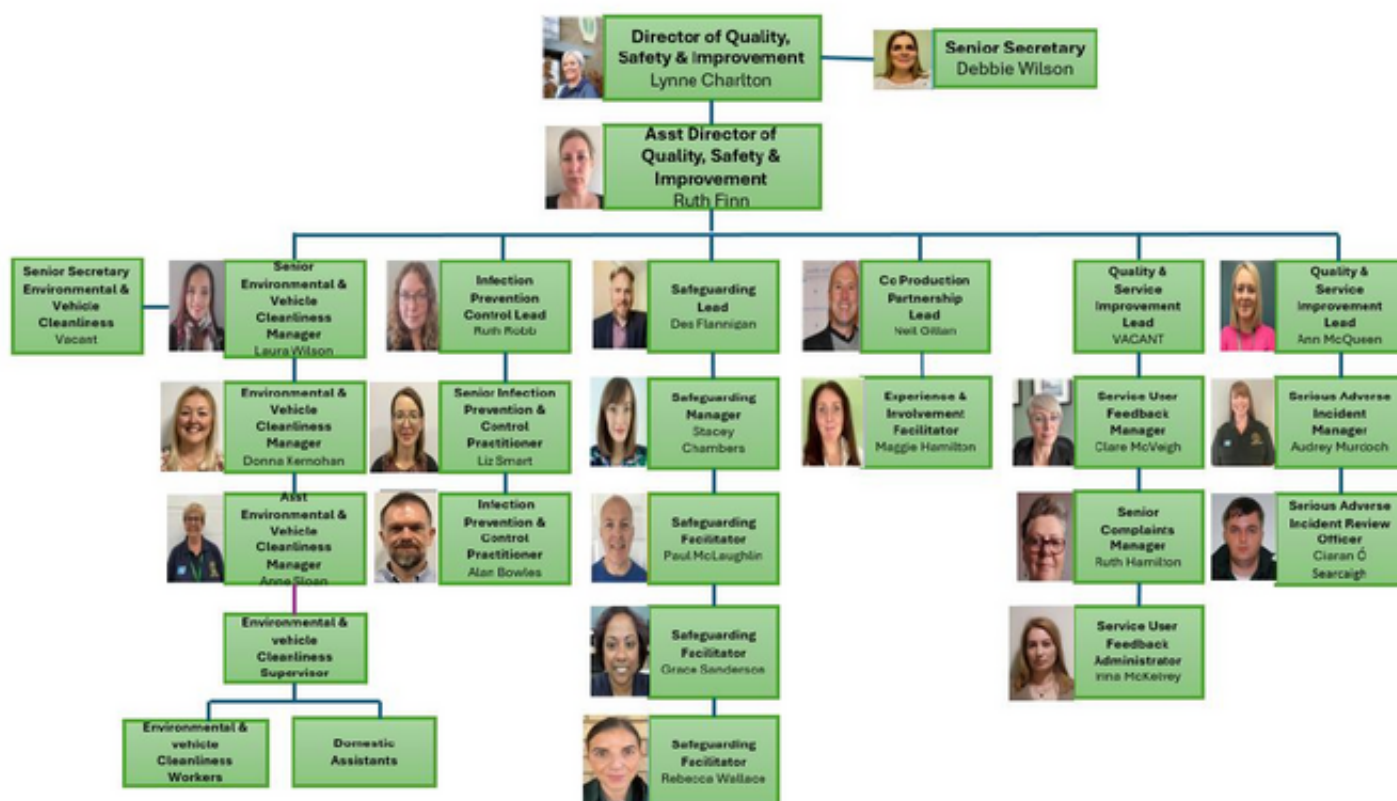
It will demonstrate how NIAS has achieved compliance with the NI extant strategic regional action plan for the prevention and control of Health Care Associated Infections (HCAI) 'Changing the Culture' (2010).

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.

2.1 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:



3. 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 to NIAS IPC and EVC improvement group quarterly. IPC KPIs reported include HH, PPE, E-Learning and ANTT
- Reporting of audit results, improvements and KPI performance to the NIAS Patient Experience, Quality and Safety Committee (PEQS) biannually
- 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 Regulation and Quality Improvement Authority (RQIA) independent inspection and regulation.

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

3.1 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.

3.2 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.

3.3 Risk register

Risk 871 on the QSI Directorate rated as low risk relates to the potential risk to patients and staff of Healthcare Associated Infection (HCAI) if staff do not adhere to the NIAS Hand Hygiene Policy. The IPC team have taken several actions in relation to this including staff education, regular audit and respectful challenge, working with Trade Unions and Employee Relations to support line managers and undertaking a Quality Improvement project which are discussed in more detail later in the report.

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).

4. Infection Prevention and Control Team

The Team structure is as outlined below.

Post	Band	Date of Appointment	Incumbent
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	August 2025	Mrs. Elizabeth Smart
Infection Prevention and Control Practitioner	7	January 2026	Mr. Alan Bowles

April 2025 saw the restructure of the IPC team when Miss Claire Fitzsimons who held the Band 7 post left the service to pursue a promotional opportunity and Mr Paul McMillan who held the Band 6 post retired from the service. We wish both staff members well with their future endeavours and thank them for their service. The team were fortunate to be able to reprofile the team and recruit two Band 7 Senior IPC Practitioners who joined the team in August 2025 and January 2026.

4.1 Key Service Achievements IPC April 2025 to March 2026

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
1. 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
2. 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

3.	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.
4.	Quality improvement IPCT have begun to build QI capacity within own service and are utilising QI methodology when undertaking service improvement projects	- 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 completed a QI project funded by 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 the IPC Resource in November 2023 and continue to maintain this to allow staff easy access to IPC advice and information regarding Health Care Associated Infections. - The IPCT have supported with the review and implementation of new IT devices including the Toughbook to aid operational staff.
5.	Digital enablers The IPCT has developed the NIAS IPC service 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.
6.	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.
7.	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' - 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 Infection Prevention Control Nurse Lead/Leader Forum (IPC NLF) an influential group of Senior NI IPC leaders who influence NI IPC strategic direction and policy.

4.2 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 2025-2026 auditing by the IPC team was paused during May and June as part of the Quality Improvement project.

Audit performance is outlined in the following sections.

4.2.1 Hand Hygiene

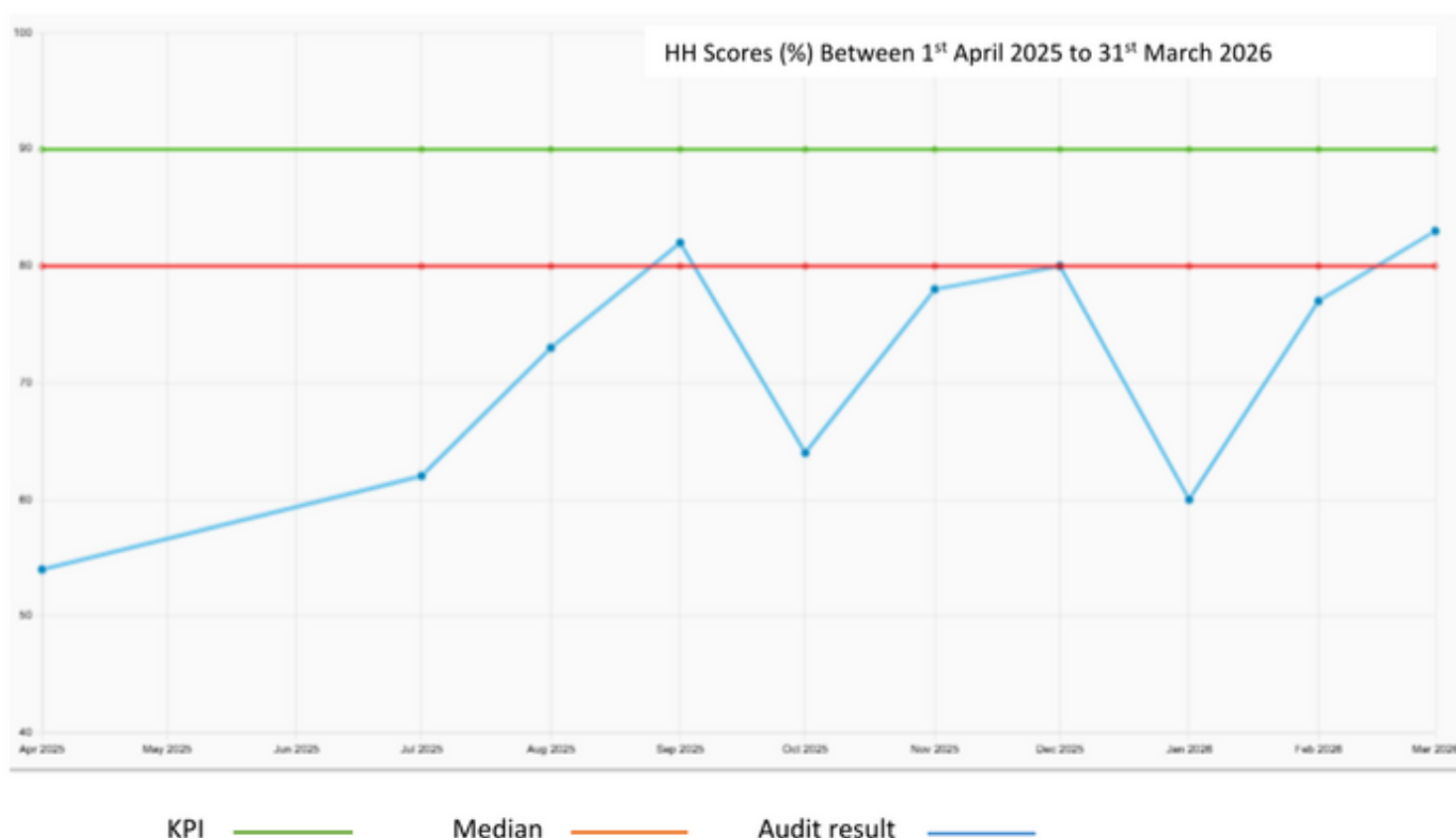
Hand hygiene (HH) auditing is carried out monthly by the IPCT at 6 major Emergency Departments (EDs) within NI, with the KPI set at 90% compliance.

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 shows the Trust average for HH compliance between 1st April 2025 to 31st March 2026. The target is 90%.



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

		Altnagelvin Hospital ED - NIAS ...	Antrim Area Hospital ED - NIAS ...	Craigavon Area Hospital ED - NIAS ...	Royal Victoria Hospital ED - NIAS ...	South West Regional Acute Hospital ED ...	Ulster Hospital Dundonald ED - NIAS ...
	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 Dundonald ED
Overall Compliance	79.6% (1868/2348)	74.7% (260/348)	74.2% (297/400)	81.0% (324/400)	73.5% (294/400)	90.3% (325/360)	83.6% (368/440)
Was the opportunity for HH taken?	81.6% (479/587)	81.6% (71/87)	76.0% (76/100)	81.0% (81/100)	74.0% (74/100)	90.0% (81/90)	87.3% (96/110)
Was Seven Step Technique undertaken?	81.9% (481/587)	81.6% (71/87)	77.0% (77/100)	81.0% (81/100)	75.0% (75/100)	90.0% (81/90)	87.3% (96/110)
Was staff member bare below the elbow when undertaking hand hygiene?	82.8% (486/587)	71.3% (62/87)	79.0% (79/100)	86.0% (86/100)	80.0% (80/100)	94.4% (85/90)	85.5% (94/110)
Is this a compliant observation?	71.9% (422/587)	64.4% (56/87)	65.0% (65/100)	76.0% (76/100)	65.0% (65/100)	86.7% (78/90)	74.5% (82/110)

The audit results 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:

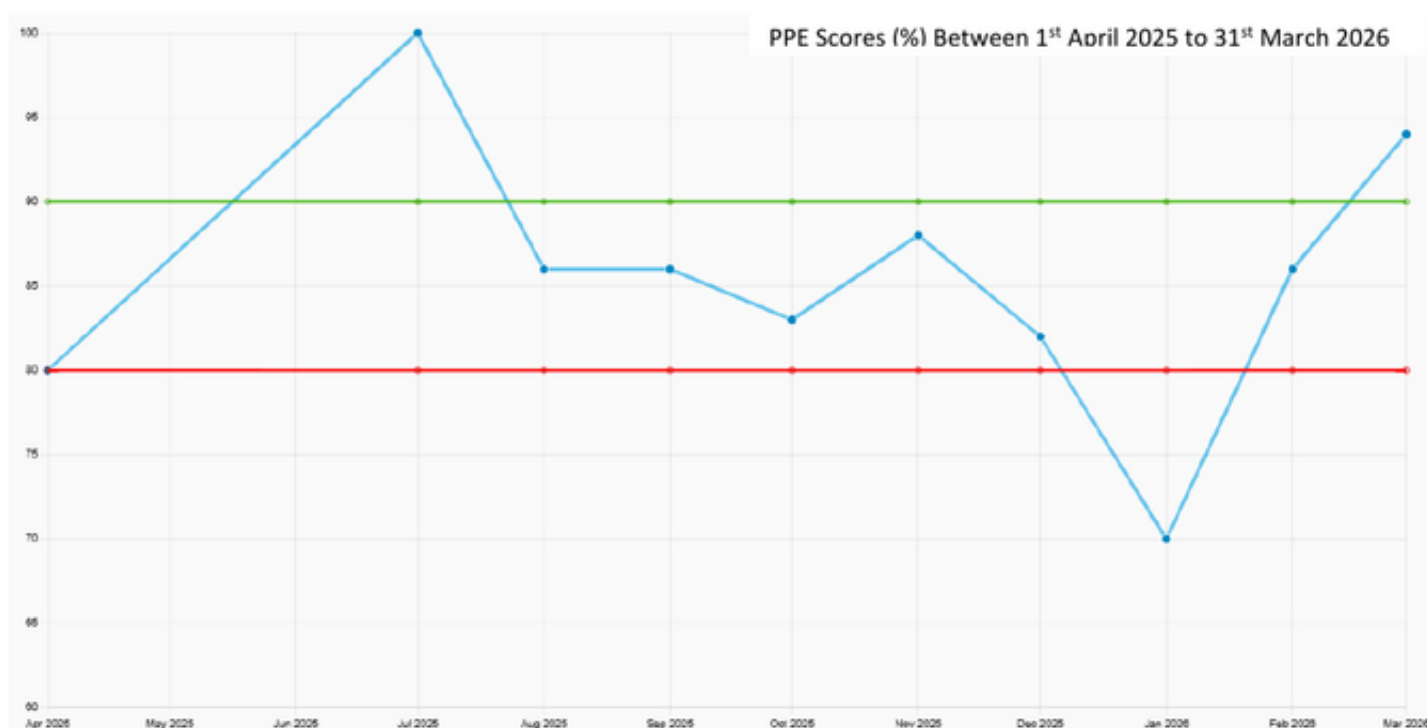
- Face to face engagement with staff at EDs around identified issues, with respectful challenge and education by the IPCT
- Provision of staff member details to Area Managers where non-compliance was observed for identification of trends and addressing of same where issues arise
- NIAS bespoke HH leaflet developed and shared with staff
- Circulation of AACE statements and resources to staff regarding BBE and the completion of a BBE QI project the results of this are outline in section 5
- 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
- IPC included in induction programmes for new staff to the organisation and for staff commencing new posts such as station supervisors, station officers or Scheduled Care team Leaders.

4.2.2 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 2025 to 31st March 2026.



KPI —— Median —— Audit result ——

The following table 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.

	April 2025		July 2025		August 2025		September 2025		October 2025		November 2025		December 2025		January 2026		February 2026		March 2026	
Location	Compliance	Count	Compliance	Count	Compliance	Count	Compliance	Count	Compliance	Count	Compliance	Count	Compliance	Count	Compliance	Count	Compliance	Count	Compliance	Count
Altnagelvin Hospital ED	-	0	-	0	-	0	-	0	-	0	-	0	-	0	-	0	100.0%	10	-	0
Antrim Area Hospital ED	80.0%	10	-	0	100.0%	7	90.0%↑	10	80.0%↓	10	70.0%↓	10	70.0%	10	50.0%↓	10	80.0%↑	10	80.0%	10
Craigavon Area Hospital ED	80.0%	10	100.0%↑	10	-	0	90.0%	10	70.0%↓	10	90.0%↑	10	80.0%↓	10	80.0%	10	50.0%↓	10	100.0%↑	10
Royal Victoria Hospital ED	90.0%	10	100.0%↑	10	70.0%↓	10	90.0%↑	10	70.0%↓	10	90.0%↑	10	90.0%	10	60.0%↓	10	90.0%↑	10	100.0%↑	10
South West Regional Acute Hospital ED	-	0	-	0	90.0%	10	90.0%	10	100.0%↑	6	-	0	100.0%	10	80.0%↓	10	-	0	-	0
Ulster Hospital Dundonald ED	70.0%	10	-	0	90.0%	10	70.0%↓	10	100.0%↑	10	100.0%	10	70.0%↓	10	80.0%↑	10	100.0%↑	10	95.0%↓	20
Total Compliance	80.0%	40	100.0%↑	20	86.5%↓	37	86.0%↓	50	82.5%↓	46	87.5%↑	40	82.0%↓	50	70.0%↓	50	86.0%↑	50	94.0%↑	50

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 too 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
- Circulation of PPE/glove newsletter
- Training sessions held with CSOs from each division covering expectations of compliance for HH, PPE and ANTT.
- IPC included in induction programmes for new staff to the organisation and for staff commencing new posts such as station supervisors, station officers or Scheduled Care team Leaders.
- Development and circulation of educational video on the appropriate use of gloves, which utilises the use of UV powder to allow staff to visualise the risk of inappropriate glove use.

4.2.3 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.

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.

In total there was 6 ambulance stations audited using the RQIA style audit tool between 1st April 2025 and 31st March 2026. The following table shows the total numbers of stations and the compliance percentage.

Station	Score	Reaudit if applicable
Bridge End	89.3%	
Cookstown	75%	90.6%
Kilkeel	78%	85%
Newcastle	88%	
Omagh	90.7%	
Whiteabbey	77.1% *first audit was a shortened RQIA Style audit as part of the snapshot programme	85.9%

Due to staff shortages it has been difficult to complete the RQIA style audits, for this reason the IPC team worked with the EVC team to develop a snapshot audit programme. A shortened version of the RQIA style audit was created focusing on critical areas such as sluices, equipment and high use staff areas such as bathrooms, kitchen and rest areas. These were announced MDT audits scheduled to take place with the station officer, area manager. Estates and Health and Safety were also invited to attend. The audit was recorded on MEG, with the report circulated via email directly after the audit.

In a two week period in December 2025 the IPC and EVC teams audited 12 stations, if there was a vehicle available it was audited using the separate vehicle audit tool. The table below shows the station and audit results.

Station	Score
Armagh	85.1%
Carrickfergus	91.5%
Coleraine	93%
Craigavon	85.4%
Coleraine	93%
Derriaghy	91.5%
Downpatrick	89.1%
Dungannon	86.5%
Larne	80.5%

Limavady	92.6%
Magherafelt	89.9%
Newtownards	79.9%
Whiteabbey	77.1%

All stations that scored below 85% were to have a MDT meeting to discuss the score and support improvement and a follow up full RQIA style environmental audit. This process was delayed to the organisation entering REAP 4 for a sustained period of time.

Common themes from the audits were identified and shared with the IPC and EVC governance group and area managers. This has resulted in the creation of a new governance framework for IPC audits including clear roles and responsibilities, timeframes for actions and the inclusion of leadership walkrounds is due to be agreed in June 2026. Additionally, a series of training days for all operational staff with line management responsibilities is planned for April, May and June 2026 to share the learning from this programme, generate solutions and refresh staff knowledge with roles and responsibilities in relation to IPC and EVC.

The IPC team have take this opportunity to refresh the structure of the RQIA style audit on MEG to improve reporting and provide greater clarity for staff.

4.3 Training and education

4.3.1 IPC mandatory E- Learning

IPC mandatory training is provided through the Learning 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

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 1st April 2025 to 31st March 2026 (figures provided by the Learning and development team).

Course	Total completed
ANTT	457
IPC Level 1 (non patient facing)	423
IPC Level 2 (patient facing)	447

Uptake of IPC mandatory training is low. 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 any e-learning. This risk was recognised by SLT and arrangements were made and communicated in late 2025/26 to provide staff the opportunity to avail of overtime to complete their training and operations made efforts to release staff to complete training with backfill to support any gaps in rotas.

The review of the regional learning package by the Infection Prevention Control Nurse Lead/Leader Forum (IPC NLF) was completed in 2025. The package was updated to reflect ambulance specific challenges. However, due to technical issues this is still awaiting upload onto the LMS platform it is hoped these will be resolved in May 2026.

4.3.2 Other IPC training education

The IPC team continued to provide non-mandatory training in this reporting period and the team delivered education to 366 staff members and UU students. 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 and the new Scheduled care team leads.

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 has been 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:

Training Course	Participants
AAP	9
NQP Induction	67
AAP Course (ANTT)	9
ACA Course	31
NQP ANTT	41
UU	46
HH day	150
Scheduled Care	13

Total	366
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The team again provided informal education for World Hand Hygiene Day 2025 speaking with 150 staff at ED and providing some educational materials. This year World Hand Hygiene Day was part of a wider Quality Improvement project with several PDSA cycles and a substantial quantity of sweets.



The team worked with Operations and health and Safety to bundle key safety messages together under the umbrella “Ready to Respond” this campaign included a poster campaign and messaging added to email signatures.



AAPs ANTT Training

4.4 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 was 1 outbreak of suspected norovirus declared affecting 7 members of staff.

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

Organisms	Number of cases
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 be 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.

5. Quality Improvement projects

This year the team were asked to share learning at the regional 2025 Infection Prevention Society (IPS) Conference on the Glove reduction Quality Improvement project..

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

This aim of this project was to utilize swabbing of writ watches as an educational tool to improve staff compliance with NIAS policy and national guidance to be "Bare Below the Elbows"

The project was recommenced in April 2025 and planned to co-ordinate with World Hygiene Day in May 2025.

Baseline data:

- Baseline data established - historic Hand Hygiene (HH) audits completed by IPC team compiled as run charts
- Data broken down to number of non-compliances due to wearing of wrist watches.
- In preparation of the swabbing intervention, an information leaflet about the project and the swab results was developed.
- The NIAS hand hygiene leaflet was updated in preparation for the upcoming staff engagement sessions.
- The NIAS Hand hygiene policy was updated and commenced the approval process.

Interventions:

- April 2025 -anonymous staff survey sent to all staff to establish staff belief around Bare the Elbows policy. 203 responses received.
- April 2025 – “Ready to Respond” messaging sent to all staff via operational teams. This brought together key safety messages for frontline staff under the title “Ready to Respond” and focused on fit testing, being Bare Below the Elbow and uniform adherence. The IPC team accompanied this with an IPC newsletter on hand hygiene and BBE.
- May 2025 – routine auditing paused, and the swabbing of watches commenced as part of a programme of staff engagement and informal education with staff. The updated NIAS Hand Hygiene leaflet for staff was handed to staff with a collection of “goodies” that included hand sanitiser and sweets.
- June 2025 – Number of swabs carried out lower than expected so this extended through the month of June. Number of swabs totalled 30 by the end of June. The NIAS HH policy was fully approved and was communicated to all staff via established routes.
- July 2025 – Routine auditing recommenced. Preparing results of staff survey and results of microbiological testing into an education piece for staff.
- September 2025 – results of staff survey and swabbing shared with senior managers
- November 2025 – results of staff survey and swabbing results shared Trust wide.

Results:

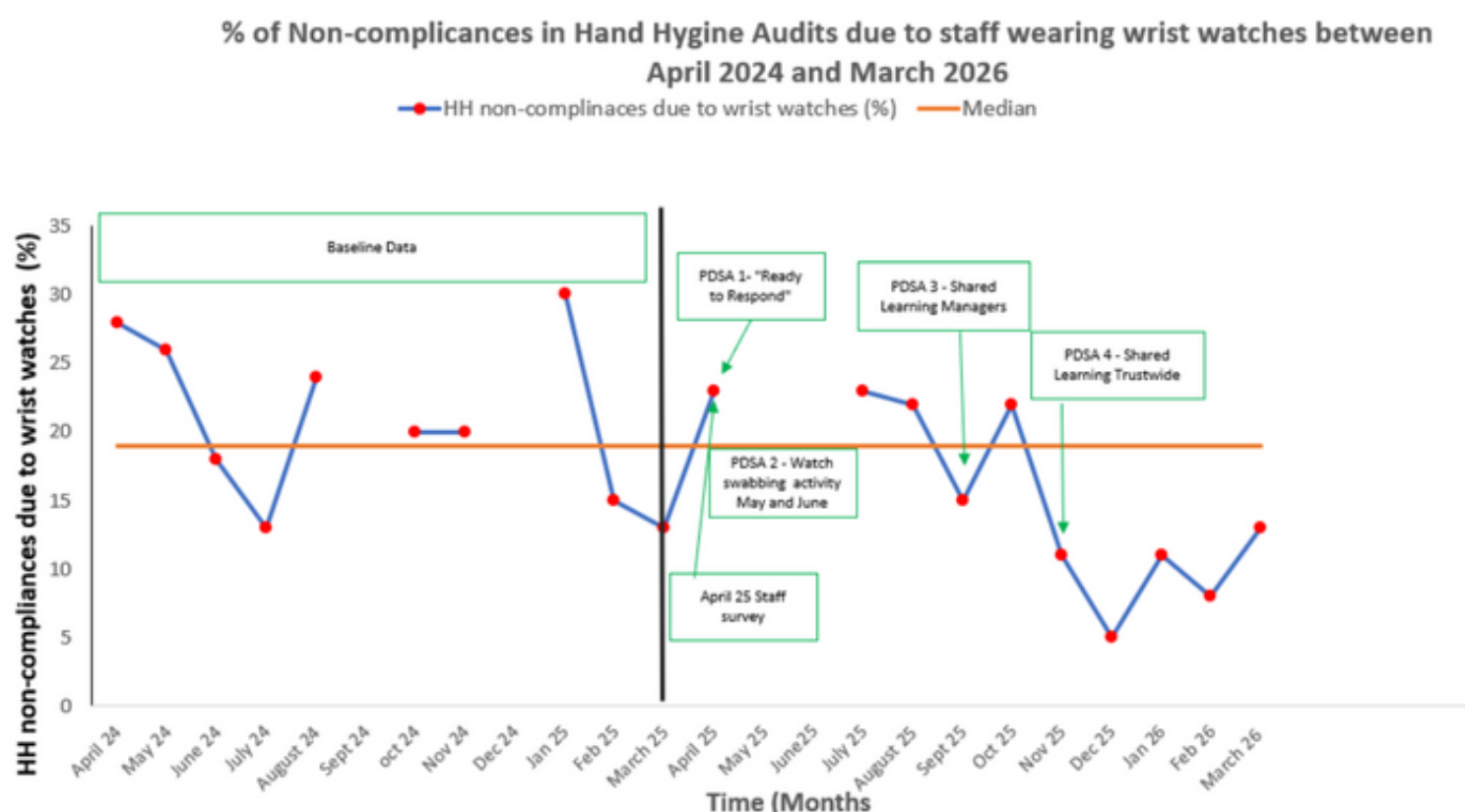
Results from the staff survey demonstrated:

- Staff were aware of the Trust hand Hygiene policy and the need to be “Bare Below the Elbows”.
- Some staff were frustrated with the policy not being clearly enforced across the service.
- Further education is required in relation to the use of gloves and items such as High Visibility clothing.
- A barrier to improvement is the lack of working clocks in vehicles.

Results from the microbiology swabbing:

- A total of 73 microorganisms were captured from 29 watch samples. Only 1 sample was culture negative. Of these microorganisms, most (97%) are regarded as normal skin or environmental organisms.
- 2 clinically significant organisms were identified, both were a *Staphylococcus aureus* (*S. aureus*), of which one was methicillin resistant *Staphylococcus aureus* (MRSA).

The run chart below demonstrates the effect of the project on the % of staff found to be non-compliant in HH audits due to wearing of wrist watches, with each PDSA cycle marked.



Actions undertaken since the audit:

- The EVC team have agreed to monitor and replace clock batteries in vehicles.

- The fleet team are seeking alternative solar powered clocks to place in vehicles.
- The IPC team with Human Resources and operations team have drafted an escalation process to support line managers in relation to staff not adhering to the HH policy specifically the requirement to be "Bare Below the Elbows". This is due to be agreed in June 2026.

The IPC team will include learning from this into 2026/27 plans for educational provision.

- The project is being written up for submission to the Infection Prevention Society for both presentation at the national conference and inclusion in the journal.

6. Preparedness Work

In this reporting period the team worked internally and externally in relation to preparedness for new and emerging threats.

The team worked closely with Emergency Preparedness, Resilience and Response (EPRR) colleagues to draft in the update of the NIAS Pandemic Preparedness Plan with multi-directorate input.

The plan builds directly on the knowledge, experience and guidance that emerged from the COVID-19 pandemic, including learning on workforce resilience, IPC at scale, command fatigue, communications, and the need for clear decision-making structures over extended periods of pressure.

It is important to clarify scope:

- High Consequence Infectious Disease (HCID) events typically involve limited numbers of patients and rely on occasional specialist clinical and operational capability.
- Pandemics represent sustained, population-level incidents, requiring whole-Trust mobilisation over weeks or months and in the case of COVID-19 even years.

The plan addresses the latter and is designed to work alongside, not replace, HCID-specific arrangements referenced under Corporate Risk 833.

The Pandemic Preparedness Plan sets out a comprehensive corporate framework, including:

- Pandemic risk and context,
- Phases of pandemic management (preparedness, response, sustainment, recovery),
- Trust-wide roles and responsibilities, (JESIP)
- EPRR principles,
- IPC principles,
- Workforce resilience and wellbeing considerations,
- Logistics, communications and supply-chain dependencies,
- Governance, review and learning mechanisms,
- Identification of NIAS Core Functions that must be protected during sustained disruption.

The plan is underpinned by a wide range of existing plans, policies and external guidance, all of which are referenced within the document. These include the NIAS Strategic Business Continuity Plan, relevant outbreak and IPC guidance, national policy and civil contingencies frameworks.

The plan is explicitly aligned with the Joint Emergency Services Interoperability Principles (JESIP), ensuring consistency with nationally recognised multi-agency command, control and decision-making arrangements

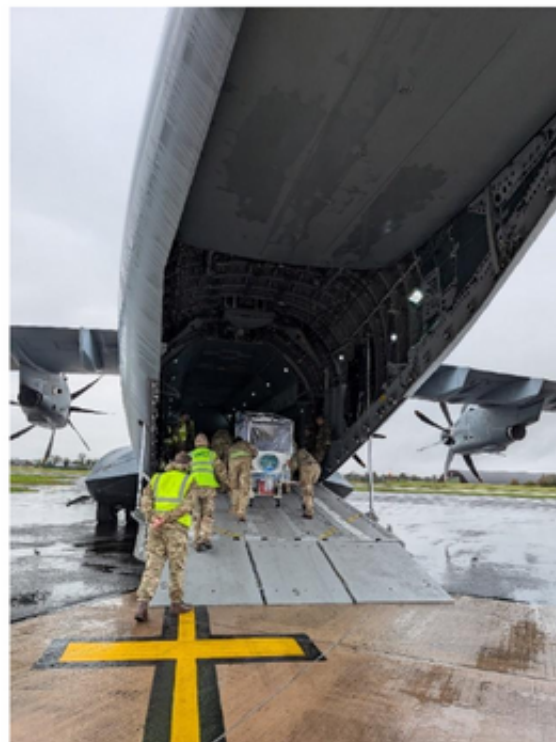
The plan is currently draft pending confirmation of final governance and assurance arrangements which are expected to happen quarter 1 of 2026/27.

The IPC team worked closely with the Regional Infection Prevention Control Nurse Lead/Leader Forum (IPC NLF) in relation to High Consequence Infectious Disease (HCID) planning. AS the current chair of the group the IPC lead with the other members of the forum have successfully worked with colleagues in the Department of Health to begin to develop a regional approach towards HCID, which will include review of care pathways, provision of training and education, PPE supplies as well as providing clear governance and escalation processes in relation to this.

While the NHS England guidance Addendum on high consequence infectious disease (HCID) personal protective equipment (PPE) does not apply to the ambulance sector, the team have influence for change in this area and fostered relationships with UKHSA colleagues. UKHSA colleagues have agreed to support the development of PPE guidance for operational crews and work is continuing with the other national services in relation to this.

The team have participated and supported HART colleagues during simulation activities at both the Regional Infectious Diseases unit at the Royal Victoria Hospital and with RAF colleagues in relation to the transport of confirmed HCID colleagues. Some photographs of the simulated exercise are included below.





7.Conclusion

The 2025/26 reporting year continued to present significant operational pressures for NIAS, with sustained periods at REAP levels 3 and 4 impacting service delivery. Despite this challenging context, the Infection Prevention and Control (IPC) service remained responsive and adaptive, ensuring that emerging risks, policy updates and national guidance were actively monitored, interpreted and disseminated across the organisation.

Key themes emerging from this year highlight a strong balance between operational resilience and strategic development. The IPC team maintained focus on core assurance activities such as audit, education and incident management, while simultaneously progressing quality improvement initiatives, strengthening governance frameworks, and contributing to wider organisational and regional preparedness planning.

The report demonstrates that fundamental IPC practices remain an ongoing challenge, particularly in relation to hand hygiene compliance, appropriate PPE use

and adherence to “Bare Below the Elbows” standards. However, it also evidences a proactive and evidence-based response through targeted education, behavioural interventions and quality improvement methodologies designed to support sustainable practice change.

Importantly, this year has reinforced the need for dual focus within IPC delivery:

- Maintaining and embedding routine IPC standards in daily practice, even in high-pressure operational environments; and
- Strengthening preparedness for emerging and high-consequence infectious disease threats, including pandemic planning and regional HCID coordination. Looking ahead, the IPC service is well-positioned to build on the progress made in 2025/26. Continued emphasis will be required on:
 - Embedding a consistent culture of IPC accountability across all staff groups
 - Enhancing compliance through leadership engagement and improved governance frameworks
 - Leveraging digital systems and data to drive performance improvement
 - Supporting workforce capability through targeted education and accessible training
 - Advancing preparedness and response capability for future infectious disease risks

In summary, while system pressure remains a defining feature of the NIAS operating environment, this year has demonstrated that IPC remains a core enabler of safe, effective care delivery, with clear opportunities to further strengthen both routine practice and strategic resilience in the year ahead



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Patient Experience, Quality and Safety (PEQS) COMMITTEE

Date: 9 April 2026

Time: 9.30 am

Location: Board Room

Attendance	
Chair:	Phelim Quinn (Committee Chair)
Attendees:	Michele Larmour
In Attendance:	Lynne Charlton (Director of Quality, Safety & Improvement)
	Heather Sharpe (AD Operations)
	Nigel Ruddell (Medical Director)
	Stacey Beggs (Temporary Board Secretary)
	Catherine Hanna (Lead Pharmacist)
	Neil Duncan (AD Operations)
	Nick Henry (AD Governance and Risk)
	Estelle Smyth (Estates Manager) <i>via MS Teams</i>
	Alex Mason (Performance Improvement Manager) <i>via MS Teams</i>
	Karl Bloomer (Consultant Paramedic) <i>via MS Teams</i>
Apologies:	Philip Graham (Non – Executive Director)
	Dale Ashford (Non – Executive Director)

Minutes of Meeting		
Agenda Item	Summary of the discussion	Actions Agreed
1.	<u>Apologies & Remarks</u> The Chair welcomed members to the meeting. The Committee NOTED the apologies as recorded above.	
2.	<u>Procedure</u> <u>2.1 Declaration of Potential Conflict of Interest:</u> The Chair asked members to declare any potential conflicts of interest now or as the meeting progressed. No conflicts were declared. <u>2.2 Quorum:</u> The Chair confirmed the meeting was quorate. <u>2.3 Confidentiality of Information:</u> The Chair reiterated confidentiality requirements.	



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	The Chair recorded thanks and acknowledged Mr Ashford's contribution to the work of the Committee.	
3.	Previous Minutes The Committee NOTED Ms Charlton sent minor changes to the previous minutes to Ms Beggs this morning which have not yet been incorporated. Pending these changes, the minutes of the previous meeting on 22 January 2026 were APPROVED on a proposal from Mr Quinn and seconded by Dr Ruddell.	
4.	Matters Arising The Committee NOTED the updates to the matters arising log and discussed key themes including culture/just culture work, SAI reporting visibility and learning from deaths, and assurance regarding EPRR resilience (including fuel and power resilience). <u>Just Culture / Being Human</u>: a draft SOP and policy is in development to ensure colleagues are content with the approach and the Committee will receive an updated paper following engagement with Trade Unions and review of revised Terms of Reference. <u>SAIs and wider learning</u>: Members reflected on the impact of the prior Trust Board presentation regarding system pressures, delayed handovers and response times, and LC referred to the development of proposals regarding strengthening visibility of incidents beyond those meeting SAI criteria internally and externally to SPPG. The Committee supported the proposal to share updated approaches with NEDs and Trust Board members and to continue scrutiny at this Committee. <u>Learning from deaths</u>: Management described work to review deaths of patients under the care of NIAS based on Learning from Death guidance and principles aligned to other UK ambulance services supported by BI, with intent to produce a structured (SBAR-style) paper to support formal engagement with SPPG. <u>External inspection assurance</u>: in respect of Independent Ambulance Services, Members discussed the potential wider system risk of regulatory inspection capacity and the need to ensure NIAS is not left vulnerable. The Committee noted Internal Audit activity commencing on IAS management and the appointment	Ms Charlton



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	of an assurance officer to manage risks and coordinate learning across trusts. <u>EPRR fuel and resilience</u>: the Committee noted that NIAS aims to remain self-sufficient for at least 10 days' fuel supply, has revised bunker refill thresholds to increase resilience, and is progressing work to confirm generator/fuel interfaces and contingency relocation arrangements for sites. EPRR/Estates Leads – confirm generator/fuel arrangements and provide assurance update to PEQS.	Ms Sharpe / Mr Sinclair
5	<u>Standing Items – Identification of Risks / Learning from Regulatory Letter (RQIA)</u> The Committee welcomed Ms Smyth to the meeting for this agenda item. Ms Charlton advised members of RQIA regulatory correspondence received relating to a Whistleblowing concern. An update on organisational learning identified, actions taken in response, including position with assurances sought by the regulator was provided. Ms Charlton referred to previous committee discussions regarding strengthening IPC and EVC assurances and NIAS internal validation processes to ensure that audit findings align with on-the-ground conditions. The Committee discussed actions to address infrastructure and environmental concerns (including electrical charger inspection processes, pest control, and physical fabric issues) and noted recent appointments within Estates to strengthen governance and assurance (Head of compliance & projects/strategy). Members discussed the whistleblowing element referenced in the correspondence and the importance of staff feeling able to raise concerns internally. The Committee emphasised that culture and leadership visibility must reduce reliance on external routes for escalation. The Committee discussed operating context at REAP Level 4, the risk of normalising unacceptable practice, and whether baseline expectations require review in light of sustained system pressures. Ms Charlton	



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	advised that in recognition of the initial organisational nature of learning identified, that presentations relating to same had been shared, with individual officers and at organisational IPC/ EVC and Learning Outcomes meeting. Further task and finish meeting had also been arranged to follow up on actions in progress as identified within regulatory response. Members agreed further learning should be captured and escalated through the appropriate and governance routes.	
6.	<u>EPRR – Highlight Report</u> The Committee NOTED the detailed EPRR highlight report and discussed progress against standards and recommendations, including governance improvements via EPRR group structures and escalation of heightened risks (including CBRN) within the corporate risk framework. Members received updates on HART/SORT capability, including Internal Audit findings linking capability to funding, data accuracy improvements, recruitment progress (including positive movement on gender balance), strengthened management structures, and business cases to address capacity gaps. The Committee discussed major event planning (including the Fleadh festival), ensuring robust bronze/silver/gold command structures, provider assurance over medical provision, and multi-agency exercises (including CBRN preparedness). Members noted cross-border collaboration with NAS and shared training initiatives, and welcomed evidence of culture change within special operations. The Committee skipped to Item 12.	
12.	<u>Call Segmentation for Category 2 & 3 Incidents</u> The Chair welcomed Mr Bloomer and Mr Mason to the meeting, and the Committee discussed the rationale for call segmentation to introduce a time-limited segmentation model within the EOC, enabling early clinical review of selected Category 2 and 3 calls prior to ambulance dispatch, improving patient outcomes and resource utilisation. emphasising clinical safety and governance oversight.	



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	Management advised the approach is evidence-based, informed by learning from other UK services (including experience in Wales), and will be implemented cautiously with safety nets, monitoring and the ability to pause/revert if required. Dr Ruddell described the work to date focussing on safeguards within the process to ensure that no patients would be inadvertently disadvantaged and confirmed that he was content with the governance proposals. Members discussed the role of senior clinical staff in triage and alternative pathways, resourcing of clinical support (including expanded coverage), and the need for clear checkpoints and reporting to demonstrate impact on response times and outcomes. The Committee agreed the Trust Board should be sighted on the change in protocols and the safeguards in place, recognising NEDs' role is assurance rather than operational decision-making. <u>Next Steps</u> Interim Director of Operations / Medical Director – Provide an update to Trust Board on the approved call segmentation approach, including safeguards, implementation timeline and monitoring arrangements.	Mr Sinclair/Dr Ruddell
13.	<u>PEQS Terms of Reference (ToR)</u> The Committee discussed the regional work to harmonise Safety Committees' Terms of Reference across HSC trusts and the Department's draft ToR, noting that proposals are ambitious, extensive and aspirational and may require further clarification on prescribed expectations and proportionality. Members noted the risk of duplication across committees (particularly where topics overlap with culture/being human frameworks) and agreed that work plans and reporting routes should be mapped to ensure clear accountability and avoid duplication. It was agreed that NIAS will continue with the current Terms of Reference for PEQS, pending feedback from the regional discussions and will consider any necessary feedback where elements are overly ambitious or not operationally deliverable or appropriately scoped. In the interim Mr Quinn has requested that the Assistant Director of Governance and Risk map the current PEQs	Mr Henry



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	TOR with the DoH draft to identify if there are any gaps and also to provide an update to the Committee following the regional ToR harmonisation discussion.	
Due to time constraints the Committee agreed to reconvene another meeting to cover items 7 – 11 and AOB.		
	<u>Date of Next Meeting</u> 11 June 2026	

SIGNED: P. Quinn

DATE: 11/6/26



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Patient Experience, Quality and Safety (PEQS) COMMITTEE (Reconvened Meeting of 9 April)

Date: 16 April 2026

Time: 9.30 am

Location: MS Teams

Attendance	
Chair:	Phelim Quinn (Non-Executive Director)
Attendees:	Philip Graham (Non-Executive Director)
In Attendance:	Lynne Charlton (Director of Quality, Safety & Improvement)
	Neil Sinclair (Interim Director of Operations and Chief Paramedic Officer)
	Nigel Ruddell (Medical Director)
	Stacey Beggs (Temporary Board Secretary)
	Neil Duncan (Assistant Director of Operations)
Apologies:	

Minutes of Meeting		
Agenda Item	Summary of the discussion	Actions Agreed
1.	<u>Apologies & Remarks</u> Apologies were noted (none received). The Chair welcomed attendees and confirmed the meeting was reconvened to complete outstanding business from 9 April.	
2.	<u>Procedure</u> i) The Chair requested declarations of any actual/potential conflicts of interest; none were declared. (ii) Quorum was confirmed. (iii) The confidentiality of information and discussions was reiterated.	
3.	<u>Independent Ambulance Service (IAS) update</u> The Committee received the IAS report from Mr Duncan and noted strengthened governance and assurance arrangements.	



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	Members discussed ongoing issues relating to vetting/Access NI checks and the importance of consistent oversight for third-party providers. In this regard a relevant, recent early alert was discussed, including learning dissemination and the introduction of unique staff identifiers to support assurance. The Committee reflected on wider vulnerabilities arising from the continued absence of formal regulation of IAS providers and emphasised the need for robust data-sharing protocols and cross-Trust learning (including sharing audit outcomes). Members also noted related risks within bespoke taxi arrangements and the strategic intent to reduce reliance on external providers by increasing in-house capacity. Next Steps • Management to continue engagement with providers regarding AccessNI/vetting compliance and report any material change to the Committee. • Management to incorporate stronger data-sharing arrangements into the framework and ensure cross-Trust learning is disseminated.	Neil Sinclair
4.	Education and Training Update The Committee acknowledged significant progress since the 2022 education review, noting cultural and operational improvements within the function. Members recognised constraints on training time and the need to prioritise content and delivery models, including engagement with trade unions where appropriate. The Committee agreed that the legacy review programme should be formally closed and transitioned to a refreshed reporting template that provides clearer oversight, improved data extraction, and greater focus on outcomes/impact (including supervision and non-clinical training). Next Steps • Interim Director of Operations/Chief Paramedic Officer to develop and circulate a revised training/education reporting template (including outcome measures) for Committee consideration.	Neil Sinclair



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	Education team to work with relevant SMEs/Corporate Services to improve data quality and dashboard functionality.	
5.	PCS Update The Committee noted progress in service development, including improved structures and leadership. Members discussed rising demand, complaints, and cancellations, and the continued challenge of managing requests from across the system in the absence of formal clinical triage/eligibility criteria. The Committee discussed the planned rota change intended to reduce external reliance and invest in NIAS capacity, and highlighted the need for clearer targets and an oversight-focused report format. Members discussed the wider strategic context for PCS in light of planning guidance and emerging savings pressures, noting the risk that PCS capacity could be reduced/downscaled despite service transformation work and rising demand. The Committee noted that requests for PCS continue to increase across the system, with growing levels of complaints and cancellations, and that NIAS is frequently asked to provide transport beyond what is currently sustainable. Members highlighted that the absence of formal system-wide clinical triage and eligibility criteria for PCS referrals creates a significant challenge: demand does not always equate to clinical need, and NIAS has limited ability to consistently distinguish or prioritise requests without agreed criteria. The Committee emphasised the importance of NIAS making a clear, evidence-based case to commissioners (including through the planning guidance response) setting out: the distinction between demand and clinical need, the patient safety and service risks associated with reducing PCS provision without an agreed triage/eligibility model, and the requirement for the Department/commissioners to progress eligibility/triage arrangements to enable NIAS to manage risk and respond appropriately to the savings/commissioning environment.	



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	Members also noted that a planned PCS rota change is intended to reduce external reliance (including IAS) and invest in NIAS capacity and agreed that future PCS reporting should be more "oversight-focused", with clearer targets/trajectories and reduced operational detail to support Committee scrutiny. Next Steps • PCS leads to refine future reporting to Board/Committee level (reduced operational detail) and incorporate measurable targets/trajectories. • Management to reflect the need for system-wide eligibility/triage criteria in external planning/commissioning responses.	Neil Duncan/Neil Sinclair
6.	Serious Adverse Incident (SAI) update & Service User Feedback	
	<u>SAI Update</u> The Committee welcomed the update on SAIs, and were provided with an explanation of the internal process followed to consider reported safety incidents as Query SAIs (SAIs) and subsequently determine if the threshold for meeting regional criteria for notification as an SAI. An increased volume of QSAIs & SAIs in 25/26 v 24/25 was noted and while it was recognised that increased reporting can reflect improving safety culture, the committee were advised that there was an increased number of cases considered which were attributable in part to system pressures, delayed ambulance handover, and resource challenges, resulting in delayed ambulance response Referring to the paper members were informed of the top 3 National Ambulance Risk & Safety Forum (NARSF) SAIs themes as well as the top 3 NIAS internal themes. key learning was and highlighted which had resulted in tangible service improvements (e.g., changes to guidance/education and defibrillator capability). The Committee were advised of the position in relation to the timeliness of review and the challenge & performance & challenge in relation to achieving the timelines within the regional SAI procedure. Actions to address were outlined and the committee supported further development toward improving measures (timeliness/trajectory).	



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	Members were updated on a renewed focus on family engagement and trauma-informed practice and of the current position with implementation of recommendations arising from SAls Mr Quinn referenced a recent presentation shared at Trust Board in relation to QSAls and patient outcomes and advised the committee of the Boards decision to write to the Minister regarding patient safety concerns and the impact of system wide pressures and ambulance handover delay on protracted ambulance response. <u>Next Steps</u> QSI team to provide update in relation to performance measures associated with timeliness of completion of report and family engagement in future updates. <u>Service User Feedback</u> Service user feedback was noted; members were advised of the position with the implementation of the new regional Model Complaints Handling process. An increase in complaints largely associated with a rise in emergency response delays and provision of scheduled transport was highlighted, alongside with a rise in compliments. Key learning themes and actions to address were highlighted and progress with e learning was referenced. Members recognised the impact of delays on staff and patient experience and supported continued embedding of organisational learning through the new feedback process. <u>Next Steps</u> Patient experience team will include narrative on the 'human impact' and staff support in subsequent service user feedback reports.	Ms Charlton
7.	<u>Any Other Business / Forward Workplan</u> The forward workplan will be maintained.	



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	A paper on organisational learning from Coroners' cases (including the staff experience and learning themes) was requested. A Statement of Concern letter from SOAS was noted; management will meet with relevant parties on 5 May to discuss and ensure appropriate engagement with the regulator and organisational learning. 'People to Partners' was flagged for follow-up. Next Steps • Medical Director and Litigation Manager to agree scope/format and bring a paper on Coroners' cases to the Committee. • Director of Quality, Safety & Improvement to progress 'People to Partners' item and update the Committee.	Dr Ruddell/Mr Sinclair/A Vitty Ms Charlton
8.	<u>Date of Next Meeting</u> 11 June 2026	

SIGNED: P Quinn

DATE: 11/6/26



Northern Ireland Ambulance Service
Health and Social Care Trust



STRATEGIC PERFORMANCE & FINANCE COMMITTEE (SPF)

Date: 2 April 2026
Time: 9.30 am
Location: Board Room, NIAS HQ

Attendance	
Chair:	Paul Corrigan
Attendees:	Phelim Quinn (Non-Executive Director)
In Attendance:	Leahann Donnelly (Interim Director of Finance) Seamus Mullen (Interim Director of PPCS) Neil Sinclair (Interim Director of Operations) Stacey Beggs (Temporary Board Secretary)
Apologies:	Jim Dennison (Non-Executive Director)

Minutes of Meeting		
Agenda Item	Summary of the discussion	Actions Agreed
1.	<u>Apologies & Remarks</u> The Chair welcomed members to the meeting. The Committee NOTED apologies from Mr Dennison.	
2.	<u>Procedure: Declaration of potential conflict/pecuniary interest/confidentiality of information/quorum</u> 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. Confidentiality requirements were reiterated and the meeting was confirmed as quorate.	
3.	<u>Previous Minutes – 5/2/26</u> The minutes of the previous meeting held on 5 February 2026 were APPROVED on a proposal from Mr Quinn and seconded by Mr Corrigan.	
4.	Matters Arising	

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Members discussed demand patterns (including repeat calls and call-answer pressures) and requested that presentation be refined in the new reporting format for clarity. The Committee noted Belfast Trust's contribution to improved handover performance and discussed the wider system challenge, including the ethical and clinical risks associated with sustained handover delays. The Committee discussed demographic demand pressures (including increasing numbers of people aged over 80) and the need to ensure commissioning and establishment reflect population need. The Committee agreed that the professional operational viewpoint should be clearly articulated in forthcoming regional meetings, and that the Interim Director of Operations should be involved in meetings with the Chief Executive and Chair to represent operational impact and risk. <u>5.2 Finance Report (Month 11):</u> The Committee NOTED the month 11 finance report, the enhanced level of directorate variance analysis, and the work underway with operational teams to understand independent sector usage, vacancies and overtime. The Committee acknowledged significant improvements in the quality of financial reporting and transparency, while noting concern regarding month-on-month volatility and the need to embed stronger challenge between finance and budget holders. The Committee discussed year-end expenditure profiling, use of slippage to support priority areas (including mandatory training compliance), and continued grip and efficiency oversight. Members highlighted the importance of learning lessons for 2026/27 budget-setting and calendarisation. It was agreed that an email update would be provided to members once month 12 journals are posted and initial year-end headlines are available. <u>5.3 Business Case Register:</u> The Committee NOTED the business case register (18 open cases) and discussed the need to progress and	Ms Donnelly
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	close historic/retrospective cases, particularly estates-related cases predating the current team. Management advised processes have been strengthened and cases will be progressed for approval as soon as possible. <u>Forward Work Plan 2026/27 and Strategy Development Update:</u> The Committee NOTED the forward work plan and the strategy development progress, including completion of multiple roadshows/engagement sessions and positive feedback. Members discussed ensuring the strategy appropriately reflects NIAS as an ambulance service trust, while noting the need for alignment with future Chief Executive oversight. The update will remain a standing item.	Mr Mullen
6.	<u>Estates Update</u> The Committee NOTED the estates update and the work underway to develop an independently evidenced, optimised station footprint model aligned to the operational model. Management advised that the draft estates strategy had not yet been brought to the Committee pending completion of the optimisation work (ORH) and DoH notifications. The Committee noted ORH is approximately halfway through, with completion anticipated by end May, and that overlay work should not materially change the core strategic principles. The Committee noted engagement with PSNI and NIFRS to explore joint long-term estate planning and collaboration, with further discussions expected in late April. The Committee noted progress on HART relocation and confirmation of funding to support a comprehensive HART location solution. <u>Next Steps</u> Interim Director of PPCS: Provide an estates strategy/optimisation presentation to SPF in June 2026, with onward escalation to Trust Board thereafter.	Mr Mullen



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7.	<u>EPCR Replacement</u> The Committee received an update on EPCR replacement planning, noting the current contract end date (November 2027) and the indicative scale of costs. Members discussed key risks including business case approval timelines, dependencies with regional digital solutions (including the absence of an Encompass solution), resource constraints (including availability of technical expertise), and the likelihood of requiring a DAC/extension if approvals are delayed. Management outlined mitigation activity including securing specialist input (interim/consultancy), exploring options for additional project accounting capacity, and simplifying specifications to ensure integration requirements are captured. Members noted the financial implications of potential short-term contract extensions and the need to reflect these risks in budget profiles and planning assumptions. <u>Next Steps</u> Interim Director of Operations (SRO) – Provide a further EPCR replacement progress update to SPF within the next six months, including risk mitigation and timeline/approval status.	Mr Sinclair
8.	<u>Any Other Business</u> The Committee NOTED discussion on additional costs associated with event cover and the importance of applying a consistent approach to requesting funding/recharge for additional support. Management advised that emergency planning arrangements are now more formalised, with clearer expectations communicated to event organisers and partner trusts. The Committee noted engagement with SHSCT and WHSCT to recharge for additional support and that NIAS will seek appropriate charging where additional resilience cover is required.	
9.	<u>Next Meeting</u> 4 June 2026	



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Action Summary:

Director of Operations – Identify an operational budget holder/manager to attend a future SPF meeting to explain budget principles, controls and hotspot management; ensure directors provide written matters arising updates in advance.

Interim Director of Finance – Circulate a month 12/year-end headlines email update once journals are posted (mid-April) and preliminary position is available.

Interim Director of PPCS – Provide an estates strategy/optimisation presentation to SPF in June 2026, with onward escalation to Trust Board thereafter.

Interim Director of Operations (SRO) – Provide a further EPCR replacement progress update to SPF within six months, including risk mitigation and approval status.

Interim Director of PPCS – Progress closure of historic business cases, prioritising estates-related cases.

SIGNED:

DATE: 18/6/26

03-06-26

Trust Board and Committee Forward Work Plan 2026-27

Trust Board

Meeting	28 May	25 June	24 September	26 November	17 December	11 February	23 March	27 May
Standing Items: - Performance Report - Finance Report - Chair's Report - CEx Report - Committee Business - CIC Update	End Year Performance Update End of Year Finance Update approved call segmentation approach	Final Annual Report and Accounts HSC Core Standards (Emergency Planning) Trust Annual Safeguarding Report	IPC Annual Report Positive experiences reflected in Care Opinion and Compliments Domestic Abuse Update (Public) Board Assurance Framework Corporate Risk Register GARAC Annual Report	Corporate Plan Mid-Year Progress Report Board Governance Self-Assessment Tool Draft Winter Plan Complaints Annual Report	Annual Quality Report	Corporate Risk Register Draft Financial Plan Review of Committee Structure / Terms of Reference Review of Standing Orders	Corporate Plan End Year Progress Report Board Assurance Framework	
To Be scheduled: - Cyber Training? - RCC	Draft Annual Report							

Commented [SB1]: including safeguards, implementation timeline and monitoring arrangements – Safety C'ttee 9-4-26

Dates highlighted in yellow are the aligned Trust Board Meeting dates with all HSC Trusts

NED WORKSHOPS: 5 May and 3 Nov

03-06-26

Governance, Audit and Risk Assurance Committee (GARAC)

	14 May	23 June	15 October	3 December	28 January	Feb Date TBC	11 March
<u>Standard Agenda Items:</u> DAC Register Fraud Update Internal Audit Updates External Audit Updates DoH Correspondence <u>Notes for next year</u> Remove NIAO Checklist for this year – add to 27/28 schedule SFI's Review removed – consider sending via email if any legislative changes, and review frequency next year	Corporate Risk Register Corporate Governance Code of Good Practice NI (if there is an updated version)? Draft Annual Report and Accounts / Draft Charitable Trust Funds Trustees Annual Report Internal Audit Progress report Recommendation f/up HIA Annual Report IA Strategy and 26/27 plan External Audit	Focus on Final Annual Report and Accounts HIA HSC General Annual Report (IA) Draft RTTCWG report Counter Fraud End of Year Report 2025-26 GARAC Annual Report	Board Governance Self-Assessment Tool. Mid-Year Assurance Statement. Focus on any relevant risks on CRR. HIA Mid-Year Report (IA) Highest Scoring Directorate Risk Register IGG and Cyber Security Update	Focus on Internal Audit recommendations	Corporate Risk Register TORs review Risk Appetite Statement Review Review of Standing Orders	Extra meeting re: Progress on IA	IGG and Cyber Security Update

Commented [SB2]: Has to be w/c 11 May onwards

Commented [SB3R2]: Paul Corrigan needs early start at 9/9.30 and needs to leave at 11.30

Commented [SB4]: Has to be w/c 22 June but before TB

03-06-26

People, Culture and Organisational Development Committee (PCOD)

Standing Items	23 April	26 June	10 September	12 November	21 January
Workforce Information and HR Report	Policy Development	Managing Good Attendance	OD and Learning	Managing Good Attendance	Employee Relations
Equip Update	Employee Relations	Workforce Planning (OREL and Tactical)	Pay and Conditions	Workforce Planning (OREL and Tactical)	Resourcing & Retention (incl JE)
Culture, Sexual Safety & Workplace Safety	Digital Transformation	Industrial Relations & Partnership Working	Resourcing & Retention (incl JE) Governance & Reporting	Digital Transformation	Equality Diversity & Inclusion
	Governance & Reporting	Annual Report: Employment Law Case Annual Update	Annual Report: Equality, Diversity and Inclusion Report & Article 55	Litigation	Policy Development
	Change Management Projects (MOC)	Assistance to Study Annual Report (NJR)		Change Management Projects (MOC)	Annual Report: Safeguarding Employment Update Annual Report
	Mandatory & Driver Training (GARAC)			HR input into new Corporate Plan	
	Management response to IA				
	Ops – absence				

Commented [SB5]: GARAC - • Dissatisfied with turn around time of management responses – 25% compliance rate for 4-week turnaround. Brona was actioned to discuss internally. Suggested adapting risk register to reflect and a NED to receive regular updates (suggested someone at PCOD - Paul or Jim)

Commented [SB6]:

Commented [SB7R6]: • Ops to attend regarding absence hot spots and how they are being managed in terms of leadership and accountability

03-06-26

Patient, Experience, Quality and Safety Committee (PEQS)

Standing Agenda Items:	9 April	11 June	27 Aug	19 Nov	14 Jan
Performance Report (on SAs, complaints etc./clinical KPIS)	IAS report PEQS ToR (TBC) Education / Training Update PCS Update	(EVC) Annual Report Presentation and EVC Update Report. Infection Prevention and Control Annual Report Pharmacy bi-annual report	Service User Feedback Annual Report Presentation and Update. Education / Training Update	EVC Update Report. IPC Update report Pharmacy bi-annual report	Service User Feedback Update Report. TORs review Adverse Incident management report
Identification of Risk	Service User Feedback	Safeguarding Update	IAS Update	HART capacity update	Service User Feedback Report
Safeguarding Update	SAI Update Report EPRR update People to Partners (TB 19 Feb – <u>suggest c/f to June</u>) Learning from Regulatory Letter (RQIA)	Domestic Abuse Update HART capacity update Coroners cases Quality and Service Improvement – Quality Strategy final update report. Co Production, Partnership and Involvement– Strategy final Update report	PCS Update Quality and Service Improvement – Annual Quality Report update/ approval. EPRR Highlight Report	Annual Update re: Violence & Aggression Co Production, Partnership and Involvement update report and Mid-Year Assurance approvals.	Education and Training PCS Update SAI Update Report OOCA Update
		HSC Core Standards (Emergency Planning)	SAI Bi Annual Report OOCA improvement (c/f from June)		

Commented [SB11]: See matters arising document for 11 June mtg and mins from 16 April

Commented [SB9]: As per Safety C'ttee 16-4-26

Commented [SB8]: Under Identification of Risk

Commented [SB10]: Carried forward from April's meeting

03-06-26

Strategic Performance and Finance Committee (SPF Committee)

Meeting	Other potential items	2 April	18 June	3 Sep	10 Dec	4 Feb
<u>Standing Agenda Items:</u>	Overview of Sustainability	Estates Update	2026-27 Opening Budget Allocation	Capital budget, expenditure and forecast.	Suggested item (NH): Demand and Capacity Programme Board	Capital budget, expenditure and forecast.
Performance Report	Focus on Service Delivery Model	Suggested item (NH): EPCR Replacement	Suggested item (NH): GRS Migration	Finance update for fleet		2027-28 Draft Financial Plan
Performance Deep Dive on specific area		Finance Update for Fleet	Corporate Plan Year End Update	Suggested item (NH): Fleet and Equipment Management System Replacement		TORs review
Finance Report inc. Directorate Budget Report			operational budget holder/manager			Suggested items (NH): Sustainability Update Fleet Update
Trust Budget Report and Year-End Forecast			estates strategy/optimisation	EPCR replacement progress update		
Business Case Update			Operational delivery assurance (NS)	Estates Strategy/Optimisation (c/f from June Mtg)		
Strategy Development/ Corporate Plan Update						
Overtime budget and expenditure						

Commented [SB12]: Sustainability on Feb agenda

Commented [SB17]: Mid year update

Commented [SB19]: End year update - projection

Commented [SB13]: See mins of Feb Mtg

Commented [SB14]: April Mtg: to attend a future SPF meeting to explain budget principles, controls and hotspot management; ensure directors provide written matters arising updates in advance.

Commented [SB15]: April Mtg: estates strategy/optimisation

Commented [SB18]: April Mtg

Commented [SB16]: As per mtg on 2-4-26: operational budget holder/manager should attend a future meeting to explain how policies and financial controls operate on the ground, including hotspot management, to support NED understanding and staff assurance