Northern Ireland Ambulance Service
Health and Social Care Trust

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Annual Report and Accounts

For year ended 31 March 2017

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Any enquiries regarding this document should be addressed to the Director of Finance at the following address:

Northern Ireland Ambulance Service HSC Trust,
Knockbracken Healthcare Park, Saintfield Road,
Belfast, BT8 8SG.

This publication is also available for download from our website at www.nias.hscni.net.

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Chairman's Preface

When I prepared the Preface for last year's Annual Report I thought it was to be my last as I was nearing the completion of my second term of four years, having been appointed in 2008. However I am still in post as my term was extended due to some important developments. I am now well into my 9th year and I really do expect this to be the last Annual Report which I have had the honour to present.

During the last eight years there has been considerable change to the Northern Ireland Ambulance Service (NIAS). We are no longer just a means of conveying ill patients to hospital. While emergency response, particularly for patients faced with a life threatening condition, will always remain our core business, paramedics now diagnose and can refer appropriate patients to Alternative Care Pathways other than hospital admission through very busy Accident and Emergency (A&E) centres. In fact some 24% of 999 calls in 2016-17 did not require conveyance to hospital with patients being referred to other services, the most common being referral to GPs, falls teams and diabetes services. In addition paramedics can also diagnose, treat and refer some patients direct to specific hospital services other than Emergency Departments such as medical assessment units, cardiac catheterisation labs and minor injuries. Heavily congested Accident and Emergency (A&E) units, particularly at peak times, continue to be a major challenge for NIAS with many hours being lost with ambulances tied up awaiting patient hand-over to the Emergency Department. While much change occurred in 2016-17 the foundations have been laid which will herald significant change in future years. Demand continues to grow in the region of 3% each year through a growing, ageing population and funding still falls short of demand growth. Consequently our response times to Category A emergencies have fallen for another year. This has prompted a major demand/capacity analysis which commenced during the year and will prioritise calls which are currently labelled as Category A into those which require the fastest emergency response and which we will attempt to meet within target anywhere in the Province including rural and remote locations not close to the larger hospitals. It is proposed that future targets will also take account of clinical outcomes as well as response time. While budget restrictions continue I am pleased to report that NIAS met its mandatory target of financial break-even for another year.

I have had much pleasure in working with the new Chief Executive, Mr Shane Devlin, who joined in December from the Belfast HSC Trust. Shane has brought fresh thinking and initiative to the Executive team which undoubtedly will bear fruit in the ever increasing challenges which face Health and Social Care in the Province and the Ambulance Service in particular.

The previous Chief Executive, Mr Liam McIvor, moved to the Business Services Organisation in April 2016 and, in the interim period to December when Shane took up post, the organisation was in the capable hands of two Interim Chief Executives from within the NIAS Executive Team. Ms Roisin O'Hara, the Director of Human Resources & Corporate Services was the Interim Chief from April to October and during this time one of her Assistant Directors, Ms Michelle Lemon, stepped up into Roisin's post. Dr David McManus, the Medical Director, became Interim Chief in October until Shane joined and while David retained many of his specific responsibilities as Medical Director he was ably assisted during this time by the Assistant Medical Director, Dr Nigel Ruddell.
I wish to thank most sincerely the two Interim Chief Executives and their Deputies plus the whole Senior Executive Management Team for their close collaboration during the period from April to December when we changed from the previous long serving Chief Executive to the new person at the helm. There have been no other changes to the Board of NIAS during the year, however Mr Norman McKinley, a Non-Executive Director, completed his eight years of service at the beginning of April 2017 and I wish to thank Norman for his very valuable contributions over the years and in particular as Chair of the Audit Committee for six years.

In March 2016 the Minister of Health announced that Northern Ireland would have a Helicopter Emergency Medical Service (HEMS). These plans have been taken forward during the year through numerous meetings under the leadership of Dr McManus. The helicopter and aviation services will be provided by a charity, Air Ambulance Northern Ireland (AANI), and the medical services will be provided by NIAS. A lead clinician and a team of Emergency Doctors will be appointed along with flight paramedics and the administration back-up. HEMS will be based on a site operated by AANI and NIAS at the Maze Long Kesh Development Corporation near Lisburn. This is a very suitable site which is reasonably central for the Province and close to hospitals which can admit emergency patients transported by helicopter. The helicopter base is on a large site which is not close to houses and other buildings. It is planned that HEMS will be operational by the time this Annual Report is issued and I am pleased that the extension to my term has allowed me to witness this important milestone in medical care for the population of Northern Ireland.

Finally I wish to thank all NIAS staff who have worked with me since my appointment in 2008. This includes the front-line and control room staff who provide the services, all the administration staff including various secretaries who have suffered my impatience at times and last but not least my fellow Directors. I have been privileged to work with such a dedicated team providing a 24/7 critical component of Northern Ireland's health service. I wish you all success in the future and if nothing else I can forecast that the rate of change will increase as NIAS strives to be the most efficient and responsive ambulance service in the British Isles.

Mr Paul Archer
Chairman
15 June 2017

Performance Report

Performance Overview

Chief Executive Overview of Performance

In this Annual Report we again highlight the Purpose, Mission, Vision and Values of the Northern Ireland Ambulance Service (NIAS). These key statements direct our actions and intentions.

NIAS has achieved a great deal in recent years which provides a strong stable platform on which to build the Service to meet the challenges we face. We continue to invest in our ambulance personnel by bringing in new staff, increasing the number of clinicians we employ and training them in new skills and interventions. We have developed and delivered a series of Alternative Care Pathways which provide a different option to the traditional response of transport to hospital for patients. As a result we are treating and caring for more patients at home, accessing alternative destinations and are continuing to work with our staff, patients and other stakeholders to extend this development. By the end of March 2017, in comparison to the same period in 2013-14, non-conveyance rates have increased from 17% (circa. 2,369 patients per month) to 24% (circa. 3,439 patients per month).

We acknowledge, with regret, our inability to achieve the targets set in regard to providing a sub 8 minute response to 72.5% of Category A (life threatening) calls. Increasing demand for emergency response has impacted heavily on our capacity to respond promptly. We delivered a sub 8 minute response to these life threatening calls in 51% of cases throughout Northern Ireland in 2016-17. We remain committed to improving the speed of our response to the most clinically urgent patients while providing timely and appropriate services, including alternatives to hospital attendance, for those whose need is less immediate. At the end of 2016-17 we initiated a major piece of work to truly understand our capacity and demand with a view to developing a new model for the provision of ambulance services. This review, which is based on similar reviews in other ambulance services, will provide an evidence base to how we should allocate our resources as we move forward.

Ambulance vehicles are equipped with the best clinical and technology systems to provide the best possible care to patients. We continue to invest in our capacity to take 999 calls, establish the clinical urgency of the call and quickly dispatch an appropriate ambulance resource to respond. Our Quality Assurance regime demonstrates that more than 97% of 999 calls

are appropriately triaged on the basis of clinical urgency in line with internationally accredited standards. Operating from a single emergency Control Centre for the whole of Northern Ireland means that these benefits are felt by all equally and the recent investments in mobile technology ensure that the location of ambulances are clearly presented to the Control Centre officers at all times. The securing of Department of Health (DoH) capital resource funds has supported ambulance fleet and estate upgrades by replacing ageing infrastructure on a regular basis. As of the end of March 2017 over 97% of our fleet is under five years old.

We are very pleased to note that in February 2017 we moved back into partnership with trade unions with regards to job evaluations. This partnership approach has allowed us to move forward with important new developments, such as Helicopter Emergency Medical Service (HEMS) and the Clinical Support Desk (CSD). I value greatly an engaged approach to improvement and our partnership with trade unions is exceptionally important to this.

The Ambulance Service has engaged directly and positively with other providers, Commissioners and the DoH to ensure that the consequences of changes in the wider healthcare environment have been recognised and taken account of. We were particularly pleased to secure additional funding related to demographic changes impacting on NIAS, and will continue to press for additional funding to reflect increasing pressures on service delivery.

Expenditure on ambulance services this year was in excess of £70 million (including non-cash items). We have deployed our finances to support change and consolidate service delivery. We have also reduced expenditure in key areas over the period to create greater efficiency and secure value for money. We will continue to critically review our expenditure to drive further efficiencies which we hope will continue to be used to improve patient care. We continue to highlight within this report the financial

NIAS Staff participating in one of many Road Safety demonstrations in 2016-17

constraints within which we operate. Given the difficult financial environment facing us, we will have even more cause to consider the value we place on our ambulance service and the investment we wish to make in pre-hospital care.

Looking ahead it is clear that the near future offers no indication of respite from the challenges we face, particularly increasing demand, rising expectations and less funding. In October 2016, the then Minister of Health launched her 10 year approach to transforming Health and Social Care (HSC), "Health and Wellbeing 2026: Delivering Together". This ambitious plan was the Minister's response to the Expert Panel's report "Systems, Not Structures: Changing Health and Social Care" which was published on the same date. "Delivering Together" presents a vision of transformed Health and Social Care services, based on a population health model that puts patients at the centre of services through co-production. It set an ambitious plan which aimed to see a future in which:

- people are supported to keep well in the first place with the information, education and support to make informed choices and take control of their own health and well-being;
- when care is needed, people have access to safe, high quality care and are treated with dignity, respect and compassion;
- staff are empowered and supported to do what they do best; and
- our services are efficient and sustainable for the future.

It is clear that the NIAS Strategy 2017 to 2021 must be aligned to the overall programme of HSC reform as outlined above. However, we find ourselves in a distinctly different position than that of the other five Trusts in Northern Ireland by the nature of our unique and regional service. Therefore the Northern Ireland strategic health context must overlay a NIAS context.

NIAS has a vital role to play in the delivery of urgent and emergency care, providing a range of clinical responses to patients in their homes and community settings, and can potentially integrate seamlessly across the spectrum of providers in health and social care. We can increasingly shift the balance of care away from hospitals, reduce demand on emergency departments and take the pressure off general practice. There are real benefits to be gained for patients by investing in NIAS services to improve the future sustainability and performance of the health system overall.

NIAS will continue to provide a clinically safe service. Ambulance staff will be trained and equipped to provide safe care and our systems and procedures will be geared toward providing timely, safe and appropriate responses to those in need, with the highest priority attached to the most clinically urgent cases. However, growth in demand which is not matched by additional ambulance resources to meet that demand reduces our capacity to respond promptly to patients. This continual narrowing of the gap between the supply of ambulances and the demand for ambulances reduces, in particular, our capacity to deal with surges in demand such as pressures within the wider Health and Social Care (HSC) system in meeting Emergency Department (ED) targets.

The continuing financial pressure associated with the delivery of annual efficiency savings presents challenges leading to uncertainty on how this can be delivered in future without directly impacting on patient services. NIAS will continue to explore all opportunities with Commissioners and highlight pressures and concerns accordingly.

The Trust continues to manage the principal risks relating to corporate performance in line with our risk management strategy and governance structures.

These current and future changes continue to be a significant challenge to the Trust, particularly in relation to available resources and configuration of services. We are fully engaged with the DoH, the HSCB, and provider organisations such as HSC Trusts, and will continue to work with them in order to manage the risk and opportunity in this area as it is identified. The future continues to remain positive but challenging within a financially constrained environment.

The performance overview and analysis which follows provides a fuller and deeper description of our efforts this year in pursuit of our strategic aims and objectives.

Working in Partnership with NIAS is part of the Foundation Year Doctors core training hosted at NIAS Headquarters

Purpose and Activities of the Trust

The Northern Ireland Ambulance Service (NIAS) was established by the Northern Ireland Ambulance Service Health and Social Services Trust (Establishment) Order (Northern Ireland) 1995 as amended by the Health and Social Services Trusts (Establishment) (Amendment) Order (Northern Ireland) 2008 and Section 1 of the Health and Social Care (Reform) Act (Northern Ireland) 2009. NIAS responds to the needs of a population in Northern Ireland in excess of 1.8 million people in the pre-hospital environment. It directly employs in excess of 1,100 staff, across sixty one ambulance stations/ deployment points, two Ambulance Control Centres (Emergency and Non-Emergency), a Regional Education and Training Centre and Headquarters. NIAS has an operational area of approximately 5,450 square miles, serviced by a fleet of 313 ambulance vehicles. We provide ambulance care, treatment and transportation services to the people of Northern Ireland twenty four hours per day, seven days per week, and three hundred and sixty five days per year.

Eddie Murphy (PCS Supervisor, Broadway) received National PTS Staff Member of the year award

The principal ambulance services we provide are:

- **Emergency response to patients with sudden illness and injury.** In addition to providing timely ambulance response and transportation to hospital we offer clinical triage and advice to non-emergency callers and offer alternatives to hospital attendance and emergency ambulance response;

- **Non-emergency patient care and transportation.** The journeys undertaken cover admissions, hospital outpatient appointments, discharges and inter-hospital transfers and we seek to prioritise these on the basis of clinical condition with high priority accorded to cancer, renal and terminally-ill patients;

- **Specialised health transport services.** We liaise directly with clinical professionals in Northern Ireland and beyond in an effort to ensure the seamless movement of patients with specialist health needs such as organ transplant and access to critical/intensive care facilities; and

- **Co-ordination of planning for major events and response to mass casualty incidents and disasters.** We have a defined role to play in the assessment of major events and in coordinating the health response to major incidents.

Purpose...

"The Northern Ireland Ambulance Service is highly valued by the people of Northern Ireland. It exists to improve their health and well-being, and applies the highest levels of human knowledge and skill to preserve life, prevent deterioration and promote recovery. The Ambulance Service touches lives at times of basic human need, when care and compassion are what matter most."

Mission...

"The Northern Ireland Ambulance Service will provide safe, effective, high-quality, patient-focussed care and services to improve health and well-being by preserving life, preventing deterioration and promoting recovery."

Vision...

"Improved health and well-being for the Northern Ireland community through safe, effective, high-quality care and services provided by the Northern Ireland Ambulance Service as an integral part of the whole healthcare system."

Values...

"Our values provide common ground for cooperation to achieve shared aspirations. In adopting and endorsing these values, the Northern Ireland Ambulance Service commits to "living" those values every day in our engagement with patients, public and colleagues providing healthcare services."

Respect and Dignity

We value each person as an individual, respect their aspirations and commitments in life, and seek to understand their priorities, needs, abilities and limits. We take what others have to say seriously. We are honest about our point of view and what we can and cannot do.

Commitment to quality of care

We earn the trust placed in us by insisting on quality and striving to get the basics right every time: safety, confidentiality, professional and managerial integrity, accountability, dependable service and good communication. We welcome feedback, learn from our mistakes and build on our successes.

Compassion

We respond with humanity and kindness to each person's pain, distress, anxiety or need. We search for the things we can do, however small, to give comfort and relieve suffering. We find time for those we serve and work alongside. We do not wait to be asked, because we care.

Improving lives

We strive to improve health and well-being and people's experiences of the health service. We value excellence and professionalism wherever we find it – in the everyday things that make people's lives better as much as in clinical practice, service improvements and innovation.

Working together for patients

We put patients first in everything we do, by reaching out to staff, patients, carers, families, communities, and professionals within and outside the health service. We put the needs of patients and communities before organisational boundaries.

Everyone counts

We use our resources for the benefit of the whole community, and make sure nobody is excluded or left behind. We accept that some people need more help, that difficult decisions have to be taken – and that when we waste resources we waste others' opportunities. We recognise that we all have a part to play in making ourselves and our communities healthier.

Strategic Aims...

To deliver a safe, high-quality ambulance service providing emergency and non-emergency clinical care and transportation which is appropriate, accessible, timely and effective.

To achieve best outcomes for patients using all resources while ensuring high quality corporate governance, risk management and probity.

To engage with local communities and their representatives in addressing issues which affect their health, and participate fully in the development and delivery of responsive integrated services.

Strategic Objectives...

Further develop the service delivery model for scheduled and unscheduled care and transportation to address rural issues and exploit partnership opportunities.

Review and develop operational systems and processes to support the service delivery model and provide necessary assurances of appropriateness, accessibility, timeliness and effectiveness.

Build and maintain a high-performing, appropriately skilled and educated workforce, suitably equipped and fit for the purpose of delivering safe, high-quality ambulance services.

Promote and develop an open, transparent and just culture focused on patients and patient safety.

Establish and develop agreed outcome-based, clinical and non-clinical, quality indicators for patients to identify opportunities to improve outcomes for patients and pursue the resources and processes necessary to deliver better outcomes.

Review existing resources and ensure resource utilisation is aligned with delivery of agreed outcome-based quality indicators for patients and high quality corporate governance, risk management and probity.

Establish processes, built around our Patient and Public Involvement (PPI) strategy, to enable effective communication and engagement with all our communities and their representatives.

Use those PPI processes to clarify the ambulance role, function and resource with the community and agencies responsible for setting policy and commissioning ambulance services, and test this against their perceived/assessed needs and expectations.

Work with all stakeholders, in particular regional and local commissioners and other providers of health and social care services, to establish processes to enable and support full participation of the ambulance service in the development and delivery of responsive integrated health services.

Performance Analysis

Directorate Analysis

Operations Directorate

Strategic Aim 1: To deliver a safe, high-quality Ambulance Service providing emergency and non-emergency clinical care and transportation which is appropriate, accessible, timely and effective.

The Trust delivers this strategic aim through the Directorate objectives and prioritised work streams.

The Operations Directorate contributes to this strategic aim through delivering on the following objectives and Key Performance Indicators (KPIs) in its Emergency and Non-Emergency Control Centres, Frontline Services and Fleet and Estates Department.

Emergency and Non-Emergency Control Centres

Objective: Receive emergency, Healthcare Professional and routine calls.

Telephone calls are received via Automatic Call Distribution (ACD) which is a call handling system. We receive three types of telephone call; 999 calls; Healthcare Professionals (HCP) calls and Routine calls. When a telephone call arrives at our telephone switchboard, the system delivers it automatically to the first available and suitable call-taker and the whole process occurs within 2 seconds.

During 2016-17 the Emergency Ambulance Control (EAC) team handled telephone calls as follows:

Number	Type of Phone Call
210,027	999 Calls
143,804	Routine Calls
38,757	Healthcare Professional Calls
305,618	Outgoing Calls
698,206	**Total**

The figure for 999 calls represents a 4.87% increase in 999 calls over 2015-16.

Key Performance Indicator: Answer 95% of 999 calls within 2 seconds.

89.79% of calls were answered in two seconds.

Objective: Provide on-line advice to callers as appropriate. Record information, prioritise work- load and plan Ambulance dispatch.

Emergency Medical Dispatchers (EMDs) who take the 999 calls are required to remain on the line for certain health critical situations. The purpose of them remaining on the line is to provide support and advice to callers until one of our operational Ambulance resources is in attendance at the scene. Our EMDs have available to them a selection of advice

on subjects ranging from detecting ineffective breathing to delivering Cardio Pulmonary Resuscitation (CPR), managing a choking patient, to supporting callers in the process of childbirth.

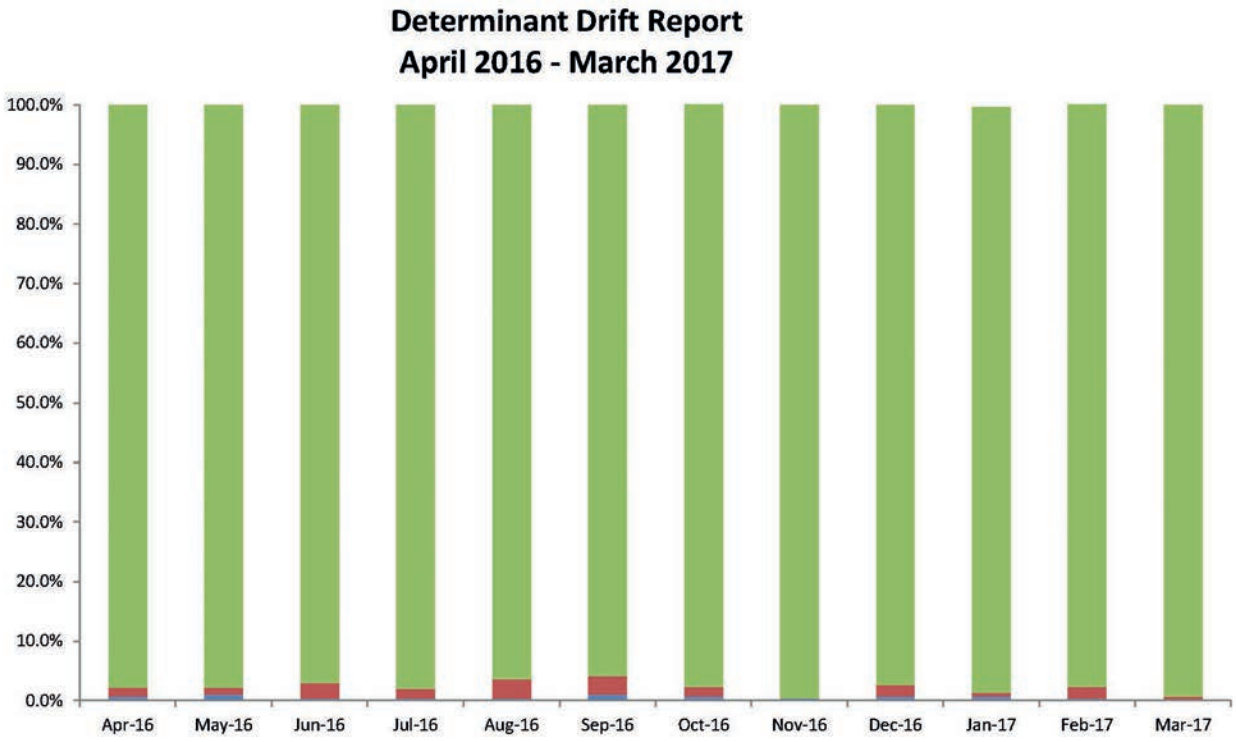
The average telephone call time is around 4 minutes and the longest times can be in the region of an hour. In some instances the EMD stays on the line to provide assistance and advice until an ambulance arrives.

All 999 calls are processed through a Medical Priority Dispatch System (MPDS), which is an international system accredited by the International Academies of Emergency Dispatch (IAED). This system enables EMDs to take the caller through a set of questions. These questions allow the EMDs to quickly evaluate the patient status and scene conditions and then categorise the call by chief complaint/incident type and set a 'determinant level' which identifies the severity of the patient's condition in terms of Minor through to Potentially Immediately Life Threatening.

NIAS is committed to reviewing a percentage of 999 calls in line with annual call volume. For 2016-17 this equated to approximately 2.72% of 999 calls or approximately 62 calls per week. Calls are measured across seven areas including customer service and final coding to ensure the highest standards of patient care are provided.

Key Performance Indicators: Achieve compliance with the protocol standards for 999 call taking. No more than 5% of calls audited should be either under or over prioritised.

There has been consistent progress in Quality Assurance since September 2014 with full



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Correctly Prioritised	97.8%	97.8%	97.0%	98.1%	96.3%	95.9%	97.8%	99.6%	97.4%	98.2%	97.8%	99.3%
Under-Prioritised	1.5%	1.1%	2.6%	1.5%	3.3%	3.0%	1.5%	0.0%	1.9%	0.7%	1.9%	0.7%
Over-Prioritised	0.7%	1.1%	0.4%	0.4%	0.4%	1.1%	0.7%	0.4%	0.7%	0.7%	0.4%	0.0%

audit volume met since April 2015. Feedback on the randomly selected calls is now available for EMDs the following working day in most cases ensuring minimum delay in recognising professional competency and identifying any areas for improvement/risk. The overall trend has seen a reduction in deviations across all areas. This minimises risk and waste in terms of response and increases the quality of standardised patient care. NIAS now meets IAED standards in all seven areas of protocol compliance.

The International Academies of Emergency Dispatch (IAED) hosted their bi-annual Ireland Navigator Conference in Dublin on the 14th and 15th March 2017. NIAS nominated five of our Emergency Medical Dispatchers (EMDs) for individual 999 calls during which they had remained compliant to the Medical Priority Dispatch System (MPDS) and had overseen a successful or beneficial patient outcome. All five of our EMDs were shortlisted and the eventual recipient was Kelly McKee from NIAS.

Kelly McKee (EMD) with her IAED Compliance Award

Front Line Services

Objective: To provide emergency and non-emergency response, care and transportation to patients.

NIAS applied a number of performance improvement measures to achieve this objective and related Key Performance Indicators, which included the development and implementation of a response Performance Improvement Plan (PIP). The Plan was designed to distribute actions across four key objectives:

- Increasing response capacity;
- Improving tactical deployment of resources;
- Improving timeliness of response in key elements of the call timeline; and
- Addressing staff issues.

NIAS was required under the Commissioning Direction Plan to formally report to the Health and Social Care Board (HSCB) on performance indicators for Category A performance and turnaround times at Emergency Departments.

The Trust had set a range of internal performance indicators focusing on response times associated with the category or coding of the call.

Key Performance Indicator: Resources are deployed in line with the Category/Code and measured through Key Performance Indicators.

When the call taking process is completed calls are categorised for Deployment as follows:

Call Type	Category/Code	Key Performance Indicator
999 Life-threatening	A (Purple/Red)	< 8 minutes
999 Serious, but not life-threatening	B (Amber)	< 21 minutes
999 Neither Life-threatening nor serious	C (Green)	< 60 minutes
Health Care Professional (HCP) Calls GPs who 'book' an ambulance after seeing a patient and deciding they need to be admitted to hospital within a set time frame	HCP Calls	1 hour
		2 hours
		3 hours
		4 hours
Routine	Routine	As agreed between caller and call taker

NIAS paramedics teaching young people at St Louise's Comprehensive College how to perform CPR on Restart a Heart Day 2016

The following table describes the performance against these Key Performance Indicators for the year 2016-17:

KPI	Belfast Division	South Eastern Division	North Division	South Division	West Division	Regional	RAG
By March 2017 Cat A calls to be responded to < 8 mins: Regionally 72.5% and LCG 67.5%	62.0%	45.5%	43.9%	46.3%	55.2%	51.0%	R
95% of Category B response < 21 mins	79.5%	71.3%	75.2%	77.0%	81.4%	76.9%	R
95% of Category C Non-Health Care Professional < 60 mins	85.4%	85.4%	91.2%	92.5%	94.9%	89.5%	A
Category Health Care Professional (formerly GP Urgent) within agreed target of either 1, 2, 3 or 4 hrs	61.2%	60.4%	64.7%	59.9%	67.6%	62.6%	R
Average of 95% of Category A have a conveying resource < 21 mins	75.1%	66.5%	72.5%	69.9%	76.6%	72.3%	R
RAG	Red - not achieved, Amber - partially achieved, Green - achieved						

ACA Recruits who graduated during 2016-17 with trainer Glenn O'Rorke

Key Performance Indicator: By March 2017, 72.5% of all Category A (life threatening calls) should be responded to within eight minutes, 67.5% in each Local Commissioning Group (LCG) area.

Underachieving against the ambulance response key performance indicators is due to a number of pressures that include an increase in demand. Since 2011-12 when NIAS last achieved the target there has been a 19.4% growth overall in the number of emergency and urgent calls (an average of over 6,800 additional calls per year).

The following table demonstrates the growth of emergency and urgent call activity between 2011-12 and 2016-17:

999 Calls and Urgent Journeys/Card 35 HCP

	2011-12	2016-17	
Location	**Actual**	**Actual**	**% Growth since 2011-12**
N Ireland	177,412	211,800	19.4%
Belfast	46,922	54,599	16.4%
North	42,480	50,973	20.0%
South East	32,357	37,861	17.0%
South	29,895	35,812	19.8%
West	25,758	32,555	26.4%

The following table demonstrates Category A (life-threatening calls) activity and performance since 2011-12:

Year	Number of Cat A Calls resulting in an emergency response which arrives at the scene of the incident	Number of Cat A calls resulting in an emergency response which arrive at the scene of the incident within 8 minutes	Category A life-threatening - % sub 8 minute response
2011-12	45,714	33,224	72.7%
2012-13	49,624	33,887	68.3%
2013-14	50,913	34,422	67.6%
2014-15	56,934	32,862	57.7%
2015-16	56,256	30,101	53.5%
2016-17	56,926	29,043	51.0%

Other challenges that have impacted on our ability to achieve the target include the following:

- Matching limited resources to deal with increasing demand over the whole 24/7 period with significant pressures between 20:00 hours and 08:00 hours and at weekends;

- Experiencing longer on scene times due to implementation of more complex care pathways for patients and acute health and social service changes;

- Continued loss of available response hours due to requests for Diverts, increase in number of multiple responses to incidents e.g. Road Traffic Collisions (RTCs), increases in travel time particularly in urban and city areas due to congestion;

- Winter and seasonal pressures;

- Impact of Major Incidents and special events on service delivery;

- Unforeseeable increase in the amount of long term absenteeism among staff due to critical and long-term sickness which resulted in higher than estimated levels of retirement;

- A challenging timescale for a comprehensive and wide ranging programme of workforce stabilisation founded on rigorous and extensive training both in the classroom and on the road. Whilst this is of great benefit to patients and the service on completion of the training it does mean that these staff are not available to the Trust until they are fully qualified. In 2016-17 NIAS recruited and trained 43 Ambulance Care Attendants (ACAs), 48 Emergency Medical Technicians (EMTs), 27 Bank Paramedics and 10 Bank EMTs. This programme provided great opportunities for internal staff and new recruits with a career in the ambulance service; and

- Delayed Ambulance turnaround times continue to be a challenge for NIAS. Congestion at Emergency Departments (EDs) impact on ambulance crews being able to hand patients over in a timely manner to hospital staff for care and treatment as well as delaying the time available to make the ambulance ready for the next call. The performance indicator agreed with Commissioners is that ambulances should turnaround at ED within 30 minutes. In 2016-17, 53.81% of all ambulance arrivals at hospitals resulted in ambulance turnaround times greater than the standard 30 minutes. This is a decline from the previous year (50.2%). NIAS has been working closely with hospital staff to facilitate timely patient flows across the Emergency Department. Four Hospital Ambulance Liaison Officers (HALO) continue to assist with patient flow and facilitating patient turnaround performance. Over the winter months NIAS increased the hours of operation of the HALOs to cover extended hours such as weekends and early evening. Their contribution is an invaluable NIAS constituent to meeting demand for non-urgent services, and protecting capacity on emergency and urgent services in meeting unscheduled demand. The table below shows performance against the turnaround target at acute hospitals in 2016-17:

SUMMARY OF PERFORMANCE AGAINST KPI WITHIN ACUTE HOSPITALS - 2016-17 Totals and Percentages					
Hospital Attended	**Under 30 mins Total**	% Under 30 mins	**Over 30 mins Total**	% Over 30 mins	**Overall Total**
Altnagelvin Hospital	8,934	57.59%	6,580	42.41%	**15,514**
Antrim Area Hospital	12,558	54.12%	10,645	45.88%	**23,203**
Belfast City Hospital	2,340	48.05%	2,530	51.95%	**4,870**
Causeway Hospital	5,458	60.09%	3,625	39.91%	**9,083**
Craigavon Hospital	8,352	46.26%	9,704	53.74%	**18,056**
Daisyhill Hospital	5,024	58.79%	3,522	41.21%	**8,546**
Mater Hospital	2,650	35.76%	4,760	64.24%	**7,410**
Royal Victoria Hospital	12,088	37.25%	20,367	62.75%	**32,455**
South West Hospital	4,879	55.29%	3,945	44.71%	**8,824**
Ulster Hospital	7,136	31.95%	15,197	68.05%	**22,333**
Total	**69,419**	**46.19%**	**80,875**	**53.81%**	**150,294**

Key Performance Indicator: Provide non-urgent transport of patients across Northern Ireland through its Patient Care Service (PCS) to locally agreed specifications.

The NIAS Patient Care Service (PCS) is targeted at patients requiring limited clinical interventions but with high substantial mobility needs who are attending Outpatient appointments, being discharged from the acute setting or being transferred to an alternative healthcare facility.

The PCS is supported by the Voluntary Car Service (VCS) which is made up of volunteers across the region who transport individual PCS patients to predominantly renal and cancer facilities across Northern Ireland. In 2016-17 NIAS non-emergency services carried out 199,243 routine journeys, which is the equivalent of 546 journeys every day.

Fleet and Estate Department

Objective: To provide a professionally managed, safe and reliable ambulance fleet which supports the operational model for service delivery.

During 2016-17 the annual fleet replacement cycle continued, a total of 23 Accident and Emergency (A&E) vehicles, 22 Patient Care Service (PCS) vehicles and 13 cars were purchased. In addition, specialist vehicles were also purchased for the Hazardous Area Response Team (HART) maintaining their equipment transport capability.

Key Performance Indicator: Age of fleet should be less than 5 years old.

Compliance with the age of fleet key performance indicators is described overleaf.

Fleet Profile 2016-17 (% less than 5 yrs old)	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Emergency Ambulances	91.4	91.4	87.1	87.9	93.1	95.7	96.6	98.3	98.3	98.3	98.3	98.3	97.4
Non-Emergency Ambulances	68.9	70.8	76.4	80.2	80.2	80.4	82.2	73.4	78.4	78.4	79.3	79.3	81.1
Rapid Response Vehicles	69.0	69.0	69.0	69.0	69.0	71.4	76.2	81	85.7	85.7	88.1	88.1	71.4

With Commissioner support, NIAS achieved a high compliance in the fleet replacement programme. The percentages for Non-Emergency Ambulances and Rapid Response Vehicles will be addressed from April 2017 as the new vehicles are commissioned into service.

The fleet continues to adopt the latest technologies in safety such as Telemetry and CCTV and minimising the vehicles environmental impact, with the last batch of A&E vehicles increasing our fleet that meet the latest Euro 6 emission standards.

The vehicle fleet and equipment continue to improve allowing the Trust to procure more user friendly equipment to assist with manual handling. Some examples of these are:

- Hydraulic stretcher trolleys reducing the need to lift patients;
- Vehicle tail lifts allowing bariatric patient carrying capacity in A&E Ambulances in addition to the existing capacity in PCS fleet thereby providing access to services for a greater range of patients;
- We have increased the number of A&E Mercedes 519 Euro 6 Ambulances this year, which are all capable of carrying bariatric stretchers and patients, thus increasing the availability of vehicles suitable for the increasing number of bariatric cases requiring emergency care;
- Almost 80% of A&E vehicles are now equipped with telemetry which allows remote monitoring of vehicle data and supports fleet management decisions with key data; and
- PCS vehicles were changed in configuration to focus on stretcher, single and double wheelchair PCS vehicles. These distinct configurations will assist in matching vehicles to patient needs and the configurations of future vehicles will be reviewed annually to ensure best fit with demand.

Objective: Responsible fleet management including environmental considerations.

Key Performance Indicator: Compliance with Euro 6 standards.

NIAS's fleet replacement vehicles are compliant with Euro 6 standards. These emission standards set the acceptable limits of exhaust emissions on new vehicles. The standards are laid out in European Union Directives and have become

increasingly stringent. The latest stage, Euro 6, became a mandatory requirement for all light commercials from September 2016, and will reduce nitrogen dioxide emissions by more than 55%. They control the harmful constituents of exhaust gases, namely nitrogen oxides (NOx), total hydrocarbon (THC), non-methane hydrocarbons (NMHC), carbon monoxide (CO) and particulate matter (PM). All our new A&E vehicles are compliant with Euro 6 and this means less carbon and other pollutants are produced by our fleet, which in total travels in excess of 7 million miles annually.

Objective: Commission and build a replacement Ambulance Station in Enniskillen.

Key Performance Indicator: To deliver Project milestones as per plan.

Planning permission was granted for the replacement Enniskillen Ambulance Station on the site of the former Erne Hospital. NIAS have decanted from their old premises which have been demolished and are in new modular accommodation adjacent to the development site. This will enable the replacement station to be completed with no disruption to Ambulance Services during construction. The project is on target for completion in late 2017.

Objective: To provide Corporate Social Responsibility in Estates planning and delivery, prioritising the Environment and the Community.

Key Performance Indicator: To meet BREEAM (Building Research Establishment Environmental Assessment Methodology) Excellence.

Work began on the new NIAS Enniskillen Station during 2016-17

BREEAM excellence incorporates factors of environmental impact, energy efficiency and sustainability. BREEAM is a widely recognised sustainability assessment tool for new building construction and other projects. It challenges developers to make effective use of resources and focus on sustainable value and efficiency.

Assessments are carried out by independent, licensed assessors and certified on a scale of Pass, Good, Very Good, Excellent and Outstanding. NIAS building programmes are designed to achieve BREEAM Excellent in accordance with Central Procurement Department (CPD) Health Project Policy. In achieving that rating the Enniskillen Ambulance Station design considered issues such as low impact design and carbon emissions reduction; design durability and resilience; adaption to climate change; and ecological value and biodiversity protection.

Human Resources and Corporate Services Directorate

The Trust also delivers Strategic Aim 1 through the Human Resources and Corporate Services Directorate supported by the Human Resources Department and the Education, Learning and Development Department.

The NIAS Human Resources Strategy outlines the strategic direction for the Human Resources and Corporate Services Directorate and supports a vision for people management, management capability and capacity and sustaining the workforce to ensure that NIAS meets the challenges ahead. Key Strategic Themes inform the Directorates Key Performance Indicators (KPIs) and, following ratification by Trust Board, provide a basis for assessing delivery of the Directorates key objectives. A new Strategy will be developed to support the new Corporate Strategy once agreed.

Transformation and Modernisation

Business Services Transformation Programme

The implementation of the Business Services Transformation Programme (BTSP) within NIAS continued throughout 2016-17, with readiness to transition the NIAS Recruitment function to the regional Recruitment Shared Services Centre (RSSC) being a key priority for Human Resources. The Directorate continues to work closely with RSSC and with NIAS Managers to facilitate a seamless transition of the NIAS Recruitment function to RSSC. This is due to commence in May 2017 and includes the full deployment of the E-Recruitment system throughout the Trust.

Whilst the Human Resources Payroll, Travel and Subsistence (HRPTS) system has been in operation since March 2014 work remains ongoing, both locally and regionally, to ensure full benefits realisation. Regionally, Human Resources staff continue to contribute to the identification and implementation of system enhancements to ensure full benefits realisation both within NIAS and the wider Health and Social Care (HSC) environment. Locally, Human Resources staff continue to support managers and staff in optimising the use of Manager Self Service (MSS) and Employee Self Service (ESS). Plans are also currently being developed to further extend deployment of the new system.

Following successful transition of the NIAS Payroll processing function to the Payroll Shared Services Centre (PSSC) in March 2015, close liaison continues with PSSC to ensure any payroll issues are resolved promptly and appropriately.

Transforming Your Care

Transformation Your Care is a significant element of the Trust's internal modernisation and reform programme. There were no targets or deliverables set by HSCB for delivery in 2016-17, however, NIAS set three internal targets in line with the funding allocated by HSCB. These were:

1. In comparison to the 2013-14 baseline, increase non-conveyances to Emergency Department by 10,000 by the end of March 2017.

2. Increase Usage of Alternative Care Pathways by 20% and Alternative Destinations by 10%.

3. Increase Hear and Treat rate by 20% by the end of March 2017 with a 12% increase by the end of July 2016.

Outcomes:

1. Increase Non-Conveyances to the Emergency Department by 10,000 by the end of March 2017.

Total Reductions in Conveyances to ED in comparison with pre-TYC baseline i.e. 2013-14, as at March 2017	14,698 *
Full Year (12 Month) Target	10,000

Please note, totals marked with a * are compiled from the NIAS Command and Control system and external data sources, and as such are subject to change.

Non-conveyance information includes patients who were not conveyed for a whole range of reasons. The important headline is that as a service our non-conveyance rate (calls with no conveyance as a percentage of all calls) has gone from 17% prior to this project to 24%. This is comparable with other Ambulance Services.

2. Use of Alternative Care Pathways to Increase by 20% and Alternative Destinations by 10%.

	March 2017 (Target number of patients increase)	Mar 2017 (Actual)	Cumulative (Apr 16 - Mar 17)
Alternative Care Pathways	247	442 *	3,882 *
Alternative Destination	129	185 *	1,852 *

Please note, totals marked with a * are compiled from the NIAS Command and Control system and external data sources, and as such are subject to change.

By the end of March 2017 all pathways were regional apart from Falls and Minor Injuries in Belfast and the Alcohol Recovery Centre which is only available in the Belfast locality. During 2016-17 a Heart Failure pathway was introduced in the Belfast and Southern Trusts. A Hyperglycaemia pathway, piloted in the South Eastern locality, is being evaluated in April 2017. A Safeguarding pathway was introduced regionally for potentially vulnerable patients and has received very positive feedback with almost all referrals deemed appropriate from social care.

A comprehensive Embedding Programme was implemented with a model called 'Impact' which gave a focus on a particular pathway each month for six months of the year. In these months breakfast clubs were organised with a focus on a particular topic, Continuous Professional Development (CPD) was arranged, ride-alongs and Emergency Department information sessions from the Speciality teams from each Alternative Care Pathway (ACP) were held.

3. Hear and Treat rate to increase by 20% of eligible calls by the end of March 2017 with a 12% increase by the end of July 2016.

	Total Emergency Calls	Emergency calls identified as eligible for NIAS GP	Actual eligible calls triaged by NIAS GP	% Downgraded ICV Suitable	% Calls resolved by providing Telephone advice with no face-to-face resource (i.e. Hear and Treat)	HCP Ringbacks	% Ambulance arrived before Triage Complete	NIAS GP on duty
Cumulative Total (Apr 16 – Mar 17)	211,800	24,442	7,504	27%	12%	12%	5%	53%

The desk in Ambulance Control, staffed by General Practitioners (GPs) continued in 2016-17. The Paramedic Clinical Support Desk (CSD) was not progressed due to issues relating to agreeing a job description in partnership with trade unions. A range of actions were taken to resolve these issues and trade unions re-engaged in job evaluations in March 2017. In 2016-17 a Contingency CSD plan was developed with support from the Director of Operations and Medical Director. This included enhancing performance management and audit of the General Practitioners in Ambulance Control, consideration of a further recruitment exercise, changes to the triage system and call stack to make referrals to the GPs safer and managed more effectively. However the 'Hear and Treat' results did not improve due to the decreasing availability of GPs and other issues so the internal target was not achieved. It was agreed to continue to pursue the Paramedic Clinical Support Desk as the preferred option.

Other Information

Maintaining relationships with all the providers of the Alternative Care Pathways is an important and growing service within NIAS. There are 40 different services to liaise with, queries to respond to, audit and review meetings. In 2016-17 there were amendments made to Alternative Care Pathways such as Falls and Acute Care at Home Services. Changes to consent for referral for Diabetes and Seizures pathways were

NIAS staff presented on improving compliance with the Acute Care Syndrome Care Bundle at the 'Delivering Safer Care' conference in Craigavon

implemented in line with national guidance. There are ongoing meetings to scope new pathways in conjunction with Integrated Care Partnerships, Trusts, the Public Health Agency, the HSC Board and the Community/Voluntary sector.

The Transformation and Modernisation team made a wide range of presentations on the changing service delivery in NIAS, in Trust locality meetings, to GPs at Federation and Practice Based Learning sessions, at regional meetings and conferences and at the National Paramedic Conference.

As highlighted already, a comprehensive programme of education for Paramedics was commenced. In addition members of the Training team completed a university module in Patient Assessment and Clinical Reasoning. This will aid their support to frontline staff in clinical assessment relating to the Alternative Care Pathways.

Other highlights from the Transformation and Modernisation work streams are as follows:

+ Development of the new pathways had a programme of comprehensive engagement built in. A range of meetings were held with nursing home managers to explain the new pathways and discuss appropriate ambulance usage;

+ As in previous years a suite of monthly reports were developed by the Information Department (utilising funding for a full-time postholder) as well as a wide range of ad hoc reports to support the develop and evaluation of pathways and new in-reach work (such as presentations to Nursing Home managers);

+ Initial evaluation of the new ACPs was a key impetus for the development and rollout of a new Quality Improvement Programme which

has focused on the use of Care Bundles and Clinical Performance Indicators with 5 clinical areas being focused on and staff given feedback as real-time as possible on the quality of their patient assessment;

- A Communications programme was implemented including use of social media, participation on local radio shows and community education events. A number of service user engagement events were held in October and November 2016 in the Kennedy and Bloomfield shopping centres. These events gave our staff the opportunity to speak to the public about the role of NIAS and specifically the Alternative Care Pathways;

- A new Clinical Newsletter was developed which has been greeted favourably by operational staff and has been used to share good news stories and clinical education relating to the new pathways;

- In August 2016 the Adastra system (an IT system used by the Out of Hours GP service) was introduced in Emergency Ambulance Control to facilitate the referral of patients who contacted 999 but whose condition was assessed as being suitable to be dealt with by a GP and did not require an emergency ambulance;

- Work continues with the HSCB to develop a regional Directory of Services to ensure NIAS has access to Trust based Care Pathways;

- Development of a mobile app to support the Alternative Care Pathways was approved in March 2017. This app will also contain the Clinical Practice Guidelines used by operational staff and should help support the clinical decision making of operational ambulance staff; and

- A structured patient questionnaire was developed to evaluate patient experience of NIAS Alternative Care Pathways and to link these with outcomes for patients as agreed by the Medical Director. The survey took place in October and November 2016. The process involved working with the relevant teams (Falls, Diabetes, COPD, Community Nursing, Minor Injury Units) and asking patients when they make contact with them if they would be willing to be contacted by NIAS by phone with a short survey. The results were almost all positive. Some of the comments received are shown below:

"Very positive experience with NIAS attending call with this gentleman. Had a raiser recliner insitu very quickly."

"Patient's daughter was given a key person to contact to benefit care."

"Patients will have an in-depth full multidisciplinary assessment."

"We have knowledge this patient is being followed up by other disciplines."

"This patient will now be seen at a level three clinic. To be seen by multidisciplinary team."

"Patient received a comprehensive geriatric assessment which included a full functional and cognitive assessment from a Specialist, as well as Nursing, Medical and Physiotherapy assessment."

"Patient was given information and advice to help reduce the chance of falling. GP changing medication."

The Transformation and Modernisation Programme was concluded with completion of a comprehensive Post-Project Evaluation and a celebration event in April 2017. A new Programme will be established for 2017-18 and beyond.

Partnership and Employee Engagement

Key Performance Indicator: To proactively manage industrial relations to deliver enhanced working practices and environment.

Entering into 2016-17 industrial relations remained challenging for NIAS with the continued withdrawal of trade unions from partnership working on job evaluation processes. Renewed engagement with Trade Unions during this period resulted in Trade Unions resuming their participation in these processes during the latter part of the year. Productive partnership working is now ongoing in relation to job evaluation processes.

Ongoing consultation and negotiation continued with trade unions via the Trust's established industrial relations machinery where progress has been made on issues such as allocation of rest periods, late finishes, allocation of annual leave and attendance management.

Complaints

Key Performance Indicator: To manage complaints in line with the Trust's Complaints Policy and Procedure and related Departmental guidance.

NIAS continues to manage complaints in line with its Complaints Policy and Procedure which is reflective of the HSC Standards and Guidelines for Resolution and Learning in the management of complaints.

All complaints are acknowledged within two working days and the Trust aims to respond to all complaints within 20 working days.

During 2016-17 NIAS received a total of 163 complaints. This figure represents a slight increase of 1.8% on the number of complaints received during 2015-16 which was 160. The types of complaints are as follows; ambulances being late or not arriving 43%; staff attitude 41%; quality of treatment and care; 7%, suitability of equipment/vehicle; 2%, and other complaints accounting for 7%. There were three complaints referred to the Northern Ireland Public Services Ombudsman during 2016-17. Further details regarding complaints received is accessible on the NIAS website www.nias.hscni.net

Compliments

During 2016-17 NIAS received a total of 229 compliments which has increased by 26% on the 2015-16 number of 182 received compliments. Here is a typical example of a compliment we received during this period:

"They treated my husband and family with such dignity, compassion and sensitivity. I will never forget that morning as long as I live, thanks to the Ambulance staff who attended, they have made it easier for me to cope" – January 2017

The majority of compliments related to Accident & Emergency and Patient Care Services.

Whistleblowing

NIAS continues to promote the existence of its Whistleblowing Procedure in line with the Public Interest Disclosure Order. During the 2016-17 reporting period, 2 complaints were received under the NIAS Whistleblowing Procedure.

Education, Learning and Development Department

The strategic objective for this area of business is to build and maintain a high performing, appropriately skilled and educated workforce, suitably equipped and fit for the purpose of delivering safe, high-quality ambulance services.

The main means for delivery of Education Learning and Development (ELD) initiatives is the Regional Ambulance Training Centre (RATC). The RATC produces and delivers a comprehensive annual Education Learning and Development (ELD) Plan which supports Trust priorities, Transformation and Modernisation programme and shaping and developing the future workforce.

Key Performance Indicator: Maintaining a competent and professional workforce to enable staff to deliver optimum patient safety and care through the promotion of a life-long learning culture and delivery of effective Education, Training and Development programmes.

Key Performance Indicator: Modernising Education, Training and Development, seeking new and innovative ways for staff to learn, ensuring reflective practice and transfer of learning.

2016-17 was again another particularly busy year for the RATC. The primary focus remained on clinical priorities and work continued from the previous year to provide training aligned with recruitment to assist in stabilising the

EMT recruits who were the first to graduate during 2016-17 under the new Programme for Level 4 Diploma for Associate Ambulance Practitioners (AAP) with trainers Mickey Hughes, John Amos and Glenn O'Rorke

workforce. The delivery of an Emergency Medical Technician (EMT) programme in the first quarter and two Ambulance Care Attendant (ACA) programmes (quarter one and quarter two) added newly trained personnel to the Emergency and Non-Emergency workforce.

A significant event in the year was the cessation of the traditional EMT and Paramedic training options with the withdrawal of the Institute of Health and Care Development (IHCD) Ambulance programmes. This led to a major piece of work for RATC to develop a replacement EMT and associated driving programmes. This was achieved with the approval of RATC by awarding body FutureQuals as a centre for delivery of new accredited, regulated qualifications. In quarter three delivery of the new programmes commenced with the first cohort of students undertaking the Level 2 Award in Ambulance Driving and Level 3 Certificate in Emergency Response Ambulance Driving. This was followed by the commencement of the programme for Level 4 Diploma for Associate Ambulance Practitioners (AAP). The AAP programme prepares recruits to work as an EMT and subsequent to the classroom element of the course, qualification is gained after 750 hours of workplace practice placement. The first students enter practice placement in April 2017.

A second major development was the initiation of a Paramedic Education Project which has been established in recognition of recent and emerging developments within the Paramedic profession across the UK. Key deliverables of this ongoing project include scoping out options and recommending a way forward for the current and future provision of Under-Graduate Paramedic Education to meet the needs of NIAS and the wider HSC arena, and the development of a formal Clinical Supervision Strategy.

A programme of post qualification training and development was delivered to existing frontline operational staff. For the Emergency tier, this included Transformation and Modernisation subject content aimed at the use of Alternative Care Pathways. In addition to this, a small ELD team was developed to assist in transformation and modernisation related education and this included the delivery of a clinical update seminar day for all Paramedics, rolled out over a number of days in 2016-17.

The RATC's Clinical Training Officers, Divisional Training Officers and Clinical Support Officers, supported by the RATC administration team, continue to deliver a variety of education and training, as well as clinical support to frontline staff, assisting in clinical governance and the Quality Improvement (QI) programme.

Other ELD initiatives continue, supported by the Senior Learning and Development Officer. Areas include progress towards Investor in People recognition and review of Statutory and Mandatory Training, with a blended approach to learning adopted and a view to moving towards more Technology Enhanced Learning methods being used in the future.

Shaping and Developing Future Workforce

Key Performance Indicator: To develop and implement workforce strategies and plans which integrate effectively with service and financial planning and through which NIAS can meet changing needs and continue to provide high quality, effective, responsive and safe patient care.

During 2016-17 the Trust developed and implemented an action plan to meet key frontline requirements in relation to workforce, recruitment and related training. This formed part of the workforce stabilisation programme which commenced in June 2014. In addition during 2016-17 the Trust commenced discussions with the Department of Health (DoH) in relation to commencing a NIAS Workforce Review in 2017-18. This review will be undertaken in partnership with Trade Union colleagues and in conjunction with the DoH.

Additional information in respect of the workforce is contained in the staff report on page 97.

Equality, Personal and Public Involvement (PPI) and Patient Experience Department

This department delivers on this strategic aim and objective through the following areas of business:

1. Equality and Human Rights;
2. Personal and Public Involvement;
3. Patient and Client Experience; and
4. Corporate Social Responsibility.

Equality and Human Rights

In delivering Equality and Human Rights priorities, the key aims for the Trust are reflected in its Human Resources Strategy. These are:

- To promote and embed a culture of equality of opportunity and human rights in the provision of patient care, within the workforce and in the development of Trust policy; and
- To promote a culture of engagement, ensuring involvement with representative groups and individuals.

Key Performance Indicator: To support the Trust in complying with statutory obligations associated with Trust policy and decision making.

Key Performance Indicator: To work to mainstream Equality and Human Rights considerations in service delivery, policy development and strategic planning through screening and engagement and consultation processes.

During 2016-17 performance against these objectives and key performance indicators was monitored by the Trust's Equality and Personal and Public Involvement (PPI) Steering Group. Partnerships with other HSC organisations and Section 75 and staff groups had a central role in the delivery of this work.

Performance against the related objectives and key performance indicators:

- Monitoring of the provision of telephone interpreting services for those accessing the 999 system who are not fluent in English;
- Collaborative working with other HSC Trusts to review equality schemes and engage with the Equality Commission for Northern Ireland in relation to the delivery of statutory duties within Health and Social Care;

- Development and implementation of Alternative Care Pathways – work was undertaken during 2016-17 to engage with Section 75 representative groups to ensure involvement of those impacted by changes to service delivery; and

- Participation in PRIDE – in 2016 the Trust promoted and participated in Pride Events in Belfast and Derry/Londonderry. Trust staff were involved in these events alongside staff from across HSC and the Public Health Agency HSC Lesbian, Gay, Bisexual and Transgender (LGBT) Staff Forum. This was part of the Trust's work to promote equality of opportunity for our staff and to engage with the LGBT community in respect of service delivery.

Personal and Public Involvement (PPI)

Key Performance Indicator: To ensure those who use our services and their representatives have an ability to influence and shape policy and service delivery decisions.

The Trust's Personal and Public Involvement (PPI) Strategy outlines its commitment to involving key stakeholders such as service users, carers and their representatives in the development of services. The Trust continued to participate in regional PPI work with other HSC organisations to ensure a collaborative approach across HSC. This included contribution to the delivery of PPI Standards for HSC and related training and awareness programmes for staff.

NIAS staff participated in the 2016 PRIDE event in Belfast

Mainstreaming of PPI into key policy development processes continued and, to this end, staff attended events and engaged with service users and their representatives around the development of a number of policy areas from service delivery considerations to the implementation of PPI itself within the Trust.

In addition to outlined work streams associated with the Trust's Transformation and Modernisation work streams such as Alternative Care Pathways, PPI systems were a key focus. Engagement and Communication Plans were produced to ensure involvement of key stakeholders impacted by changes such as service users and their representatives. Implementation of these plans included:

- Service user focus groups;
- Engagement with representative groups; and
- Development of a public awareness campaign including visits to shopping centres throughout Northern Ireland.

This ensured input of service users and their representatives to the development of the Trust's Transformation and Modernisation agenda. Performance against delivery of these plans was monitored by the Trust's Transformation and Modernisation Programme Board.

Following attendance at Regional PPI Forum social media training, staff followed up on enhancing social media capacity by developing contacts with, and visiting, the PSNI social media team in January. This interaction and learning will inform social media strategy to help enhance options for PPI engagement.

PPI involvement with service users as part of the Transformation and Modernisation work streams has continued with a key priority being engagement around Transformation and Modernisation and related Alternative Care Pathways.

A number of engagement events have taken place incorporating, as appropriate, the NIAS Community Education team and promotion of Alternative Care Pathways in conjunction with the Transformation and Modernisation Team. These include engagement with service user and community groups as well as public engagement events, for example, in shopping centres. Further shopping centre events are being developed, taking into account an evaluation of those held already.

A successful workshop to develop the future community engagement strategy was convened with relevant staff. This was informed in part by initial quantitative research on annual visits. Both this engagement and further research will feed into the objectives and actions for enhancing effective PPI through community education. For example, this may involve looking at the effectiveness of community education visits in terms of feedback/evaluation and front-facing communication themes.

Staff also participated in the Regional PPI Forum, including other Trusts and service users, and met with the Rainbow Project regarding the future development of Diversity Champion status within NIAS. This work falls under the Trust's PPI obligations through a range of awareness raising, training and policy proofing tools which will enhance inclusiveness and participation. The project development process is ongoing. Staff also liaised with colleagues in Education,

Learning and Development to assess the extent and appropriateness of statutory and mandatory training around equality, PPI and human rights.

Patient and Client Experience

Key Performance Indicator: To mainstream the Minister's Patient and Client Experience Standards; Dignity, Respect, Attitude, Behaviour and Communication.

Key Performance Indicator: To obtain feedback from service users on their experiences of our services.

This work presents a particular challenge in an ambulance operating environment. The Trust worked in partnership with the Public Health Agency to deliver this objective by developing an ambulance appropriate methodology. This included undertaking surveys, completion of observations of practice and gathering patient stories as part of the regional 10,000 Voices project. Progress against the patient experience standards is monitored by the Trust's Equality and Personal and Public Involvement Steering Group and the Trust Board.

A review of the systems for undertaking the Patient/Client Experience Standards methodology was undertaken to mainstream the standards within core clinical practice. This included a review of systems of observations of clinical practice including monitoring of the standards. Observations of practice continued during 2016-17, providing further evidence of positive patient experience as well as identifying areas for improvement. The information gathered from observation of practice was used to complement that obtained through the use of other patient experience tools and methodologies. The outcome of observations helped managers and staff to identify gaps and put in place arrangements to improve practice and deliver more person centered care.

In the main, results from feedback have been very positive and reflect patient satisfaction in terms of compliance with the standards. Learning related to a minority of individual experiences which did not meet our required standards related to delays in ambulance arrival and staff attitude. These reflect themes included in Trust complaints and work has been undertaken in terms of relevant training programmes to address issues around attitude and behaviour. It is important to recognise that these issues are in the minority in terms of results obtained.

The Trust continues to gather and analyse patient experience stories as part of the regional 10,000 Voices project. We have now collected over 300 patient stories related to the Ambulance Service, the vast majority of which have been positive.

With support from the PHA, we intend to continue to promote 10,000 Voices and gather more stories from patients and staff within NIAS, reviewing progress and learning from results with service users. Further work is underway to use 10,000 Voices as a learning and engagement tool for the Transformation and Modernisation Programme around Transforming Your Care and Alternative Care Pathways. A pilot of a separate survey on Alternative Care Pathways was launched in February.

A work-plan has been developed which includes:

+ A workshop with service users and the PHA to be held with the aim of analysing the themes emerging from patient stories collected so

far and considering learning outcomes and improvements;

- A focus on the regional priorities on staff introductions and patient-centred communication skills;

- The re-launch of the “Hello My Name is…” campaign within the Trust;

- Engagement with the Communications Team on options for a NIAS 10,000 Voices awareness and promotional campaign; and

- The relaunch of the 10,000 Voices staff survey.

Staff attitude, behaviour and communication are continuing themes reflected in complaints and the Trust continues to work to address these issues through internal processes including training. Staff attitude and awareness of the patient experience standards across all staff groups has been prioritised through the Corporate Induction Resource Pack and training and clinical training programmes.

Corporate Social Responsibility

Key Performance Indicator: To mainstream Corporate Social Responsibility actions across directorates through the development and implementation of an action plan.

The Trust works with Business in the Community on the implementation of its Corporate Social Responsibility agenda. This works across directorates with a focus during 2016-17 on the themes of People, Place and Planet. Work streams included:

1. Delivering a 30 week Youth Volunteer Academy initiative in partnership with PSNI. This initiative is targeted at young people from secondary school age upwards. The aim is to have participants from all backgrounds and communities involved particularly those who could benefit from additional support and encouragement. The objectives of the scheme are:

    - To encourage good citizenship, learning and development and the spirit of adventure;

NIAS welcomed NIFRS crews in Lurgan to our First Response Scheme in September 2016

- To provide young people with an opportunity to be heard, to have their say in issues that affect them and to influence social change;

- To promote a practical and positive understanding of the emergency services, the criminal justice system, policing with the community, and the wider public services; and

- To build community relations by promoting positive engagement between young people and the emergency services.

2. Participating in its annual 'Cares Challenge', available as part of our membership of Business in the Community, NIAS staff helped a local breast cancer charity with its daily activities in its retail outlet at Kennedy Centre, Belfast. NIAS administrative staff assisted in stock control and organisation in the shop while operational staff performed health checks at the shop front.

3. Participating in the Arena Network Environmental Benchmarking Survey and NIAS was again awarded Gold Level for its efforts in promoting environmentally friendly practices. This was the second year in succession that the Trust was recognised in this particular area of work which is central to our Corporate Social Responsibility commitments.

Medical Directorate

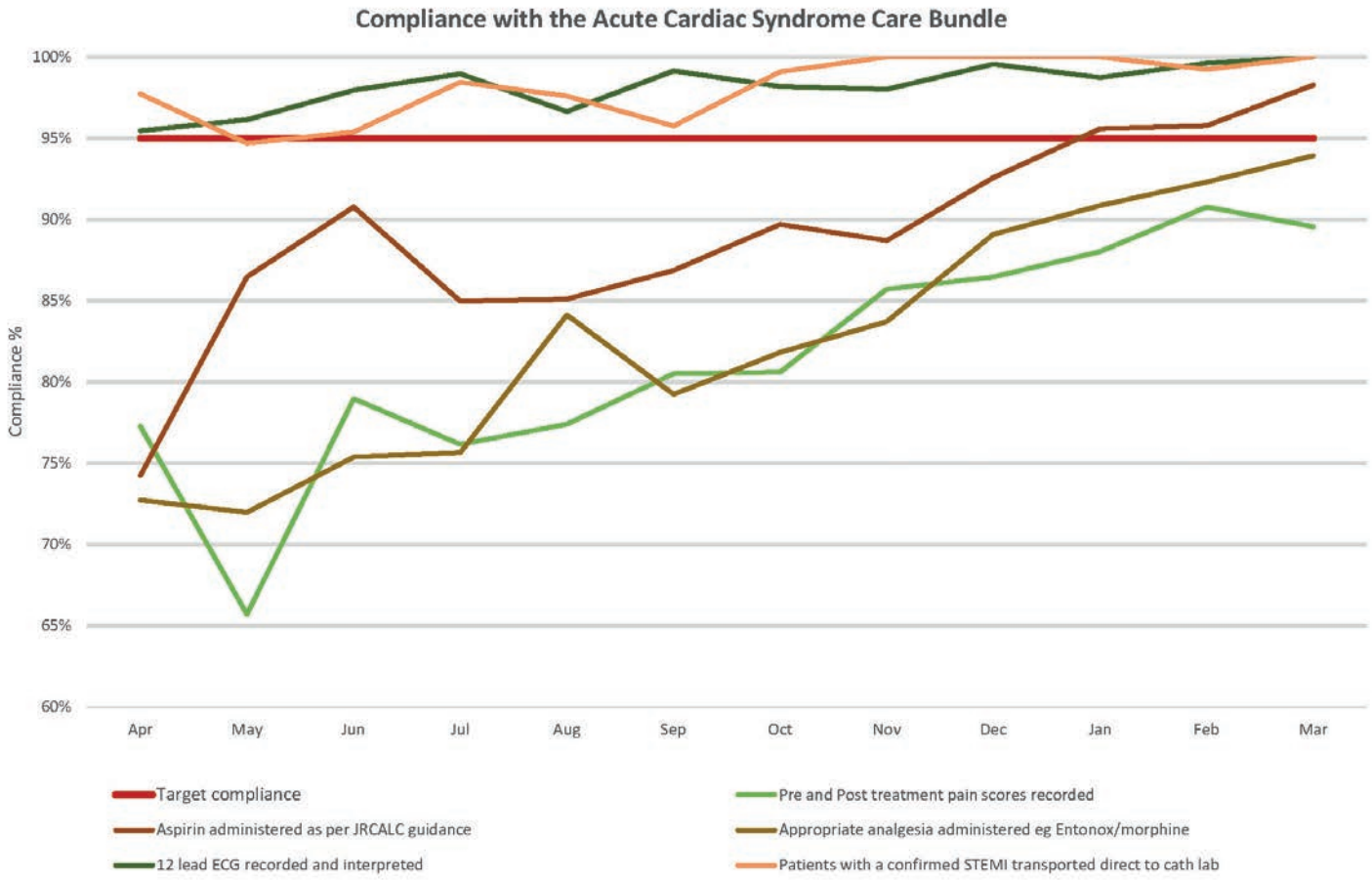
Quality Improvement Programme

A programme to monitor and review compliance with the Alternative Care Pathways using Quality Improvement methodology was introduced last year with the initial reports for a number of care bundles reported to Trust Board in June 2016. Further reports have been submitted to Trust Board and the Trust's Assurance Committee. These reports facilitate monitoring and feedback at an organisational, divisional and local level. Please refer to the report below.

A presentation was made on Quality Improvement work in NIAS at the Delivering Safer Care Conference and the group submitted a poster which received very favourable feedback from HSC colleagues. A presentation was also made by the Transformation and Organisational Change Programme Manager and Team Members on the QI work on the management of Acute Cardiac Syndrome at the Faculty of Medical Leadership and Management conference.

Historically clinical feedback to staff was given via Observational 'ride-alongs' by Clinical Support Officers (CSOs) and random audit of Patient Report Forms (PRFs) by CSOs focusing on completion of key fields rather than clinical assessment. Clinical Performance Indicators for Cardiac and Stroke were analysed by Clinical Audit team within 6 months.

The area of initial focus for the NIAS Quality Improvement Programme in NIAS has been introducing a new process for reviewing a summary of our Clinical Performance Indicators in 'real-time' by CSOs reviewing 7 PRFs per



Five areas of clinical practice currently fall under the QI programme, they are:

- Stroke
- Acute Cardiac Syndrome
- Cardiac Arrest
- Falls
- Hypoglycaemia

Each area has an associated "care bundle". Care bundles are collections of interventions that when delivered together, result in better patient outcomes than when implemented individually. They are being used increasingly within healthcare to set standards for the delivery of care, performance reporting, and commissioning of services.

A care bundle is distinct in several ways from just any checklist about patients' care. The elements in a bundle are best practices based on evidence, and all clinicians should know them. In routine clinical practice, these elements may not always be done in the same way, making patient care vary. A bundle, therefore, aims to tie them together into a cohesive unit that must be adhered to for every patient, every time.

Stroke Care Bundle

- Time of onset of symptoms
- FAST recorded
- Blood glucose recorded
- Blood pressure recorded
- Standby placed to a stroke centre

ACS Care Bundle

- Two timed sets of basic observations
- Pre AND post treatment pain scores recorded
- Aspirin administered as per JRCALC guidance
- GTN administered as per JRCALC guidance
- Appropriate analgesia administered e.g. Entonox / morphine
- 12 Lead ECG recorded and interpreted
- Patients with a confirmed STEMI transported direct to cath lab

Cardiac Arrest Care Bundle

- History of event documented
- Was "arrest witnessed" documented?
- Bystander CPR recorded
- Public access defibrillator used
- Presenting rhythm recorded
- NIAS resuscitation attempt recorded
- Defibrillation recorded for shockable rhythms
- Advanced airway management
- Intravenous / intraosseous access attempted
- ETCO2 recorded
- ROSC at hospital recorded
- ROLE recorded
- Standby recorded

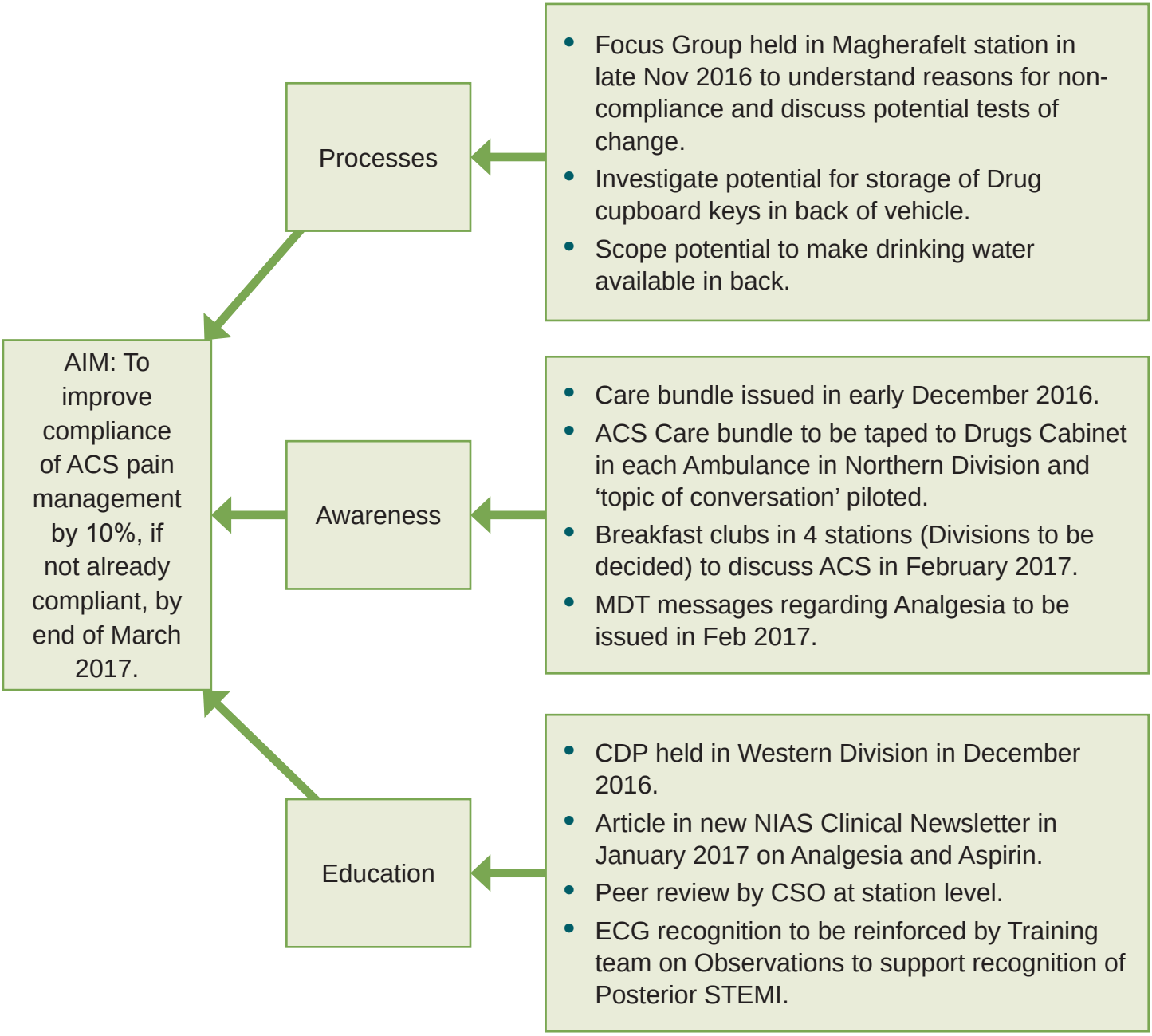
month per station across 5 clinical categories. The aim is to give staff feedback on their clinical assessment of the patient within a few days where possible. This will support evaluation of usage of the Alternative Care Pathways. See a sample of the Care Bundles to the left.

Quality Improvement Methodology was used to identify and carry out tests of change across the 5 clinical categories currently being monitored in order to improve compliance with the bundles. Clinical Support Officers were key in identifying solutions and working on implementing these.

For example, to improve compliance with the Acute Cardiac Syndrome Care Bundle a focus group was held in Magherafelt Ambulance Station to identify some of the key issues impacting compliance.

Below is the Driver Diagram used to successfully improve compliance with the ACS care bundle.

The five categories of Clinical Performance Indicators considered this year were Acute Cardiac Syndrome, Diabetes, Cardiac Arrest, Stroke and Falls.



Staff from NIAS Ambulance Control contributing to HSC Change Day

Plans to further develop Quality Improvement (QI) within NIAS are currently being developed. Preparatory work to enable the addition of two new categories to the Clinical Performance Indicators has commenced.

Electronic Patient Report Form (ePRF)

Following the introduction of a revised Patient Report Form (PRF) in 2015-16 to reflect new clinical guidelines, referral pathways and regional early warning scores, the policy for PRF completion was reviewed and updated, submitted to and approved by Trust Board in December 2016. The timely collation, audit and reporting of clinical data and sharing of relevant clinical information to support the quality and safety of our clinical care and the further development of care pathways and integration with other clinical services and healthcare professionals is significantly constrained by the current manual clinical recording systems in use within the Trust. This would be greatly enhanced by the introduction of an electronic Patient Report Form (ePRF).

The progress of the Outline Business Case (OBC) for the introduction of an electronic Patient Report Form (ePRF) had been significantly delayed due to the availability of revenue funding. This has resulted in a significant delay on project deadlines and milestones.

Despite this the Trust has continued to engage with HSCB in the development of a regional Electronic Health Care Record (EHCR) which will require significant capital and revenue investment and as part of the business case development, various options including the position of an ambulance ePRF were considered within that project. Engagement with HSCB is still ongoing to scope if the ePRF should remain as a stand-alone initiative linking with the EHCR or should become an integral part of the EHCR development. The Trust met with the eHealth Strategy Team on a number of occasions to progress this and, as an outcome of these meetings, it was agreed that a revised Outline Business Case be resubmitted to the Commissioner to obtain indicative support for revenue funding to allow the project to proceed to consider procurement options and more detailed costings, at which stage a further review would take place in advance of formal commitment to funding. As a result of this process, conditional support for revenue funding for the business case has now been received from the Health and Social Care Board (HSCB). Feedback has also been received from the Department of Health (DoH) in relation to the business case in February 2017. These queries have now been addressed and approval of the outline business case, which was submitted in October 2016, is now awaited from the DoH to allow the Trust to proceed.

Failure to progress an ePRF will seriously constrain the Trust's ability to provide timely clinical information to further improve and maintain effective, high quality clinical care and support referral pathways and other initiatives including consideration of the introduction of outcome based performance indicators.

Community Resuscitation Strategy

NIAS is charged with leading the implementation of the Northern Ireland Community Resuscitation Strategy, and the Implementation Group chaired by the NIAS Medical Director continued to meet during the year. Progress reports from various sub-groups, including cardio pulmonary resuscitation (CPR) training, automatic external defibrillators/public access defibrillation, communication and data and information sub-groups were received and considered.

As part of the implementation of the Community Resuscitation Strategy, the Implementation Group and its sub groups, with representatives from a range of other organisations and providers, supported and facilitated the UK Resuscitation Council "Restart a Heart Day" in October 2016. Over four thousand people participated in CPR training regionally on that day. This received considerable media attention. Planning for future events has already commenced and it is hoped to train even more people in CPR in 2017.

Following engagement by the Medical Director with the Department of Health, the Chief Medical Officer and the Permanent Secretary, confirmation of recurrent funding for Community Resuscitation Development Officers (CRDOs) from the Health and Social Care Board (HSCB) and the Public Health Agency (PHA) was received for 2017-18 onwards. Recruitment of the CRDO posts was delayed while the outcome of engagement with Trade Unions in relation to job evaluation was awaited. The evaluation of the CRDO posts and subsequent recruitment will now take place early in 2017-18.

NIAS continues to engage with a number of organisations and community groups regarding the placement of public access defibrillators. This includes sporting organisations as well as Government Departments. Meetings with Belfast City Council and Mid Ulster District Council took place with further meetings with two other Councils scheduled. NIAS currently facilitates twelve Community First Responder Groups and during the year has also facilitated the activation of two additional groups and engagement with a further two groups is continuing. During the year a Community First Responder scheme was also established in Lurgan as a pilot with the Northern Ireland Fire and Rescue Service.

An electronic form for the registration of defibrillators which was placed on the NIAS website for use by members of the public has resulted in the number of public access defibrillators recorded on the emergency ambulance control mapping system rising to over three hundred. This facilitates their deployment in the event of an out of hospital cardiac arrest in the vicinity. Work is continuing to further enhance this and to develop an app to make this information available to members of the public who can respond to such incidents. NIAS is also continuing to participate in the development of a national Automatic External Defibrillator (AED) register and out of hospital arrest outcome study.

Helicopter Emergency Medical Service (HEMS)

Following a statement by the Minister in September 2015, and a public consultation from November 2015 to January 2016, in March 2016 the Health Minister made a public announcement regarding the establishment of a HEMS service in Northern Ireland and that the HSCB would commission NIAS to deliver the service.

Following the announcement NIAS continued to meet with the Department of Health and HSCB as well as a potential charitable partner to clarify the funding and delivery model. The Minister announced that the charitable partner would be Air Ambulance Northern Ireland (AANI). A Memorandum of Understanding between NIAS and AANI was approved during the year.

The Trust submitted a strategic outline business case for HEMS to DoH in December 2016 and funding support for an investment proposal for pre-project costs for a Project Manager and operational and clinical leads has been received. NIAS participated in meetings with the Chief Medical Officer (CMO) and other HSC Trusts regarding the delivery model and an anticipated date of commencement for the HEMS service.

Following advice from the CMO confirming the operational model as a doctor/paramedic, a further announcement was made by the Minister at the beginning of March 2017 that the service would be based at the Maze/Long Kesh site with a potential commencement date of twelve weeks following the announcement.

The recruitment of the operational lead and HEMS paramedics was delayed while the

The HEMS dream took a step closer with a Ministerial Announcement in March 2016

outcome of engagement between the Trust and Trade Unions regarding the job evaluation process was awaited. The job evaluation process was completed in the first week of March 2017 with the recruitment process commencing on 10 March 2017. The clinical lead was appointed in March 2017 and the operational lead, flight paramedics and HEMS doctors will be appointed during April 2017 to support the commencement of the service.

The HEMS Management Board has been established and has met in advance of the commencement of the service with agreement on membership, Terms of Reference and standing agenda items in relation to financial reporting and monitoring.

It has been agreed that the clinical advisory groups for HEMS and the Regional Trauma Network be combined and the NIAS Medical Director has been asked to lead the Project Board for the development of the Regional Trauma Network. The first meeting of the Regional Trauma Network Board took place in December 2016 and the Clinical Advisory Group was appointed in January 2017. The Clinical Advisory Group is currently meeting monthly and initial Standing Operational Procedures have been developed.

The service will operate in daylight hours and will be physician led supported by paramedics to provide advanced lifesaving interventions at the scene of the most serious incidents across Northern Ireland, before ultimately delivering the patients to the major trauma centre that provides the necessary specialties to improve the patient's survival and recovery. The service will provide a primary response role initially and develop into a secondary response role at an appropriate time in the future.

Medical Equipment

The Trust's Medical Equipment Group reports to the Assurance Committee and considers incidents relating to medical equipment, the development and introduction of new medical equipment and devices, incidents and issues relating to medicines and medicines management, as well as device and medicines alerts. During the year a number of items of new medical equipment were introduced to ensure compliance with current clinical guidelines and best practice. Of note, new cardiac monitor defibrillators to replace current equipment were specified and procured. These are key devices in the provision of patient care and are compliant with the data recording and transmission technology essential for the Trust's modernisation programme. In addition, other items of equipment were updated and replaced. This included, for example, the introduction of safer hypodermic needles and a new maternity pack that is compliant with national guidelines and includes the national maternity pre-hospital screening and action tool.

Infection Prevention and Control

The Infection Prevention and Control Group continues to advise the Trust on matters relating to infection prevention and control, and the reduction of the risk to patients of healthcare acquired infection, as well as the safeguarding of staff and patients from other infections. Activity in this regard is reported to Trust Board through the Assurance Committee. No healthcare acquired infections (HCAIs) were reported within the Trust during the year.

An audit of Personal Protective Equipment for use in the management of patients with a significant infection was completed during the

year and a programme of fit testing for all new operational ambulance staff is ongoing. The group continue to monitor key performance indicators in relation to infection prevention and control including compliance with infection control procedures such as handwashing and cannula insertion, compliance with the clinical waste policy, decontamination of vehicles and equipment, vehicle and station cleanliness and compliance with the controls assurance standard.

Following a planned Regulation and Quality Improvement Agency (RQIA) Infection Prevention and Control Inspection, a Quality Improvement Plan was developed and progress against actions are reported to the Trust's Assurance Committee.

As an outcome of this review the Trust, in collaboration with RQIA, developed an ambulance specific audit and inspection tool for use within NIAS. A planned inspection by RQIA took place in order to validate the tool and the result of this is awaited. In addition, as an outcome of this process, the Trust is now included in the RQIA programme of unscheduled infection prevention and control inspections.

Risk Management

The Trust's Risk Management Strategy and Risk Management Policy were reviewed and following consideration by the Senior Executive Management Team (SEMT) and the Trust's Assurance Committee, were approved by Trust Board in October 2016. The Trust's Corporate Risk Register is presented monthly to the SEMT and to the Assurance Committee as a standing agenda item and then to the Trust Board. Similarly, Directorate Local Risk Registers are presented periodically to the Trust's Assurance Committee.

During the year a series of Directorate specific Risk Register workshops, facilitated by the Risk Manager, have taken place.

A format for the Board Assurance Framework has been agreed by the Assurance Committee and work is ongoing to populate the Framework. A populated Framework was presented to the Assurance Committee in January 2017 which will now be further updated to reflect strategic aims in the 2017-2020 Corporate Plan for 2017-18 and beyond.

Improvements in Incident Reporting

A review of the incident reporting procedure to enhance the reporting of patient related incidents commenced but completion has been delayed whilst awaiting the appointment of administrative support for the Risk Manager. As an outcome of the Departmental review of regional Serious Adverse Incident (SAI) reporting procedures in which NIAS participated, a revised regional SAI reporting procedure was published in November 2016. This has been adopted within the Trust and incorporated into the revised NIAS incident reporting procedure. NIAS continues to participate in the learning outcomes review from SAIs regionally.

The first meeting of the Trust's Learning Outcomes Review Panel took place in September 2016. The panel has been established to enhance and support individual and organisational learning from events such as untoward incidents, disciplinary investigations, claims, compliments, SAIs, as well as feedback at organisational, local and individual levels. The outcome from the panel is reported to the Trust's Assurance Committee.

Regular reports on complaints, compliments, adverse incidents including SAIs involving NIAS, Coroner's reports, medication and device alerts continue to be provided to the Assurance Committee as standing agenda items. NIAS also continues to review relevant National Institute of Clinical Excellence (NICE) guidelines and regional learning and quality letters and reports. New Joint Royal College Ambulance Liaison Committee (JRCALC) Clinical Guidelines published in March 2016 including the new Resuscitation Guidelines have been received and have been distributed to operational staff. An aide memoire in PDF format containing protocols and referral pathways has been developed for use by staff and the Clinical Guidelines are now also available to staff in the form of an app. Relevant learning letters received from PHA and HSCB are circulated to all operational staff and presented to the Trust's Assurance Committee.

The Trust has a number of systems and procedures in place for the reporting and management of incidents. Incidents are graded according to severity and include a range of incidents such as patient safety incidents, staff safety incidents, health and safety related incidents, vehicle incidents, incidents involving medicines and incidences involving medical devices.

The Northern Ireland Ambulance Service initiated a complete review of its incident management procedures in 2016. This review has already seen a 53% increase in the number of incidents reported, demonstrating improved staff engagement and significantly increasing our ability to react to, and learn from incidents as appropriate. This is an ongoing process to enhance our incident management procedures so as to support the continual improvement of the services we provide to the public.

Between 1 April 2016 and 31 March 2017 there were a total of 3,382 reported incidents; this is an increase of approximately 53% on the previous year. As set out above this is to be welcomed and was expected due to improvements in

NIAS ICS/PCS staff play a vital role in supporting their A&E colleagues on a daily basis

incident reporting processes, a pilot of online incident reporting, the inclusion of other Trust interface incidents and safeguarding pathway reports.

There were 466 incidents of violence and aggression against ambulance service staff, this is an increase of 117 incidents on the previous year. There were 319 health and safety related incidents. These incidents include manual handling/patient handling incidents, sharps incidents and slips, trips and falls. This is a decrease of 53 incidents from last year. Of the 319 health and safety related incidents, 75 were reportable to the Health and Safety Executive for Northern Ireland (HSENI) under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR), which is an increase of 53 on last year. This increase was also expected due to significant changes and improvements in processes. There were a further 297 vehicle related incidents, mostly of a minor nature.

There were 23 security related incidents. These incidents involved reports of loss of equipment, unauthorised access, Personal Protective Equipment (PPE) and uniform issues. There was one incident of the attempted theft of a vehicle. Incidents were reported to PSNI as appropriate.

There were 274 incidents reported involving medical devices. This was an increase of 138 from last year. The majority of incidents were categorised as minor. There were no incidents where patients were harmed as a result of an incident involving a medical device.

In terms of incidents involving medicines, there were 195 reported incidents. This is an increase of 120 on last year. Of the 195 incidents the majority were categorised as minor. Incidents categorised as moderate included three incidents of an adverse reaction to medication, three incidents of medication being delivered via the wrong route and two incidents of the wrong quantity. In all of these cases, an appropriate level of investigation was carried out and remedial action was taken including measures to reduce the likelihood of a recurrence. Incidents involving controlled drugs were reviewed by the DoH Drugs Inspection Unit who were content with the outcomes and actions taken.

There were 186 incidents in the category of access, appointment, admission, transfer and discharge. The majority of these reports involved reported delays in transfers. There were 436 incidents reported in respect of communication. These involve communication both internally and externally with other Health Care Professionals (HCP's) and with patients. This is slight increase on last year, however overall the figures do not indicate any significant trends. There were 153 reports of safeguarding referrals made to the various Trusts and RQIA as necessary. The remaining incidents were infrastructure and resource related. These incidents involved staffing, facilities, IT and the environment.

During this period NIAS identified five potential Serious Adverse Incidents (SAIs). Three of these cases are still undergoing investigation and two of the cases have been investigated and managed as per regional protocols and learning has taken place. NIAS is involved in a further 12 SAIs raised by other Trusts and the Health and Social Care Board. In the majority of these, NIAS has been involved in the transportation or a particular aspect of care of a patient at some point when an SAI has subsequently been raised regarding aspects of their overall care but not necessarily in relation to the care provided by

NIAS. In such cases NIAS fully participates in the multi-agency incident review and investigation by contributing information such as timelines, statements and Patient Report Forms to assist the investigation being carried out by other Trusts. NIAS adopts relevant learning from these incidents. All potential and actual Serious Adverse Incidents are reported to, and reviewed by, the Trust's Assurance Committee.

NIAS reported a number of interface incidents, primarily involving the inappropriate use of services. Satisfactory responses have been received from the particular Trusts involved and learning has taken place.

In January 2016 a system was set up to formally record information and investigation requests from other Trusts. These requests can range from basic information requests such as Patient Report Forms and timelines to a request for a formal investigation into the incident with feedback to the Trust involved. These investigations may also be escalated to an SAI or safeguarding investigation. For the financial year 2016-17, there were 151 requests for information and assistance. This is an increasing trend which will be discussed at the next Learning Outcomes Review Group.

Arrangements are also in place to review learning from other organisations and from a variety of external sources, for example national and regional alerts, newsletters, medical device alerts and medication alerts.

Emergency Preparedness and Business Continuity

The Trust's Emergency Planning Team continue to participate in a full programme of major incident planning and multi-agency exercises to test such plans. During the year nine such exercises were undertaken which is more than double the number for the previous year. Operational pressures continue to cause difficulty in providing personnel and vehicles for these exercises, an increasing number of which are taking place as table-top rather than live exercises. During the year NIAS was involved in twelve such table top exercises in addition to the live exercises noted above. A further twenty-five training sessions also took place during the year.

During the year NIAS responded to 9 potential major incidents and as well as 9 airport alerts. There were no major incidents declared by NIAS.

The NIAS Hazardous Area Response Team (HART) responded to almost 600 calls, a significant increase on the previous year. These included 111 deployments involving Breathing Apparatus or Hazardous Materials (HAZMAT), 17 incident involving restricted space, 10 incidents at height, 13 incidents involving inland water operations and 2 mountain rescues.

The Trust was commissioned to deliver Hospital Major Incident Medical Management and Support (HMIMMS) and Major Incident Medical Management and Support (MIMMS) training to the wider HSC by the Health and Social Care Board and Department of Health respectively. Four courses were scheduled and took place during the year.

In relation to Business Continuity this continues to be overseen by the Trust's Emergency Preparedness and Business Continuity Group. The Group reviews incidents, business continuity issues and airport alerts as standing agenda items and any learning outcomes identified

and actioned. The activity of the group is reported to the Trust Assurance Committee. 21 business continuity incidents were reported and successfully managed. These included the need to evacuate ambulance stations due to civil disturbance, flooding, power failures, vehicle and other infrastructure issues.

Training delivered by the Cabinet Office Emergency Planning College has been undertaken by Directorate Business Continuity leads. A Business Impact Analysis questionnaire has been developed for use within the Trust and distributed to Directorate leads for completion with support from the Emergency Planning Team. Due to constraints within the Emergency Planning Team, and the Trust being informed that the Department of Finance is no longer able to provide expert support and advice for this process, this has not been fully completed. The recruitment of a temporary dedicated Business Continuity lead was therefore undertaken and an appointment made in February 2017. As an immediate outcome of this, a review of the existing Business Continuity Plans and the Trust's Business Continuity Strategy and Policy has commenced. The development of a programme of testing Business Continuity Plans will follow in early 2017-18.

NIAS staff celebrated the completion of the Youth Volunteer Academy Scheme in March 2016

Finance and ICT Directorate

Strategic Aim 1: To deliver safe high-quality Ambulance Services providing emergency and non-emergency clinical care and transportation which is appropriate, accessible, timely and effective.

Strategic Aim 2: To achieve best outcomes for patients using all resources while ensuring high quality corporate governance, risk management and probity.

Strategic Aim 3: To engage with local communities and their representatives in addressing issues which affect their health, and participate fully in the development and delivery of responsive integrated services.

The Finance and Information Communication and Technology Department (ICT) Directorate supports the delivery of these strategic aims through the Finance Department, the Information Communication and Technology Department and the Information Department. Directorate objectives and prioritised work streams are established to support these aims.

Finance

In support of Strategic Aim 2, the Finance Department has the following key objective :

+ Regular review and enhancement of financial systems and procedures to promote the efficient and economical conduct of the business and safeguard financial propriety and regularity

Key Performance Indicators used to measure success during 2016-17 include:

1. Financial Position on a monthly basis reported to Chief Executive as Accounting Officer, HSCB, DoH and Trust Board;

2. Delivery of Efficiency Savings reported to HSCB, DoH and Trust Board;

3. Performance by Directorate against Budget reported to Trust Board;

4. Capital Expenditure comparison with Capital Resource Limit reported monthly to DoH and Trust Board;

5. Legislative and Departmental Directives and Circulars are adopted and implemented;

6. Prompt Payment of invoices reported monthly to DoH and Trust Board.

Performance for the period under review is highlighted in the Financial Resources and Performance section of this report. More detail is contained in the Annual Accounts.

Related developments and trends likely to affect future performance or positioning are also described in the Financial Resources and Performance Section of this report. Some of these developments include:

+ Co-ordinating the progression of internal audit recommendations across the Trust;

+ The embedding of shared services, new systems and associated processes and procedures;

+ The implementation of DoH Procurement Strategy at Trust Level;

+ Development and ongoing maintenance of a database of all Trust contracts;

+ A Review of the Directorate structure to manage changing and increasing responsibilities at both Trust and regional level, and

+ The application of new directives from DoF and DoH.

Information, Communication and Technology

In support of Strategic Aim 1, the ICT Department has the following key objective :

+ Maintain and strengthen the infrastructure, enabling change and supporting the introduction of ICT innovations which improve the delivery of patient care.

Key Performance Indicators used to measure success during 2016-17 include:

1. Demand on ICT services as managed through the IT Help Desk; and

2. Types of calls.

Performance for the period under review is reported as follows:

Demand on ICT services remains high with on average over 1,000 support calls logged with the support desk each month. As the team continues to deliver new technologies and improve access to ICT systems to users both locally and at remote Ambulance Stations demand on ICT resources is likely to grow.

ICT Support Calls Logged 2014-15 to 2016-17:

	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar	Total
2014-15	2,356	2,400	3,109	3,248	11,113
2015-16	3,095	3,264	3,940	3,794	14,093
2016-17	3,418	2,719	3,257	3,657	13,051

Support calls to the ICT helpdesk are prioritised into one of five categories (Immediate 4 Hours, Urgent 1 Day, High 2 Days, Medium 3 Days, Low 7 Days) based on potential impact to the delivery of patient care. Performance for the ICT Department under these five categories for 2016-17 is outlined below:

	Apr-Jun		Jul-Sep		Oct-Dec		Jan-Mar	
Target to Respond to 95%	**No of Calls**	**% Met**	**No of Calls**	**% Met**	**No of Calls**	**% Met**	**No of Calls**	**% Met**
Immediate	42	95%	23	100%	33	97%	25	100%
Urgent	116	99%	138	99%	119	97%	153	100%
High	60	100%	21	100%	27	96%	32	91%
Medium	1,136	99%	1,033	99%	1,229	98%	1,239	98%
Low	2,064	100%	1,504	100%	1,849	100%	2,208	100%
Total	**3,418**		**2,719**		**3,257**		**3,657**	

In 2016-17 the ICT Department focused on a programme of work to improve infrastructure within the Trust which included the following:

- A project to replace the NIAS Telephony platform at HQ, Altnagelvin and the short term contingency site was completed. This provides NIAS with a telephony architecture capable of using the latest Voice Over Internet Protocol (VOIP) technology across all NIAS estate;
- Work was undertaken to refresh the NIAS core network switching and firewall hardware as well as replacing the central computer and data storage hardware at Altnagelvin;
- A technology refresh of the NIAS core Microsoft platforms took place to more effectively support the needs of the organisation. Modernising these platforms provides enhanced functionality and capability whilst also ensuring full supportability and reducing risk; and
- A fundamental review and update of the Trust's ICT Strategy was carried out during 2016-17 and full engagement across Directorates enabled users to influence a range of key strategic objectives. These will drive the ICT strategy for the next five years and aim to support clinically led improvements to patient care.

Information Department (including Information Governance)

At all times the patient is the Trust's focus together with the need to ensure information governance - confidentiality, security and accuracy.

In support of Strategic Aim 1, the Information Department has the following key objectives:

- Manage business intelligence informatics with the development, production and delivery of complex statistical and qualitative and quantitative reports on emergency and non-emergency corporate activity for NIAS Trust Board, Executive Directors, Senior Managers and externally to Health and Social Care (HSC) organisations such as the Department of Health, the Health and Social Care Board, HSC Trusts and other relevant stakeholders;

- Deal with all associated proactive and ad hoc requests which relate to operational performance and acute service modernisation projects, for example, Transforming Your Care, Helicopter Emergency Medical Services (HEMS), Supply and Demand reviews and Quality Improvement. Information extracted and manipulated supports performance management across the organisation and the wider HSC and includes monitoring of how quickly we are getting to patients, types and categories of calls we have received, how quickly we are turning around at hospital and diverts that may have affected patient flows. This data provides key information for strategic planning, decision making and statutory reporting requirements, and

- Manage the Clinical Audit function within the Trust by receiving, processing and scanning on average, 17,000 Patient Report Forms (PRFs) per month, including electrocardiogram (ECG) strips, supporting the development of Quality Improvement Clinical Performance indicators to support the Transforming Your Care Team and Medical Directorate for Stroke, Acute Cardiac Syndrome, Cardiac, Falls, Hypoglycaemia and ad hoc processing to support Continuous Professional Development (CPD) of frontline operational staff and Primary Percutaneous Coronary Intervention (PPCI), monitoring returns for Catheterisation Laboratory attendances at the Royal Victoria Hospital and Altnagelvin Hospital. Clinical returns are also made to Department of Health in relation to specific stroke monitoring returns.

In support of Strategic Aim 2, the Information Department has the following key objectives:

- Provide a central source of information for areas including Data Protection, Records Management, Freedom of Information, Access to Health Records, Police Service of Northern Ireland enquiries, Police Ombudsman enquiries, Coroners Service enquiries, Solicitor enquiries, Court Orders, Summons for Staff, Assembly Questions and lost property enquiries, along with information releases to other HSC bodies or relevant stakeholders;

- Develop policies and procedures and act as a centralised point of contact for service users and staff requesting information or seeking guidance on information governance responsibilities, and

+ Develop a training programme for staff in the area of Information Governance using a combination of face-to-face, e-learning, workbooks and regional materials.

Key Performance Indicators used to measure success during 2016-17 include:

1. Controls Assurance Standards for Information Management and reported to Audit Committee, Assurance Committee and Trust Board;

2. Compliance with Responses to Freedom of Information requests reported to Trust Board; and

3. Compliance with Responses to Data Protection – Subject Access Request reported to Trust Board.

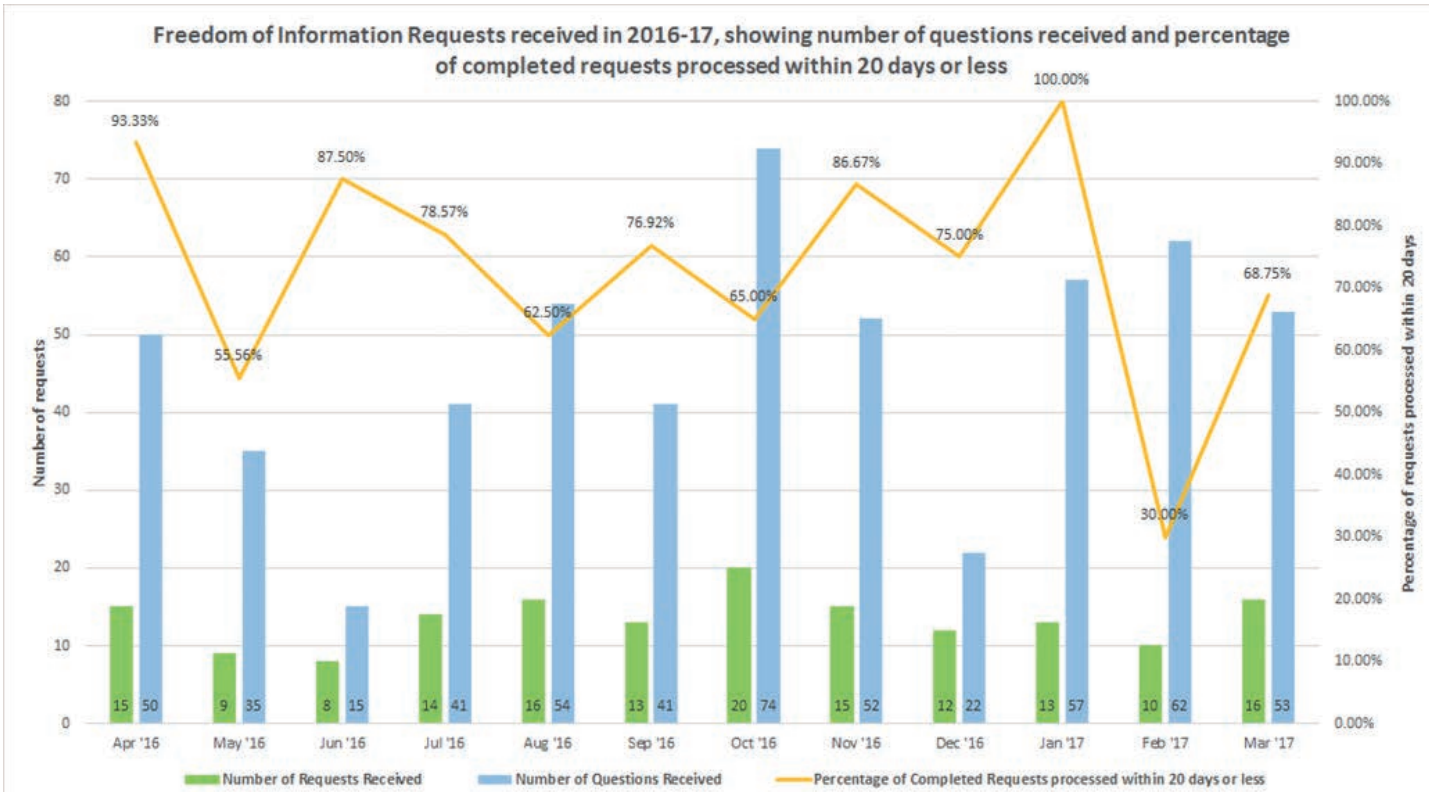
Performance for the period under review is as follows:

1. Information Management Control Assurance Standard

The Information Management Controls Assurance Standard has been self-assessed as 76% as at end March 2017. This achieves the required 75% target, is considered to be 'substantive' and shows an improvement on last year's score of 75%.

2. Freedom of Information Act 2000

The Freedom of Information Act (2000) relates to any information held in an electronic or manual format and can be accessed by anyone who requests it. Exemptions are limited and unless they specifically apply, information must be released. During 2016-17, 73.91% of requests were processed within 20 working days. It is noted that during this period the Trust noted a 19.2% increase in requests received against the previous year. For 2016-17, 161 requests were received which relates to 556 questions received compared with 478 questions in the previous year.

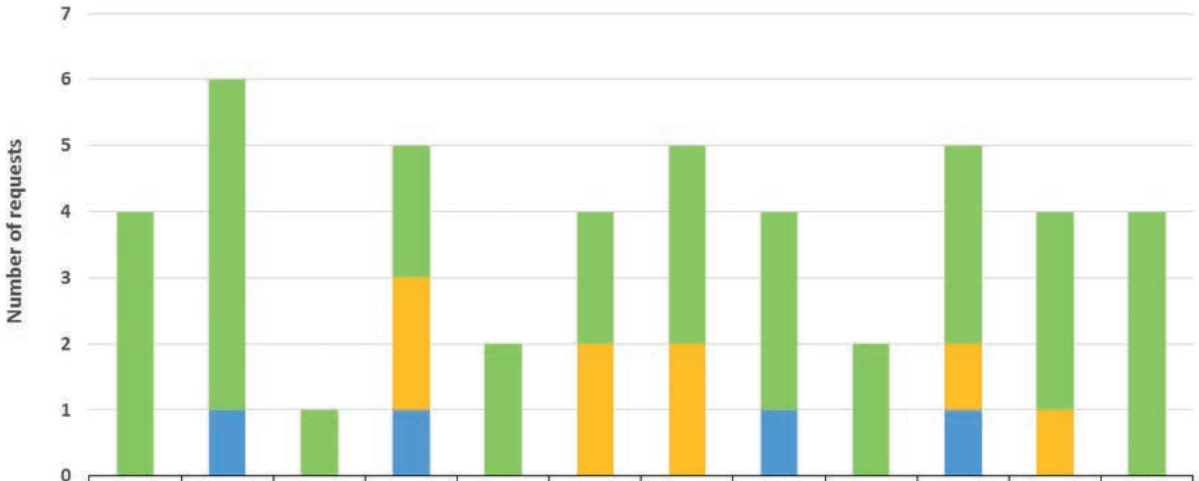


3. Data Protection Act 1998 – Subject Access Requests

The Data Protection Act 1998 allows an individual to have the right to see and/or receive a copy of personal data held about them on both electronic and manual records and to have any incorrect data amended or deleted. Requests can be received from patients, staff members or other individuals acting on someone else's behalf.

An example of the records we release under DPA, would include patient report forms, call incident logs, disciplinary files.

During 2016-17, 81% of Subject Access Requests were processed within 40 calendar days (this is based on this requests that were fully processed i.e. identity and fee received, if these are not received, the request is closed and stood down).



	Apr '16	May '16	Jun '16	Jul '16	Aug '16	Sep '16	Oct '16	Nov '16	Dec '16	Jan '17	Feb '17	Mar '17
Completed within 40 days	4	5	1	2	2	2	3	3	2	3	3	4
Completed outside 40 days	0	0	0	2	0	2	2	0	0	1	1	0
Stood Down	0	1	0	1	0	0	0	1	0	1	0	0

Information Overview

Information reports are generated from a range of data sources but primarily from information held in Command and Control systems for Emergency and Non-Emergency activity along with Clinical Audit Systems. Access to other bespoke software systems such as Global Rostering Systems and executive information systems are also used to ensure effective business intelligence and informatics.

The Information Governance Steering Group oversees all aspects of information governance. It also leads and fosters an information governance culture and is chaired by the Director of Finance and ICT as the Trusts nominated Senior Information Risk Owner (SIRO). The Medical Director is the Trust's nominated Caldicott Guardian and Personal Data Guardian.

Related developments and trends likely to affect future performance or positioning of this service include the following:

- Embedding the ongoing monitoring and extension of service development initiatives;
- Supporting the informatics and governance aspects associated with the introduction of an Air Ambulance in Northern Ireland;
- Extending the scope and scale of clinical performance indicators to be in line with the United Kingdom whilst recognising the constraints of existing manual patient report forms, and
- Supporting the Supply and Demand Review of the Northern Ireland Ambulance Service Project.

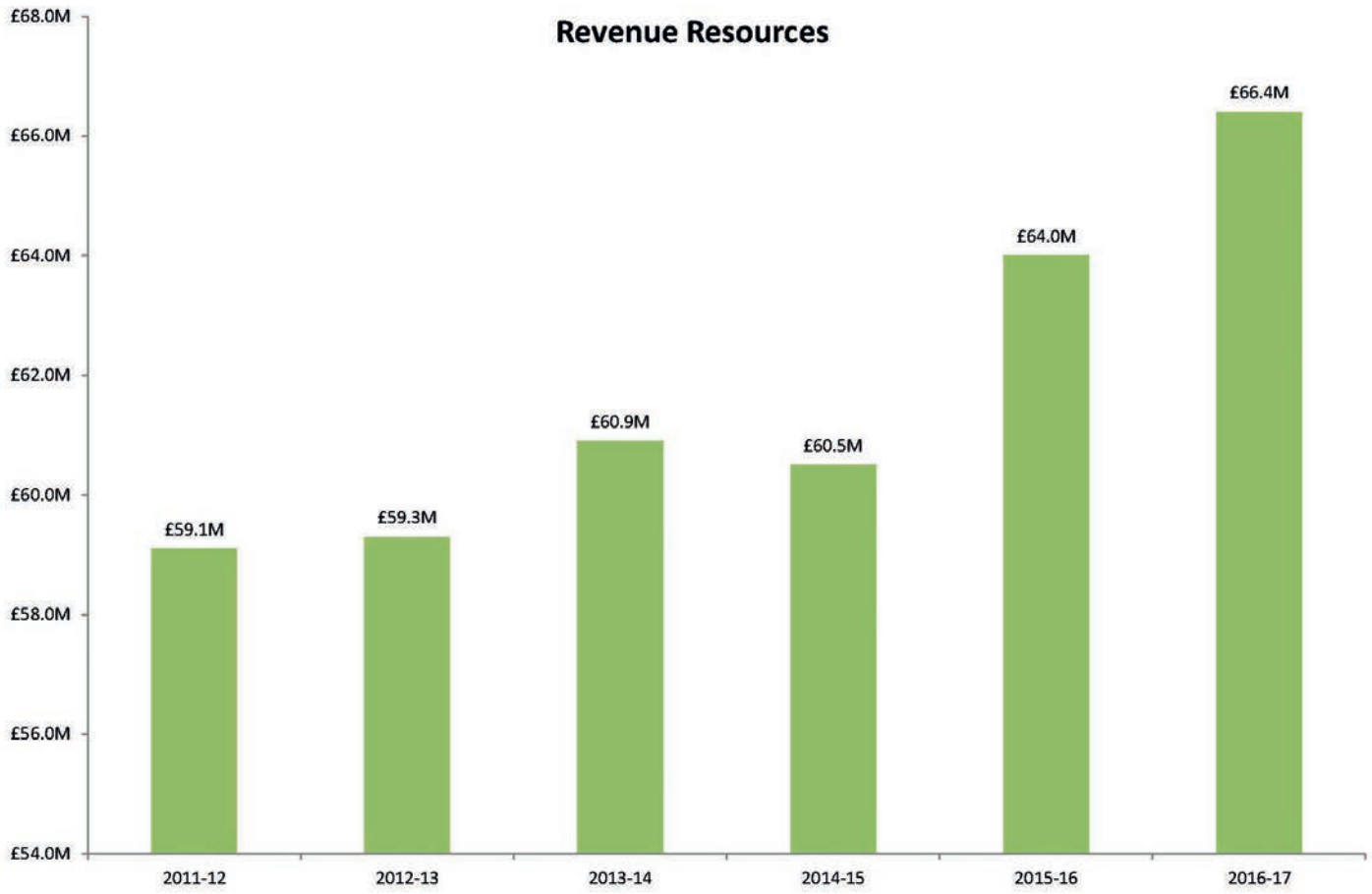
Members of our Finance and ICT Directorate play a vital role in supporting our operations

Financial Resources and Performance

Revenue Resources

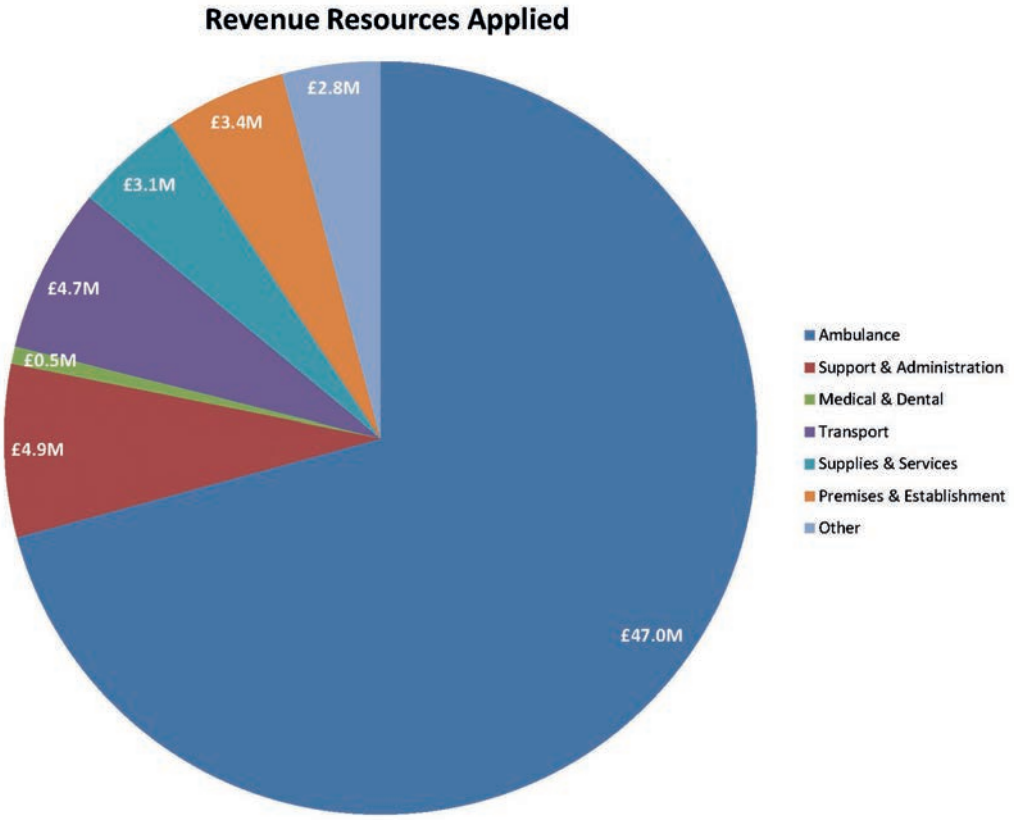
The Health and Social Care Board (HSCB) provide the majority of the revenue resources available to the Trust through the Service and Budget Agreement. This sets the service activity and outcomes to be delivered within the Revenue Resource Limit that is made available to meet the Health and Social Care needs of the population. The total revenue resources available to the Trust for the last six years are shown below.

The resources available each year can vary due to a number of factors, for example supported developments, support for unavoidable costs pressures and the level of cash releasing efficiency savings required. The increase in 2016-17 is due to a number of supported developments, for example investment in additional ambulance provision linked to demography changes and Transforming Your Care. The Trust also received an additional allocation in 2016-17 to support increased National Insurance costs due to changes in employers National Insurance contributions introduced by HMRC. The HSCB also provided additional funding to support the commissioning of a Helicopter Emergency Medical Service (HEMS).



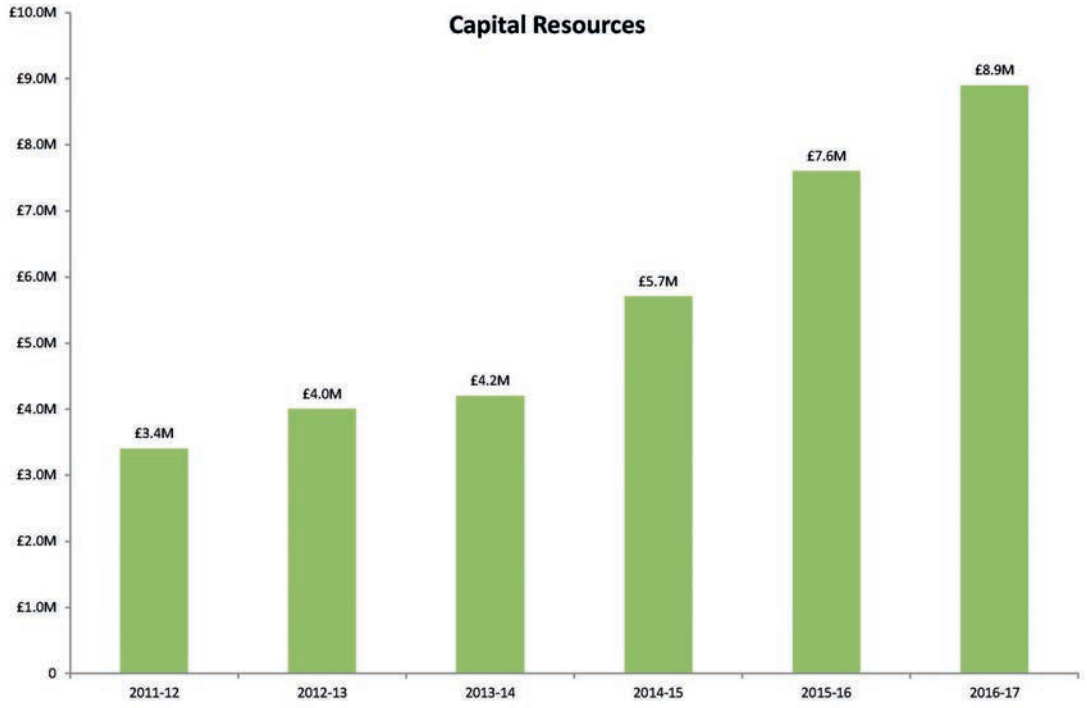
Revenue Expenditure

These resources are applied to provide the full range of services provided by NIAS. Over £52m (79%) of total expenditure in the Ambulance Service is on staff costs the vast majority of this expenditure is on front line Ambulance Service provision. Non pay expenditure of £14m is largely made up of the costs of running the Ambulance fleet, clinical and non-clinical services and supplies and premises and establishment costs. The breakdown of expenditure between these areas in 2016-17 is shown below.



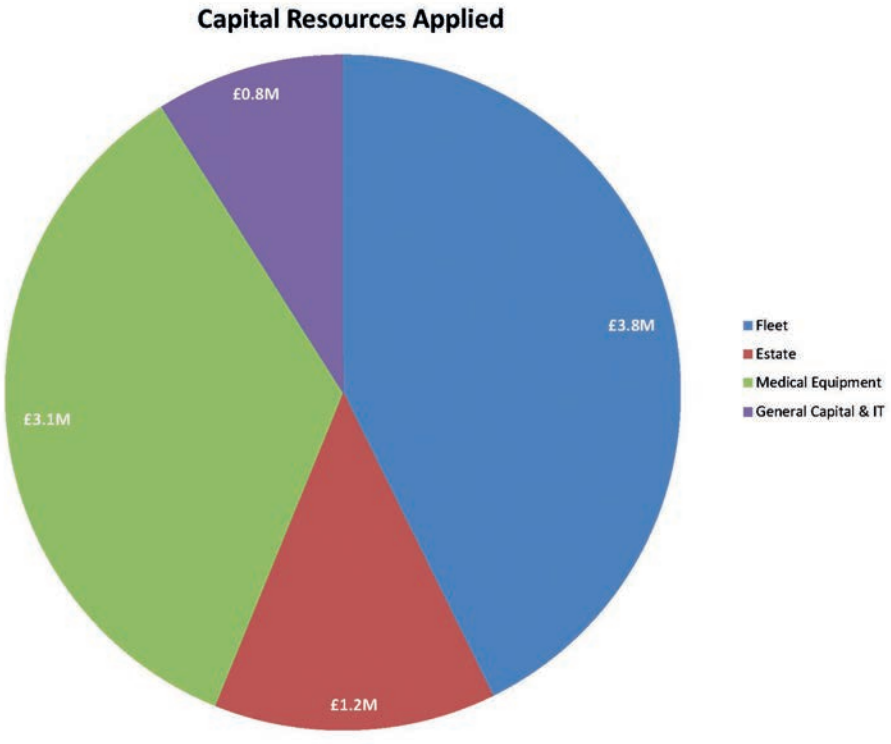
Capital Resources

The DoH provide capital resources to the Trust through the Capital Resource Limit. This is based upon a number of factors, including overall resources available and the prioritisation of schemes across all Health and Social Care bodies. The total capital allocations made to the Trust for the last six years are shown overleaf.



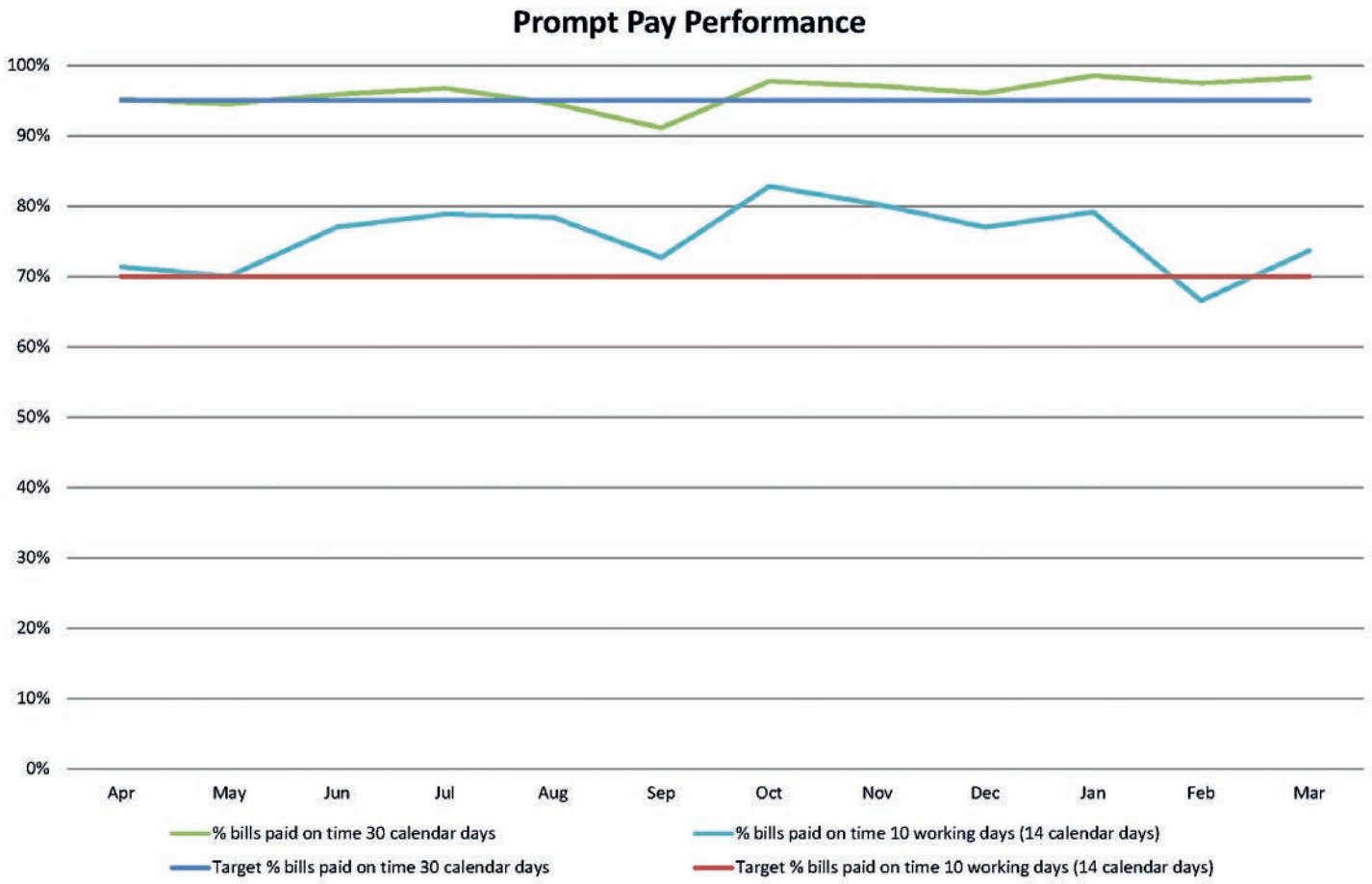
Capital Expenditure

These resources are applied broadly across the areas of Fleet, Estate, Medical Equipment and General Capital and Information Communications and Technology. A breakdown of the £8.9m expenditure in 2016-17 between these areas is shown below. Significant schemes during the year included the beginning of construction of the new Ambulance Station in Enniskillen. The Trust has also been able to maintain investment in replacing the Ambulance fleet in a managed cycle. Importantly, the Trust purchased replacement cardiac monitor defibrillators in the year.



Prompt Payment of Invoices

The Trust is required to pay non-health and Social Care trade creditors in accordance with the Better Payments Practice Code and Government Accounting Rules. The target is to pay 95% of invoices within 30 calendar days of receipt of a valid invoice, or the goods and services, whichever is the latter. A further regional target to pay 60% of invoices within 10 working days (14 calendar days) is also in place. The Trust has implemented and maintained a range of plans to improve and maintain performance in this area which has resulted in sustained improvements. The performance for each month is shown below. The cumulative target for the year was achieved and 96.30% of invoices by volume were paid on time within 30 calendar days. The Trust will continue with efforts to maintain this level of performance in 2017-18. Performance by number and value of invoices is shown in Note 14.1 on Page 145 of the Annual Accounts



Long Term Expenditure Trends and Plans

In common with the rest of the Public Sector and with the Health and Social Care system, 2016-17 has been another year of challenge. The Trust has delivered against a range of statutory and regulatory financial duties during the year. Overall, expenditure levels were over £70 million (including non-cash items – see note 3.1 of the accounts). This was against a backdrop of financial savings. Cumulative savings of an additional £0.4 million were required from NIAS for the 2016-17 financial year. The Trust will continue to work with all stakeholders to achieve these savings while maintaining safe and effective care to patients.

With the support of the HSCB, the Trust also delivered a significant investment plan mostly in response to changes in service delivery both in NIAS and in the wider Health and Social Care system. Overall, the Trust delivered a small surplus of £1k.

The Trust also benefited from £8.9 million of capital investment. This included the replacement of ambulance vehicles and investment in the ambulance estate, medical equipment and information and communications technology.

Looking ahead, the Trust faces a range of financial pressures. The current political and economic environment locally, nationally and internationally has the potential to significantly add to these pressures.

The consolidation and introduction of a range of developments, for example the Alternative Care Pathways, the Helicopter Emergency Medical Service and Community First Response, will have financial implications for the Trust. There will be further requirements to deliver cash releasing efficiency savings in 2017-18 and additionally, some resources provided non recurrently during 2016-17 will need to be considered into 2017-18. Levels of capital investment will also need to be maintained in order to maintain fleet, estate and technology to appropriate standards.

The Trust is grateful for the support of the HSCB and DoH in securing the levels of investment in the ambulance service in 2016-17 and previous years. Trust will continue to work with all HSC partners to build on this and continue to provide safe, effective and quality care within available resources.

NIAS, in common with other HSC Trusts, draws down cash directly from the DoH to cover both revenue and capital expenditure. Cash deposits held by the Trusts are minimal and any interest earned is repaid to the DoH. As such, there are no effects of interest costs on outturn and no potential impact of interest rate changes.

Accounts Direction

NIAS accounts have been prepared in a form determined by the Department of Health based on guidance from the Department of Finance Financial Reporting Manual (FReM) and in accordance with the requirements of Article 90(2)(a) of the Health and Personal Social Services (Northern Ireland) Order 1972 No 1265 (NI 14) as amended by Article 6 of the Audit and Accountability (Northern Ireland) Order 2003.

Accounting Policies

The accounting policies follow IFRS to the extent that it is meaningful and appropriate to HSC Trusts. Where a choice of accounting policy is permitted, the accounting policy which has been judged to be most appropriate to the particular circumstances of the HSC Trust for the purpose of giving a true and fair view has been selected. The HSC Trust's accounting policies have been applied consistently in dealing with items considered material in relation to the accounts. There have been no significant changes to accounting policies in the year.

Principal Risks and Uncertainties

The Trust continues to manage the principal risks relating to corporate performance in line with our Corporate Risk Management Policy, Strategy and governance structures. NIAS complies with DoH guidance and assurance processes regarding the identification and management of risks. This is delivered through the Audit Committee and the Assurance Committee and subsequent reporting to NIAS Trust Board. The Trust's Board Assurance Framework (BAF) template has been reviewed and continues to reflect levels of assurance linked to the delivery of the NIAS strategic objectives. The Trust continues to develop compliance measures to ensure that appropriate risk management processes are adopted at all levels in all activities and supports initiative and innovation whilst learning from mistakes and taking responsibility. The Trust is committed to the further development of a culture where people are encouraged to challenge and expect to be challenged about how and why they do things in the interest of their patients, staff, the Trust and the public. The Trust is committed to the proportionate management of risk that ensures the Trust discharges its duty of care to our patients, staff and those who may be affected by our activities. The Trust complies with the regional Serious Adverse Incident Reporting and Follow-up Procedures and participated in the review and implementation of the process in 2016-17. NIAS continues to review and engage with the other HSC Trusts in relation to the investigation and reporting of Serious Adverse Incidents; these are reported to the Assurance Committee as a standing agenda item.
The Trust Board has signalled its concern through the Corporate Risk Register in respect of the following risks, which management to continue to monitor and actively manage:

- There is a risk to the Trust in the provision of safe care to the public as demand for ambulance response increases and transportation continues to outstrip capacity and compromises the delivery of safe high quality care. Demand has been increasing by 5% annually (increase of 26% since 2012);

- Due to increased operational pressures there is reduced capacity to carry out vehicle cleaning; this has led to a lack of compliance with Infection Prevention and Control Policy and Procedures and a potential increased risk to patient safety;

- There is a risk to the Trust that increased levels of sickness absence could lead to an inability to deliver the required service, and contribute to the inability to achieve financial

balance. There are associated reputational issues;

- If the funding to enable the Trust to introduce an Electronic Patient Report Form (ePRF) is not forthcoming, there is a risk to meeting the strategic objectives of the Trust and the delivery of safer, higher quality patient care, and

- If Directorates do not have adequate resources to support the Trust's key priorities, there will be delays in the delivery of organisational objectives. There is also a risk to the timely delivery of Departmental objectives and an inability to meet statutory requirements. There is the potential to lead to further delays in meeting statutory requirements.

These risks continue to be managed through the Corporate Risk Register and assurance processes.

Mr Shane Devlin
Chief Executive
15 June 2017

NIAS Paramedics, Sean Martin, Rory O'Connor and Jacqueline O'Neil, participated at the annual Road Safe Roadshow event at the Belfast City Hall

Accountability Report

Corporate Governance Report

Directors Report

The Trust Board is made up of six Non-Executive Directors, and five Executive Directors. The Trust Board normally meets bi-monthly in venues across Northern Ireland and one annual general meeting is held. Arrangements for access by the general public at public meetings are published in the local press and Trust website to encourage public attendance and the agenda is widely circulated. Non-Executive Directors form the membership of the three Trust Board Committees: the Remuneration Committee, the Audit Committee and the Assurance Committee.

The Remuneration Committee provides advice and assurance to the Trust Board about appropriate remuneration and terms of service for the Chief Executive and other Senior Executives. The Audit Committee provides assurance of effective internal financial controls including the management of associated risks. The Assurance Committee provides assurance of effective controls in non-financial matters including the management of associated risks.

NIAS Trust Board undertook an annual Governance assessment to test structures and processes based on a DoH audit tool. This will be subject to further follow up and development to provide further assurance in this area.

Director of Operations, Brian McNeill talked to Donna Traynor in Emergency Ambulance Control during BBC Ambulance Day, 30 November 2016

Membership of Trust Board and Committees and Record of Attendance of Members:

Member	Designation	Trust Board	Audit Committee	Assurance Committee	Remuneration Committee
Mr Paul Archer	Chairman	9 out of 9	1 out of 4*	*	3 out of 3
Mr Shane Devlin	Chief Executive (from 5 December 2016)	1 out of 1	1 out of 1*	1 out of 1*	*
Mr Norman McKinley	Non-Executive Director	7 out of 9	2 out of 4	0 out of 1	*
Dr James Livingstone	Non-Executive Director	8 out of 9	3 out of 4	3 out of 3	*
Mr William Abraham	Non-Executive Director	8 out of 9	4 out of 4	2 out of 2	*
Mr Trevor Haslett	Non-Executive Director	9 out of 9	*	2 out of 3	2 out of 3
Mr Alan Cardwell	Non-Executive Director	9 out of 9	*	*	3 out of 3
Mr Liam McIvor	Chief Executive (to 25 April 2016)	1 out of 1	*	*	*
Mr Brian McNeill	Director of Operations	8 out of 9	1 out of 4*	3 out of 3*	*
Dr David McManus	Medical Director (Interim Chief Executive from 10 October 2016 until 4 December 2016)	9 out of 9	1 out of 4*	3 out of 3*	*
Mrs Sharon McCue	Director of Finance and Information Communications Technology	9 out of 9	4 out of 4*	2 out of 3*	*
Ms Roisin O'Hara	Director of Human Resources and Corporate Services (Interim Chief Executive from 25 April 2016 to 9 October 2016)	9 out of 9	1 out of 4*	3 out of 3*	*
Ms M Lemon	Director of Human Resources and Corporate Services - Acting from 29 April 2016 until 31 October 2016	1 out of 1	*	2 out of 2*	*

*Not a Committee member – In attendance only as required.

Roisin O'Hara was Interim Chief Executive from 25 April 2016 to 9 October 2016.

Michelle Lemon was Director of Human Resources and Corporate Services – Acting from 29 April 2016 to 31 October 2016.

Doctor David McManus was Interim Chief Executive from 10 October 2016 to 04 December 2016.

Shane Devlin was appointed to the post of Chief Executive on 05 December 2016.

Interests Held by Board Members

A declaration of board members interests has been completed and is available at www.nias.hscni.net or on request from the Chief Executive's Office, Northern Ireland Ambulance Service, Knockbracken Healthcare Park, Saintfield Road, Belfast, BT8 8SG.

Personal Data Related Incidents

The Trust is not aware of any reportable data breaches or any significant personal data related incidents in 2016-17.

Statement of Disclosure to Auditors

All directors have confirmed that, to the best of their knowledge, there is no relevant audit information of which the Trust's auditors are unaware. They have confirmed that they have taken steps as directors in order to make themselves aware of any relevant audit information and to ensure that auditors are aware of that information.

Fees Paid to Northern Ireland Audit Office

The responsibility for the audit of the Trust rests with the Northern Ireland Audit Office (NIAO). The accounts include a non-cash charge of £24,000 (2015: £24,000) for the statutory audit of the 2016-17 annual accounts (Public and Charitable Funds). In addition to this amount, during the year the Trust received services from the Northern Ireland Audit Office to the value of £1,201 (2016:£nil, 2015: £1,173). This was in respect of fees for the National Fraud Initiative 2016-17 exercise. No other audit or non-audit services were provided by NIAO to the Trust in 2016-17.

New Emergency Medical Dispatchers graduating during 2016-17

Statement of Accounting Officer Responsibilities

Under the Health and Personal Social Services (Northern Ireland) Order 1972 (as amended by Article 6 of the Audit and Accountability (Northern Ireland) Order 2003), the Department of Health has directed the Northern Ireland Ambulance Service HSC Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The financial statements are prepared on an accruals basis and must provide a true and fair view of the state of affairs of the Northern Ireland Ambulance Service HSC Trust, of its income and expenditure, changes in taxpayers' equity and cash flows for the financial year.

In preparing the financial statements the Accounting Officer is required to comply with the requirements of the Government Financial Reporting Manual (FREM) and in particular to:

- Observe the Accounts Direction issued by the Department of Health including relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in FREM have been followed, and disclose and explain any material departures in the financial statements;
- Prepare the financial statements on the going concern basis, unless it is inappropriate to presume that the Northern Ireland Ambulance Service HSC Trust will continue in operation;
- Keep proper accounting records which disclose with reasonable accuracy at any time the financial position of the Northern Ireland Ambulance Service HSC Trust; and
- Pursue and demonstrate value for money in the services the Northern Ireland Ambulance Service HSC Trust provides and in its use of public assets and the resources it controls.

The Permanent Secretary of the Department of Health as Principal Accounting Officer for Health and Social Care Resources in Northern Ireland has designated the Chief Executive of the Northern Ireland Ambulance Service HSC Trust as the Accounting Officer for the Trust. During the 2016-17 financial year, Mr L McIvor was Chief Executive until 24 April 2016, Ms R O'Hara was the Interim Chief Executive from 25 April until 9 October 2016, Dr D McManus was the Interim Chief Executive from 10 October until 4 December 2016 and Mr S Devlin was appointed as Chief Executive from 5 December 2016. The responsibilities of an Accounting Officer, including responsibility for the propriety and regularity of the public finances for which the Accounting Officer is answerable, for keeping proper records and for safeguarding the Northern Ireland Ambulance Service HSC Trusts assets, are set out in the Accountable Officer Memorandum, issued by the Department of Health.

Governance Statement

1. Introduction and Scope of Responsibility

The Board of the Northern Ireland Ambulance Service HSC Trust (NIAS) is accountable for internal control. As Accounting Officer and Chief Executive of the Trust, I have responsibility for maintaining a sound system of internal governance that supports the achievement of the organisation's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am responsible in accordance with the responsibilities assigned to me by the Department of Health (DoH).In essence, the role of Accounting Officer is to see that the Trust carries out the following functions in a way that ensures the proper stewardship of public money and assets:

- To enter into and fulfil Service Level Agreements with Health and Social Care Commissioners;
- To meet statutory financial duties; and
- To maintain and develop relationships with patients, the local community, Commissioners, other HSC bodies and suppliers.

The Trust is directly accountable to the DoH for the performance of these functions.

The Trust works in partnership with the DoH, the Health and Social Care Board (HSCB) and the Public Health Agency (PHA) and also works closely with other partner organisations through the establishment and representation on various working groups, all with a view to improving the quality, safety, effectiveness and efficiency of services. These arrangements continue to be reviewed and updated in response to changes in the structure of Health and Social Care across Northern Ireland.

2. Compliance with Corporate Governance Best Practice

NIAS applies the principles of good practice in Corporate Governance and continues to further strengthen its governance arrangements. NIAS does this by undertaking continuous assessment of its compliance with Corporate Governance best practice and applying such principles and processes where applicable.

Emergency Ambulance Control remains at the centre of our operational activity

The Trust Board is engaged in an ongoing process of self-assessment against the Board Governance Self-Assessment Tool issued by DoH. The assessment covers four key areas: Board composition and commitment; Board evaluation, development and learning; Board insight and foresight; and Board engagement and involvement. Executive and Non-Executive Directors are engaged to develop and progress action plans arising from the self-assessment exercise.

The Trust's Audit Committee annually reviews its effectiveness and application of good practice through the Audit Committee Self-Assessment checklist, issued by the National Audit Office.

Areas of improvement are highlighted for consideration through this process. This checklist and process has been used as a framework for a similar self-assessment exercise for the Assurance Committee with plans being developed to address areas for improvement in the coming year.

3. Governance Framework

The Board exercises strategic control over the operation of the organisation through a system of corporate governance which includes:

- a schedule of matters reserved for Board decisions;
- a Scheme of Delegation, which delegates decision making authority within set parameters to the Chief Executive and other officers; and
- Standing Orders and Standing Financial Instructions, including the establishment of an Audit Committee, an Assurance Committee and a Remuneration Committee.

The Audit Committee's primary role is to independently contribute to the Trust Board's overall process for ensuring that an effective internal financial control system is maintained.

The Assurance Committee is responsible for assuring the Trust Board that effective and regularly reviewed arrangements are in place to support the implementation, maintenance and development of governance (clinical and non-clinical) and risk management and that such matters are properly considered and communicated to the Board.

The Remuneration Committee's primary role is to advise the Board about appropriate remuneration and terms of service for the Chief Executive and Executive Directors employed by the Trust.

Membership of the Trust Board and Committees and also the record of attendance of members are shown on page 66 of the Accountability Report. During the year, the appraisal processes in place did not identify any significant performance related issues of members of Trust Board or Committees.

The Audit Committee met on four occasions during the year and membership is comprised of Non-Executive Directors only. The Audit Committee completes the National Audit Office Audit Committee Self-Assessment Checklist on an annual basis as part of the assessment of its effectiveness. The results are submitted to the DoH each year and an action plan developed to address any areas for improvement. No

significant performance related issues were identified during this review. Additionally, each year the Chair of Audit Committee provides the Trust Board with an Audit Committee Annual Report.

The Assurance Committee met on three occasions during the year and membership is comprised of Non-Executive Directors only.

The Remuneration Committee met on three occasions during the year and membership is comprised of Non-Executive Directors only. The Chair of the Trust Board is the Chair of the Remuneration Committee.

4. Business Planning and Risk Management

Business planning and risk management is at the heart of governance arrangements to ensure that statutory obligations and Ministerial priorities are properly reflected in the management of business at all levels within NIAS.

The Board identifies the strategic and corporate aims and objectives and risks and monitors the achievement of these in the public interest. It has established a framework of prudent and effective controls to manage these risks, underpinned by core controls assurance standards. Decisions are taken by the Board within a framework of good governance to build a successful organisation, which is always striving to achieve excellence.

Business Planning

The Trust's Corporate Plan sets the strategic direction for the Trust in line with the stated purpose, mission and vision of the organisation, aligned to the relevant principles and values, which direct action consistent with Ministerial priorities. The Trust has been working during the year to develop a new strategy which will cover the period 2017-2021. A number of workshops have been carried out to engage Trust Board and senior managers in its formulation. The Corporate Plan will be subject to approval by the Department of Health.

NIAS develops an Annual Business Plan and Trust Delivery Plan to take account of available resources and outline Trust priorities in terms of actions and activity to secure objectives for the year. The Trust Delivery Plan is subject to approval by the Health and Social Care Board.

Risk Management

The Board of the Northern Ireland Ambulance Service HSC Trust has established an Assurance Committee, which is a committee of the Board, and is responsible for overseeing all aspects of risk management within the organisation. The Assurance Committee meets at least three times a year and reviews the Risk Registers, compliance with Controls Assurance Standards and the report of Untoward and Serious Adverse Incidents as standing items, as well as other health and safety and risk management issues. The meetings are recorded and the minutes are reported to the Trust Board. The Trust's Medical Director has been given delegated responsibility for the oversight of risk management and is supported in this regard by a Risk Manager.

The Trust Board continues to review the arrangements in place with reference to DoH guidance and advice in order to strengthen the arrangements for Risk Management. The Trust's Corporate Risk Management Strategy, which was reviewed, updated and approved by the

Trust Board in 2016-17, specifies a number of reactive and proactive ways in which risk can be identified. The means of identification include, although not exclusively, untoward incident reporting, serious adverse incident reporting, complaints management, risk assessment, horizon-scanning at Trust Board level, claims management, controls assurance, benchmarking and consultation with staff and service users. The Strategy also places upon all Trust employees the responsibility to be aware of and to report any and all risks to which they or the Trust are exposed.

This process enables identified risks to be recorded on the Risk Register, evaluated and, if necessary, re-evaluated in line with the Australia/ New Zealand Standard (AS/NZS 4360) Risk Management Standard. In accordance with the Trust's Risk Management Strategy, this takes into account the likelihood and potential impact on the Trust's patients, employees, environment, reputation and resources. This evaluation then prompts the development of individual risk treatment plans against which progress is monitored through the Trust's Risk Register.

Corporate Risks are those that impact on the organisation as a whole or which cannot be resolved immediately or adequately reduced by treatment at a local level. They are recorded on the Corporate Risk Register, which is reviewed on a continual basis. Local Risks are those which have a localised impact and which can be reduced to an acceptable level by treatment at a local level. These are recorded on the Local Risk Register and are the responsibility of the Trust's line management. Local Risk Register updates are forwarded to the relevant Directors for distribution and review at local level on a regular basis. The Trust has further developed the mechanisms for the review of Local Risk Registers by ensuring they are formally reviewed by the Senior Executive Management Team, the Assurance Committee and Trust Board. The Trust has also reviewed and updated a risk appetite statement which defines the amount of risk the organisation is willing to accept. This is included in the Corporate Risk Management Strategy and has been agreed and approved by the Trust Board. Risk Management and Assessment was included as part of the mandatory training for all staff during the year.

NIAS welcomed a new Chief Executive, Shane Devlin, in December 2016

The Trust continues to develop policies, processes and audit function in relation to Infection Prevention and Control. During the year, the Regulation and Quality Improvement Authority (RQIA) in conjunction with NIAS developed an Ambulance Service specific Infection prevention and Control Assessment Tool. This was validated during an announced inspection. No immediate issues were identified during this visit and the Trust awaits the formal RQIA report. The Trust has also been included in the RQIA schedule of unannounced visits. The Trust's Infection Prevention and Control Group oversees activities in this area and reports to Assurance Committee and Trust Board.

5. Information Governance

In NIAS, information governance is the framework of legislation and best practice guidance that regulates the manner and way in which we collect, obtain, handle, use, share and disclose information. The Trust holds information obtained from our patients, clients, suppliers, Police, Solicitors, Coroners and other stakeholders, as well as from our staff. We use this information to provide assurance on the level of care and service provision we deliver to our patients and for planning and business continuity. Good quality information forms the basis of high quality care. We are very aware of the importance of keeping personal data in a secure and confidential manner and train all staff to support this culture through face to face training, e-learning and workbooks. Information Governance was included as part of the mandatory training for all staff during the year.

The Director of Finance and ICT has been appointed as Senior Information Risk Officer (SIRO) to ensure a well-defined information governance structure is in place. This role is supported by Information Asset Owners who are Senior Managers who have been trained and are accountable for information governance in their own work areas within the Trust. During 2016-17 we have continued to embed an information governance framework within the Trust. We are currently working on the development of an Information Asset Register and the identification of all manual and electronic records across the Trust. The Trust's Information Governance Steering Group reviews the management of all information risks and information governance arrangements within the Trust and reports to the Assurance Committee. We have also been ensuring that we are keeping up to date with legislation changes such as Investigatory Powers Act 2016 and General Data Protection Regulations which may impact on the Trust going forward.

The Medical Director has been appointed as the Trust's Caldicott Guardian and Personal Data Guardian with particular responsibility for access to, and the use of, person identifiable and patient information. The Medical Director also has a representative role on the UK Council of Caldicott Guardians. The Caldicott Guardian and the SIRO support the Trust Board in recognising the importance of best practice in relation to the broader information governance agenda.

Data loss or mismanagement does occasionally happen and while these breaches are relatively minor in nature, nevertheless the Trust continues to use the learning from such incidents to inform and develop good practice. There have been no significant information related breaches brought to the attention of the SIRO during 2016-17.

6. Public Stakeholder Involvement

The Trust aims to ensure that those who use our services and their representatives have an opportunity to influence and shape policy and service delivery decisions. Our Personal and Public Involvement Strategy outlines our commitment to involving key stakeholders and their representatives in the development of our services. Service user engagement and involvement is mainstreamed into key policy development processes. Personal and Public Involvement was included as part of the mandatory training for all staff during the year.

A key priority remained a programme of engagement on Transformation and Modernisation and related Alternative Care Pathways. Engagement and Communication Plans were produced to ensure involvement of key stakeholders. This ensured input of service users and their representatives to the development of the Trust's Transformation and Modernisation agenda. Performance against delivery of these plans was monitored by the Trust's Transformation and Modernisation Programme Board. During 2016-17, the Trust engaged with key stakeholders through presentations to service user groups on Alternative Care Pathways and a programme of shopping centre events.

The Trust has continued to gather and analyse patient experience stories as part of the regional 10,000 Voices project. Patient stories are provided to public sessions of the Trust Board and shared with managers and staff. Further work will be undertaken to use 10,000 Voices as a learning and engagement tool for the Transformation and Modernisation Programme.

7. Assurance

The Trust has an Assurance Framework based on DoH guidance 'An Assurance Framework: A Practical Guide for Boards of Arm's Length Bodies'. This framework is regularly updated and submitted to the Assurance Committee for approval. This identifies the assurances provided to NIAS by its governance structure and highlights any gaps in assurance. This supports improvements in the level of assurance and underpins the challenge function of the Trust Board.

A further important source of assurance is provided by internal audit whose audit plans are based on key risks and systems within the organisation. As part of the annual audit programme internal audit carried out a review of Risk Management (Including Management of Assurances) and provided satisfactory assurance.

The Trust endeavours to continually improve its structures and processes of assurance through self-assessment exercises and resultant improvement plans. The Trust Board has been engaged in an ongoing process of self-assessment using the Board Governance Self-Assessment Tool issued by DoH. Similarly the Audit Committee annually tests its application of good practice using a Self-Assessment checklist, issued by the National Audit Office.

As a regional service, the Trust Board is committed to holding its public board meetings in locations across Northern Ireland. It also takes the opportunity to engage with front line staff and gain informal insight and assurance in various ambulance facilities prior to public Trust Board meetings. The Trust also contributes to both Mid-

Year and Year End Accountability Meetings with DoH and HSCB which are designed to provide assurances on the Trust's systems of internal control.

These structures and processes and the sources of independent assurance outlined in this statement provide an appropriate and acceptable quality of assurance to Trust Board.

Controls Assurance Standards

The Trust assessed its compliance with the applicable Controls Assurance Standards which were defined by the Department and against which a degree of progress is expected in the year.

The Department expected all HSC bodies to achieve a Substantive overall level of compliance for each applicable standard. Departmental Guidance HSS (PPM) 1/2005 includes standards which are not applicable to the Trust. These are excluded from the table below.

The new extended Information Management and the Management of Purchasing standards continue to present significant challenges, however the Trust was able to achieve overall substantive compliance in these areas this year. In relation to Information Management the Trust continues with efforts to fully complete a data flow exercise to inform the creation of an Information Risk Register. In relation to the Management of Purchasing the Trust continues to work with Centres of Procurement Expertise to ensure that the purchase of all works, products and services conforms to an appropriate method of procurement.

The Trust continues to develop systems and processes to deliver compliance with Controls Assurance Standards. An action plan will be developed for any areas of non-compliance within controls assurance standards and progress against the plan will be monitored throughout the year.

The Trust recognises that the overall assessment for each controls assurance standard is based on a number of criteria. While there may be significant internal control issues identified by internal audit that are reflected in the self-assessment against specific criteria, overall substantive compliance has been achieved. Areas identified by internal audit as significant internal control issues are considered overleaf.

NIAS convened a Health and Well being group during 2016-17 representing management, trade unions and staff

The Trust achieved the following levels of compliance for 2015-16:

Standard	Expected Level of Compliance	Trust Level of Compliance	Reviewed By
Buildings, land, plant and non-medical equipment	75% - 99% (Substantive)	80% (Substantive)	Self-Assessment
Emergency Planning	75% - 99% (Substantive)	89% (Substantive)	Internal Audit
Environmental Management	75% - 99% (Substantive)	80% (Substantive)	Self-Assessment
Financial Management (Core Standard)	75% - 99% (Substantive)	90% (Substantive)	Internal Audit
Fire Safety	75% - 99% (Substantive)	90% (Substantive)	Self-Assessment
Fleet and Transport Management	75% - 99% (Substantive)	84% (Substantive)	Self-Assessment
Governance Standard (Core)	75% - 99% (Substantive)	80% (Substantive)	Internal Audit
Health & Safety	75% - 99% (Substantive)	84% (Substantive)	Self-Assessment
Human Resources	75% - 99% (Substantive)	83% (Substantive)	Internal Audit
Infection Control	75% - 99% (Substantive)	84% (Substantive)	Self-Assessment
Information Communication Technology	75% - 99% (Substantive)	83% (Substantive)	Self-Assessment
Information Management	75% - 99% (Substantive)	76% (Substantive)	Self-Assessment
Management of Purchasing & Supply	75% - 99% (Substantive)	76% (Substantive)	Self-Assessment
Medical Devices & Equipment Management	75% - 99% (Substantive)	88% (Substantive)	Self-Assessment
Medicines Management & Optimisation	75% - 99% (Substantive)	88% (Substantive)	Self-Assessment
Risk Management (Core Standard)	75% - 99% (Substantive)	82% (Substantive)	Internal Audit
Security Management	75% - 99% (Substantive)	83% (Substantive)	Self-Assessment
Waste Management	75% - 99% (Substantive)	84% (Substantive)	Self-Assessment

8. Sources of Independent Assurance

The Northern Ireland Ambulance Service obtains Independent Assurance from the following sources:

- Internal Audit;
- Business Services Organisation; and
- Regulation and Quality Improvement Authority (RQIA).

The Trust also relies on other significant assurance functions, both internal and external to the organisation, and considers the implications of any relevant findings for the governance of the organisation. These may include, but will not be limited to, any reports issued by the Comptroller and Auditor General or Public Accounts Committee, reviews by DoH commissioned bodies, the Medicines Regulatory Group and other professional and regulatory bodies with responsibility for the performance of staff or functions (e.g. Joint Royal Colleges Ambulance Liaison Committee (JRCALC), Health and Care Professions Council (HCPC), Royal Colleges and other accreditation bodies).

Internal Audit

The Northern Ireland Ambulance Service utilises an internal audit function (commissioned from the Business Services Organisation), which operates to defined standards and whose work is informed by an analysis of risk to which the Trust is exposed and annual audit plans which are based on this analysis. In 2016-17 Internal Audit reviewed the systems as outlined below:

Audit Assignment	Overall Level of Assurance
Financial Review	Satisfactory - Non Pay Expenditure, Bank and Cash and Charitable Trust Funds Limited - Payments to Staff in relation to HRPTS processes (Five Priority 1 Findings)
Procurement and Management of Contracts	Limited - Procurement and Contract Management in the areas reviewed (patient taxis; voluntary ambulance service; private ambulance providers, estates and fleet - Five Priority 1 Findings) Unacceptable assurance in relation to the control over Volunteer Drivers (One Priority 1 Finding)
Human Resources Directorate Risk Audit	Limited (Six Priority 1 Findings)
Operations – Management of Clinical Equipment and Stock Management Over Non Controlled Drugs	Satisfactory (One Priority 1 Finding)
Risk Management	Satisfactory (No Priority 1 Findings)
Governance	Satisfactory (One Priority 1 Finding)
Stock Taking	Satisfactory (No Priority 1 Findings)

In her annual report, the Head of Internal Audit reported that there is a satisfactory system of internal control designed to meet the organisations objectives for the year ended 31 March 2017.

Overall satisfactory assurance was provided in relation to non-pay expenditure, bank and cash and charitable trust funds. However, specific limited assurance was provided in respect of payments to staff in relation to Human Resources, Payroll, Travel and Subsistence (HRPTS) processes. A number of Priority One findings were identified in relation to system administration, role allocation, the transfer of approval rights and the reporting of overpayments. These findings were previously reported in the 2015-16 review of this area. The Trust continues to work within the regional structures to address control weaknesses in this area.

Limited Assurance was provided in relation to Procurement and Contract Management processes in the areas reviewed and five Priority 1 findings were identified in relation to patient taxis; voluntary ambulance service; private ambulance providers, estates and fleet. Unacceptable assurance was provided in relation to the control over Volunteer Drivers. One Priority 1 finding in relation to a lack of robust processes in place to ensure that all journeys and mileage claimed are accurate and appropriate was identified. Immediate action has been taken and an action plan to address all the issues identified in this area has been developed.

Limited Assurance was provided in the Human Resources Directorate Risk Audit. Six Priority 1 findings in relation to training and adherence to statutory requirements and best practice were identified.

The Management of Ambulance Service Marked Cars was subject to audit in 2014-15 and the need to strengthen arrangements to allocate, manage and monitor their use was emphasised. This area was reviewed in 2015-16 and the overall level of assurance remained limited. In 2016-17, a further independent review was completed and the Trust continues to work to bring these issues to a satisfactory conclusion.

Recommendations to address all control weaknesses have been considered by the Audit Committee and have been or are currently being implemented. Progress on implementation will continue to be reviewed by Internal Audit and considered by the Audit Committee.

9. Review of Effectiveness of the System of Internal Governance

As Accounting Officer, I have responsibility for the review of effectiveness of the system of internal governance. My review of the effectiveness of the system of internal governance is informed by the work of the internal auditors and the executive managers within the Trust who have responsibility for the development and maintenance of the internal control framework, and comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Trust Board, Audit Committee and Assurance Committee. A plan to address weaknesses and ensure continuous improvement to the system is in place.

10. Internal Governance Divergences

Progress on prior year significant internal control issues

Internal Audit carried out a follow up review on previous audit recommendations. Progress has been made and 114 (69%) of the 166 recommendations examined were fully implemented, a further 51 (30%) were partially implemented and 1 (1%) was not yet implemented at the time of review. Of the 51 partially implemented recommendations 4 (8%) are partially dependent on input from another HSC organisation in order to fully implement the recommendation. The recommendation not yet implemented was in respect of the arrangements and documentation for both planned and reactive vehicle maintenance.

A number of Internal Audit recommendations remain partially implemented, in particular in respect of Information Governance; revised arrangements in respect of the new FPL and Human Resource, Payroll, Travel and Subsistence (HRPTS) systems; Marked Cars and Fleet Management.

In terms of Information Governance, an information risk template has been developed to enable an Information Asset Register to be compiled following completion of a data flow exercise across the organisation. It has been recognised by internal audit that a comprehensive data flow exercise to identify instances where data is transferred outside of NIAS, in particular in response to Freedom of Information requests, subject access requests and other sensitive information, has commenced but remains to be completed for all Directorates. Whilst it has been accepted that some initial work has taken place to pilot this exercise, a full analysis of information governance risks for inclusion in the appropriate risk register needs to be carried out and an Information Asset Register compiled. A temporary Project Manager has been appointed and a work schedule developed to progress the extensive programme of work in this area.

In terms of FPL and HRPTS, system administration and controls and procedures to confirm roles and responsibilities continue to develop as the new systems and ways of working are embedded.

Some progress has been made in relation to the management of the allocation of marked cars and the Trust has completed an independent review of this area. Key actions are being progressed to address the recommendations made by Internal Audit.

Contracts and Contract Management issues also remain a challenge but a priority for the Trust. The length of time to fully implement recommendations has been highlighted within the Trust. This is against a backdrop of pressures and limited resources and also a recognition that external factors can impact on the Trust ability to implement recommendations in a timely fashion. A significant amount of work has been completed during the year to progress all audit recommendations and plans are in place to consolidate this progress in 2017-18. All audit recommendations include an implementation date and a responsible officer. Progress on the implementation is monitored regularly and reviewed formally and independently at mid-year and year end.

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Update on prior year control issues which have now been resolved and are no longer considered to be control issues

Financial Position 2016-17

The Trust continues to operate in an increasingly difficult financial environment. In the 2016-17 financial year the Trust achieved a breakeven position with a small surplus of income over expenditure. Cumulative savings of an additional £0.4 million were implemented through a range of measures. In addition, the Trust delivered a capital programme of £8.9 million, which was within the Capital Resource Limit (CRL) set by the Department of Health (DoH).

NIAS attended in excess of 211,000 999 and Urgent/Card 35 HCP calls during 2016-17

Transforming Your Care

The NIAS Transformation and Modernisation Programme has been in place since 2014-15. This encompassed a range of projects including the NIAS Transforming Your Care project. Ten Alternative Care Pathways were implemented by March 2016 to provide appropriate alternatives to hospital attendance and ambulance transportation, contributing to improved care for patients close to home. NIAS has worked closely with other Trusts and Integrated Care Partnerships on the development of Alternative Care Pathways. By March 2017 a further two pathways were implemented, a further one was piloted and a significant programme of embedding and increasing usage of the pathways was implemented. This programme of change has been embedded and is not seen to present an ongoing risk.

Mid Staffordshire NHS Foundation Trust Public Enquiry (The Francis Report)

The Trust has reviewed this report and has a time-bound action plan in place to address the recommendations relevant and appropriate to an Ambulance Service. This plan has been considered and approved by Trust Board.

Progress against the plan was reported through the Assurance Committee and subsequently Trust Board. The vast majority of actions directly applicable to NIAS having been implemented. During 2016-17 the Trust continued to focus on addressing any outstanding actions and reported progress to Assurance Committee and Trust Board. The small number of actions that are applicable to NIAS that are ongoing are now dealt with as part of normal business.

Serious Adverse Incidents (Donaldson Review – The Right Place, The Right Time)

As an outcome of the Departmental review of regional Serious Adverse Incident (SAI) reporting procedures in which NIAS participated, a revised regional SAI reporting procedure was published in November 2016. This has been adopted within the Trust and formally incorporated into the revised NIAS incident reporting procedure. NIAS continues to participate in the learning outcomes review from SAIs regionally.

The first meeting of the Trust's Learning Outcomes Review Panel took place in September 2016. The panel has been established to enhance and support individual and organisational learning from events such as untoward incidents, disciplinary investigations, claims, compliments, Serious Adverse Incidents (SAIs) etc. as well as feedback at organisational, local and individual levels. The outcomes from the panel are reported to the Trust's Assurance Committee as part of normal business.

Helicopter Emergency Medical Service (HEMS)

Significant progress has been made in this area during 2016-17. In March 2016 the Health Minister made a public announcement regarding the establishment of a HEMS service in Northern Ireland and that the HSCB would commission NIAS to deliver the service. Following the announcement NIAS met on a number of occasions with the Department of Health and HSCB and the Minister has announced that the charitable partner is Air Ambulance Northern Ireland (AANI).

A Memorandum of Understanding between NIAS and AANI was approved by Trust Board in July 2016. Business case approval for HEMS was received in March 2017.

NIAS participated in meetings with the Chief Medical Officer (CMO) and other HSC Trusts regarding the delivery model and an anticipated date of commencement for the HEMS service. A further announcement was made by the Minister at the beginning of March 2017, following advice from the CMO, confirming the operational model as a doctor/paramedic based at the Maze/Long Kesh (MLK) site.

The HEMS Management Board has been established and has met in advance of the commencement of the service with agreement on membership, Terms of Reference and standing agenda items in relation to financial reporting and monitoring.

It has been agreed that the clinical advisory groups for HEMS and the Regional Trauma Network be combined and the NIAS Medical Director has been asked to lead the Project Board for the development of the Regional Trauma Network. The first meeting of the Regional Trauma Network Board took place in December 2016. The HEMS Clinical and Operational Leads have been appointed and the launch of the service is anticipated in the early part of 2017-18. This development will now be mainstreamed as part of normal Trust business.

Community Resuscitation Strategy

As part of the implementation of the Community Resuscitation Strategy, the Implementation Group and its Sub-Groups with representatives from a range of other organisations and

providers, supported and facilitated the UK Resuscitation Council “Restart a Heart Day” in October 2016. Over four thousand people participated in CPR training regionally on that day. This received considerable media attention and a review of the day took place at the most recent meeting of the Implementation Group in December 2016. Planning for the day in 2017 has already commenced and it is hoped to train even more people in CPR in 2017.

NIAS continues to engage with a number of organisations and community groups regarding the placement of public access defibrillators. This includes a number of sporting organisations as well as Government Departments. Meetings with Belfast City Council and Mid-Ulster Council have taken place in June 2016. NIAS has also facilitated the activation of two further Community First Responder Groups and engagement with a further two groups is continuing.

Following engagement by the Medical Director with DoH, the CMO and Permanent Secretary, confirmation of recurrent funding for Community Resuscitation Development Officers (CRDOs) from the Health & Social Care Board (HSCB)/ Public Health Agency (PHA) was received. This resulted in a number of resuscitation initiatives being maintained, particularly in the Northern Division, and also enabled the recruitment of the CRDOs to commence with appointments expected very early in 2017-18. This development will now be mainstreamed as part of normal Trust business.

Update on prior year control issues which continue to be considered control issues

Management of Contracts

During 2014-15 an audit was carried out to consolidate the findings from a series of audit assignments in this area dating back to 2011-12. Significant progress has been made and arrangements in respect of vehicle maintenance contracts have been largely addressed.

However, arrangements for facilities management and works (e.g. maintenance, repair and minor works) also required formalisation. NIAS has been actively engaged with BSO Procurement and Logistics to specify and implement such new contracts. The award of this contract took place in April 2017. As the Trust has implemented procurement processes and has valid contracts in place for these areas, other contracts have expired. The Trust continues to work with Centres of Procurement Expertise to ensure that the purchase of all works, products and services conforms to an appropriate method of procurement.

In addition, further areas for improvement in relation to procurement and management of contracts have been identified during the year. Some immediate actions have been taken and an action plan to address all issues in this area has been developed. However, the Trust has not been able to address all of these issues to an acceptable standard within available resources and it is likely that specific additional resources in this area will be required to achieve compliance.

Agenda for Change

Job Evaluations for NIAS Paramedics, RRV Paramedics and EMT posts within NIAS remain ongoing.

In 2013, following exhaustion of internal Partnership processes, these three Job Evaluations were passed to the HSC Regional Management and Trade Union Leads, who in partnership referred the posts to the Regional Quality Assurance (RQA) team to consider further under the NHS Job Evaluation Scheme.

The RQA is a partnership group comprising Trade Union and Management. The process sits out with NIAS Trust authority and NIAS is not represented in the RQA Team.

In December 2015 NIAS received Partnership correspondence from the Regional Job Evaluation Leads indicating that conclusions on the three posts had been reached in that the EMT (Band 4); Paramedic (Band 5) and RRV Paramedic (Band 5) posts remained unchanged. It was advised that these outcomes require validation through the production of a Job Evaluation report. NIAS are supporting the RQA team in the production of this report by providing access to the related IT system. Once provided the report will be issued to all affected staff, who will have the right to request a review of the outcome.

From December 2015, the Trust has engaged with Regional leads and DoH colleagues to urge for this process to be brought to a conclusion through due process however the position has not moved forward in this regard. The Trust has met recently with the Departmental Workforce Policy Directorate to attempt to conclude this process. The Trust will continue to prioritise this matter and will advise staff accordingly of any developments in this area.

The Trust recognises the potential for significant non recurrent and recurrent costs in relation to Agenda for Change and will continue to work through due process with Commissioners and DoH to address any potential cost issues with future reviews or job evaluations if they arise.

Business Services Transformation Programme and Shared Services

NIAS continues to participate in the Business Services Transformation Programme (BSTP) which is a programme of replacing aged Finance and Human Resources systems for all Health and Social Care bodies in Northern Ireland.

The new Finance, Procurement and Logistics (FPL) system was implemented in June 2013 and the new Human Resources, Payroll, Travel and Subsistence (HRPTS) system was implemented in March 2014. This was a significant achievement and created exceptional demands upon NIAS and the HSC as a whole.

2016-17 was the second full year of accounts payable, accounts receivable and payroll services being provided to NIAS in a shared service environment by the Business Services Organisation (BSO). The Trust continues to work with BSO to make improvements and to realise the expected benefits of the new systems.

A number of audits have been conducted in BSO Shared Services as part of the BSO Internal Audit plan. This includes a follow up on Shared Service Audits in 2016-17.

While progress has been made in many areas during the year, there are a number of areas where further weaknesses have been identified. Limited assurance has been provided in respect of the BSO Payroll Shared Service Centre and an unacceptable assurance was provided in respect of the Payroll System and Function Stability. A significant number of priority one findings and recommendations have been reported. These include findings relating to the management of customer queries, maternity pay calculations and variance monitoring. It was also highlighted that fifteen of the eighteen previous audit recommendations had not been fully implemented.

BSO have advised that all recommendations in the 2016-17 internal audit reports have been accepted and action plans are in place to assist with the implementation of these recommendations.

The recommendations in these Shared Service audit reports are the responsibility of BSO Management to take forward and the reports have been presented to the BSO Governance and Audit Committee.

NIAS will continue to work with BSO Shared Services to improve controls in this area.

In the interim, the Trust has retained an element of processing in relation to travel and expenses within NIAS and has put additional controls in place to mitigate and minimise any effect of these weaknesses.

BSO have also advised that the hold on the transition of the recruitment shared service to other HSC organisations has been lifted and a number of HSC organisations, including NIAS, will transition to the new system and shared service early in 2017-18.

Category A Response Performance

Category A response targets have not been achieved in 2016-17 and continue to present a significant challenge for the immediate future. NIAS achieved 51% against the 72.5% target. There has been a further 4.87% (9,479 calls) increase in 999 demand compared with last year. Efforts will continue, and be increased, to maximise the use of existing resources to achieve Category A targets without compromising our overall commitment to respond promptly and appropriately to all 999 and non 999 requests for ambulance assistance.

NIAS will continue to engage with HSC Commissioners to secure additional investment to address annually increasing demand for ambulance services. NIAS have commenced a Demand Capacity Review in order to determine if and how existing resources could be used to:

a. Meet the continued trend of increasing demand, generated from Unscheduled Care (i.e. 999 calls, Health Care Professional/ Doctors Urgent Calls) and

b. Identify the level of uplift that would be required to achieve performance within a range of planning scenarios including potential acute service reconfigurations.

Employee Relations

NIAS continued to face employee relations challenges during 2016-17. Trade Unions withdrew from partnership working on Job

Evaluation from August 2015. During 2016-17 as a result of a renewed engagement with Trade Unions during the year they are again participating in these partnership processes.

Staff Welfare

The divergence between resource availability and demand (highlighted previously) presents as a staff welfare issue in respect of non-provision or disturbance of planned rest periods, late finishes by ambulance personnel and meeting demand for fulfilling leave requirements of ambulance personnel.

A Health and Well-Being Group, with representatives from staff, trade unions and management, was established during 2016-17. This group will be concerned with developing and implementing an action plan to take forward a range of staff health and well-being initiatives. Key priorities identified to date include development of a peer support model. The Trust has engaged with Inspire (formerly Carecall) in taking this work forward. Work to date has included a pilot within Emergency Ambulance Control (EAC) and a Health & Well-being Audit within southern area.

Attendance Management

Attendance Management continues to present a challenge to NIAS albeit with robust application of procedures being maintained. The NIAS sickness absence target for 2016-17, as established by the DoH, was to 'improve sick absence rates by 5% on 2015-16 levels'. As a consequence, NIAS had to achieve an absence rate of 9.91% in 2016-17. Despite all efforts as outlined below, the Trust did not meet this target in 2016-17. The cumulative absence rate at 31 March 2017 was 10.34%.

In 2016-17, NIAS continued to progress with its Workforce Stabilisation Programme for frontline vacancies. In addition, the revised NIAS Attendance Management Policy was approved by the Trust Board. The supporting Attendance Management procedure has been consulted

NIAS welcomed the establishment of a new group of Community First Responders in Crossmaglen during 2016-17

upon widely and is in final draft form. The new policy and procedure will be implemented, supported by robust training and management support, in the first quarter of 2017-18. The revised NIAS Attendance Management Policy/ Procedure is compliant with the HSC Regional Policy Framework for Best Practice for Managing Attendance.

As highlighted above, the Trust's Health and Well-Being Steering Group will continue to address staff welfare issues which have been signalled as potentially contributing to non-attendance.

Electronic Patient Care Report Form (EPRF)

Progress on the introduction of an electronic Patient Report Form (ePRF) has been significantly delayed due to the lack of support for revenue funding by the Commissioner. This resulted in a significant delay on project deadlines and milestones. Despite this the Trust has continued to engage with HSCB in the development of a regional Electronic Health Care Record (EHCR) which will replace, as a minimum, the current Patient Administration Systems (PAS) in hospitals. This will require significant capital and revenue investment and as part of the business case development, various options including the position of an ambulance ePRF were considered within that project. Engagement with HSCB is still ongoing to scope if the ePRF should remain as a stand-alone initiative linking with the EHCR or should become an integral part of the EHCR development. As a result of this process, conditional support from HSCB has been received. Subject to business case approval, this will allow the project to proceed to consider procurement options and more detailed costings, at which stage a further review would take place in advance of formal commitment to funding.

HSC Structural Change

The announcement of structural change in the HSC identifying the replacement of the HSC Board with revised commissioning and performance management arrangements raises a potential risk as the new commissioning and planning arrangements are yet unknown. NIAS is anxious to retain the regional focus on service development and improvement developed under the current arrangements and build on this to support initiatives such as the Alternative Care Pathway Programme introduced over recent years to support and endorsement across the HSC system, contributing to enhanced system working, reduced attendances at ED, and better care for patients.

A further element of structural change under consideration is the extension of shared services into ICT, Business Information, Medical/Nurse/ AHP Bank and Occupational Health Services and the new proposed Public Sector wide shared services approach. NIAS is anxious to ensure that core line-of-business systems and processes are appropriately supported and secured in any change proposals.

NIAS will continue to engage at all levels throughout the HSC system to secure a resolved position which safeguards ambulance priorities in the revised arrangements.

Identification of new issues in the current year and anticipated future issues

Financial Position 2017-18

There are a range of challenges expected in 2017-18 and achieving savings and delivering financial balance is an increasing challenge. The current political and economic environment, internationally, nationally and locally, has the potential to add significantly to the financial challenges ahead.

The outlook for 2017-18 is increasingly constrained, particularly in respect of resource funding. In a statement to the House of Commons on 24 April 2017 the Secretary of State for Northern Ireland outlined an indicative Budget position for Northern Ireland Departments. This position was based on the advice of the Head of the Northern Ireland Civil Service (NICS) in conjunction with the NICS Board. The purpose of this statement was to provide clarity to Departments as to the basis for Departmental allocations in the absence of an Executive, so that Permanent Secretaries can plan and prepare to take more detailed decisions in that light. The Departmental allocations set out by the Secretary of State provide the basis on which Departments are now planning for 2017-18. However, the Secretary of State was clear that the indicative budget position did not constrain the ability of an incoming Executive to adjust its priorities during the year. He also advised that some £42 million Resource DEL and £7 million Capital DEL was left unallocated in order to maintain flexibility for a new Executive to allocate resources to meet further priorities as they deem appropriate. Therefore, while there is the potential for an incoming Executive to adjust these plans and also to allocate the unallocated resources, individual Departments cannot anticipate any additional funding at this stage until such decisions are made.

Across the HSC sector it is expected that the significant financial challenges faced will intensify and extensive budget planning work to support the 2017-18 financial plan is ongoing between the Trust, HSCB and Department of Health (DoH). However, as with other financial years the Trust will continue to work with all stakeholders and remains committed to achieving financial break-even and achieving any further required savings while maintaining safe and effective care to patients.

Paramedic Education

The Trust's in-house Paramedic-in-Training programme, which was approved by the Health and Care Professions Council and largely based on Institute of Healthcare Development (IHCD) ambulance training modules, was formally closed during 2016-17 as a direct result of the withdrawal of IHCD modules. NIAS has therefore established a formal Paramedic Education Project which key deliverables include sourcing an interim pre-registration paramedic programme to meet the short term needs of the Trust and the development of a longer term paramedic education solution that will meet the future needs of both the Trust and the wider HSC arena. The project will continue to progress against defined timeframes during 2017-18 and includes representation from Trust Directors, the DoH and HSCB Commissioners.

Succession Planning

Given the growth in demand for the service and movement to new service models it is anticipated that the management structure will change and opportunities will appear with consequential challenges to succession planning. This may be further impacted by potential Trust Board level changes to include the appointment of a new Chair.

It is the intention to review and mainstream the issues identified as control issues in this statement into normal NIAS business in 2017-18.

11. Conclusion

The NIAS Trust has a rigorous system of accountability which I can rely on as Accounting Officer to form an opinion on the probity and use of public funds, as detailed in and required by Managing Public Money Northern Ireland.

Further to considering the accountability framework within the Trust and in conjunction with assurances given to me by the Head of Internal Audit, I am content that NIAS has operated a sound system of internal control and governance during the period 2016-17, that supports the achievement of policies, aims and objectives.

Mr Shane Devlin
Chief Executive
15 June 2017

Remuneration and Staff Report

Remuneration Report for the Year Ended 31 March 2017

Section 421 of The Companies Act 2006, as interpreted for the public sector requires HSC bodies to prepare a Remuneration Report containing information about directors' remuneration. The Remuneration Report summarises the remuneration policy of the Northern Ireland Ambulance Service Health and Social Care Trust and particularly its application in connection with senior managers. The report must also describe how the Trust applies principles of good corporate governance in relation to senior managers remuneration.

Senior managers include the Chief Executive and the four Executive Directors who operate at Board level and are listed on page 66 of this report and also overleaf.

Remuneration Committee

The membership of the Remuneration Committee is comprised exclusively of Non-Executive Directors and the Committee is chaired by the Chair of the Trust Board. Executive Director attendance is restricted to the Chief Executive and the Director of Human Resources and Corporate Services who absent themselves at appropriate points in the meeting to prevent any issues such as an actual or perceived conflict of interest arising.

Remuneration Policy

The policy on the Remuneration of Directors and Senior Managers for current and future periods is governed and administered on the basis of the DoH Departmental Directives and Circulars on HSC Senior Executive Salaries. NIAS applies the Senior Executive Performance Management Scheme as set out within Departmental Circular HSS(SM) 1/2003. The circular sets out the following requirements which are applied within the Trust:

- The Board determines the strategic and operational corporate objectives of the Trust for the year ahead taking into account the parameters established by the Department and incorporating them within the Trust Delivery Plan;
- The Chairman agrees the Chief Executive's performance objectives, undertakes review of performance and objectives, and completes a final report on the Chief Executive's performance;
- The Chief Executive agrees individual performance objectives of Executive Directors, undertakes review of performance and objectives, and completes a final report on Executive Director's performance;

- Senior Executives agree performance objectives with the Chief Executive, participate in reviews and take responsibility for personal development;

- Performance objectives are linked to Trust Delivery Plans and Strategic Plans. Performance objectives are clearly defined and measurable;

- Each Director's performance is reviewed by the Chief Executive on an annual basis. The approach adopted is based on an assessment of the Executive Director's contribution towards the achievement of agreed objectives aligned to the Trust's Strategic and Trust Delivery Plan. A similar approach is used by the Chairman for the Chief Executive. Performance pay would be considered within the total pay limit determined by the DoH;

- The Remuneration Committee encourages effective appraisal of staff and scrutinises objectives for consistency, robustness and alignment with priorities. The Committee also ensures that a robust process has taken place and monitors for consistency of assessment before recommending overall banding and award for senior executives;

- The Remuneration Committee recommendations are presented to Trust Board for consideration and approval; and

- The Remuneration Committee has yet to meet in order to make recommendations in respect of senior executive salaries related to performance related pay for 2016-17.

Service Contracts

The Trust Medical Director is employed under a contract issued in accordance with HSC Medical Consultant Terms and Conditions of Service (Northern Ireland) 2004. All of the other Senior Executives in the year 2016-17 were on the pre 23 December 2008 Senior Executive Contract. The contractual provisions applied are those detailed and contained within Circular HSS (SM) 2/2001.

Directors

Non-Executive Directors

Mr Paul Archer, Chairman appointed on 16 October 2008 for a period of four years (extended from 16 October 2012 to 15 October 2016 and further extended to 30 September 2017).

Mr Norman McKinley, Non-Executive Director, appointed on 1 May 2009 for a period of four years (extended from 3 April 2013 to 7 April 2017).

Dr James Livingstone, Non-Executive Director, appointed on 1 November 2012 for a period of four years (extended from 1 November 2014 to 30 October 2020).

Mr William Abraham, Non-Executive Director, appointed on 18 May 2015 for a period of four years.

Mr Trevor Haslett, Non-Executive Director, appointed on 18 May 2015 for a period of four years.

Mr Alan Cardwell, Non-Executive Director, appointed on 1 August 2015 for a period of four years.

The terms and conditions applicable to Non-Executive Directors are issued by the DoH.

Executive Directors

Mr Liam McIvor, Chief Executive, appointed on 1 October 2004 to 24 April 2016.

Ms Rosin O'Hara, Interim Chief Executive, appointed on 25 April 2016 to 9 October 2016.

Dr D McManus, Interim Chief Executive, appointed on 10 October 2016 to 4 December 2016.

Mr Shane Devlin, Chief Executive, appointed 5 December 2016.

Mr Brian McNeill, Director of Operations, appointed 1 June 2005.

Dr David McManus, Medical Director, appointed 1 May 2003.

Mrs Sharon McCue, Director of Finance and Information Communications Technology, appointed 4 March 2002.

Ms Roisin O'Hara, Director of Human Resources & Corporate Services, appointed 1 March 2002.

Mrs Michelle Lemon, Director of Human Resources & Corporate Services - Acting, appointed 1 August 2015 to 30 September 2015 and from 29 April 2016 to 31 October 2016.

Duration of Contract

All Senior Executives are on permanent Contracts of Employment with continuation subject to satisfactory performance.

Notice Periods

A three-month' notice period is to be provided by either party except in the event of summary dismissal. There is nothing to prevent either party waiving the right to notice or from accepting payment in lieu of notice.

Termination Payments

Statutory provisions only as detailed in contract. There were no payments made to directors in respect of compensation for loss of office during 2016-17.

Retirement Age

Currently, employees are required to retire at age 65 years; occupational pensions are normally effective from age 60 years. With effect from 1 October 2006 with the introduction of the Equality (Age) Regulations (Northern Ireland) 2006, employees can ask to work beyond age 65 years.

Senior Management Remuneration (Audited)

The salary, pension and the value of any taxable benefits in kind of the most senior members of the Trust were as follows:

	2016-17					2015-16				
Name	**Salary £000s**	**Bonus/ Performance Pay £000**	**Benefits in Kind (rounded to nearest £100)**	**Pension Benefit (rounded to nearest £1,000)**	**Total £000s**	**Salary £000s**	**Bonus/ Performance Pay £000**	**Benefits in Kind (rounded to nearest £100**	**Pension Benefit (rounded to nearest £1,000)**	**Total £000s**
Non-Executive Members										
P Archer	25 - 30	-	-	-	**25 - 30**	25 - 30	-	-	-	**25 - 30**
M Hanratty (to 31 July 2015)	-	-	-	-	**-**	0 - 5 (5 - 10*)	-	-	-	**0 - 5 (5 - 10*)**
N McKinley	5 - 10	-	-	-	**5 - 10**	5 - 10	-	-	-	**5 - 10**
J Livingstone	5 - 10	-	-	-	**5 - 10**	5 - 10	-	-	-	**5 - 10**
W Abraham (from 18 May 2015)	5 - 10	-	-	-	**5 - 10**	5 - 10	-	-	-	**5 - 10**
J Haslett (from 18 May 2015)	5 - 10	-	-	-	**5 - 10**	5 - 10	-	-	-	**5 - 10**
A Cardwell (from 1 Aug 2015)	5 - 10	-	-	-	**5 - 10**	0 - 5 (5 - 10*)	-	-	-	**0 - 5 (5 - 10*)**
Executive Members**										
L McIvor (to 24 Apr 2016)	5 - 10 (85 - 90*)	0 - 5	-	-	**5 - 10**	80 - 85	0 - 5	-	10	**95 - 100**
S Devlin (from 5 Dec 2016)	20 - 25 (70 - 75*)	0 - 5	1,400***	30	**50 - 55**	-	-	-	-	**-**
S McCue	70 - 75	0 - 5	-	-	**70 - 75**	70 - 75	0 - 5	-	10	**80- 85**
R O'Hara	70 - 75	0 - 5	-	34	**105 - 110**	65 - 70	0 - 5	-	9	**75 - 80**
D McManus	100 - 105	0 - 5	-	10	**110 - 115**	100 - 105	0 - 5	-	(33)	**65 - 70**
B McNeill	70 - 75	0 - 5	-	8	**80 - 85**	70 - 75	0 - 5	-	8	**80 - 85**
J Wright (from 1 Aug 2015 to 31 Dec 2015)	-	-	-	-	**-**	25 - 30 (60 - 65*)	0 - 5	-	59	**85 - 90**
M Lemon (from 1 Aug 2015 to 30 Sep 2015 and 29 Apr 2016 to 31 Oct 2016)	55 - 60 (60 - 65*)	0 - 5	-	23	**80 - 85**	10 - 15 (60 - 65*)	0 - 5	-	19	**25 - 30**
Highest Earners' Total Remuneration (£'000)	**100-105**					**100-105**				
Median Total Remuneration	**£32,801**					**£34,193**				
Ratio	3.1					3.0				

Please note that the salary bandings for each board member within the remuneration table are reflective of estimated salary increases for the Senior Executive pay award payable from 1 April 2016. Approval in respect of the senior executive pay award for 2016-17 was not received by the date of the accounts being prepared and as such the CETV values noted overleaf have been calculated using pre adjustment salary figures.

Bonuses relate to the performance in the year in which they become payable to the individual. The bonuses reported in 2016-17 relate to performance in 2015-16 and the comparative bonuses reported for 2015-16 relate to performance in 2014-15.

The value of pension benefits accrued during the year is calculated as (the real increase in pension multiplied by 20) plus (the real increase in any lump sum) less (the contributions made by the individual).

The real increases exclude increases due to inflation or any increases or decreases due to a transfer of pension rights.

The Single Total Figure of Remuneration includes the salary, bonus/performance pay, benefits in kind as well as pension benefits.

* denotes full-year equivalent salary

** During the financial year there were a number of additions to the membership of the Board as set above and on pages 91 and 92. The remuneration information disclosed above reflects the relevant directors' salaries on a pro-rata basis.

*** The monetary value of benefits in kind covers any benefits provided by the employer and treated by HM Revenue and Customs as a taxable emolument. The benefit in kind listed relates to a leased car.

Senior Employees' Remuneration (Audited)

Name	Real increase in pension and related lump sum at age 60 £000s	Total accrued pension at age 60 and related lump sum £000s	CETV at 31/03/16 £000s	CETV at 31/03/17 £000s	Real increase in CETV £000s
Executive Members					
S Devlin * (from 05 Dec 2016)	0 - 2.5 + lump sum of 0 - 2.5	10 - 15 + lump sum of 5 - 10	131	151	16
R O'Hara	0 - 2.5 + lump sum of 5 - 7.5	25 - 30 + lump sum of 75 - 80	453	504	37
D McManus	0 - 2.5 + lump sum of 2.5 - 5	70 - 75 + lump sum of 215 - 220	1,557	1,631	23
B McNeill	0 - 2.5 + lump sum of 0 - 2.5	25 - 30 + lump sum of 85 - 90	595	631	16
M Lemon	0 - 2.5 + lump sum of 0 - 2.5	10 - 15 + lump sum of 30 - 35	158	179	16

* This pension information is for the full financial year as the member was in employment within the HSC sector for this whole period.

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members. In addition, no entries are provided in respect of pensions for Executive members who either leave the Trust's employment or reach the applicable pensionable age during the financial year.

Cash Equivalent Transfer Value

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the HSC pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated in accordance with The Occupational Pension Schemes (Transfer Values) (Amendment) Regulations 2008 and do not take account of any actual or potential benefits resulting from Lifetime Allowance Tax which may be due when pension benefits are taken.

Real Increase in CETV

This reflects the increase in CETV effectively funded by the employer. It does not include the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period. However, the real increase calculation uses common actuarial factors at the start and end of the period so that it

disregards the effect of any changes in factors and focuses only on the increase that is funded by the employer.

Fair Pay Disclosure (Audited)

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisations workforce.

The banded remuneration of the highest paid Director in the Northern Ireland Ambulance Service HSC Trust in the financial year 2016-17 was £100k - £105k (2015-16: £100k - £105k). This was 3.1 times (2015-16: 3.0 times) the median remuneration of the workforce, which was £32,801 (2015-16: £34,193).

In accordance with Circular Reference: HSC(F) 23-2013 Amendment on Disclosure of Highest Paid Director and Median Remuneration, (Hutton Fair Pay review Disclosure) staff pay in March (excluding severance payments) should be annualised.

Staff who were on the top of their pay scale on 31st March 2015 received a 1% non-recurrent pay award and in accordance with the above circular this payment included in the March 2016 gross pay was annualised. In relation to 2016-17 a pay award of 1% was made to all staff which was implemented and arrears paid in November 2016, thus there was no significant effect on the March 2017 gross pay. This timing difference has resulted in an increase in the median total remuneration ratio.

NIAS Corporate Responsibility activity continued during 2016-17 with staff volunteering on 'Be a Saint Day' in March 2016

Staff Report

Number of Senior Staff By Band

Band/Grade	Number
Consultant	2
Senior Executive Directors	4
Non-Executive Directors	6
AfC Band 8c	2
AfC Band 8b	9
Total	**23**

The information above is taken from the Human Resources. Payroll & Travel System (HRPTS) and reflects the position of staff in post on 31 March 2017. Senior Staff are defined as Level 3 staff and above (Assistant Director Level and above).

Staff Costs (Audited)

	2017			2016
Staff costs comprise:	**Permanently employed staff £000s**	**Others £000s**	**Total £000s**	**Total £000s**
Wages and salaries	41,000	618	41,618	42,483
Social security costs	4,794	0	4,794	3,414
Other pension costs	6,031	0	6,031	5,348
Sub-Total	**51,825**	**618**	**52,443**	**51,245**
Capitalised staff costs	(76)	0	(76)	(23)
Total staff costs reported in Statement of Comprehensive Expenditures	**51,749**	**618**	**52,367**	**51,222**
Less recoveries in respect of outward secondments			(11)	0
Total Net Costs			**52,356**	**51,222**

Staff costs include £nil (2016: £nil) relating to the Charitable Trust Funds.

Staff Costs exclude £76k charged to capital projects during the year (2016: £23k).

The Trust participates in the HSC Pension Scheme. Under this multi-employer defined benefit scheme both the Trust and employees pay specified percentages of pay into the scheme and the liability to pay benefit falls to the DoH. The Trust is unable to identify its share of the underlying assets and liabilities in the scheme on a consistent and reliable basis.

As per the requirements of IAS 19, full actuarial valuations by a professionally qualified actuary are required at intervals not exceeding four years. The actuary reviews the most recent actuarial valuation at the Statement of Financial Position date and updates it to reflect current conditions. A full valuation for Resource Accounts purposes as at 31 March 2012 was certified in February 2015 and is used in the 2016-17 accounts.

Average Number of Persons Employed (Audited)

The average number of whole time equivalent persons employed during the year was as follows:

	2017			2016
	Permanently employed staff No.	Others No.	Total No.	Total No.
Medical and dental	2	0	2	2
Nursing and midwifery	0	0	0	0
Professions allied to medicine	0	0	0	0
Ancillaries	0	0	0	0
Administrative and clerical	89	23	112	106
Ambulance staff	1,073	4	1,077	1,062
Works	3	0	3	3
Other professional and technical	0	0	0	0
Social services	0	0	0	0
Other	0	0	0	0
Total Average Number of Persons Employed	**1,167**	**27**	**1,194**	**1,173**
Less average staff number relating to capitalised staff costs	(2)		(2)	(1)
Less average staff number in respect of outward secondments	(1)		(1)	0
Total Net Average Number of Persons Employed	**1,164**	**27**	**1,191**	**1,172**

The number of persons employed include nil (2016: £nil) relating to the Charitable Trust Funds.

Staff Composition (by Gender)

	Male	Female	Total
Consultant	2	0	2
Senior Executive Directors	2	2	4
Non-Executive Directors	6	0	6
Senior Staff*	6	5	11
Employees	893	355	1,248
Total	**909**	**362**	**1,271**

The information above is taken from the Human Resources Payroll & Travel System (HRPTS) and reflects the position of staff in post on 31 March 2017.

*Senior Staff defined as Level 3 staff and above i.e. Assistant Director Level and above

Staff Policies Applied During 2016-17

NIAS is fully committed to complying with its responsibilities to promote Equality of Opportunity in line with employment law and best practice. Employment policies operate in line with the Trust's Equality of Opportunity and Equality Scheme.

During the reporting period 2016-17, a total of 53 applications were received from applicants who declared a disability. In this regard NIAS continued to meet its statutory responsibilities under the Disability Discrimination Act (NI) 1997 (DDA) by making reasonable adjustments both to the selection process itself and the appointment processes.

NIAS also continues to support students attending training at the Regional Ambulance Training Centre (RATC) in respect of disabilities declared and makes appropriate reasonable adjustments to both learning and examination requirements.

During the same period NIAS continued to engage with employees where necessary to agree the provision of reasonable adjustments to their post/employment circumstances, under DDA, enabling their continued employment with the Trust.

Off Payroll Engagements

There were no 'off-payroll' engagements at a cost of over £58,200 per annum in place during 2016-17.

Expenditure on Consultancy

The Trust spent £18,703 on consultancy during 2016-17 (2016: £NIL).

Sickness Absence Data

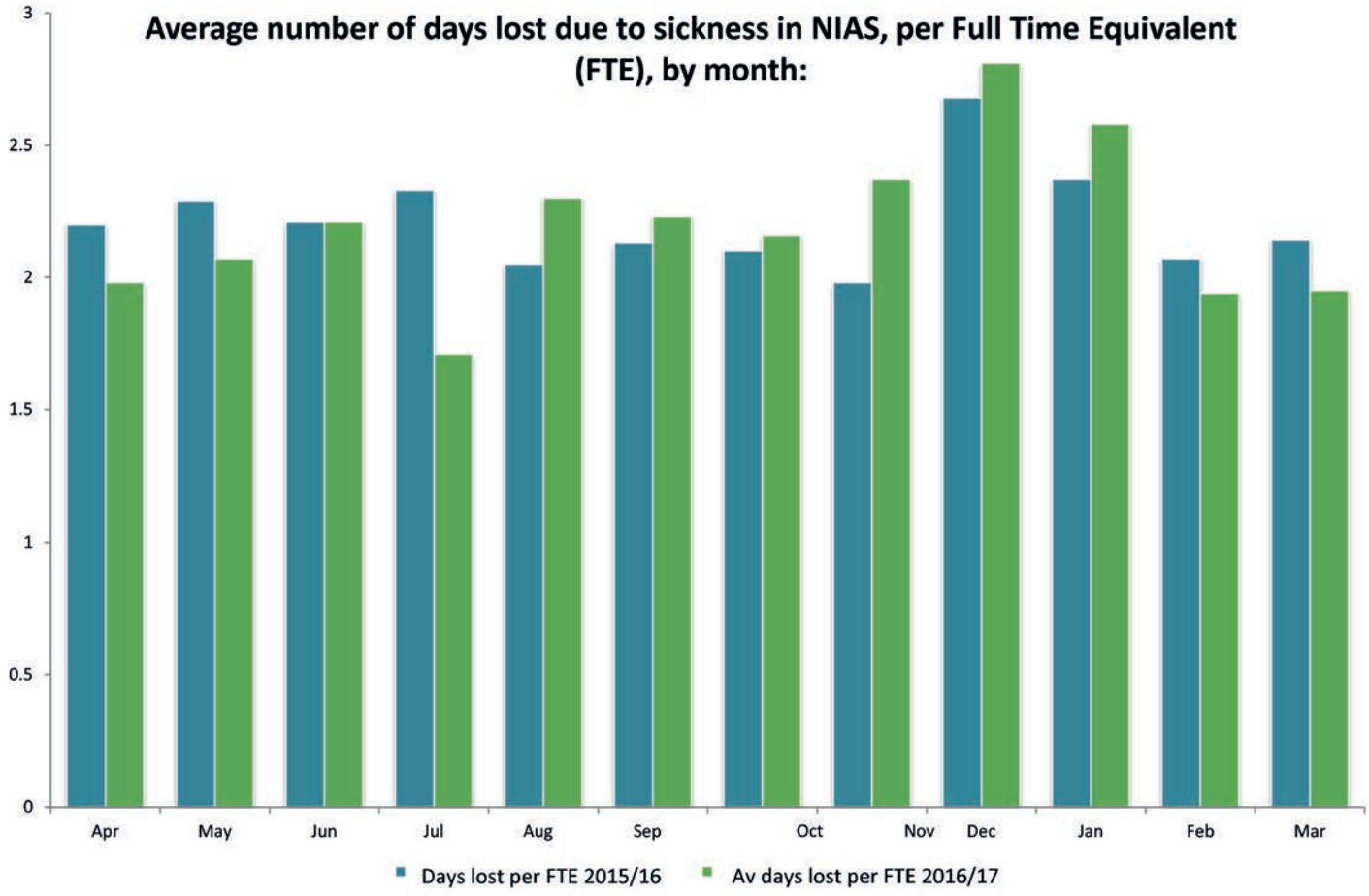
Attendance management continues to present a challenge to NIAS albeit with robust application of procedures being maintained. NIAS sickness absence target for 2016-17, as established by the Department of Health (DoH), was to "improve sickness absence rates by 5% on 2015-16 levels". The sickness absence target for NIAS for 2016-17 was 9.91%.

Whilst the monthly percentage absence recorded for March 2017 was 8.69% (which is lower than the NIAS target) and a downward trend in sickness absence has been evidenced since January 2017, the Trust is failing to meet its 2016-17 target. Cumulatively at 31 March 2017 absence levels within NIAS were totalling 10.32%.

In the context of the divergence between resource availability and demand presenting as staff welfare issues, in 2016-17 NIAS continued to progress with its Workforce Stabilisation Programme for frontline vacancies. During 2016-17 a total of 77 appointments were made to front-line posts. This included 44 new appointees to the organisation.

The table below shows the number of days lost due to sickness in 2015-16 and 2016-17 per Full Time Equivalent (FTE):

Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total 2016-17
No. of days lost 2015-16	2,535	2,720	2,670	2,820	2,472	2,568	2,572	2,415	3,268	2,887	2,514	2,628	**32,069**
Days lost per FTE 2015-16	2.20	2.29	2.21	2.33	2.05	2.13	2.10	1.98	2.68	2.37	2.07	2.14	**27.00**
No. of days lost 2016-17	2,404	2,506	2,674	2,071	2,774	2,707	2,622	2,883	3,417	3,133	2,400	2,403	**31,994**
Headcount	1,215	1,210	1,209	1,210	1,208	1,215	1,212	1,216	1,216	1,214	1,237	1,232	**1,216**
Av days lost per FTE 2016-17	1.98	2.07	2.21	1.71	2.30	2.23	2.16	2.37	2.81	2.58	1.94	1.95	**26**



During 2016-17 the NIAS Attendance Management Policy was reviewed, consulted upon widely and approved by Trust Board. The Policy's supporting Attendance Management Procedure was also reviewed, consulted upon extensively and is in final draft form. Both the revised Policy and Procedure have been developed ensuring compliance with the HSC Regional Policy Framework for Best Practice for Managing Attendance and will be implemented during Quarter 1 of 2017-18. The introduction of the new Policy and Procedure will be supported by robust management training and management support. In addition during 2016-17 a NIAS Health and Wellbeing Group was established with representatives throughout the Trust being invited to determine key deliverables to support the welfare of staff.

Reporting of Early Retirement and Other Compensation Scheme - Exit Packages (Audited)

Exit Package Cost Band	Number of Compulsory Redundancies		Number of Other Departures Agreed		Total Number of Exit Packages by Cost Band	
	2017	2016	2017	2016	2017	2016
<£10,000	0	0	0	0	0	0
£10,001 - £25,000	0	0	0	0	0	0
£25,001 - £50,000	0	0	0	2	0	2
£50,001 - £100,000	0	0	0	0	0	0
£100,001 - £150,000	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0
£200,001 - £250,000	0	0	0	0	0	0
£250,001 - £300,000	0	0	0	0	0	0
£300,001 - £350,000	0	0	0	0	0	0
£350,001 - £400,000	0	0	0	0	0	0
Total Number of Exit Packages by Type	**0**	**0**	**0**	**2**	**0**	**2**
	£000s	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**
Total Resource Cost	**0**	**0**	**0**	**78**	**0**	**78**

Redundancy and other departure costs have been paid in accordance with the provisions of the HSC Pension Scheme Regulations and the Compensation for Premature Retirement Regulations, statutory provisions made under the Superannuation Act 1972. Exit costs are accounted for in full in the year in which the exit package is approved and agreed and are included as operating expenses at Note 3. Where early retirements have been agreed, the additional costs are met by the employing authority and not by the HSC pension scheme. Ill-health retirement costs are met by the pension scheme and are not included in the table.

Staff Benefits

The Northern Ireland Ambulance Service HSC Trust paid £nil staff benefits in 2017 (2016 £nil).

Trust Management Costs

	2017 £000s	2016 £000s
Trust Management Costs	4,473	4,353
Income:		
RRL	71,584	70,057
Income per Note 4	504	495
Non cash RRL for movement in clinical negligence provision	0	0
Less interest receivable	0	0
	72,088	70,552
Less adjustments as detailed in HSS (THR) 2/99	(335)	(301)
Total Income	**71,753**	**70,251**
% of Total Income	**6.2%**	**6.2%**

The above information is based on the Audit Commission's definition "M2" Trust management costs, as detailed in HSS (THR) 2/99.

Retirements Due to Ill-Health

During 2016-17 there were 2 early retirements from the Trust, agreed on the grounds of ill-health (2016: 1). The estimated additional pension liabilities of these ill-health retirements will be £5k (2016: £12k). These costs are borne by the HSC Pension Scheme.

Accountability and Audit Report

Funding Report

Regularity of Expenditure (Audited)

The responsibilities of an Accounting Officer, including responsibility for the propriety and regularity of the public finances for which the Accounting Officer is answerable, for keeping proper records and for safeguarding the Northern Ireland Ambulance Service HSC Trust's assets, are set out in the Accountable Officer Memorandum, issued by the Department of Health.

The Chief Executive discharges these responsibilities through a governance framework that is tested regularly and on which annual independent assurances are obtained. This framework and the assurances obtained are set out in the Governance Statement for 2016-17 on pages 69 to 89.

The Comptroller and Auditor General provides an annual opinion to the Northern Ireland Assembly which includes an opinion on regularity. The full Certificate and Report of the Comptroller and Auditor General is set out on pages 106 to 108.

Fees and Charges (Audited)

The Northern Ireland Ambulance Service HSC Trust did not pay any fees or charges during the year (2016: £nil).

Remote Contingent Liabilities (Audited)

In addition to contingent liabilities reported within the meaning of IAS37, the Northern Ireland Ambulance Service HSC Trust also reports liabilities for which the likelihood of a transfer of economic benefit in settlement is too remote to meet the definition of contingent liability.

The Trust continues with the agreed process in respect of Agenda for Change in partnership with Trade Unions. However, at this stage, there remain uncertainties over the outcome of the process and the Trust cannot establish the extent to which claims that could be made, nor can it make a reliable estimate of any potential claims under employment legislation that may arise (see Note 21.1 of the Accounts).

NIAS Community Education initiative continued during 2016-17 with a number of shopping centre visits

Losses and Special Payments

Type of loss and special payment		2016-17		2015-16
		Number of Cases	£	£
Cash losses				
	Cash Losses - Theft, fraud etc	0	0	0
	Cash Losses - Overpayments of salaries, wages and allowances	0	0	0
	Cash Losses - Other causes	0	0	0
		0	**0**	**0**
Claims abandoned				
	Waived or abandoned claims	0	0	0
		0	**0**	**0**
Administrative write-offs				
	Bad debts	0	0	0
	Other	0	0	0
		0	**0**	**0**
Fruitless payments				
	Late Payment of Commercial Debt	0	0	0
	Other fruitless payments and constructive losses	3	908	2,211
		3	**908**	**2,211**
Stores losses				
	Losses of accountable stores through any deliberate act	0	0	0
	Other stores losses	0	0	3,858
		0	**0**	**3,858**
Special Payments				
	Compensation payments			
	— Clinical Negligence	1	4,525	4,361
	— Public Liability	0	0	0
	— Employers Liability	14	82,927	40,609
	— Other	1	4,000	0
		16	**91,452**	**44,970**
	Ex-gratia payments	**5**	**2,407**	**817**
	Extra contractual	**0**	**0**	**0**
	Special severance payments	**0**	**0**	**0**
	TOTAL	**24**	**94,767**	**51,856**

Losses and Special Payments over £250,000

The Northern Ireland Ambulance Service HSC Trust did not make any individual payments for losses and special payments over £250k during the year (2016: £nil).

Special Payments

The Northern Ireland Ambulance Service HSC Trust did not make any special payments or gifts during the year (2016: £nil).

Other Payments

The Northern Ireland Ambulance Service HSC Trust did not make any other payments during the year (2016: £nil).

Mr Shane Devlin
Chief Executive
15 June 2017

ACA Recruits who graduated during 2016-17 with trainer Jonny Noble

The Certificate and Report of the Comptroller and Auditor General to the Northern Ireland Assembly

I certify that I have audited the financial statements of the Northern Ireland Ambulance Service Health and Social Care Trust and its group for the year ended 31 March 2017 under the Health and Personal Social Services (Northern Ireland) Order 1972, as amended. The financial statements comprise the Consolidated Statements of Comprehensive Net Expenditure, Financial Position, Changes in Taxpayers' Equity, Cash Flows, and the related notes. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Remuneration and Staff Report and the Assembly Accountability Disclosures that are described in those reports as having been audited.

Respective responsibilities of the Board, Accounting Officer and auditor

As explained more fully in the Statement of Accounting Officer's Responsibilities, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. My responsibility is to audit, certify and report on the financial statements in accordance with the Health and Personal Social Services (Northern Ireland) Order 1972, as amended. I conducted my audit in accordance with International Standards on Auditing (UK and Ireland). Those standards require me and my staff to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the group's and Northern Ireland Ambulance Service Health and Social Care Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Northern Ireland Ambulance Service Health and Social Care Trust; and the overall presentation of the financial statements. In addition I read all the financial and non-financial information in the Annual Report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by me in the course of performing the audit. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my certificate.

I am required to obtain evidence sufficient to give reasonable assurance that the expenditure and income recorded in the financial statements have been applied to the purposes intended by the Assembly and the financial transactions recorded in the financial statements conform to the authorities which govern them.

Opinion on regularity

In my opinion, in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by the Assembly and the financial transactions recorded in the financial statements conform to the authorities which govern them.

Opinion on financial statements

In my opinion:

- the financial statements give a true and fair view of the state of the group's and of Northern Ireland Ambulance Service Health and Social Care Trust's affairs as at 31 March 2017 and of the net expenditure for the year then ended; and

- the financial statements have been properly prepared in accordance with the Health and Personal Social Services (Northern Ireland) Order 1972, as amended and Department of Health directions issued thereunder.

Opinion on other matters

In my opinion:

- the part of the Remuneration and Staff Report and the Assembly Accountability Disclosures to be audited have been properly prepared in accordance with Department of Health directions made under the Health and Personal Social Services (Northern Ireland) Order 1972, as amended; and

- the information given in the Performance Report and Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

I have nothing to report in respect of the following matters which I report to you if, in my opinion:

+ adequate accounting records have not been kept; or

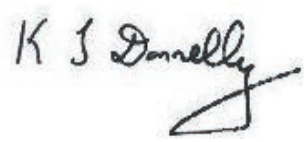
+ the financial statements and the parts of the Remuneration and Staff Report and Assembly Accountability Disclosures to be audited are not in agreement with the accounting records; or

+ I have not received all of the information and explanations I require for my audit; or

+ the Governance Statement does not reflect compliance with Department of Finance's guidance.

Report

I have no observations to make on these financial statements.



KJ Donnelly
Comptroller and Auditor General
Northern Ireland Audit Office
106 University Street
Belfast
BT7 1EU

23 June 2017

Annual Accounts

Consolidated Statement of Comprehensive Net Expenditure for the year ended 31 March 2017

This account summarises the income generated and expenditure consumed on an accruals basis. It also includes other comprehensive income and expenditure, which includes changes to the values of non-current assets and other financial instruments that cannot yet be recognised as income or expenditure.

		2017		2016	
	NOTE	Trust £000s	Consolidated £000s	Trust £000s	Consolidated £000s
Income					
Income from activities	4.1	354	354	385	385
Other operating income	4.2	150	151	110	114
Deferred Income	4.3	0	0	0	0
Total Operating Income		504	505	495	499
Expenditure					
Staff costs		(52,367)	(52,367)	(51,222)	(51,222)
Purchase of goods and services	3.1	(3,239)	(3,239)	(3,014)	(3,014)
Depreciation, amortisation and impairment charges	3.1	(5,319)	(5,319)	(6,216)	(6,216)
Provision expense	3.1	(520)	(520)	(542)	(542)
Other expenditures	3.1	(10,642)	(10,643)	(9,506)	(9,507)
Total Operating Expenditure		**(72,087)**	**(72,088)**	**(70,500)**	**(70,501)**
Net Operating Expenditure		**(71,583)**	**(71,583)**	**(70,005)**	**(70,002)**
Finance income	4.2	0	0	0	0
Finance expense	3.1	0	0	0	0
Net Expenditure for the Year		**(71,583)**	**(71,583)**	**(70,005)**	**(70,002)**
Revenue Resource Limit (RRL) and capital grants	24.1	71,584	71,584	70,057	70,057
Add back charitable trust fund net expenditure		0	0	0	(3)
Surplus / (Deficit) against RRL		**1**	**1**	**52**	**52**

OTHER COMPREHENSIVE EXPENDITURE

		2017		2016	
	Note	Trust £000s	Consolidated £000s	Trust £000s	Consolidated £000s
Items that will not be reclassified to net operating costs:					
Net gain/(loss) on revaluation of property, plant and equipment	5.1-2 / 8.1	546	546	798	798
Net gain/(loss) on revaluation of intangibles	6.1-2 / 8.1	0	0	0	0
Net gain/(loss) on revaluation of charitable assets		0	2	0	0
Items that may be reclassified to net operating costs:					
Net gain/(loss) on revaluation of investments		0	0	0	0
TOTAL COMPREHENSIVE EXPENDITURE for the year ended 31 March		**(71,037)**	**(71,035)**	**(69,207)**	**(69,204)**

The notes on pages 114 to 153 form part of these accounts.

Consolidated Statement of Financial Position as at 31 March 2017

This statement presents the financial position of the Trust. It comprises three main components: assets owned or controlled; liabilities owed to other bodies; and equity, the remaining value of the entity.

		2017		2016	
		Trust	Consolidated	Trust	Consolidated
	NOTE	£000s	£000s	£000s	£000s
Non Current Assets					
Property, plant and equipment	5.1-2	34,264	34,264	29,969	29,969
Intangible assets	6.1-2	341	341	482	482
Financial assets	7.1	0	11	0	9
Trade and other receivables	12.1	0	0	0	0
Other current assets	12.1	0	0	0	0
Total Non Current Assets		**34,605**	**34,616**	**30,451**	**30,460**
Current Assets					
Assets classified as held for sale	9.1	127	127	13	13
Inventories	10.1	90	90	71	71
Trade and other receivables	12.1	585	585	586	586
Other current assets	12.1	131	131	264	264
Intangible current assets	12.1	0	0	0	0
Financial assets	7.1	0	0	0	0
Cash and cash equivalents	11.1	118	118	112	112
Total Current Assets		**1,051**	**1,051**	**1,046**	**1,046**
Total Assets		**35,656**	**35,667**	**31,497**	**31,506**
Current Liabilities					
Trade and other payables	13.1	(14,454)	(14,454)	(12,050)	(12,050)
Other liabilities	13.1	(2,261)	(2,261)	0	0
Intangible current liabilities	13.1	0	0	0	0
Provisions	15.1-5	(844)	(844)	(530)	(530)
Total Current Liabilities		**(17,559)**	**(17,559)**	**(12,580)**	**(12,580)**
Total Assets Less Current Liabilities		**18,097**	**18,108**	**18,917**	**18,926**
Non Current Liabilities					
Provisions	15.1	(2,683)	(2,683)	(2,770)	(2,770)
Other payables > 1yr	13.1	0	0	(2,261)	(2,261)
Financial liabilities	7.1	0	0	0	0
Total Non Current Liabilities		**(2,683)**	**(2,683)**	**(5,031)**	**(5,031)**
Total Assets Less Total Liabilities		**15,414**	**15,425**	**13,886**	**13,895**
Taxpayers' Equity and Other Reserves					
Revaluation reserve		6,819	6,819	6,377	6,377
SoCNE reserve		8,595	8,595	7,509	7,509
Other reserves - charitable fund		0	11	0	9
Total Equity		**15,414**	**15,425**	**13,886**	**13,895**

The notes on pages 114 to 153 form part of these accounts.

The financial statements on pages 110 to 113 were approved by the Board on 15 June 2017 and were signed on its behalf by:

Mr Paul Archer
Chairman
15 June 2017

Mr Shane Devlin
Chief Executive
15 June 2017

Consolidated Statement of Cash Flows for the year ended 31 March 2017

The Statement of Cash Flows shows the changes in cash and cash equivalents of the Trust during the reporting period. The statement shows how the Trust generates and uses cash and cash equivalents by classifying cash flows as operating, investing and financing activities. The amount of net cash flows arising from operating activities is a key indicator of service costs and the extent to which these operations are funded by way of income from the recipients of services provided by the Trust. Investing activities represent the extent to which cash inflows and outflows have been made for resources which are intended to contribute to the Trust's future public service delivery.

	NOTE	2017 £000s	2016 £000s
Cash Flows from Operating Activities			
Net surplus after interest/Net operating cost		(71,583)	(70,002)
Adjustments for non cash costs		5,693	6,562
(Increase) / decrease in trade and other receivables		134	26
Less movements in receivables relating to items not passing through the Net Expenditure Account			
Movements in receivables relating to the sale of property, plant and equipment		0	0
Movements in receivables relating to the sale of intangibles		0	0
Movements in receivables relating to finance leases		0	0
Movements in receivables relating to PFI and other service concession arrangement contracts		0	0
(Increase) / decrease in inventories		(19)	32
Increase / (decrease) in trade payables		2,404	351
Less movements in payables relating to items not passing through the Net Expenditure Account			
Movements in payables relating to the purchase of property, plant and equipment		(2,100)	142
Movements in payables relating to the purchase of intangibles		0	624
Movements in payables relating to finance leases		0	0
Movements in payables relating to PFI and other service concession arrangement contracts		0	0
Use of provisions	15.1-5	(293)	(253)
Net Cash Outflow from Operating Activities		**(65,764)**	**(62,518)**
Cash Flows from Investing Activities			
(Purchase of property, plant & equipment)	5.1	(6,787)	(7,760)
(Purchase of intangible assets)	6.1	0	(624)
Proceeds of disposal of property, plant & equipment		182	264
Proceeds on disposal of intangibles		0	0
Proceeds on disposal of assets held for resale		14	0
Drawdown from investment fund		0	0
Share of income reinvested		0	0
Net Cash Outflow from Investing Activities		**(6,591)**	**(8,120)**
Cash Flows from Financing Activities			
Grant in aid		72,361	70,655
Capital element of payments - finance leases and on balance sheet (SoFP) PFI and other service concession arrangements		0	0
Net Financing		**72,361**	**70,655**
Net Increase / (Decrease) in Cash & Cash Equivalents in the Period		**6**	**17**
Cash & Cash Equivalents at the Beginning of the Period	11.1	**112**	**95**
Cash & Cash Equivalents at the End of the Period	11.1	**118**	**112**

Consolidated Statement of Changes in Taxpayers' Equity for the year ended 31 March 2017

This statement shows the movement in the year on the different reserves held by the Trust. The SoCNE Reserve reflects a contribution from the Department of Health. The Revaluation Reserve reflects the change in asset values that have not been recognised as income or expenditure. The SoCNE Reserve represents the total assets less liabilities of the Trust, to the extent that the total is not represented by other reserves and financing items.

	NOTE	SoCNE Reserve £000s	Revaluation Reserve £000s	Charitable Fund £000s	Total £000s
Balance at 31 March 2015		**6,382**	**5,651**	**6**	**12,039**
Changes in Taxpayers Equity 2015-16					
Grant from DoH		70,655	0	0	70,655
Transfers between reserves		72	(72)	0	0
(Comprehensive expenditure for the year)		(70,005)	798	3	(69,204)
Transfer of asset ownership		381	0	0	381
Non cash charges - auditors remuneration	3.1	24	0	0	24
Movement - other		0	0	0	0
Balance at 31 March 2016		**7,509**	**6,377**	**9**	**13,895**
Changes in Taxpayers Equity 2016-17					
Grant from DoH		72,361	0	0	72,361
Transfers between reserves		104	(104)	0	0
(Comprehensive expenditure for the year)		(71,583)	546	2	(71,035)
Transfer of asset ownership		180	0	0	180
Non cash charges - auditors remuneration	3.1	24	0	0	24
Balance at 31 March 2017		**8,595**	**6,819**	**11**	**15,425**

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2017

NOTE 1 STATEMENT OF ACCOUNTING POLICIES

1 Authority

These accounts have been prepared in a form determined by the Department of Health based on guidance from the Department of Finance's Financial Reporting manual (FReM) and in accordance with the requirements of Article 90(2)(a) of the Health and Personal Social Services (Northern Ireland) Order 1972 No 1265 (NI 14) as amended by Article 6 of the Audit and Accountability (Northern Ireland) Order 2003.

The accounting policies follow IFRS to the extent that it is meaningful and appropriate to HSC Trusts. Where a choice of accounting policy is permitted, the accounting policy which has been judged to be most appropriate to the particular circumstances of the HSC Trust for the purpose of giving a true and fair view has been selected. The HSC Trust's accounting policies have been applied consistently in dealing with items considered material in relation to the accounts, unless otherwise stated.

1.1 Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment.

1.2 Currency and Rounding

These accounts are presented in UK pounds sterling. The figures in the accounts are shown to the nearest £1,000.

1.3 Property, Plant and Equipment

Property, plant and equipment assets comprise: Land, Buildings (excluding Dwellings), Transport Equipment, Plant & Machinery, Information Technology, Furniture and Fittings, and Assets under Construction.

Recognition

Property, plant and equipment must be capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the Trust;
- it is expected to be used for more than one financial year;

- the cost of the item can be measured reliably; and
- the item has a cost of at least £5,000; or
- collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £1,000, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- items form part of the initial equipping and setting-up cost of a new building or station, irrespective of their individual or collective cost.

On initial recognition property, plant and equipment are measured at cost including any expenditure such as installation, directly attributable to bringing them into working condition. Items classified as “under construction” are recognised in the Statement of Financial Position to the extent that money has been paid or a liability has been incurred.

Valuation of Land and Buildings

Land and buildings are carried at the last professional valuation, in accordance with the Royal Institute of Chartered Surveyors (Statement of Asset Valuation Practice) Appraisal and Valuation Standards in so far as these are consistent with the specific needs of the HSC.

The last valuation was carried out on 31 January 2015 by Land and Property Services (LPS) which is an independent executive body within the Department of Finance (DoF). The valuers are qualified to meet the ‘Member of Royal Institution of Chartered Surveyors’ (MRICS) standard.

Professional revaluations of land and buildings are undertaken at least once in every five year period and are revalued annually, between professional valuations, using indices provided by LPS.

Land and buildings used for the Trust’s services or for administrative purposes are stated in the Statement of Financial Position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses.

Fair values are determined as follows:

- land and non-specialised buildings – open market value for existing use;
- specialised buildings – depreciated replacement cost; and

+ properties surplus to requirements – the lower of open market value less any material directly attributable selling costs, or book value at date of moving to non-current assets.

Modern Equivalent Asset

DoF has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. LPS have included this requirement within the latest valuation.

Assets Under Construction (AUC)

Assets in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Short Life Assets

Short life assets are not indexed. Short life is defined as a useful life of up to and including 5 years. Short life assets are carried at depreciated historic cost as this is not considered to be materially different from fair value and are depreciated over their useful life.

Where estimated life of fixtures and equipment exceed 5 years, suitable indices will be applied each year and depreciation will be based on indexed amount.

Revaluation Reserve

An increase arising on revaluation is taken to the Revaluation Reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease is recognised as an impairment charged to the Revaluation Reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure.

1.4 Depreciation

No depreciation is provided on freehold land, since land has unlimited or a very long established useful life. Items under construction are not depreciated until they are commissioned. Properties that are surplus to requirements and which meet the definition of “non-current assets held for sale” are also not depreciated.

Otherwise, depreciation is charged to write off the costs or valuation of property, plant and equipment and similarly, amortisation is applied to intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. Assets held under finance leases are also depreciated over the lower of their estimated useful lives and the terms of the lease. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis.

The following asset lives have been used:

Asset Type	Asset Life
Freehold Buildings	15 - 70 years
Leasehold Property	Remaining period of lease
IT Assets	3 - 10 years
Intangible Assets	3 - 10 years
Other Equipment	3 - 15 years

1.5 Impairment Loss

If there has been an impairment loss due to a general change in prices, the asset is written down to its recoverable amount, with the loss charged to the Revaluation Reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure within the Statement of Comprehensive Net Expenditure. If the impairment is due to the consumption of economic benefits the full amount of the impairment is charged to the Statement of Comprehensive Net Expenditure and an amount up to the value of the impairment in the Revaluation Reserve is transferred to the Statement of Comprehensive Net Expenditure Reserve. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited firstly to the Statement of Comprehensive Net Expenditure to the extent of the decrease previously charged there and thereafter to the Revaluation Reserve.

1.6 Subsequent Expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure, which meets the definition of

capital restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

The overall useful life of the Trust's buildings takes account of the fact that different components of those buildings have different useful lives. This ensures that depreciation is charged on those assets at the same rate as if separate components had been identified and depreciated at different rates.

1.7 Intangible Assets

Intangible assets includes any of the following held - software, licences, trademarks, websites, development expenditure, patents, goodwill and intangible assets under construction. Software that is integral to the operating of hardware, for example an operating system is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset.

Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use;
- the intention to complete the intangible asset and use it;
- the ability to sell or use the intangible asset;
- how the intangible asset will generate probable future economic benefits or service potential;
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and
- the ability to measure reliably the expenditure attributable to the intangible asset during its development.

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Trust's business or which arise from contractual or other legal rights. Intangible assets are considered to have a finite life. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to the Trust; where the cost of the asset can be measured reliably. All single items over £5,000 in value must be capitalised while intangible assets which fall within the grouped asset definition

must be capitalised if their individual value is at least £1,000 each and the group is at least £5,000 in value.

The amount recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date of commencement of the intangible asset, until it is complete and ready for use.

Intangible assets acquired separately are initially recognised at fair value. Following initial recognition, intangible assets are carried at fair value by reference to an active market, and as no active market currently exists depreciated replacement cost has been used as fair value.

1.8 Non-current Assets Held for Sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. In order to meet this definition IFRS 5 requires that the asset must be immediately available for sale in its current condition and that the sale is highly probable. A sale is regarded as highly probable where an active plan is in place to find a buyer for the asset and the sale is considered likely to be concluded within one year. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value, less any material directly attributable selling costs. Fair value is open market value, where one is available, including alternative uses.

Assets classified as held for sale are not depreciated.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount. The profit from sale of land which is a non depreciating asset is recognised within income. The profit from sale of a depreciating asset is shown as a reduced expense. The loss from sale of land or from any depreciating assets is shown within operating expenses. On disposal, the balance for the asset on the Revaluation Reserve is transferred to the Statement of Comprehensive Net Expenditure Reserve.

Property, plant or equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.9 Inventories

Inventories are valued at the lower of cost and net realisable value. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

NOTE 1 STATEMENT OF ACCOUNTING POLICIES

1.10 Income

Operating Income relates directly to the operating activities of the Trust and is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable.

Grant in Aid

Funding received from other entities, including the Department and the Health and Social Care Board are accounted for as grant in aid and are reflected through the Statement of Comprehensive Net Expenditure Reserve.

1.11 Investments

The Northern Ireland Ambulance Service HSC Trust does not have any investments.

The Charitable Trust Funds are invested on behalf of the Northern Ireland Ambulance Service HSC Trust by the NIHPSS Common Investment Fund (see Note 1.25).

1.12 Other Expenses

Other operating expenses for goods or services are recognised when, and to the extent that, they have been received. They are measured at the fair value of the consideration payable.

1.13 Cash and Cash Equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

1.14 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The Trust as Lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease

payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the Trust's surplus / deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated. Leased land may be either an operating lease or a finance lease depending on the conditions in the lease agreement and following the general guidance set out in IAS 17. Leased buildings are assessed as to whether they are operating or finance leases.

The Trust as Lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.15 Private Finance Initiative (PFI) Transactions

The Northern Ireland Ambulance Service HSC Trust has had no PFI transactions during the year.

1.16 Financial Instruments

+ Financial Assets

Financial assets are recognised on the Statement of Financial Position when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the

contractual rights have expired or the asset has been transferred.

Financial assets are initially recognised at fair value.

+ Financial Liabilities

Financial liabilities are recognised on the Statement of Financial Position when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Financial liabilities are initially recognised at fair value.

+ Financial Risk Management

IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the relationships with HSC Commissioners, and the manner in which they are funded, financial instruments play a more limited role within Trusts in creating risk than would apply to a non public sector body of a similar size, therefore Trusts are not exposed to the degree of financial risk faced by business entities.

Trusts have limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day to day operational activities rather than being held to change the risks facing the Trusts in undertaking activities. Therefore the HSC is exposed to little credit, liquidity or market risk.

+ Currency Risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and Sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

+ Interest Rate Risk

The Trust has limited powers to borrow or invest and therefore has low exposure to interest rate fluctuations.

+ Credit Risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk.

+ Liquidity Risk

Since the Trust receives the majority of its funding through its principal Commissioner which is voted through the Assembly, it is therefore not exposed to significant liquidity risks.

1.17 Provisions

In Accordance with IAS 37, provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties.

Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using the following discount rates issued by DoF with effect from 31 March 2017:

Rate	Time Period	Real Rate
Short-term	0 – 5 years	-2.70%
Medium-term	5 – 10 years	-1.95%
Long-term	10+ years	-0.80%

The discount rate to be applied for employee early departure obligations is +0.24% with effect from 31 March 2017.

The Trust has also disclosed the carrying amount at the beginning and end of the period, additional provisions made, amounts used during the period, unused amounts reversed during the period and increases in the discounted amount arising from the passage of time and the affect of any change in the discount rate.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the Trust has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

A restructuring provision is recognised when the Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.18 Contingencies

Where the time value of money is material, contingent liabilities which are required to be disclosed under IAS 37 are stated at discounted amounts and the amount reported to the Assembly separately noted. Contingent liabilities that are not required to be disclosed by IAS 37 are stated at the amounts reported to the Assembly.

Under IAS 37, the Trust discloses contingent liabilities where there is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

In addition to contingent liabilities disclosed in accordance with IAS 37, HSC Trusts should disclose for Assembly reporting and accountability purposes certain statutory and non-statutory contingent liabilities where the likelihood of a transfer of economic benefit is remote, but which have been reported to the Assembly in accordance with the requirements of Managing Public Money Northern Ireland.

1.19 Employee Benefits

Short-term Employee Benefits

Under the requirements of IAS 19 Employee Benefits, staff costs must be recorded as an

expense as soon as the organisation is obligated to pay them. This includes the cost of any untaken leave (including untaken flexi leave) that has been earned at the year end. This cost has been estimated using average staff numbers and costs applied to the average untaken leave balance determined from the results of a representative sample to ascertain leave balances as at 31 March 2017. It is not anticipated that the level of untaken leave will vary significantly from year to year.

Retirement Benefit Costs

The Trust participates in the HSC Pension Schemes. Under these multi-employer defined benefit schemes both the Trust and employees pay specified percentages of pay into the schemes and the liability to pay benefit falls to the DoH. The Trust is unable to identify its share of the underlying assets and liabilities in the schemes on a consistent and reliable basis. Further information regarding the HSC Pension Schemes can be found in the HSC Pension Schemes Statement in the Departmental Resource Account for the Department of Health.

The costs of early retirements are met by the Trust and charged to the Statement of Comprehensive Net Expenditure at the time the Trust commits itself to the retirement.

As per the requirements of IAS 19, full actuarial valuations by a professionally qualified actuary are required at intervals not exceeding four years. The actuary reviews the most recent actuarial valuation at the Statement of Financial Position date and updates it to reflect current conditions. The 2012 valuation for the HSC Pension scheme will be used in 2016-17 accounts.

1.20 Reserves

Statement of Comprehensive Net Expenditure Reserve

Accumulated surpluses are accounted for in the Statement of Comprehensive Net Expenditure Reserve.

Revaluation Reserve

The Revaluation Reserve reflects the unrealised balance of cumulative indexation and revaluation adjustments to assets.

Charitable Fund Reserve

The Charitable Fund Reserve reflects the total value of charitable donations received by the Trust which have yet to be utilised.

1.21 Value Added Tax

Where output VAT is charged or input VAT is recoverable, the amounts are stated net of VAT. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets.

1.22 Third Party Assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. Details of third party assets are given in Note 23 to the accounts.

1.23 Government Grants

The note to the financial statements distinguishes between grants from the UK government entities and grants from the European Union.

1.24 Losses and Special Payments

Losses and special payments are items that the Northern Ireland Assembly would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had HSC Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However, the note on losses and special payments in the Assembly Accountability section of the Annual Report is compiled directly from the losses and compensations register which reports amounts on an accruals basis with the exception of provisions for future losses.

1.25 Charitable Trust Account Consolidation

The Government's Financial Reporting Manual (FReM) consolidation accounting policy requires the Trust's financial statements to consolidate the accounts of controlled charitable organisations and funds held on trust. As a result the financial performance and funds have

been consolidated. The Trust has accounted for these transfers using merger accounting as required by the FReM.

It is important to note however the distinction between public funding and the other monies donated by private individuals still exists.

The Board of the Northern Ireland Ambulance Service HSC Trust as corporate trustee has delegated responsibility to manage the internal disbursements of Charitable Trust Funds to the Director of Finance & ICT. The director ensures that charitable donations received by the Trust are appropriately managed, invested, expended and controlled, in a manner that is consistent with the purposes for which they were given and with the Trust's Standing Financial Instructions, Departmental guidance and legislation.

All such funds are allocated to the area specified by the benefactor and are not used for any other purpose than that intended by the benefactor.

1.26 Accounting Standards that have been Issued but have not yet been Adopted

Under IAS 8 there is a requirement to disclose those standards which have been issued but not yet adopted.

The IASB issued new and amended standards (IFRS 10, IFRS 11 & IFRS 12) that affect the consolidation and reporting of subsidiaries, associates and joint ventures. These standards were effective with EU adoption from 1 January 2014.

Accounting boundary IFRS' are currently adapted in the FReM so that the Westminster departmental accounting boundary is based on ONS control criteria, as designated by Treasury. A similar review in NI, which will bring NI departments under the same adaptation, has been carried out and the resulting recommendations were agreed by the Executive in December 2016. With effect from 2020-21, the accounting boundary for departments will change and there will also be an impact on departments around the disclosure requirements under IFRS 12. ALBs apply IFRS in full and their consolidation boundary may change as a result of the new Standards.

Management consider that any other new accounting policies issued but not yet adopted are unlikely to have a significant impact on the accounts in the period of the initial application.

1.27 Impact of Implementation of ESA 2010 on Research and Development Expenditure

Following the introduction of the 2010 European System of Accounts (ESA10), there has been a change in the budgeting treatment (a change from the revenue budget to the capital budget) of research and development (R&D) expenditure.

The Northern Ireland Ambulance Service HSC Trust's expenditure on research and development during the year was £nil.

NOTE 2 SEGMENTAL ANALYSIS

2.1 Analysis of Next Expenditure by Segment

For operational purposes, the services provided by the Northern Ireland Ambulance Service are broadly divided into emergency and non-emergency services. The Executive Directors along with Non Executive Directors, Chairman and Chief Executive form the Trust Board which co-ordinates the activities of the Trust and is considered to be the Chief Operating Decision Maker. As the Trust Board of the Northern Ireland Ambulance Service in its capacity as the 'Chief Operating Decision Maker' receives financial information for the Trust as a whole and makes decisions based on the provision of an ambulance service for the whole of Northern Ireland, it is appropriate that the Trust reports on a one operational segment basis.

NOTE 3 STAFF COSTS AND OPERATING EXPENSES

3.1 Staff Costs and Operating Expenses

	2017		2016	
	Trust £000s	Consolidated £000s	Trust £000s	Consolidated £000s
Staff costs[1]:				
— Wages and salaries	41,558	41,558	42,464	42,464
— Social security costs	4,788	4,788	3,413	3,413
— Other pension costs	6,021	6,021	5,345	5,345
Purchase of care from non-HSC bodies	0	0	0	0
Revenue grants to voluntary organisations	1,090	1,090	0	0
Capital grants to voluntary organisations	0	0	0	0
Personal social services	0	0	0	0
Recharges from other HSC organisations	725	725	384	384
Supplies and services - Clinical	1,908	1,908	1,826	1,826
Supplies and services - General	288	288	511	511
Establishment	1,382	1,382	1,467	1,467
Transport	4,670	4,670	4,843	4,843
Premises	1,765	1,765	1,709	1,709
Bad debts	0	0	0	0
Rentals under operating leases	167	167	161	161
Rentals under finance leases	0	0	0	0
Finance cost of finance leases	0	0	0	0
Interest charges	0	0	0	0
PFI and other service concession arrangements service charges	0	0	0	0
Research & development expenditure	0	0	0	0
Clinical negligence - other expenditure	0	0	0	0
BSO services	301	301	277	277
Training	470	470	405	405
Professional fees	17	17	16	16
Patients travelling expenses	0	0	0	0
Costs of exit packages not provided for	0	0	0	0
Elective care	0	0	0	0
Other charitable expenditure	0	1	0	1
Miscellaneous expenditure	1,244	1,244	1,117	1,117
Non Cash Items				
Depreciation	5,178	5,178	4,974	4,974
Amortisation	141	141	145	145
Impairments	0	0	1,097	1,097
(Profit) on disposal of property, plant & equipment (excluding profit on land)	(170)	(170)	(220)	(220)
(Profit) on disposal of intangibles	0	0	0	0
Loss on disposal of property, plant & equipment (including land)	0	0	0	0
Loss on disposal of intangibles	0	0	0	0
Provisions provided for in year	543	543	522	522
Cost of borrowing of provisions (unwinding of discount on provisions)	(23)	(23)	20	20
Auditors remuneration	24	24	24	24
Add back of notional charitable expenditure	0	0	0	0
Total	**72,087**	**72,088**	**70,500**	**70,501**

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2017

NOTE 3 STAFF COSTS AND OPERATING EXPENSES

[1] Further detailed analysis of staff costs is located in the Staff Report on page 97 within the Accountability Report.

In addition to the notional auditors remuneration above, during the year the Trust received services from its External Auditor (the Northern Ireland Audit Office) to the value of £1,201 (2016: £nil). This was in respect of fees for the National Fraud Initiative 2016-17 exercise.

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2017

NOTE 4 INCOME

4.1 Income from Activities

	2017		2016	
	Trust £000s	Consolidated £000s	Trust £000s	Consolidated £000s
GB/Republic of Ireland Health Authorities	0	0	0	0
HSC Trusts	1	1	0	0
Non-HSC:- Private patients	0	0	0	0
Non-HSC:- Other	353	353	385	385
Clients contributions	0	0	0	0
Total	**354**	**354**	**385**	**385**

4.2 Other Operating Income

	2017		2016	
	Trust £000s	Consolidated £000s	Trust £000s	Consolidated £000s
Other income from non-patient services	139	139	110	110
Seconded staff	11	11	0	0
Charitable and other contributions to expenditure by core trust	0	0	0	0
Donations / Government grant / Lottery funding for non current assets	0	0	0	0
Charitable income received by charitable trust fund	0	1	0	4
Investment income	0	0	0	0
Research and development	0	0	0	0
Profit on disposal of land	0	0	0	0
Interest receivable	0	0	0	0
Total	**150**	**151**	**110**	**114**

4.3 Deferred Income

	2017		2016	
	Trust £000s	Consolidated £000s	Trust £000s	Consolidated £000s
Research and development income released	0	0	0	0
Income released from conditional grants	0	0	0	0
Total	**0**	**0**	**0**	**0**
TOTAL INCOME	**504**	**505**	**495**	**499**

NOTE 5 CONSOLIDATED PROPERTY, PLANT & EQUIPMENT

5.1 Consolidated Property, Plant & Equipment - Year Ended 31 March 2017

	Land £000s	Buildings (Excluding dwellings) £000s	Assets under Construction £000s	Plant and Machinery (Equipment) £000s	Transport Equipment £000s	Information Technology (IT) £000s	Furniture and Fittings £000s	Total £000s
Cost or Valuation								
At 1 April 2016	1,610	8,757	5,476	5,629	20,472	2,690	143	44,777
Indexation	0	308	0	122	494	13	0	937
Additions	0	115	5,381	0	2,633	742	17	8,888
Donations / Government grant / Lottery funding	0	0	0	0	0	0	0	0
Reclassifications	0	3,618	(5,161)	0	1,469	0	74	0
Transfers	180	0	0	0	3,391	0	0	3,571
Revaluation	0	0	0	0	0	0	0	0
Impairment charged to the SoCNE	0	0	0	0	0	0	0	0
Impairment charged to the revaluation reserve	0	0	0	0	0	0	0	0
Reversal of impairments (indexation)	0	0	0	0	0	0	0	0
Disposals	(5)	0	0	(7)	(3,060)	(206)	0	(3,278)
At 31 March 2017	**1,785**	**12,798**	**5,696**	**5,744**	**25,399**	**3,239**	**234**	**54,895**
Depreciation								
At 1 April 2016	0	503	0	5,079	7,887	1,296	43	14,808
Indexation	0	18	0	114	248	11	0	391
Reclassifications	0	0	0	0	0	0	0	0
Transfers	0	0	0	0	3,518	0	0	3,518
Revaluation	0	0	0	0	0	0	0	0
Impairment charged to the SoCNE	0	0	0	0	0	0	0	0
Impairment charged to the revaluation reserve	0	0	0	0	0	0	0	0
Reversal of impairments (indexation)	0	0	0	0	0	0	0	0
Disposals	0	0	0	(7)	(3,051)	(206)	0	(3,264)
Provided during the year	0	323	0	184	4,238	419	14	5,178
At 31 March 2017	**0**	**844**	**0**	**5,370**	**12,840**	**1,520**	**57**	**20,631**
Carrying Amount								
At 31 March 2017	**1,785**	**11,954**	**5,696**	**374**	**12,559**	**1,719**	**177**	**34,264**
At 31 March 2016	**1,610**	**8,254**	**5,476**	**550**	**12,585**	**1,394**	**100**	**29,969**
Asset Financing								
Owned	1,785	11,954	5,696	374	12,559	1,719	177	34,264
Finance leased	0	0	0	0	0	0	0	0
On B/S (SoFP) PFI and other service concession arrangements contracts	0	0	0	0	0	0	0	0
Carrying Amount At 31 March 2017	**1,785**	**11,954**	**5,696**	**374**	**12,559**	**1,719**	**177**	**34,264**

Any fall in value through negative indexation or revaluation is shown as an impairment.

The total amount of depreciation charged in the Statement of Comprehensive Net Expenditure Account in respect of assets held under finance leases and hire purchase contracts is £nil (2016: £nil).

During the year the Trust had no assets funded from donations, government grants or lottery funding.

The carrying amount as at 31 March 2017 includes £nil (2016: £nil and 2015: £nil) relating to the Charitable Trust Funds.

NOTE 5 CONSOLIDATED PROPERTY, PLANT & EQUIPMENT

5.2 Consolidated Property, Plant & Equipment - Year Ended 31 March 2016

	Land £000s	Buildings (Excluding dwellings) £000s	Assets under Construction £000s	Plant and Machinery (Equipment) £000s	Transport Equipment £000s	Information Technology (IT) £000s	Furniture and Fittings £000s	Total £000s
Cost or Valuation								
At 1 April 2015	1,535	7,690	4,369	5,535	19,611	2,264	142	41,146
Indexation	0	686	0	67	138	0	1	892
Additions	0	0	5,068	27	2,018	505	0	7,618
Donations / Government grant / Lottery funding	0	0	0	0	0	0	0	0
Reclassifications	0	0	(2,864)	0	2,718	0	0	(146)
Transfers	0	381	0	0	0	0	0	381
Revaluation	75	0	0	0	0	0	0	75
Impairment charged to the SoCNE	0	0	(1,097)	0	0	0	0	(1,097)
Impairment charged to the revaluation reserve	0	0	0	0	0	(1)	0	(1)
Reversal of impairments (indexation)	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	(4,013)	(78)	0	(4,091)
At 31 March 2016	**1,610**	**8,757**	**5,476**	**5,629**	**20,472**	**2,690**	**143**	**44,777**
Depreciation								
At 1 April 2015	0	254	0	4,611	7,965	981	36	13,847
Indexation	0	36	0	60	73	0	0	169
Reclassifications	0	0	0	0	(134)	0	0	(134)
Transfers	0	0	0	0	0	0	0	0
Revaluation	0	0	0	0	0	0	0	0
Impairment charged to the SoCNE	0	0	0	0	0	0	0	0
Impairment charged to the revaluation reserve	0	0	0	0	0	(1)	0	(1)
Reversal of impairments (indexation)	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	(3,969)	(78)	0	(4,047)
Provided during the year	0	213	0	408	3,952	394	7	4,974
At 31 March 2016	**0**	**503**	**0**	**5,079**	**7,887**	**1,296**	**43**	**14,808**
Carrying Amount								
At 31 March 2016	**1,610**	**8,254**	**5,476**	**550**	**12,585**	**1,394**	**100**	**29,969**
At 1 April 2015	**1,535**	**7,436**	**4,369**	**924**	**11,646**	**1,283**	**106**	**27,299**
Asset Financing								
Owned	1,610	8,254	5,476	550	12,585	1,394	100	29,969
Finance leased	0	0	0	0	0	0	0	0
On B/S (SoFP) PFI and other service concession arrangements contracts	0	0	0	0	0	0	0	0
Carrying Amount At 31 March 2016	**1,610**	**8,254**	**5,476**	**550**	**12,585**	**1,394**	**100**	**29,969**
Asset Financing								
Owned	1,535	7,436	4,369	924	11,646	1,283	106	27,299
Finance leased	0	0	0	0	0	0	0	0
On B/S (SoFP) PFI and other service concession arrangements contracts	0	0	0	0	0	0	0	0
Carrying Amount At 1 April 2015	**1,535**	**7,436**	**4,369**	**924**	**11,646**	**1,283**	**106**	**27,299**

NOTE 6 CONSOLIDATED INTANGIBLE ASSETS

6.1 Consolidated Intangible Assets - Year Ended 31 March 2017

	Software Licenses £000s	Information Technology £000s	Websites £000s	Development Expenditure £000s	Payments on Account & Assets under Construction £000s	Total £000s
Cost or Valuation						
At 1 April 2016	709	0	30	0	0	739
Indexation	0	0	0	0	0	0
Additions	0	0	0	0	0	0
Donations / Government grant / Lottery funding	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0
Transfers	0	0	0	0	0	0
Revaluation	0	0	0	0	0	0
Impairment charged to the SoCNE	0	0	0	0	0	0
Impairment charged to the revaluation reserve	0	0	0	0	0	0
Disposals	(41)	0	0	0	0	(41)
At 31 March 2017	**668**	**0**	**30**	**0**	**0**	**698**
Amortisation						
At 1 April 2016	227	0	30	0	0	257
Indexation	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0
Transfers	0	0	0	0	0	0
Revaluation	0	0	0	0	0	0
Impairment charged to the SoCNE	0	0	0	0	0	0
Impairment charged to the revaluation reserve	0	0	0	0	0	0
Disposals	(41)	0	0	0	0	(41)
Provided during the year	141	0	0	0	0	141
At 31 March 2017	**327**	**0**	**30**	**0**	**0**	**357**
Carrying Amount						
At 31 March 2017	**341**	**0**	**0**	**0**	**0**	**341**
At 31 March 2016	**482**	**0**	**0**	**0**	**0**	**482**
Asset Financing						
Owned	341	0	0	0	0	341
Finance leased	0	0	0	0	0	0
On B/S (SoFP) PFI and other service concession arrangements contracts	0	0	0	0	0	0
Carrying Amount At 31 March 2017	**341**	**0**	**0**	**0**	**0**	**341**

Any fall in value through negative indexation or revaluation is shown as an impairment.

During the year the Trust had no assets funded from donations, government grants or lottery funding.

The carrying amount as at 31 March 2017 includes £nil (2016: £nil and 2015: £nil) relating to the Charitable Trust Funds.

NOTE 6 CONSOLIDATED INTANGIBLE ASSETS

6.2 Consolidated Intangible Assets - Year Ended 31 March 2016

	Software Licenses £000s	Information Technology £000s	Websites £000s	Development Expenditure £000s	Payments on Account & Assets under Construction £000s	Total £000s
Cost or Valuation						
At 1 April 2015	709	0	30	0	0	739
Indexation	0	0	0	0	0	0
Additions	0	0	0	0	0	0
Donations / Government grant / Lottery funding	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0
Transfers	0	0	0	0	0	0
Revaluation	0	0	0	0	0	0
Impairment charged to the SoCNE	0	0	0	0	0	0
Impairment charged to the revaluation reserve	0	0	0	0	0	0
Disposals	0	0	0	0	0	0
At 31 March 2016	**709**	**0**	**30**	**0**	**0**	**739**
Amortisation						
At 1 April 2015	85	0	27	0	0	112
Indexation	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0
Transfers	0	0	0	0	0	0
Revaluation	0	0	0	0	0	0
Impairment charged to the SoCNE	0	0	0	0	0	0
Impairment charged to the revaluation reserve	0	0	0	0	0	0
Disposals	0	0	0	0	0	0
Provided during the year	142	0	3	0	0	145
At 31 March 2016	**227**	**0**	**30**	**0**	**0**	**257**
Carrying Amount						
At 31 March 2016	**482**	**0**	**0**	**0**	**0**	**482**
At 1 April 2015	**624**	**0**	**3**	**0**	**0**	**627**
Asset Financing						
Owned	482	0	0	0	0	482
Finance leased	0	0	0	0	0	0
On B/S (SoFP) PFI and other service concession arrangements contracts	0	0	0	0	0	0
Carrying Amount At 31 March 2016	**482**	**0**	**0**	**0**	**0**	**482**
Asset Financing						
Owned	624	0	3	0	0	627
Finance leased	0	0	0	0	0	0
On B/S (SoFP) PFI and other service concession arrangements contracts	0	0	0	0	0	0
Carrying Amount At 1 April 2015	**624**	**0**	**3**	**0**	**0**	**627**

NOTE 7 FINANCIAL INSTRUMENTS

7.1 Financial Instruments

As the cash requirements of the Northern Ireland Ambulance Service HSC Trust are met through Grant-in-Aid provided by the Department of Health, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with the Trust's expected purchase and usage requirements and the Trust is therefore exposed to little credit, liquidity or market risk.

The Trust did not have any financial instruments as at 31 March 2017 (2016: £nil).

The Charitable Trust Funds has a share in the NIHPSS Common Investment Fund.

	Investments	
	2017 £000s	2016 £000s
Balance at 1 April	9	10
Additions	1	3
Disposals	(1)	(4)
Revaluations	2	0
Balance at 31 March	**11**	**9**
Trust	0	0
Charitable trust fund	11	9
	11	**9**

7.2 Market Value of Investments as at 31 March 2017

	Held in UK £000s	Held outside UK £000s	2017 Total £000s	2016 Total £000s
Investment properties	0	0	0	0
Investments listed on Stock Exchange	0	0	0	0
Investments in CIF	11	0	11	9
Investments in a Common Deposit Fund or Investment Fund	0	0	0	0
Unlisted securities	0	0	0	0
Cash held as part of the investment portfolio	0	0	0	0
Investments in connected bodies	0	0	0	0
Other investments	0	0	0	0
Total Market Value of Fixed Asset Investments	**11**	**0**	**11**	**9**

NOTE 8 IMPAIRMENTS

8.1 Impairments

	2017		
	Property, plant & equipment	Intangibles	Total
	£000s	£000s	£000s
Total value of impairments for the period	0	0	0
Impairments which revaluation reserve covers (shown in Other Comprehensive Expenditure Statement)	0	0	0
Impairments Charged / (Credited) to Statement of Comprehensive Net Expenditure	**0**	**0**	**0**

	2016		
	Property, plant & equipment	Intangibles	Total
	£000s	£000s	£000s
Total value of impairments for the period	1,097	0	1,097
Impairments which revaluation reserve covers (shown in Other Comprehensive Expenditure Statement)	0	0	0
Impairments Charged / (Credited) to Statement of Comprehensive Net Expenditure	**1,097**	**0**	**1,097**

NOTE 9 ASSETS CLASSIFIED AS HELD FOR SALE

9.1 Assets Classified as Held for Sale

	Transport	
	2017 £000s	2016 £000s
Cost		
At 1 April	488	2,619
Transfers in	481	326
Transfers out	0	(179)
(Disposals)	(460)	(2,278)
Impairment	0	0
At 31 March	**509**	**488**
Depreciation		
At 1 April	475	2,619
Transfers in	354	134
Transfers out	0	0
(Disposals)	(447)	(2,278)
Impairment	0	0
At 31 March	**382**	**475**
Carrying Amount at 31 March	**127**	**13**

Non current assets held for sale comprise non current assets that are held for resale rather than for continuing use within the business.

At 31 March 2017 non current assets held for resale comprise A&E Ambulances and other support vehicles.

Due to the specification of ambulance vehicles, their age and high mileage, the resale market is uncertain and most vehicles are sold through auction houses or a contract with the Ministry of Defence.

During the year ended 31 March 2017, vehicles with a fair value (less costs to sell) of £13k (2016: £nil) were sold.

The assets are valued at the lower of their carrying value (representing net book value) and fair value (less costs to sell).

NOTE 10 INVENTORIES

10.1 Inventories

	2017		2016	
	Trust £000s	Consolidated £000s	Trust £000s	Consolidated £000s
Pharmacy supplies	0	0	0	0
Theatre equipment	0	0	0	0
Building & engineering supplies	0	0	0	0
Fuel	19	19	18	18
Community care appliances	0	0	0	0
Laboratory materials	0	0	0	0
Stationery	7	7	8	8
Laundry	0	0	0	0
X-Ray	0	0	0	0
Stock held for resale	0	0	0	0
Orthopaedic equipment	0	0	0	0
Heat, light and power	0	0	0	0
Medical & surgical equipment	51	51	36	36
Other	13	13	9	9
Total	**90**	**90**	**71**	**71**

NOTE 11 CASH AND CASH EQUIVALENTS

11.1 Cash and Cash Equivalents

	2017		2016	
	Trust £000s	Consolidated £000s	Trust £000s	Consolidated £000s
Balance at 1st April	112	112	95	95
Net change in cash and cash equivalents	6	6	17	17
Balance at 31st March	**118**	**118**	**112**	**112**

The following balances at 31 March were held at:

	2017		2016	
	Trust £000s	Consolidated £000s	Trust £000s	Consolidated £000s
Commercial banks and cash in hand	118	118	112	112
Balance at 31st March	**118**	**118**	**112**	**112**

NOTE 12 TRADE RECEIVABLES, FINANCIAL AND OTHER ASSETS

12.1 Trade Receivables, Financial and Other Assets

	2017		2016	
	Trust	Consolidated	Trust	Consolidated
	£000s	£000s	£000s	£000s
Amounts Falling Due Within One Year				
Trade receivables	0	0	0	0
Deposits and advances	0	0	0	0
VAT receivable	508	508	530	530
Other receivables - not relating to fixed assets	58	58	49	49
Other receivables - relating to property plant and equipment	19	19	7	7
Other receivables - relating to intangibles	0	0	0	0
Trade and Other Receivables	**585**	**585**	**586**	**586**
Prepayments and accrued income	131	131	264	264
Current part of PFI and other service concession arrangements prepayment	0	0	0	0
Other Current Assets	**131**	**131**	**264**	**264**
Carbon reduction commitment	0	0	0	0
Intangible Current Assets	**0**	**0**	**0**	**0**
Amounts Falling Due After More Than One Year				
Trade receivables	0	0	0	0
Deposits and advances	0	0	0	0
Other receivables	0	0	0	0
Trade and Other Receivables	**0**	**0**	**0**	**0**
Prepayments and accrued income	0	0	0	0
Other Current Assets Falling Due After More Than One Year	**0**	**0**	**0**	**0**
TOTAL TRADE AND OTHER RECEIVABLES	**585**	**585**	**586**	**586**
TOTAL OTHER CURRENT ASSETS	**131**	**131**	**264**	**264**
TOTAL INTANGIBLE CURRENT ASSETS	**0**	**0**	**0**	**0**
TOTAL RECEIVABLES AND OTHER CURRENT ASSETS	**716**	**716**	**850**	**850**

The balances are net of a provision for bad debts of £nil (2016:£nil).

NOTE 13 TRADE PAYABLES AND OTHER CURRENT LIABILITIES

13.1 Trade Payables and Other Current Liabilities

	2017		2016	
	Trust	Consolidated	Trust	Consolidated
	£000s	£000s	£000s	£000s
Amounts Falling Due Within One Year				
Other taxation and social security	1,119	1,119	1,261	1,261
VAT payable	0	0	0	0
Bank overdraft	0	0	0	0
Trade capital payables - property, plant and equipment	6,075	6,075	3,975	3,975
Trade capital payables - intangibles	0	0	0	0
Trade revenue payables	1,690	1,690	1,242	1,242
Payroll payables	3,279	3,279	3,213	3,213
VER payables	0	0	0	0
BSO payables	28	28	36	36
Other payables	1,234	1,234	860	860
Accruals and deferred income	1,029	1,029	1,463	1,463
Accruals and deferred income - relating to property, plant and equipment	0	0	0	0
Accruals and deferred income - relating to intangibles	0	0	0	0
Trade and Other Payables	**14,454**	**14,454**	**12,050**	**12,050**
Current part of finance leases	0	0	0	0
Current part of long term loans	2,261	2,261	0	0
Current part of imputed finance lease element of on balance sheet (SoFP) PFI and other service concession arrangements contracts	0	0	0	0
Other Current Liabilities	**2,261**	**2,261**	**0**	**0**
Carbon reduction commitment	0	0	0	0
Intangible Current Liabilities	**0**	**0**	**0**	**0**
Total Payables Falling Due Within One Year	**16,715**	**16,715**	**12,050**	**12,050**
Amounts Falling Due After More Than One Year				
Other payables, accruals and deferred income	0	0	0	0
Trade and other payables	0	0	0	0
Clinical negligence payables	0	0	0	0
Finance leases	0	0	0	0
Imputed finance lease element of on balance sheet (SoFP) PFI and other service concession arrangements contracts	0	0	0	0
Long term loans	0	0	2,261	2,261
Total Non Current Other Payables	**0**	**0**	**2,261**	**2,261**
TOTAL TRADE PAYABLES AND OTHER CURRENT LIABILITIES	**16,715**	**16,715**	**14,311**	**14,311**

NOTE 13 TRADE PAYABLES AND OTHER CURRENT LIABILITIES

13.2 Loans

When the Trust was established in 1995 it was funded by originating capital known as Public Dividend Capital (PDC) and also by a loan known as Interest Bearing Debt (IBD). After a change in the way the Trusts were financed in 2007-08 the PDC Reserve and the Income and Expenditure Reserve were replaced by what is now known as the Statement of Comprehensive Net Expenditure Reserve. The IBD balance for NIAS was retained / frozen as at 31 March 2007 with no further payments of interest or principle. The Department of Health advised in March 2017 that this loan will be cleared in 2017-18.

	Government Loans	
	2017	2016
Amounts Falling Due:	**£000s**	**£000s**
In 1 year or less	2,261	0
Between 1 and 2 years	0	0
Between 2 and 5 years	0	2,261
In 5 years or more	0	0
Total	**2,261**	**2,261**

	2017	2016
	£000s	**£000s**
Wholly repayable within 5 years	2,261	2,261
Wholly repayable after 5 years, not by instalments	0	0
Wholly or partially repayable after 5 years by instalments	0	0
Total	**2,261**	**2,261**
Total repayable after 5 years by instalments	**0**	**0**
Loans wholly or partially repayable after 5 years:	**0**	**0**

Terms of payment	**Interest Rate**
Originating Capital Debt	8.75%

NOTE 14 PROMPT PAYMENT POLICY

14.1 Public Sector Payment Policy - Measure of Compliance

The Department requires that Trusts pay their non HSC trade payables in accordance with applicable terms and appropriate Government Accounting guidance. The Trust's payment policy is consistent with applicable terms and appropriate Government Accounting guidance and its measure of compliance is:

	2017 Number	2017 Value £000s	2016 Number	2016 Value £000s
Total bills paid	19,304	49,478	17,241	44,066
Total bills paid within 30 days of receipt of an undisputed invoice*	18,590	48,445	15,248	42,130
% of bills paid within 30 days of receipt of an undisputed invoice	**96.3%**	**97.9%**	**88.4%**	**95.6%**
Total bills paid within 10 day target	14,676	41,606	11,002	36,295
% of bills paid within 10 day target	**76.0%**	**84.1%**	**63.8%**	**82.4%**

* New late payment legislation (Late Payment of Commercial Debts Regulations 2013) came into force on 16 March 2013. The effect of the new legislation is that a payment is normally regarded as late unless it is made within 30 days after receipt of an undisputed invoice.

From 1 April 2015 the scope of the prompt payment compliance measurement increased to take account of all categories of supplier payments made by Trusts, with the only exception being payments made to other organisations within the broader HSCNI.

14.2 The Late Payment of Commercial Debts Regulations 2002

	£
Amount of compensation paid for payment(s) being late	0
Amount of interest paid for payment(s) being late	0
Total	**0**

This is also reflected as a fruitless payment in the Accountability and Audit Report Section of the Annual Report on page 103.

NOTE 15 PROVISIONS FOR LIABILITIES AND CHARGES

15.1 Provisions for Liabilities and Charges - 2017

	Pensions Relating to Former Directors £000s	Pensions Relating to Other Staff £000s	Clinical Negligence £000s	Other £000s	2017 £000s
Balance at 1 April 2016	0	0	88	3,212	3,300
Provided in year	0	0	9	680	689
(Provisions not required written back)	0	0	0	(146)	(146)
(Provisions utilised in the year)	0	0	(5)	(288)	(293)
Cost of borrowing (unwinding of discount)	0	0	(9)	(14)	(23)
At 31 March 2017	**0**	**0**	**83**	**3,444**	**3,527**

Provisions have been made for five types of potential liability: Clinical Negligence, Employer's and Occupier's Liability, Injury Benefit and Industrial Tribunal. The provision for Injury Benefit relates to the future liabilities for the Trust based on information provided by the HSC Superannuation Branch. For Clinical Negligence, Employer's and Occupier's claims, as well as Industrial Tribunal claims the Trust has estimated an appropriate level of provision based on professional legal advice.

The Trust has no provisions relating to either the Review of Public Administration or the Comprehensive Spending Review.

15.2 Comprehensive Net Expenditure Account Charges

	2017 £000s	2016 £'000
Arising during the year	689	596
Reversed unused	(146)	(74)
Cost of borrowing (unwinding of discount)	(23)	20
Total Charge within Operating Expenses	**520**	**542**

15.3 Analysis of Expected Timing of Discounted Flows - 2017

	Pensions Relating to Former Directors £000s	Pensions Relating to Other Staff £000s	Clinical Negligence £000s	Other £000s	2017 £000s
Not later than 1 year	0	0	14	830	844
Later than 1 year and not later than 5 years	0	0	19	500	519
Later than 5 years	0	0	50	2,114	2,164
At 31 March 2017	**0**	**0**	**83**	**3,444**	**3,527**

The provision in respect of other liabilities and charges comprises: £730k for Employer's and Occupier's Liability; and £2,714k for Injury Benefit.

NOTE 15 PROVISIONS FOR LIABILITIES AND CHARGES

15.4 Provisions for Liabilities and Charges - 2016

	Pensions Relating to Former Directors £000s	Pensions Relating to Other Staff £000s	Clinical Negligence £000s	Other £000s	2016 £000s
Balance at 1 April 2015	0	0	92	2,919	3,011
Provided in year	0	0	7	589	596
(Provisions not required written back)	0	0	0	(74)	(74)
(Provisions utilised in the year)	0	0	(4)	(249)	(253)
Cost of borrowing (unwinding of discount)	0	0	(7)	27	20
At 31 March 2016	**0**	**0**	**88**	**3,212**	**3,300**

Provisions have been made for six types of potential liability: Clinical Negligence, Employer's and Occupier's Liability, Injury Benefit, Procurement and Industrial Tribunal. The provision for Injury Benefit relates to the future liabilities for the Trust based on information provided by the HSC Superannuation Branch. For Clinical Negligence, Employer's and Occupier's claims, as well as Procurement and Industrial Tribunal claims the Trust has estimated an appropriate leave of provision based on professional legal advice.

15.5 Analysis of Expected Timing of Discounted Flows - 2016

	Pensions Relating to Former Directors £000s	Pensions Relating to Other Staff £000s	Clinical Negligence £000s	Other £000s	2016 £000s
Not later than 1 year	0	0	14	516	530
Later than 1 year and not later than 5 years	0	0	19	563	582
Later than 5 years	0	0	55	2,133	2,188
At 31 March 2016	**0**	**0**	**88**	**3,212**	**3,300**

The provision in respect of other liabilities and charges comprises: £495k for Employer's and Occupier's Liability; and £2,717k for Injury Benefit.

NOTE 16 CAPITAL COMMITMENTS

16.1 Contracted Capital Commitments at 31 March not otherwise included in these Financial Statements

	2017 £000s	2016 £000s
Property, plant & equipment	1,836	28
Intangible assets	0	0
	1,836	**28**

This contracted capital commitment relates to the construction of the new ambulance station in Enniskillen which is scheduled for completion in late 2017. This is being funded by the Department of Health through allocations to the Trust through the Capital Resource Limit.

NOTE 17 COMMITMENTS UNDER LEASES

17.1 Operating Leases

Total future minimum lease payments under operating leases are given in the table below for each of the following periods.

Obligations under operating leases comprise:	2017 £000s	2016 £000s
Land		
Not later than 1 year	0	0
Later than 1 year and not later than five years	0	0
Later than 5 years	0	0
	0	**0**
Buildings		
Not later than 1 year	103	167
Later than 1 year and not later than five years	217	318
Later than 5 years	19	29
	339	**514**
Other		
Not later than 1 year	0	0
Later than 1 year and not later than five years	0	0
Later than 5 years	0	0
	0	**0**

Obligations under operating leases for Ambulance Stations are recorded fully under Buildings, as the leases do not split the lease cost between land and buildings.

NOTE 17 COMMITMENTS UNDER LEASES

17.2 Finance Leases

The Northern Ireland Ambulance Service HSC Trust has not entered into any finance leases as at either 31 March 2017 or 31 March 2016.

17.3 Operating Leases - Lessor Agreements

The Northern Ireland Ambulance Service HSC Trust has not entered into any lessor agreements as at either 31 March 2017 or 31 March 2016.

NOTE 18 COMMITMENTS UNDER PFI AND OTHER SERVICE CONCESSION ARRANGEMENT CONTRACTS

18.1 PFI Contracts

The Northern Ireland Ambulance Service HSC Trust has not entered into any PFI contracts as at either 31 March 2017 or 31 March 2016.

NOTE 19: OTHER FINANCIAL COMMITMENTS

19.1 Other Financial Commitments

The Northern Ireland Ambulance Service HSC Trust has not entered into any noncancellable contracts (which are not leases or PFI and other service concession arrangements contracts) as at either 31 March 2017 or 31 March 2016.

NOTE 20 FINANCIAL GUARANTEES, INDEMNITIES AND LETTERS OF COMFORT

20.1 Financial Guarantees, Indemnities and Letters of Comfort

The Trust has not entered into any of the following: quantifiable guarantees, indemnities or provided letters of comfort. None of these are a contingent liability under the meaning of IAS37, since the likelihood of a transfer of economic benefit in settlement is too remote. They therefore fail to be measured following the requirements of IAS39. Managing public money requires that the full potential costs of such contracts be reported.

NOTE 21 CONTINGENT LIABILITIES

21.1 Contingent Liabilities

Material contingent liabilities are noted in the table below, where there is a 50% or less probability that a payment will be required to settle any possible obligations. The amounts or timing of any outflow will depend on the merits of each case.

	2017 £000s	2016 £000s
Clinical negligence	48	34
Public liability	3	0
Employers' liability	10	0
Accrued leave	0	0
Injury benefit	0	0
Other	0	0
Total	**61**	**34**

The Trust continues with the agreed process in respect of Agenda for Change in partnership with Trade Unions. However, at this stage, there remain uncertainties over the outcome of the process and the Trust cannot establish the extent to which claims that could be made, nor can it make a reliable estimate of any potential claims under employment legislation that may arise. The current position in respect of Agenda for Change is outlined in more detail in the Governance Statement.

A new discount rate which courts must consider when awarding compensation for future financial losses in the form of a lump sum in personal injury cases came into effect in England and Wales on 20 March 2017. The Department of Justice has power to prescribe the discount rate for Northern Ireland (in consultation with the Government Actuary and Department of Finance). The discount rate is under active consideration by the Department but will require Ministerial consideration once a Minister is in post and any change would require secondary legislation. As such, it has not been possible at this time to quantify the potential impact on the Trust of any change in the discount rate.

NOTE 22 RELATED PARTY TRANSACTIONS

22.1 Related Party Transactions

The Trust is required to disclose details of transactions with individuals who are regarded as related parties consistent with the requirements of IAS24 - Related Party Transactions. This disclosure is recorded in the Trust's Register of Interests which is maintained by the Office of the Director of Finance and is available for inspection by members of the public.

Mr Norman McKinley, Non Executive Director, also holds a position as the Executive Director of UK Operations for The British Red Cross. During 2016-17 the Trust had transactions with The British Red Cross to the value of £490,295 (2016: £220,837, 2015: £53,734) for the provision of non emergency patient transport to NIAS during periods of exceptional demand.

During the year, none of the other board members, members of the key management staff or other related parties has undertaken any material transactions with the Northern Ireland Ambulance Service HSC Trust.

The Northern Ireland Ambulance Service HSC Trust is an arms length body of the Department of Health and as such the Department is a related party and the ultimate controlling parent with which the Trust has had various material transactions during the year. During the year the Northern Ireland Ambulance Service HSC Trust has had a number of material transactions with other entities for which the Department is regarded as the ultimate controlling parent. These entities include the Health and Social Care Board, the other five HSC Trusts and the Business Services Organisation.

NOTE 23 THIRD PARTY ASSETS

23.1 Third Party Assets

The Trust held £nil cash at bank and in hand at 31 March 2017 which relates to monies held by the Trust on behalf of patients (2016: £nil). The Trust does not hold any monies on behalf of patients due to the nature of the service provided.

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2017

NOTE 24 FINANCIAL PERFORMANCE TARGETS

24.1 Revenue Resource Limit

The Trust is given a Revenue Resource Limit which it is not permitted to overspend.

The Revenue Resource Limit (RRL) for the Northern Ireland Ambulance Service HSC Trust is calculated as follows:

	2017 £000s	2016 £000s
HSCB	65,891	63,490
PHA	0	5
SUMDE & NIMDTA	0	0
DoH (excludes non cash)	0	0
Other Government Departments	0	0
Non cash RRL (from DoH)	5,693	6,562
Total agreed RRL	**71,584**	**70,057**
Adjustment for income received re Donations / Government grant / Lottery funding for non current assets	0	0
Adjustment for Research and Development under ESA10	0	0
Total Revenue Resource Limit to Statement Comprehensive Net Expenditure	**71,584**	**70,057**

24.2 Capital Resource Limit

The Trust is given a Capital Resource Limit (CRL) which it is not permitted to overspend.

	2017 £000s	2016 £000s
Gross capital expenditure	8,888	7,618
Less charitable trust fund capital expenditure	0	0
(Receipts from sales of fixed assets)	(61)	0
Net capital expenditure	**8,827**	**7,618**
Capital Resource Limit	8,831	7,658
Adjustment for Research and Development under ESA10	0	0
Overspend / (Underspend) against CRL	**(4)**	**(40)**

NOTES TO THE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2017

NOTE 24 FINANCIAL PERFORMANCE TARGETS

24.3 Cumulative Break Even Performance

The Trust is required to ensure that it breaks even on an annual basis by containing its net expenditure to within 0.25 % of RRL limits.

	2017 £000s	2016 £000s
Net Expenditure	(71,583)	(70,005)
RRL	71,584	70,057
Surplus / (Deficit) against RRL	1	52
Break Even cumulative position (opening)	790	738
Break Even Cumulative Position (Closing)	791	790

Materiality Test:

	2017	2016
Break Even in year position as % of RRL	0.00%	0.07%
Break Even cumulative position as % of RRL	1.10%	1.13%

The Department recognises a material surplus or deficit as 0.25% of RRL. The in year break even position is therefore not considered material for any of the last 5 years. The cumulative position at 31 March 2017 is £791k (1.10% of total revenue), which is considered material. This amount is the cumulative effect of non material surpluses building each year since the inception of the Trust.

NOTE 25 POST BALANCE SHEET EVENTS

25.1 Post Balance Sheet Events

There are no post balance sheet events having a material effect on the accounts.

Date Authorised for Issue

The Accounting Officer authorised these financial statements for issue on 30 June 2017.

Northern Ireland Ambulance Service
Ambulance Headquarters
Site 30, Knockbracken Healthcare Park
Saintfield Road, Belfast, BT8 8SG

Tel: 028 9040 0999
Fax: 028 9040 0900
Textphone: 028 9040 0871
Web: www.nias.hscni.net