Scottish Ambulance Service
Taking Care to the Patient

NHS SCOTLAND

**NOT PROTECTIVELY MARKED**

**Public Board Meeting** **30 September 2020**
**Item 15**

**THIS PAPER IS FOR NOTING**

# CLINICAL GOVERNANCE COMMITTEE MINUTES OF 18 MAY 2020 AND VERBAL REPORT OF 17 AUGUST 2020

| | |
|---|---|
| **Lead Director**<br>**Author** | Martin Togneri, Chair of Clinical Governance Committee<br>Lindsey Ralph, Board Secretary |
| **Action required** | The Board is asked to note the minutes and verbal report. |
| **Key points** | In compliance with the Service's Standing Orders, the approved Committee minutes are submitted to the Board for information and consideration of any recommendations that have been made by the Committee.<br><br>The minutes of the Clinical Governance Committee held on 18 May 2020 were approved by the Committee on 17 August 2020.<br><br>A verbal update of the meeting held on 17 August 2020 will be provided by the Chair of the Committee. |
| **Timing** | Minutes are presented following approval by the Committee. The Board will receive a verbal update of the most recent Committee meeting. |
| **Contribution to the 2020 vision for Health and Social Care** | The Clinical Governance Committee has responsibility, on behalf of the Board, to ensure that the appropriate work is undertaken to assess clinical governance within the Service and provide assurance to the Board that the governance arrangements are safe, effective and person centres. |
| **Benefits to Patients** | The Service practices the principles of good clinical governance to ensure that safe, effective and person centred care exists across the organisation to deliver high quality care to patients. |
| **Equality and Diversity** | No issues identified. |

**NOT PROTECTIVELY MARKED**

# MINUTE OF THE SEVENTY NINTH (79th) CLINICAL GOVERNANCE COMMITTEE AT 10.30 AM ON MONDAY 18 MAY 2020 VIA TELECONFERENCE

**Present:**
Martin Togneri, Non-Executive Director (Chair)
Irene Oldfather, Non-Executive Director
Carol Sinclair, Non-Executive Director
Francis Tierney, Non-Executive Director
Liz Humphreys, Non-Executive Director

**In Attendance:**
Keith Colver, Clinical Governance Manger – Guidelines
Frances Dodd, Director of Care Quality and Professional Development
Garry Fraser, Regional Director – West
Sarah Freeman, Head of Infection Prevention and Control
Paul Gowens, Lead Consultant Paramedic
Pippa Hamilton, PA to Director (notes)
Pauline Howie, Chief Executive
Drew Inglis, Associate Medical Director – ScotSTAR
Julie King, Service Transformation Manager
Stella MacPherson, Patient Representative
Toby Mohammed, Head of Education and Professional Development
Tim Parke, Associate Medical Director - Major Trauma
Andrew Parker, Clinical Governance Manager - Medicines
Gary Rutherford - Patient Safety Manager
Jayne Scaife, Public Protection Lead
James Ward, Medical Director

**Apologies:**
John Burnham, Associate Director of Care Quality and Professional Development
Alan Martin, Patient Experience Manager
Tom Steele, Board Chair

## ITEM 1 WELCOME AND APOLOGIES

Martin Togneri welcomed everyone to the meeting.

Martin reminded Committee that NHS Scotland is facing unprecedented demand as we respond to the COVID-19 Pandemic. The challenges faced requires the Board Governance Committees to recognise that front line staff, senior officers and the Executive Team must be allowed to deal with the COVID-19 Pandemic with as little distraction as possible. However, the Board and Governance Committees were still required to ensure good governance and provide assurance even in this difficult time.

All papers prepared for the meeting had been circulated in advance, and Martin advised that he did not intend for them to all be discussed in detail to allow time to be focused on COVID-19 related matters and items that required approval.

Committee were reminded that they were asked to submit any questions that they had on the undernoted items in advance of the meeting with a view to answers to these being sought and provided to members. Martin advised that all questions posed and answers received would be appended to the minutes of the meeting to ensure formal recording.

- Item 5.1 Patient Experience and Learning from Adverse Events Report
- Item 6.1 Clinical Governance and Patient Safety Report
- Item 6.2 Public Protection Assurance Group Update
- Item 7.1 Infection Prevention and Control Update
- Item 7.2 Education Update
- Item 8.1 Annual Report – Clinical Governance Committee
- Item 8.2 Terms of Reference – Clinical Governance Committee

Committee welcomed Sarah Freeman, Head of Infection Prevention and Control to her first Clinical Governance Committee meeting.

## ITEM 2 DECLARATIONS OF INTEREST RELEVANT TO THE MEETING

Standing declarations of interest were noted:
Martin Togneri, in his capacity as a Board member of NHS24.
Carol Sinclair, Employment with Public Health Scotland as Associate Director and Director and Trustee of Scotland's Charity Air Ambulance.
Irene Oldfather, as Director at Health and Social Care Alliance.
Paul Gowens, as Visiting Chair of Robert Gordon University

## ITEM 3 MINUTES OF MEETING HELD ON 20 FEBRUARY 2020

The minutes of the meeting held on 20 February 2020 were reviewed and approved as an accurate record of the meeting.

## ITEM 4 HOT TOPIC – CLINICAL SERVICE TRANSFORMATION UPDATE TO SUPPORT COVID-19 RESPONSE

Martin advised Committee that they would be aware that the original "Hot Topic" for this meeting was due to be on the Clinical Governance Arrangements for "Hear and Treat" between NHS24 and the Service, however given the current situation this has been postponed to accommodate Committee receiving the latest updates on the Service's COVID-19 response.

Jim Ward presented Committee with an update paper which outlined "Enhancing the Service's Chain of Response in the Context of a Global Pandemic".

Jim advised that Committee will appreciate that given the rapidly changing times, since the presented paper was prepared there have been multiple conversations taking place in relation to mobilisation for changes that would take place when moving from response to recovery.

Committee noted that the presented report is wide ranging and reflects the interventions that have been introduced including the Pandemic Escalation Plan, Advanced Critical Care Practitioners and Urgent Care Advanced Paramedics. Jim added that the paper also

provides Committee with an overview of the range of clinical guidance that has been circulated to date in response to COVID-19.

Committee were advised that in relation to COVID-19 activity seen by the Service, there had been a sharp rise in activity for incidents attended and subsequently conveyed to hospital in early March, peaking in the first week of April. Since then a steady reduction in COVID-19 related activity has been seen. Jim advised that since the third week in April call volumes had been fairly consistent, noting that COVID-19 activity represents 20-25% of the Service's 999 demand.

Stella MacPherson commented that the Service may not be seeing as many people calling as the phone lines for the 111 service are not being answered. Martin noted that the 111 lines are managed by NHS24 and not the Service, however he advised that he also sits on the NHS24 Board and asked Stella to provide her example of concern relating to NHS24 to him out with the meeting and he would raise this with NHS24. Stella agreed that she would provide Martin with the information via email and thanked him for progressing her concern.

Francis Tierney stated that on reviewing the graphs contained with the presented paper it would seem that the introduction of Card45 was having a positive impact.
Jim Ward reminded Committee that Card45 was the introduction of emergency ambulance booking arrangements for health professionals, providing clearer guidance for colleagues.

Jim Ward advised that from a clinical preparedness perspective there was a requirement to design a range of DCR tables to reflect the service pressure levels being predicted. Committee noted that the DCR tables were designed, signed off clinically by the Clinical Assurance Group and integrated into the Ambulance Control Centre (ACC) system, should they be required.

Jim Ward added that in order to mitigate the risk of demand outstripping resource availability, additional clinical telephone and video triage by Urgent Care Advanced Paramedics (UCAP) was introduced to lower acuity calls with common outcomes being self-care or community pathway utilisation.

Committee noted that the COVID-19 pandemic modelling illustrated an expected increase in calls into the Service's highest acuity category, purple, and as a result of this modelling Advanced Critical Care Practitioners (ACCPs) are working on a 24/7 rota from the National Tactical Cell to provide real time decision support to operational staff. Jim added that ACCPs have intervened in almost 60% of purple calls, offering advice on Personal Protective Equipment (PPE) guidelines, on scene decision making and clinical care ensuring that staff are adequately protected and supported. Committee were advised that work is progressing to incorporate these interventions into a "business as usual" approach by reformatting the ACC "Trauma Desk" to take on the broader "Critical Care" function which would extend to critically ill non-trauma patients.

Martin Togneri asked for clarification in relation to the call escalation codes within table 8 and whether some conditions which were previously triaged as yellow are now being categorised as green.

Jim advised that Martin was correct, noting that these are calls that have the lowest conveyance rates. Jim added that 50% of patients do not require an ambulance resource and are provided with clinical advice by the introduction of the Advanced Practitioner telephone or video consultation.
Irene Oldfather noted that the paper advised that re-contact rate to the Service for patients triaged to a non-ambulance response within 24 hours of triage sits between 1% and 2%,

which suggests that the right decisions are being made, however asked if there is any evidence in relation to re-contact outside the 24 hours. Jim Ward advised that work is ongoing by the clinical governance team and ISD with a view to accessing the linked data to gain understanding of the wider system in these circumstances.

Carol Sinclair commented that there was a very strong weave of governance and assurance contained within the paper. Carol asked how the Service plans to monitor the unsuspected consequences of the reassignment of the Advanced Practitioners, adding that she presumed that further research would be carried out in relation to any negative impacts with Datix reporting being the first place that would highlight any negatives.

Jim Ward advised that each case was reviewed to evidence any process or clinical concerns with the Service currently looking at one incident in more detail.

Carol Sinclair noted that she is thoughtful about the frequent changes to guidance being made within the system and asked if the Service was aware of any occasion where staff have used out dated guidance.

Jim Ward advised that there had been significant changes in case definition and PPE guidance in the early stages of the pandemic response, however added that by utilising the JRCALC App only one version of guidance was available to staff, which was the most up to date version, which mitigates the risk of staff following out of date guidelines. Jim added that as time had moved on the Service had reached a stage where now, on average only one or two clinical updates were being circulated per week. Committee noted that the perception and feedback from staff was now positive in relation to the circulation of guidance.

Martin Togneri noted that the VF/VT ROSC percentage showed a drop in March with a rapid recovery in April. Jim Ward advised that this was one of the most challenging areas which coincided with a series of changes in COVID-19 case definition and PPE guidelines which challenged the wider NHS system. Jim added that with feedback from staff additional communication had been developed with practical advice for staff for the safe and effective management of Out of Hospital Cardiac Arrest (OHCA) and utilisation of PPE and subsequently OHCA and PPE guidance now remained unchanged which had allowed for the position to become more stable.

Francis Tierney commented that it is very impressive to see the enormous amount of work ongoing and changes implemented, many of which will become business as usual. Jim Ward added that all of the work carried out so far has been a real team effort and thanked everyone involved.

Irene Oldfather noted that the September 2019 Committee discussed drug deaths as part of the “Hot Topic” and noted the decrease in the number of 999 calls for overdoses, advising that it was interesting to note the drop between February and March in relation to drug deaths.

Jim Ward advised that the information provided with the paper which Irene refers to were not the number of drug deaths, but the number of calls to the Service for drug overdoses. Jim advised that the data for April was awaited, which would allow for monitoring of the impacts of current patterns of vulnerable groups, together with signposting patients to appropriate support resources. Jim added that Gary Rutherford and Paul Gowens represent the Service on the national task force set up to address the number of drug related deaths in Scotland.

**Action:**

1. **Stella MacPherson** to provide details of concerns in relation to NHS24 delayed call answering to **Clinical Governance Committee Chair** to enable these to be taken up directly with NHS24.

## ITEM 5 PATIENT CENTRED CARE

## ITEM 5.1 PATIENT EXPERIENCE AND LEARNING FROM ADVERSE EVENTS

Committee noted that given the refined agenda opportunity had been given to members to comment or raise any questions on the paper prior to the meeting. It was agreed that questions raised and answers received would be appended to the minutes of the meeting ensure formal recording.

## ITEM 5.2 TEMPORARY SIGNIFICANT ADVERSE EVENT REVIEW (SAER) PROCESS DURING COVID-19

Jim Ward advised that Committee are asked to homologate the SBAR and flowchart presented which outlined the temporary Significant Adverse Events Review (SAER) process which had been adopted by the Service during the current COVID-19 pandemic.

Committee noted that the temporary process was implemented on 24th March 2020 following consultation with the Medical Director, Executive Team, Clinical Governance Committee Chair, COVID-19 Strategic Cell, NRRD Senior Leadership Team and Regional Directors.

Jim added that the SAER processes during normal operational activity were challenging due to the intensity of work and therefore a refined process was required given the increased pressures associated with COVID-19, whilst maintaining strategic oversight of any Significant Adverse Events.

Irene Oldfather stated that she agreed with the majority of the process, however noted that only one reviewer would be required when a SAER is launched, or two, if working remotely to maintain social distancing. Irene stated that to ensure good governance it would be beneficial to ensure that SAERs are reviewed by two people working remotely. Jim Ward provided assurance that currently this had been happening, with often reviews being carried out by three or four people.

Martin Togneri commented that the recommendations are somewhat open ended, specifically in relation to the timescales for review of the temporary process. Martin suggested that it would be beneficial to include a specific timeframe for review of the process, stating a review date, however restating the authority of the Medical Director to extend the temporary process after the review date if ongoing CoVID-19 exigencies rendered it necessary. It was agreed that Jim Ward would review the temporary process prior to the August Committee meeting and report back to Committee within the Patient Experience and Adverse Events paper, outlining whether the temporary process will remain in place or whether the normal process will resume.

Committee agreed to homologate the paper and noted that an update would be provided to the August Committee on whether the use of the temporary SAER process required to be extended further.

**Action:**

2. **Medical Director** to review the temporary SAER process in place prior to the August Committee meeting and provide an update within the Patient Experience and

Adverse Events paper outlining whether the temporary process would remain in place for an extended period or whether the normal process would resume.

## ITEM 6 PATIENT SAFETY

## ITEM 6.1 CLINICAL GOVERNANCE AND PATIENT SAFETY REPORT

Committee noted that given the refined agenda opportunity had been given to members to comment or raise any questions on the paper prior to the meeting. It was agreed that questions raised and answers received would be appended to the minutes of the meeting ensure formal recording.

Committee took assurance from the paper presented.

## ITEM 6.2 PUBLIC PROTECTION ASSURANCE GROUP UPDATE

Committee noted that they had been asked to submit any questions on this item prior to the meeting, however given that the paper was submitted to Committee out with the paper circulation deadline, Committee were asked to discuss this paper during the meeting.

Jayne Scaife presented Committee with an update on the work of the Public Protection Assurance Group.

Committee noted that the undernoted work streams had been identified as being key to the delivery of safe and effective services for vulnerable staff and patients.

- Improving organisational governance and assurance through improved oversight of the Public Protection agenda
- Improving patient safety through enhanced reporting and joint integrated working.
- Enhancing workforce capability through education and awareness.

Jayne highlighted to Committee that the number of Public Protection referrals to other services was currently low and work was ongoing to assess substantiated reasons for this.

Jayne added that emerging themes were being monitored during the COVID-19 pandemic, with a number of themes being identified:

- Increased number of Datix reports in relation to vulnerable adults nationally
- Increased crew reports from staff about vulnerable adults who are struggling to care for themselves due to breakdown in their support mechanisms or breakdown in care provision due to the pandemic
- Increased crew reports for patients not being able to access drug and alcohol services due to the pandemic and being found in vulnerable situations as a result.

Committee were provided with the assurance that Datix reporting was being checked regularly.

Irene Oldfather asked if work in relation to patients not being able to access drug and alcohol services due to the pandemic had been highlighted to the Integrated Joint Boards (IJBs).

Frances Dodd advised that work to map out services across Scotland was being carried out in relation to mental health, with drug and alcohol services being picked up as part of this, to try and ensure that staff have access to these services. Frances added that there was a lot of ongoing work in relation to this and reminded Committee that the Mental Health Strategy was still in development, with some areas of the Strategy currently paused as a result of

COVID-19. Committee noted that it was acknowledged that there was a lot of work still required to bring the Service to where it wanted to be in relation to this work.

Irene Oldfather commented that it was good to see that crews are recognising issues and reporting them through the system.

Carol Sinclair asked if there had been any robust feedback from staff in relation to the support they had received during this exceptional time and additional demand. Jayne advised that staff had reported good support from adult support networks within the community and the Silver COVID Cell. Jayne added that on checking back on patient outcomes, patients were receiving the referrals they needed.

Committee noted the paper and assurances provided.

**ITEM 7 EFFECTIVENESS**

**ITEM 7.1 INFECTION PREVENTION AND CONTROL UPDATE REPORT**

Committee noted that given the refined agenda opportunity had been given to members to comment or raise any questions on the paper prior to the meeting. It was agreed that questions raised and answers received would be appended to the minutes of the meeting ensure formal recording.

Committee took assurance from the paper presented.

**ITEM 7.2 EDUCATION UPDATE**

Committee noted that given the refined agenda opportunity had been given to members to comment or raise any questions on the paper prior to the meeting. It was agreed that questions raised and answers received would be appended to the minutes of the meeting ensure formal recording.

Committee took assurance from the paper presented.

**ITEM 8 COMMITTEE GOVERANCE**

**ITEM 8.1 CLINICAL GOVERNANCE ANNUAL REPORT**

Committee reviewed the Clinical Governance Committee Annual Report for 2019/2020, which provided assurance that the Committee had fulfilled its delegated responsibility to assure the Board that the governance arrangements were safe, effective and person centred.

Francis Tierney noted that within the attendance schedule appended to the Report, the February 2020 meeting outlines that he had submitted apologies to the meeting, however he was in fact in attendance and requested that this be amended prior to submission to the Board. It was agreed that the attendance schedule would be amended to reflect this change.

Committee approved the Annual Report for submission to the Board, subject to the above amendment being made.

**Action:**

3. **PA to Director** to amend the attendance schedule within the Annual Report to show Francis Tierney as in attendance at the February 2020 meeting.

## ITEM 8.2 TERMS OF REFERENCE – CLINICAL GOVERNANCE COMMITTEE

Committee noted that given the refined agenda opportunity had been given to members to comment or raise any questions on the paper prior to the meeting.

Martin Togneri advised Committee that all proposed amendments to the Terms of Reference were highlighted in tracked changes to ease readability for members. Martin asked Committee to note the increase in Non-Executive Directors within the Committee membership from four to five, advising that this amendment would be formally confirmed and approved at the May Board meeting.

Irene Oldfather noted that there was an option within the Terms of Reference for Committee to have two co-opted members and suggested that Committee make use of this option as currently Committee only had one co-opted member. Martin Togneri advised that there was work ongoing in relation to appointing additional co-opted members to all Governance Committees and asked Pauline Howie to confirm any progress of this work.

Pauline advised that work was ongoing by the Executive Team in relation to this and added that she would arrange with the Board Secretary for this to be taken forward as part of a future Board Development Session. Irene confirmed that she was content with the suggested course of action.

Committee endorsed the Terms of Reference for submission to the Board.

**Action:**

4. **Chief Executive** to arrange with **Board Secretary** for work on co-opted members for Governance Committees to be taken forward as part of a future Board Development Session.
5. **PA to Director** to forward endorsed Terms of Reference to **Board Secretary** for submission to the Board for approval.

## ITEM 8.3 ACTION TRACKER

Committee noted the following items as completed, and approved their removal from the SGC action tracker.

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| 2020/02/7.2 | Public Protection Policy |
| 2020/02/9.1 | Clinical Governance Annual Workplan 2020 – Public Protection Assurance Group |

**Action:**

1. **PA to Director** to update the action tracker.

Date of next meeting 17 August 2020 at 1000 hrs.

The meeting closed at 11:45.

# APPENDIX 1

## NOT PROTECTIVELY MARKED

## CLINICAL GOVERNANCE COMMITTEE

## QUESTIONS ON PAPERS CIRCULATED FOR MAY MEETING

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### ITEM 05.1 – PATIENT EXPERIENCE AND LEARNING FROM ADVERSE EVENT REPORT

**Questions:**

1. Compliance with Stage 1 and 2 stubbornly not achieving target, however note in later papers complaints down since Covid-19. Can any further information be provided on these points?

   ***Answer:***
   *Performance at the middle and latter part of last financial year that due to performance we were not going to recover the position on Stage 1 and particularly on Stage 2 performance. As part of the Learning from Events work we will look at process elements in relation to many aspects of the service and the complaints process may also require this level of scrutiny. We are also hopeful that the update you received today on the Advanced Practitioner work, that we will see a reduction in delays in the Yellow basket of calls and are hopeful of a resultant reduction in complaints, given the majority of complaints at both stages relate to delays.*

2. Learning from Events Group meeting due to take place at the end of April however given the current situation this did not take please, can you advise on the future plan for this Group?

   ***Answer:***
   *The initial draft terms of reference have been progressed during COVID-19 and circulated to the group, we have further refined these and the planning of the meeting is being arranged. We are hampered by some key individuals supporting vital aspects of the COVID-19 response and therefore are working to balance the governance aspects of concerns with our strategic and tactical response to COVID-19. The Director of Care Quality and Professional Development is reviewing all complaints currently and responding to them on behalf of the organisation and, as advised at Committee on 18th May the learning from adverse events is still being progressed, in a somewhat modified format.*

3. Could clarity be given to some of the categories within the Complaints Themes tables to allow understanding of their meaning?
   - Data Protection – does this mean a privacy issue?
   - Refusal of Equipment on Vehicle – does this mean patient refused?

***Answer:***
*Data Protection - This could be a number of things in regards to a breach or perceived breach in the Data Protection Act or GDPR.*
*Refusal of equipment on vehicle - there are certain pieces of equipment that are not safe to be transported on certain vehicles. For example some heavy wheelchairs, bicycles or any scooters cannot be safely secured for transport during a transfer to the hospital. This equipment would need to be transported via other means if a home to hospital transfer or if it is in a public place, Police Scotland provide a service where they collect. Eg a push bike that has been at the scene of a patient's incident.*

**4.** Within the "Uphold Rate" chart a lot of complaints about PTS were not upheld. What does this tell us?

- Does it tell us that the Patient Transport Service is not really understood and more messaging is required?

***Answer:***
*At the February Clinical Governance Committee, the Director of Care Quality and Professional Development suggested that a not upheld complaint alerted her to a further 'gift' where the clarity around the PTS position is not as well understood as it could be and we should take the opportunity to develop further mechanisms to explain aspects of the PTS service to avoid confusion. As PTS services have been significantly diminished in this time, as a result of COVID-19, we have not progressed this.*

- 70% to 80% of top 5 categories of complaints are upheld - what does this tell us and what action is being taking to learn from these incidents and how do we as a Committee know and understand that this learning is being applied?

***Answer:***
*The vast majority of the concerns are around delays in resolving the concerns raised by further triage, hear and treat, see and treat or by dispatching an ambulance. This has been highlighted through the work on Demand and Capacity for which the Board has an agreed implementation strategy. This has also been picked up in the Advanced Practitioner work, as another mechanism for dealing with delays to treatment in the yellow basket.*

- The note at figure 5b advising that there are still complaints that were received between April 2019 and 31 March 2020 which have not been closed yet and are therefore not included in the figures – approximately how many fall into that category?

***Answer:***
*There are 19 complaints outstanding from the previous financial year.*

**5.** SPSO Update

- Question on SW/31/12956/19 - can you please explain the meaning of recommendation 6 "consideration for aide memoirs for cease of resuscitation"

***Answer:***
*The advisor to the SPSO has suggested consideration of an aide memoire to be issued to all ambulance clinicians to be used to assist decision making related to the cessation of resuscitation. While theoretically a good idea, previous issuing of hard copy aide memoire cards has had variable success in uptake and*

*application e.g. SBAR handover aide memoire cards. Additionally, the Service has now moved to electronic storage, availability and updating of guidelines and procedures. Therefore, while this suggestion can be considered, it must be balanced with future systems, usability and likely uptake.*

**6.** Figure 7 Clinical Datix Report Quarter 4 2019 – is at the highest since quarter 4 2015 is there any reason that would be the case?

**Answer:**
*The vast majority of the concerns raised in the last quarter of 2019/20 related to concerns around PPE and these were addressed through the work taken forward by the Service, however the vast increase and early logistics of this were significant and took time to settle at a time where there was an increased public and staff anxiety around COVID-19. This was supported with the tactical and strategic cell arrangements, significant efforts from procurement, understanding of local stock arrangements, increased logistics infrastructure and twice daily calls to target issues and respond in an agile way to support staff. There was also a structured approach to communication with staff to address concerns and alleviate anxieties.*

**7.** Level 1 – SAER section – advised that Healthcare Improvement Scotland has postponed the notification system that was implemented on 1st January 2020. Please can explaining be provided for the reasons surrounding this?

***Answer:***

*Health Improvement Scotland suspended reporting as a gesture to allow health boards to concentrate all efforts on the COVID-19 response phase, which at that time were anticipated to be unprecedented. HIS have set a meeting date for June for all health boards which we anticipate will be to restart the process in the COVID recovery process.*

**8.** The terms of reference for the "Learning From Events Group" looking at complaints - is there a case for CGC being consulted on the terms of reference, for which the report says a first draft is available?

**Answer:**

*This was the reason the TOR for the learning from events group was included in the Clinical Governance Committee paper - to ask for feedback on the draft. One thing to note is that the learning from events group is not being created to look solely at complaints, it is being created to look at **all** feedback from both public and staff. This will include DATIX, complaints, SAERS, reviews and compliments.*

**9.** Given that there was a long period of progress towards achieving compliance with our Stage 2 complaints deadline which ended with success in March 2019, but which was then followed by a sudden and substantial decline back to below target from which we haven't as yet recovered, will the group focus part of its effort on understanding whether there were any specific changes in that period which might account for the decline and subsequent failure to recover?

**Answer:**
*The unusual trend from last year in itself could have been the result of an event and therefore could likely be a focus, as we do not want to see it repeated. All members are clear that the group should have a wide-ranging remit though, and not focus solely on timeframes and compliance. Whilst government targets are important, the*

*true priority is that we identify the learning and mitigate repeated errors and behaviours and this will be the main priority for the group.*

*The Learning from events group is part of the solution to looking at improvements in system and processes as well as improvements in care delivery. The work from this group will inform changes to process and the complaints process may be part of this, although is not the main part of this work. The majority of the work will focus on changes which result in improvements to care delivery. This may have an impact on the number of complaints, and also have a resultant impact on complaints handling as a collateral benefit.*

**ITEM 06.1 – CLINICAL GOVERNANCE AND PATIENT SAFETY REPORT**

**Questions:**

1. Noted within the medicines update the information in relation to the damaged pouches. Can more information be provided to allow for a bit more understanding of the implications of this?

   **Answer:**
   *The pouches are now about 10 years old and an increasing number were either damaged through wear and tear or the ability to confidently track them was lost due to the removal of the unique pouch number (also wear and tear). The decrease in numbers reached a point that affected the ability to return pouches in a timely manner. An initial supply of 160 pouches was secured that enabled a return to a positive balance of pouches improving turnaround times. There is a realisation that this trend will continue due to the age and volume of use of these pouches, additional pouches are on order with improved tracking elements to improve the ongoing resilience of these moving forward.*

2. Noted within the medicines update the proposals taken to the group in IN Fentanyl and IV Paracetamol. Can more information be provided to allow for a bit more understanding of the implications of these?

   **Answer:**
   *Both Intranasal Fentanyl and Intravenous Paracetamol would increase the options that Paramedics have to deliver pain relief. Unfortunately, fentanyl is unable to be supported legally within the current framework for Paramedic only administration but could potentially be progressed within our consultant led retrieval teams. IV Paracetamol is reported to decrease the requirement for opiate analgesia and support an alternative analgesic where opiates are unable to be administered on occasions, such as a low blood pressure, for example. The Medicines Management Group is keen to understand some of the potential challenges that may be met with a National rollout of IV Paracetamol so are supportive of a local to the proposer field trial in the first instance. Any progress on both of these developments have been delayed due to the need to focus on supporting COVID-19 activities across the past few months.*

**ITEM 07.2 – EDUCATION UPDATE**

## Questions:

**1.** What precisely is meant in relation to paramedic students going onto "bank contracts"?

**Answer:**
*1st and 2nd Year GCU BSc students have been given bank contracts within SAS as Band 3 Care Assistants to assist with patient transfer if required during the COVID crisis.*

*3rd Year GCU BSc students have been given band 5 contracts as Ambulance Technicians to assist with patient transfer within NHS Louisa Jordan hospital. These students are in the last 6 months of their course.*

**2.** HCPC Committee approval for the extension of the Dip HE is mentioned as being scheduled for the end of April. Did we get the approval?

**Answer:**
*Initial discussion was promising. Currently a paper is being worked up for a 3, 6 and 9 month extension as requested by the HCPC.*

**3.** Noted that the GCU aims to resume face to face teaching on 5th October, with alternative accommodation being identified in Grangemouth should GCU be unavailable. I presume that this is for GCU students and if so will there be some provision for travel to Grangemouth which would be unexpected I imagine?

**Answer:**
*The university in general aims to restart their face to face teaching for all students on the 5th of October. We hope to recommence the Diploma in Higher Education in Paramedic Practice in June and are in discussion with the university on being able to access the academy estate over the summer period if they generally remain closed. Alternative accommodation at Grangemouth has been identified and provisionally booked so that the diploma programme can restart. Students will be able to claim expenses for any additional travel incurred through the normal processes. Students have been informed that they may have to attend Grangemouth if the programme is restarted.*