Northern Ireland Ambulance Service
Health and Social Care Trust

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.	**Apologies & Remarks** Apologies were noted (none received). The Chair welcomed attendees and confirmed the meeting was reconvened to complete outstanding business from 9 April.	
2.	**Procedure** 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.	**Independent Ambulance Service (IAS) update**	
	The Committee received the IAS report from Mr Duncan and noted strengthened governance and assurance arrangements.	

	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**

	• 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.	

	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**	
	SAI Update 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).	

	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 SAIs Mr Quinn referenced a recent presentation shared at Trust Board in relation to QSAIs 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.	

	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.	**Date of Next Meeting** 11 June 2026	

SIGNED: **P Quinn**

DATE: **11/6/26**