Scottish Ambulance Service

Minutes of the Thirty Seventh Meeting of the Clinical Governance Committee held on 6th May 2009 at 10.30am at Norseman House, South Queensferry.

Present: Christine Humphries, Non Executive Director (Chairman)
Suzanne Dawson, Non Executive Director
David Garbutt, Non Executive Director
David Nelson, Patient Representative
Andrew Richmond, Non Executive Director

In Attendance: George Crooks, Medical Director
Paul Gowens, Head of Risk
Gerry Kelly, Head of Training
Sarah Kilday, Risk Manager
Theresa Houston, Non Executive Director
Pauline Howie, Chief Executive
Robin Lawrenson, Clinical Performance Manager
Stephanie Phillips, General Manager, PPU
Shirley Rogers, Director of HR and Clinical Development
Narmeen Rehman, Senior Information Officer
Stuart Sands, Auditor, Deloitte and Touche
William Mason, Continuous Improvement Manager

Isabel Blyth, Personal Assistant (Minutes)

Apologies: Bill Brackenridge, Chairman, Scottish Ambulance Service
Stuart Smith, Non Executive Director, NHS24

1. Welcome and Introduction
Christine Humphries welcomed everyone to the meeting and advised the main topics for discussion would be the QIS submission, the Clinical Governance Annual Report and the Clinical Effectiveness Strategy.

She welcomed Theresa Houston, Non Executive Director to the meeting as an observer.

2. Apologies for Absence
Apologies were noted from Bill Brackenridge, and Stuart Smith, Chairman of NHS24’s Clinical Governance Committee who had been invited to attend but will instead attend a future meeting.

3. Minutes of the Previous Meeting held on the 18th February 2009
The minutes were approved by the Committee.
4. Matters Arising
Christine Humphries said that it is important that the Committee remains clear what status the matters arising actions are. She felt it is not clear with regard to the QIS self assessment report or the Staffordshire Ambulance Service report and requested further assurance for the Committee on these items at this meeting.

5. SAFE AND EFFECTIVE CARE AND SERVICES (NHS QIS CG & RM STANDARD 1)

5.1 New Ways of Clinical Working Update
Bill Mason advised that the project had been very busy tidying up some areas of on going work and venturing into new areas. The project is focussing on standardising systems throughout the Service eg vehicle checks - this will help track any failings in equipment and eradicate them.

Work is also being undertaken regarding clinical feedback and handling of patient information. The project will communicate to staff the proposed development of obtaining feedback to hospitals eg on reperfusion patients. Also with the use of SEWS SBAR the project is looking to improve information passing between the Service and hospitals. Work has also been carried out with the Service’s trainers looking at future training and development and the continuity of developing staff within the organisation. Staff will be encouraged to speak about any areas they don’t feel confident in and given additional support in training eg skills atrophy.

David Nelson reported that he had attended team meetings and had been impressed by the calibre of staff and the amount of work being undertaken and advised that the level of activity is great. Christine Humphries thanked David Nelson for his endorsement of the work and said the Committee required assurance that the work was being embedded into the clinical governance framework. That assurance is still required by the Committee and also assurance that the work is not being taken forward in isolation. David Garbutt said he would like to congratulate the project team on the work but he agreed that the Committee did not have the assurance it required, especially as it appeared that the project board was leading the project team and was not connected through organisational structure to the Medical Directorate. Pauline Howie advised that there are key areas in progress which will give clarity and assurance in this. There is also a team structure being developed which will be taken to the Remuneration Committee. With all these aspects now putting the project into context she wanted to emphasise the good work the project board had taken forward.

Christine Humphries said that it was noted on the record of the last meeting about the status of the Medical Director within the Services Executive Team. Pauline Howie advised that this was being considered at the next Remuneration Committee meeting. Shirley Rogers advised that the Project Board had been described as a programme of work, which includes the realignment of staff as developments are taken forward. It must be remembered that the NWCW project was brought in at a difficult time for the Service, including the front loaded model. She wished to reassure the Committee that the delivery of all the components is about people working together for the Service. It was never a short term project but a longer term system of working.

George Crooks said that within any organisation there is nothing more certain to cause uncertainty than service change. He advised that there should be posts within place
within a few weeks, which will support the Service moving forward. He reminded the Committee that it was almost a year ago to the day that the meeting took place on the front loaded model, which the Service has since moved on from and a new system, NWCW, put in place. He had reviewed the existing clinical governance/effectiveness systems within the Service when developing the proposal for the Medical Directorate and is now in the process of implementing a number of changes. There have been a number of issues which have been recognised and are being resolved. The new structures will encourage priorities of work to be set. The Service has relied on NWCW to carry on this work whilst the structures and processes were reviewed and the work the group have carried forward has been very good. A plan will be put in place to move forward and there will be managed incremental development. The transitional phase has been planned for and is being progressed. After enquiry from Christine Humphries George Crooks advised that the Clinical Effectiveness Group had met the previous week and the minutes will be circulated to the Committee at the next meeting. The Clinical Effectiveness Group will have a wider role within the Service as we move forward. To support clinical matters there will also be a national Clinical Advisory Group (CAG) developed across the Service but currently we are asking the NWCW project to shoulder all the burdens of the different priorities and demands. A paper on this structure for the CAG will be circulated at the next meeting in August. Christine Humphries said it was reassuring that the appropriate organisational structure was being put in place.  

(Action George Crooks)

5.2 Clinical Performance
George Crooks reported that the data shown in the paper circulated to the Committee had also been circulated to the Board at the last meeting.

He continued that the Call to Needle Time is down to 39 minutes and this is one target that is very much about patient care. The Service is actively engaged with the North of Scotland (Grampian and Highland) and meets regularly around the table with other stakeholders to discuss Service developments early on at the planning stage, rather than at a later implementation stage, which has in the past caused problems. Christine Humphries said she was very pleased to see work coming through for a suite of meaningful indicators and she thanked the Management Information Team, Shirley Rogers and George Crooks for this work.

David Nelson said that the only concern he had was in the performance data for chest pain patients receiving nitrates. George Crooks advised that we are currently counting only the numbers of patients receiving nitrates but one of the longstanding questions is around self administration, where patients have self administered by the time the crew has arrived. These patients are not indicated in the data. There are also contraindications for nitrates to be considered; there are three groupings which we currently can’t show, but in the future the data collection will be refined to enable accurate reflection of nitrate administration.

Robin Lawrenson also advised that the performance indicators show a highlighted section of a very small part of the clinical work carried out by crews.
5.3 Scottish Ambulance Service Submission for QIS Review

Christine Humphries advised that the Committee needed to approve any governance issues within the submission, and reported that some comments had already been sent by Committee members to Sarah Kilday. George Crooks said that the QIS review process had been devised for the right reasons but the league table had been unhelpful as it had taken a facilitative and supportive process and made it into a pass or fail process for organisations. He asked that discussion about the submission should be framed around this understanding. He continued by saying he was confident that we will do well in the process, and explained he would not normally bring a draft document to the Committee but this was to allow input at an early stage from non executives.

Sarah Kilday advised that the draft Standard 1 which had been circulated to members had since progressed and been amended but any comments from this meeting would be included and the document finalised by the following Friday 22nd May. Standard 2 was also being worked on.

Pauline Howie suggested that the best use of time would be to discuss any issues of detail out with the Committee but highlight anything of fundamental disagreement or importance at the meeting. There will be further opportunities to see the document and Sarah Kilday said she would be happy to circulate the document again after the Committee. David Garbutt said he only had two areas of concern; emergency planning and diversity, and said he did not think that the Service had done itself justice and could show more evidence to support these areas. He would like to pick up on this with Sarah out with the meeting.

It was noted that Emergency Planning had been a weak area last year and the current position needed to be reflected in the document. Paul Gowens said that emergency planning within the Service was held up as an exemplar within the NHS but the scoring of the review is again causing an issue. But he advised the Committee should be reassured that emergency planning within the Service is of a high standard. Sarah Kilday added that a lot of the submitted evidence will reflect this.

It was noted that not all non executives had been involved with the submission to date. Pauline Howie said that she would share the document with the Non Executive Directors.

Bill Mason advised that the information governance scoring will plummet because of the change in scoring system. This is due to non applicable (to the Service) points being scored at zero which brings the average scoring down. Christine Humphries commented that it appeared the system was good at scoring but not at interpreting the meaning behind the scoring, so it is very important to get the meaning through in the submission.

The assessment panel was discussed and it was advised that the Medical Director of Northern Ireland Ambulance Service will be on the panel which is an improvement from last year when there was no representation from an ambulance service.

David Garbutt enquired whether it was possible to withhold the figures when considering the system was flawed. Pauline Howie advised that the Service has taken the view to cooperate in the process as we need to raise standards, but the scoring system has been fed back to QIS as being an issue. Sarah Kilday advised that there is narrative to support the evidence. It was noted that a lot also depends on the quality of the review team. Paul
Gowens advised that there would be the opportunity to challenge the review team on their comments as had been done by another NHS board. There was discussion around scoring in the previous round and that there is pressure to perform as successfully again but this time under a different scoring system. The Service must maintain a critical eye on how it perceives this process.

5.4 Staffordshire Report Update
Christine Humphries raised that whilst this had been discussed informally by the Board there was no formal record of it or of actions required. Pauline Howie advised that it had been discussed in private at the March Board meeting. There had been found to be many similarities eg cultural issues, between the services, and the focus on speed of response and targets and not enough on clinical matters and quality effectiveness. She said that the climate has changed within the Service but further work needs to be taken forward eg a clinical risk register.

Bill Mason advised that the independent review team had come up with an honest report, with recommendations. The NWCW Project and the development of the Medical Directorate give substantial reassurance and will be built into the action plan and will be monitored for progression.

HEALTH WELLBEING AND CARE EXPERIENCE
(NHS QIS CG&RM STANDARD 2)

6.1. Complaints, Comments and Compliments
Narmeen Rehman advised that compliance for the 20 day response to complaints was up by 30% which is a reflection of the hard work by divisions. This makes the handling of complaints at NHQ much easier and swifter.

She advised that complaints numbers had recently gone up, particularly within PTS, and visits have been made to divisions to discuss this. It had been found that there have also been recently over 1000 inappropriate uses of the PTS.

Narmeen Rehman also advised that it is now practice for the Medical Director to review all clinical complaints.

She reported that there were two issues that came out of the Ombudsman Report for one complaint and they were dealt with proactively by the Service. Complaints are also to be audited and data is being collated and will be looked at in a couple of months’ time.

Christine Humphries said that it had been a great accomplishment to improve the Service’s handling of complaints, particularly within the Divisions. George Crooks advised that the Service looks at complaints and sometimes there is a mismatch in the patient expectations and what the Service can produce. We also look into whether there might have been individual clinician error or a system error. He explained that a robust, supportive system is being put in place to enable changes to be made through organisational learning points.

David Garbutt raised that there were still complaints received on attitude and behaviour and he enquired how staff are disciplined if they are shown to have been rude to patients. Shirley Rogers advised that it depends very much on the individual situation. We also
look at individual files to see if there is a recurring problem. A caution may be given but there is no particular pattern for dealing with this but an annual survey is carried out to monitor this area. Narmeen Rehman said that in each case it was important to look at the details as some complaints are generated at a stressful time and because of the perception of patients or their family at the time. Very few complaints are taken to the Ombudsman.

Christine Humphries said that the work around PTS and the criteria for this transportation was very important and must be monitored. Narmeen Rehman advised that she meets regularly with Area Service Managers to give support as they are often the representatives who meet with complainants. Pauline Howie also advised that the criteria for the Patient Transport Service was being reviewed.

Theresa Houston said that the numbers of complaints compared with the number of patient journeys was fantastic, especially in comparison to other national organisations figures.

6.2 Child Protection and Vulnerable Adults
Bill Mason advised that he continues as the Service lead in child protection and vulnerable adults and is looking to improve EMDC staff training in this area, as well as multi level training within the Service. He also advised that the Adult Support and Protection (Scotland) Act 2007 has had an impact on the Service and we are working to implement all the aspects of the Act. Local managers are also working with local authorities.

ASSURANCE AND ACCOUNTABILITY
(NHSQIS CG&RM STANDARD 2)

7.1 Clinical Governance Committee Annual Report 2009
Christine Humphries expressed that she had thought the Committee would have had sight of the draft report for this meeting, and that it could have been used as evidence for the QIS submission. As the report is not yet finalised it had been agreed that the Committee would consider the format and layout of the report. After discussion it was agreed that for this years report the Committee would continue with the same style as used in previous years. It was considered whether consistency of style and content was required for all the governance committee annual reports. Pauline Howie advised that there was consistency in the timeline of reporting.

Andrew Richmond said that his understanding was that the report required approval by the Committee before the Audit Committee meeting in June. Pauline Howie advised it should be the Board agenda that will have the governance committee reports included. Stuart Sands said that with regard to internal control some audit committees do consider the governance annual reports as well but not all. He said he thought it was a good annual report with a lot of detail but did ask whether there has been good internal control from the Committee. Pauline Howie advised that the Service uses this format and style of report with an explicit statement of internal control as suggested, and asked that the Committee agree on a timescale that reasonably allows for the report to be approved by the Committee and sent to the Board meeting in June. Bill Mason said this timescale was achievable and that he was also hoping to streamline the report as well. It needed to be considered which audience the report was intended for.
Christine Humphries asked if it was possible to have the final draft for August instead, which would possibly allow input from the new Communications Officer. After discussion it was agreed that the 2009 report would be made ready for final comment in two weeks time and the Committee would meet briefly after the Board meeting at Barony Castle in May to discuss the circulated report. Committee members were asked to send any current comments on format and style to Bill Mason and thereafter, once the 2009 report had been circulated, comments would be welcomed on the content.

Stuart Sands assured the Committee that all elements are there to discharge the internal control requirements but a major change would be to consider the statement of internal control in the document. This will be considered along with the rest of the report.

David Garbutt advised that there was a lot of good information included in the report and he would not like to see it reduced to a briefer account, especially as it can be used as evidence. He also suggested that the Service could build the QIS system into the model wiring diagram regarding Clinical Governance and Clinical Effectiveness.

Suzanne Dawson suggested that the Communications Manager should look at all the governance reports and the process of how they feed into the Service’s Annual Report. This could be backed up by a document that could easily be read by other audiences. Andrew Richmond agreed and said there was now possibly the need for two papers; one comprehensive document and another more brief annual report. It was agreed that a paper would be requested from the Communications Manager on how best to take this forward.

(\textit{Action Communications Manager})

\textbf{7.2 Clinical Governance Internal Audit Report}

Christine Humphries said it was good to have sight of this document and said she hoped that improvements were being made across the Service and reminded the Committee that the Director General had written to the Service seeking assurance. The report is helpful to show how the Committee are addressing issues within the Service and this has been a challenging year in which the report was undertaken and was a long time in being presented.

Stuart Sands said that the report had been discussed at previous committee meetings and the final version had now been brought, this was at the request of the Audit Committee Chair. Five recommendations have been raised but one of the comments from the Audit Committee was the severity of the grading which should be changed from moderate to major. Within that context he said that it was important to look at the overall control available and show it to be in place through clinical effectiveness. He advised that changes were being made to the clinical indicator report which would mean the ability to turn data around and report on it quickly eg for underpinning reporting and KPI reporting. The June Audit Committee will include a follow up on the recommendations.

David Garbutt said that he didn’t think the report was entirely fair, especially around the Committee’s apparent keenness to address the appropriateness of KPIs, rather than focussing on how we underperform as a Service. There is an assumption that the Service is underperforming when in fact it is a data gathering issue and George Crooks has assured the Committee of this. Stuart Sands advised that at the time the report was
written this had been a fair observation on the focus of the Committee and it had been a risk. It was agreed after suggestion by David Garbutt that the word ‘potential’ could be added to the underperforming narrative to balance the assumption that could be taken from the wording.

Stuart Sands advised that the plan had been presented at the last Committee with divisional reviews and clinical reporting. Each of the reviews has been scheduled into the plan. These will be sent to Pamela McLachlan and will be reviewed for relevance to this Committee. Pauline Howie added that the Audit Committee receive as part of their papers the quarterly report on the status of the work. Christine Humphries said this was very helpful to show linkage between Committees.

7.3 Health Associated Infection – Action Plan
Shirley Rogers advised that this document had been taken to the Infection Control Committee and does address all the areas required. She advised that the alert document (Red/Amber/Green) will be sent to the Board for approval and completed and signed off for the Scottish Government. This is the third year that the report has been brought to the Committee. Although the report which is sent to the Board every month can involve heavy detail it is a useful process to monitor progress. It is a somewhat bureaucratic process, but necessary.

David Garbutt said he thought it was a good report. It was discussed that the Service was awaiting £105,000 to support infection control processes. The Committee approved the report.

7.4 Audit Work Plan 2009/10
Discussion was raised on the work plan and David Garbutt asked that the title be changed to ‘Clinical Audit Plan’ instead of ‘Clinical Performance Plan’. The plan was approved with the change of title.

7.5. Clinical Research, Improvement and Effectiveness Update & Strategy
Bill Mason advised that amendments would need to be made to the strategy as we move forward but there has been a lot of consultation taken on this document. It is not the final document, but is based on good practice. The next stage will be to draw up the work programme. David Garbutt enquired about the clinical project team running for four or more years but there appears to be no link to the Clinical Governance Committee through to the Board. Christine Humphries said that the Board needs to be very clear what is expected of a project board. Bill Mason advised that the links can be shown through the evidence gathered for the QIS submission Pauline Howie advised that work was being carried out on the structures to develop and progress these links. David Garbutt reiterated that he had no concerns on the work load of the project itself, but rather his concerns came from a governance perspective in that the project team continues to run without any link to the Medical Directorate. Christine Humphries advised that this issue was being progressed. David Garbutt also suggested that the Service look beyond UK ambulance service for benchmarking and best practice. Bill Mason advised that the Service had met with Australian ambulance services recently.

Clinical Research, Improvement & Effectiveness Update – May 2009
The paper was noted by the Committee.
7.6 Clinical Incident and Clinical Risk Report
The Committee noted the report. It was explained that telemedicine is not a replacement for an ECG being carried out by the crews, and treatment is still given to patients when appropriate. Sarah Kilday also advised that the Service is hoping to carry out a benchmarking exercise with the Welsh Ambulance Service and this will be reported on in due course.

8. ITEMS FOR INFORMATION

8.1 Divisional Operational Reports
The Committee was asked if they were happy with how the divisions engage with the Committee through their reporting. Shirley Rogers said it was a useful document for both the Committee and the Divisions as it is a means of focusing the divisions on clinical governance. As the Medical Directorate is rolled out and the new Communications Officer starts with the Service the reports could be developed. The GMs have been asked to reduce the number of acronyms and use plain English. Andrew Richmond said he welcomed the report although there may be need for some reformatting.

Shirley Rogers advised that the reports were starting to showcase developments such as pPCI and she was keen that the new communications officer would be part of this. Robin Lawrenson advised that he had held meetings in the divisions regarding compliance and clinical governance. Part of this is assuring that clinical effectiveness is part of the process.

David Nelson enquired about First Responders being mentioned in the reports and Shirley Rogers said she would ask Pat O'Meara, who is the lead, to share this with the Committee in due course, which will be towards the end of summer. Christine Humphries agreed that the First Responder contribution would be important for the Committee. Robin Lawrenson also advised that the Service is developing a Performance Indicator for this work.

9.1 Date of Next Meeting – 19th August 2009 (Please note this has been changed to the 9th September)