

Scottish Ambulance Service

Local Report ~ January 2007

**Clinical Governance & Risk Management:
Achieving safe, effective, patient-focused
care and services**

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Every person using health services should expect these to be safe and effective. The NHS Quality Improvement Scotland (NHS QIS) clinical governance and risk management standards came into effect from November 2005. They have been developed to support NHSScotland to establish systems and processes, ensuring that care and services are safe and effective. This report presents the findings from the peer review of performance against the standards.

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Contents

1	Setting the scene	5
1.1	How the standards were developed	6
1.2	How the review process works	6
1.3	Reports	8
2	Summary of findings	10
2.1	Overview of local service provision	10
2.2	Summary of findings against the standards	11
3	Detailed findings against the standards	14
	Appendix 1 – Glossary of abbreviations	28
	Appendix 2 – Details of review visit	29
	Appendix 3 – Timetable of review visits	30

1 Setting the scene

NHS Quality Improvement Scotland (NHS QIS) was set up by the Scottish Parliament in 2003 to take the lead in improving the quality of care and treatment delivered by NHSScotland. We do this by setting standards and monitoring performance, and by providing NHSScotland with advice, guidance and support on effective clinical practice and service improvements.

About this report

The 'National standards for clinical governance and risk management: achieving safe, effective, patient-focused care and services' were published in October 2005. These standards are being used to assess the quality of services provided by NHSScotland nationwide.

This report presents the findings from the peer review of the **Scottish Ambulance Service**. This review visit took place on **15 June 2006**, and details of the visit, including membership of the review team, can be found in Appendix 2.

1.1 How the standards were developed

In September 2003, a clinical governance and risk management standards project group was established and chaired by Dr John Browning, Medical Director, NHS Lanarkshire. The project group had a broad membership, drawn from a range of backgrounds, reflecting all dimensions of healthcare governance and representatives from interest groups.

The remit of the project group was to set standards for clinical governance and risk management, which integrated the healthcare risk management standards developed for NHSScotland by the Clinical Negligence and Other Risks Indemnity Scheme (CNORIS) and the generic standards (Clinical Standards Board for Scotland, 2002). These standards have, therefore, been designed to focus on clinical governance and risk management from the perspective of patient outcomes.

When developing the clinical governance and risk management standards, four focus groups were commissioned to ascertain public views on the standards. These groups were designed to capture a variety of perspectives from different geographical locations in Scotland.

1.2 How the review process works

The review process has three key parts: local self-assessment, pre-visit analysis and external peer review. The review process is described in more detail below (see also the flow chart on page 9).

Self-assessment by NHS boards

On receiving the standards, each NHS board assesses its own performance using a framework produced by NHS QIS. This framework includes guidance about the type of evidence (eg policies and reports) required to allow a proper assessment of performance against the standards to be made.

Pre-visit analysis

On receipt of the self-assessment, NHS QIS performance analysts review the self-assessment and evidence, and produce a pre-visit analysis report which is given to the NHS board for comment. Following discussion between the NHS board and the performance analysts, this report is agreed and sent to the external peer review team, together with the self-assessment and evidence.

External peer review

An external peer review team visits and speaks with local stakeholders (eg staff) about the services provided. Review teams are multidisciplinary, and include both healthcare professionals and members of the public. All reviewers are trained. Each review team is led by an experienced reviewer, who is responsible for guiding the team in its work and ensuring that team members are in agreement about the assessment reached.

The composition of each team varies, and members have no connection with the NHS board they are reviewing. Both of these factors facilitate the sharing of good practice across NHSScotland, and ensure that each review team assesses performance against the standards rather than makes comparisons between one NHS board and another.

At the start of the on-site visit, the review team meets key personnel responsible for the service under review. Reviewers then speak with local stakeholders about the services provided. After these meetings, the team assesses performance against the standards, based on the information gathered during both the self-assessment exercise, pre-visit analysis and the on-site visit.

The visit concludes with the team providing feedback on its findings to the NHS board. This includes specific examples of local initiatives drawn to the attention of the review team (recognising that other such examples may exist), together with an indication of any particular challenges.

Performance assessment statements

A quality improvement tool is used by each review team to assess performance against the standards. The quality improvement tool enables the review team to assess how an NHS board is achieving each standard through development, implementation, monitoring and reviewing. These four key stages represent the continuous improvement cycle through which each NHS board can ensure that all patients in hospitals receive safe, effective, patient-focused care and services.

The most appropriate performance assessment statement is agreed by the review team to describe an NHS board's current position against each core area. This allows an overall performance assessment statement to be arrived at for each of the standards, which indicates the NHS board's level of achievement for each standard.

The agreed standard level statements will be added together and this assessment of performance will feed into the Scottish Executive Health Department (SEHD) Performance Delivery Unit in June 2007, and will be used to determine the NHS board's targets for the following year.

Links with other organisations

Clinical governance and risk management is part of a shared agenda. During this review process we have focused on working more effectively in partnership with the organisations who monitor other aspects of healthcare governance to inform the assessment process.

We have lead responsibility for assessing the performance of all NHS Boards against the clinical governance and risk management standards. By working together we share information and scheduling, ensuring organisations are not subject to unnecessary multiple reviews.

The organisations we are working with are Audit Scotland, Chief Scientist Office, NHS Education Scotland, NHS National Services Scotland, Scottish Executive Health Department, and Scottish Health Council.

1.3 Reports

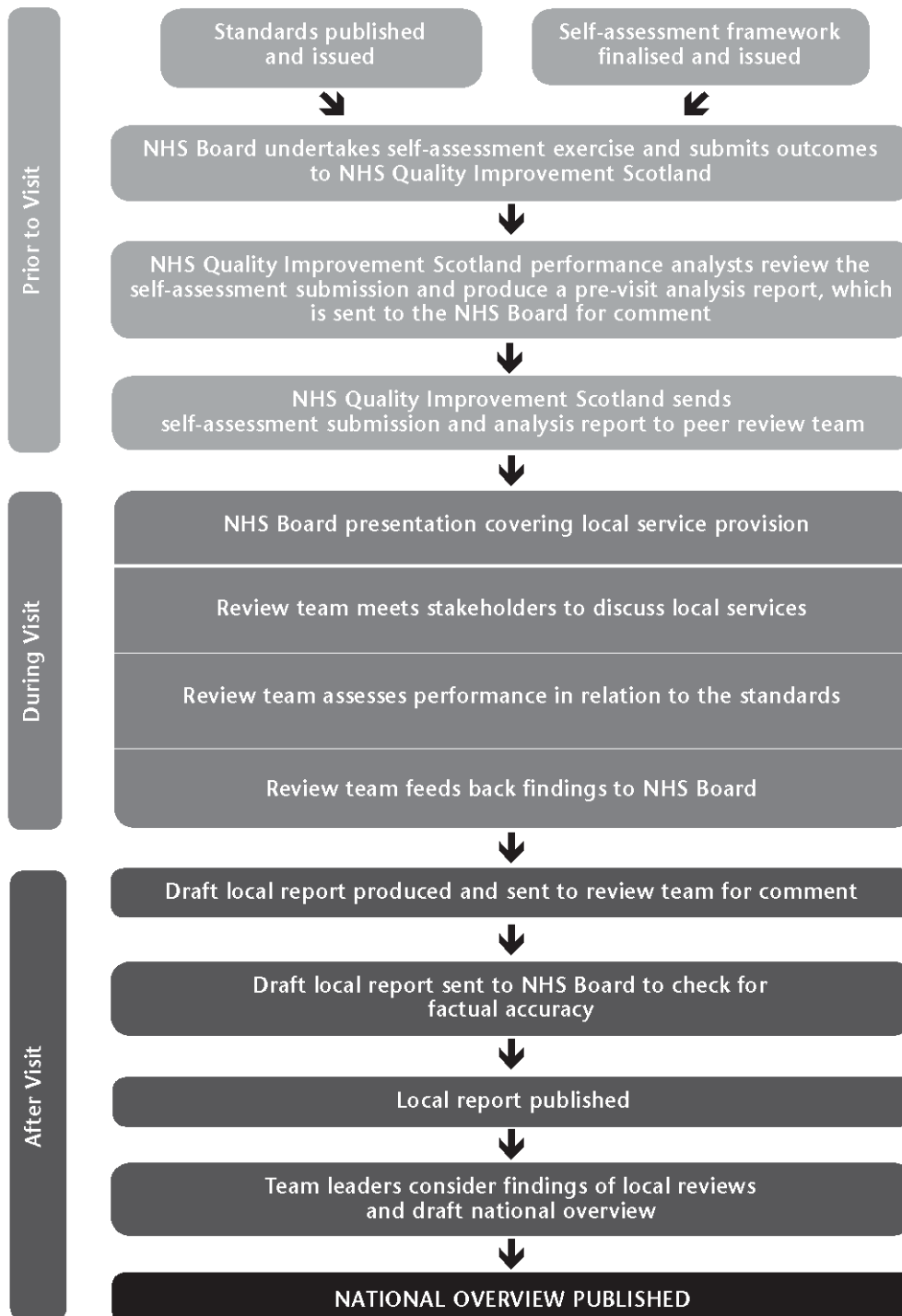
After each review visit, NHS QIS staff, with input as appropriate draft a local report detailing the findings of the review team. This draft report is sent to the review team for comment, and then to the NHS Board to check for factual accuracy. The local report will then be published and made available on the NHS QIS website.

Once the clinical governance and risk management national review cycle is completed, the team leaders will meet to examine review findings and make recommendations. The team leaders then oversee the production of a national overview of service provision across Scotland in relation to the standards. This document includes both a summary of the findings and recommendations for improvement.

Part of the remit of NHS QIS is to report whether the services provided by NHSScotland, both nationally and locally, meet the agreed standards. This does not include reviewing the work of individual healthcare professionals. In achieving this aim, variations in practice (and potential quality) within a service will be encountered and subsequently reported.

Please note – all reports published are available in print format and on the NHS QIS website.

The review process



2 Summary of findings

2.1 Overview of local service provision

The Scottish Ambulance Service is a Special Health Board of NHSScotland. It provides an ambulance service nationwide, by delivering accident and emergency services, together with non-emergency and other associated services. There are six divisions within the Scottish Ambulance Service. Services are provided from a total of 152 locations comprised of ambulance stations and home-based operating points. Each division is headed by a general manager and managed by a divisional management team. There is also an Air Ambulance Service which operates from six bases. Two of these are in Glasgow, with the others in Inverness, Shetland, Orkney and Aberdeen.

In 2002, a £22 million modernisation programme was undertaken by the Scottish Ambulance Service with the aim of radically changing the way that emergency care is managed and delivered in Scotland. One change was to prioritise responses to 999 calls using an advanced medical priority dispatch system (AMPDS). Versions of this system had already been successfully established and used in other countries. The AMPDS prioritises emergency calls on the basis of clinical need ensuring that those with the most serious conditions get the fastest response. Calls can be assessed as not requiring the skills of an emergency ambulance crew and in those instances alternative assistance, such as NHS 24, would be offered.

Further information about the Scottish Ambulance Service can be accessed via its website (www.scottishambulance.com).

2.2 Summary of findings against the standards

A summary of the findings from the review is presented in this section. A detailed description of performance against the standards/criteria is included in Section 3.

Standard 1 – Safe and effective care and services

Overall position statement:

The NHS Board is monitoring its policies, strategies, systems and processes to control risk, continually monitor care and services, and work in partnership with staff, patients and members of the public.

The Scottish Ambulance Service has a clear risk management strategy and associated policies, which clearly demonstrate an open and responsive approach to risk management throughout the Service.

The Service has emergency and business continuity plans in place. Comprehensive systems are in place for emergency planning. At the time of the visit, although business continuity planning arrangements were in place in each division, some divisions were at different stages of implementation.

Clinical effectiveness and quality improvement is monitored by the Service on a regular basis. All clinical effectiveness initiatives are tested locally before being implemented and local stakeholders are represented throughout this process. Stakeholders are also involved via divisional continuous improvement groups, which provide the main focus for clinical effectiveness at local level.

Standard 2 – The health, wellbeing and care experience

Overall position statement:

The NHS Board is monitoring the implementation of its policies, strategies, processes and procedures to provide services that take into account individual needs, preferences and choices.

The Scottish Ambulance Service is reviewing the effectiveness of its policy and partnership approach to access, referral, treatment and discharge across the organisation. The Service works closely with patients and carers when designing services. All Service consultations and projects have a project group, which includes patients, carers and other stakeholders as appropriate. A post-project evaluation group is also convened following each project to review the project and inform future work.

At the time of the visit, the Service was at an early stage of implementing its equality and diversity policies and arrangements. Regional planning groups, service redesign structures and quality improvement groups are used by the Service to identify the needs of specific groups of people.

A communications strategy is in use and is being monitored by the Service. Communication with staff is mainly via the intranet. There is, however, a system in place to reach staff who do not have access to the intranet, whereby station managers print off documents for staff to read. The Scottish Ambulance Service Board has a commitment to communicating with staff, as highlighted by the Board

visiting ambulance stations whilst holding board meetings in various parts of the country.

Standard 3 – Assurance and accountability

Overall position statement:

The NHS Board is reviewing the effectiveness of its policies, strategies, processes and procedures to promote public confidence about the safety and quality of the care and services it provides.

The Scottish Ambulance Service is reviewing the effectiveness of its policy, strategy, processes to co-ordinate clinical governance and quality assurance arrangements across the organisation. The Service framework for clinical excellence highlights the importance of engaging with staff on clinical governance. To this end, the Service had organised a national clinical symposium and local divisional workshops to raise awareness.

Appropriate systems are in place at the Service to ensure that its workforce is fit to practice. At the time of the visit, all staff held continuing professional development (CPD) portfolios.

The Service communications strategy includes internal and external communication. Implementation of the strategy is monitored as part of the standard corporate and planning development strategy. A number of methods are used to monitor external communication, for example feedback from partnership forums and the involving people group.

Appropriate performance management arrangements are in place. The Service reported that clinical governance is an integral part of the Service's performance management arrangements. Performance reports are presented to the Scottish Ambulance Service Board and management teams at agreed intervals.

The Service is monitoring the implementation of its systems, policies and procedures for information governance. The Service has an information governance strategy in place, supported by an information governance structure. An information management steering group is responsible for overseeing the implementation and operation of the information governance framework throughout the Service. The consistency and integrity of information used by staff is reviewed by the clinical effectiveness, and information and communications technology teams.

3 Detailed findings against the standards

Standard Statement 1: Safe and effective care and services

Care and services are safe, effective, and evidence-based.

Overall position statement

The NHS Board is monitoring its policies, strategies, systems and processes to control risk, continually monitor care and services, and work in partnership with staff, patients and members of the public.

Core area: 1(a) Risk management

Position statement: The NHS Board is reviewing the effectiveness of its risk management policy, strategy, systems and processes across the organisation.

Development

The Scottish Ambulance Service has an open and responsive approach to risk management, which is supported by a risk management strategy and a number of policies. The strategy details the arrangements for the management of risk within the Service and is approved by the Board and the risk management steering group.

The risk management steering group is responsible for co-ordinating, prioritising and monitoring risk management arrangements and activities for the Service. The group, which meets bi-monthly, has links to a number of other committees within the Service, for example the clinical effectiveness group. The group is chaired by the director of finance and reports to the audit committee. The review team was pleased to note the wide representation of all levels of staff on this group, from staff convenor to director level.

Implementation

A corporate risk register is used by the Service to record and monitor the risks encountered by the Service. Directors and senior managers are identified as the owners of specific risks within the corporate risk register. Risk logs are used by each division and department, project boards and groups to keep an up-to-date record of risks identified within these areas; these in turn feed into the corporate risk register. Members of the public, staff and other appropriate stakeholders are represented on each of the project boards and groups.

The risk management strategy, associated policies, minutes of the risk management steering group, national bulletins, safety action notices and risk alerts are placed on the intranet for staff to access. In addition, relevant information regarding risk management is shared with other agencies as appropriate, for example other NHS Boards and ambulance services throughout the UK.

A risk management toolkit is available for all staff on the intranet. In addition, staff are given training on dynamic risk assessment, which is a continuous process of identifying hazards, assessing risks, taking action to eliminate or reduce risk, and monitoring and reviewing the changing circumstances of an operational incident.

The training allows staff to carry out this assessment when making operational decisions. Staff also attend one-day management of risk workshops and have access to specialist staff within the national risk and emergency planning department, including out-of-hours support.

The Service promotes a culture of reporting incidents without fear of blame, and operates an adverse incident reporting system, whereby adverse incidents and 'near misses' are reported locally and cascaded up to the risk management steering group. The incident reporting procedure clearly details the process for all staff to report adverse incidents. Adverse incidents and near misses are reported quarterly to the audit committee and the clinical governance committee by the risk management steering group.

Monitoring

The Service ensures that its risk management objectives are monitored through a variety of methods, including internal reviews and self-assessments. Risk management is a standing item on the agenda of the audit committee meetings, at which high level risks and major trends are reviewed. Risk key performance indicators have been developed by the Service and are reviewed by the risk management steering group at each meeting.

The Service uses an integrated risk management, incident recording, claims and complaints database (Datix) to record appropriate information. This system allows the identification of trends which are presented, together with other relevant pieces of information from the system, to the risk management steering group and disseminated to the Service.

The review team was pleased to note the use of a structured debriefing system, whereby the Service undertakes root cause analysis following adverse incidents and near misses.

Reviewing

At the time of the visit, the review team agreed that the Service was reviewing its risk management strategy, policies and systems and processes across the organisation. The high level risk management plan, which is described in the risk management strategy, is reviewed formally on a bi-monthly basis at the risk management steering group meeting. Risks detailed in the individual risk logs and corporate risk register are also reviewed by the appropriate group and led by the appropriate risk owner.

In addition, the Scottish Ambulance Service Board takes part in an annual risk identification session, facilitated by the internal auditors. During this session, members of the Board identify individually and collectively, what they believe to be the top 10 risks for the Service, against those risks identified on the corporate risk register. The top 10 risks are then reviewed quarterly by the Board.

Core area: 1(b) Emergency and continuity planning

Position statement: The NHS Board is implementing emergency and continuity planning systems across the organisation.

Development

Overall responsibility for emergency planning and business continuity within the Service lies with the chief executive. However, delegated authority is given to the director of operations, who delegates overall management responsibility to the general manager for national risk and emergency planning. The national risk and emergency planning department employs a number of staff who are responsible for all aspects of emergency and business continuity planning.

Implementation

The Service has comprehensive systems in place for emergency planning. Business continuity arrangements are also in place, with each division having business continuity planning arrangements. Some divisions within the Service are at different stages with their business continuity planning arrangements. However, there was evidence that good progress was being made in this area.

The Service is involved in a number of regional and national groups and committees in relation to emergency planning and has contributed to the development of national guidance and regulation. The review team noted extensive co-operation between the Service and other organisations.

The review team also noted the wide range of training undertaken by staff, in respect of major incidents.

Monitoring

The Service undertakes a number of internal local and national exercises to test its emergency and continuity planning systems. For example, the Service is aware its emergency medical despatch centres (EMDCs) are heavily dependent on information technology (IT). In order to cope with any failures in their IT system, the EMDCs, at intervals, revert to paper-based systems. Some EMDCs have also been involved in full evacuation exercises, whereby the EMDC is evacuated and staff work using paper-based systems from another venue. The Service also takes part in a number of national exercises with other stakeholder organisations.

At the time of the visit, the Service reported that a divisional business continuity exercise had taken place and that all six divisions will test their business continuity plans over the next 3 years.

Reviewing

The Service reported that a structured debrief with staff takes place, following all exercises, to allow reflection and review of the systems. In addition, emergency plans are revised following changes in national guidance, legislation and best practice. As a number of divisions are at different stages with their business continuity planning arrangements, the Service is unable to demonstrate reviewing throughout the Service.

Core area: 1(c) Clinical effectiveness and quality improvement

Position statement: The NHS Board is monitoring the implementation of its co-ordinated programmes for clinical effectiveness and quality improvement across the organisation.

Development

The Service has developed a clinical governance policy and effectiveness strategy, which reflects the programme of developments recorded in its local health plan. The strategy is part of the clinical effectiveness framework, which the Service has implemented at a number of levels throughout the organisation.

Implementation

Each division has a continuous improvement group, at which patients, staff and other stakeholders are represented. These groups provide the main focus for the implementation of clinical effectiveness at local level within the Service.

Representatives from each of these divisional groups meet as the core national clinical effectiveness group. This group is responsible for the development and implementation of the clinical effectiveness strategy.

The Service reported that all clinical effectiveness initiatives are tested locally using local stakeholders, before being implemented. For example, in one area, the Service has worked with patients with asthma to record their details on its IT system, in order that patients can be treated more promptly. In some local areas, ambulance staff now have the medical history of this group of patients available en route to attending a call.

Monitoring

The Service reported that it undertakes regular patient satisfaction surveys at a national level, in addition to specific patient satisfaction assessment, in order to seek feedback from patients. Members of the public, via the Service's involving people group, are regularly involved in activities, for example local partnership groups and continuous improvement groups.

A formal complaints procedure is in place to address and monitor complaints. The Service employs a national complaints administrator to undertake this task. The Service reported that it undertakes home visits to those who have instigated complaints to explain reasons behind particular actions. In addition, the chief executive reviews and signs all complaint responses.

All operational staff use the national (joint royal colleges ambulance liaison committee) clinical guidelines, together with other appropriate clinical standards. Members of the Service are involved in the production of these guidelines via the national group and take part in the annual review of these guidelines. The Service uses clinical performance indicators to measure compliance with the guidelines. The Service reported that these guidelines are already available to staff in paper form and via the intranet. However, from mid 2006, these will also be available electronically in each ambulance.

The Service has a comprehensive approach to audit. A clinical audit strategy is in place, which the Service reported underpins its framework for clinical excellence. Front-line staff are released from their regular duties to undertake clinical audit.

Reviewing

The review team noted that, at the time of the visit, insufficient information had been provided to demonstrate that the Service approach to clinical effectiveness and quality assurance is being reviewed throughout the Board area. The team considered that a clearer demonstration of the link between management activity and the impact on patient care would be of benefit to the Service.

Standard Statement 2: The health, wellbeing and care experience

Care and services are provided in partnership with patients, carers and the public, treating them with dignity and respect at all times, and taking into account individual needs, preferences and choices.

Overall position statement

The NHS Board is monitoring the implementation of its policies, strategies, processes and procedures to provide services that take into account individual needs, preferences and choices.

Core area: 2(a) Access, referral, treatment and discharge

Position statement: The NHS Board is reviewing the effectiveness of its policy and partnership approach to access, referral, treatment and discharge across the organisation.

Development

The Scottish Ambulance Service has a patient focus and public involvement strategy, which describes the specific activities, which will be undertaken to improve patient and public involvement within the Service. The current strategy was developed, following a review of the previous strategy, between January and June 2005. Representatives from the involving people group and other patient and public representatives from a number of project groups and NHS Boards were involved in the review.

Implementation

Scottish Ambulance Service Board meetings are held in various locations around Scotland to give members of the public the opportunity to attend these meetings, which are publicised locally in advance. In addition, to raise awareness of the Service, encourage public involvement, and develop links with other stakeholders, the Service has been involved in a number of 'showcase' events. For example having a stand at the Royal Highland Show, Edinburgh.

The review team agreed that the Service is responsive to the needs of patients and carers, and works closely with these groups when designing services. Initial public consultation, via a paper and web-based consultation document, takes place before any changes to services occur. This is then followed by public meetings, meetings with other stakeholders and, where appropriate, questionnaires to specific groups. Following this process and approval by the appropriate group to move to the next stage, individual project groups and boards are set up by the Service to take forward each project. Project groups include members of the public, patients, staff and other stakeholders, relevant to the particular project. For example patients and staff who live and work in rural areas, and patients with particular medical conditions.

The Service has referral guidelines and protocols, which reflect local requirements. In addition, the Service has guidance for all callers who request an ambulance, including the public, patients and healthcare staff.

The Service works closely with other agencies, for example territorial and other Special Health Boards, such as NHS 24, to ensure the assessment process is undertaken appropriately. Each division has a multidisciplinary divisional quality improvement group, which includes representatives from other agencies. The Service reported that staff who work as part of a multidisciplinary team have the support of both the Service and partner agencies.

Carers' needs are considered by, and are represented as part of, the involving people group. The review team noted that because of the nature of the service being provided by the Scottish Ambulance Service, it can often be a particular challenge to address the needs and preferences of carers. The Service has an advocacy policy, detailing arrangements for independent advocacy. Staff advise patients of their right to involve a friend or advocate, as appropriate.

The Service has a consent policy, appropriate to the service it provides. In addition, patients are informed of all aspects of their care. Each patient is assessed using the electronic patient record/assessment tool, which has questions regarding consent, choice of treatment and capacity. This allows the patient to understand and accept or decline their options.

All discharges and transfers undertaken by the Service are in partnership with other agencies. The Service reported that ambulance staff have the right to refuse to return a patient home, or leave them there if they believe the discharge arrangements are likely to fail.

Monitoring

The Service works closely with staff, the public and stakeholders to monitor its approach to access, referral, treatment and discharge. For example, regular liaison meetings are held between Service staff and local hospital managers to consider and monitor arrangements.

Reviewing

The review team agreed that the Service is reviewing the effectiveness of its policy and partnership approach to access, referral, treatment and discharge across the organisation. The Service uses its involving people group as a resource to assist in this area. The Service reported that it had undertaken a staff survey on the subject of consent, which highlighted areas to be considered in improving policy and staff understanding.

In addition, the review team was pleased to note the post-project evaluation groups, following the delivery of each project, which are used to review the project and inform future work.

Core area: 2(b) Equality and diversity

Position statement: The NHS Board is implementing its equality and diversity policy in accordance with legislation, national guidance and best practice across the organisation.

Development

At the time of the visit, the Service reported that it has been adopting new arrangements for equality and diversity, and that this will continue over the next 12 months. The Service has some policies in relation to equality and diversity, however, these will be reviewed over the next 12 months and included in the equality and diversity steering group work programme.

Implementation

The review team noted that the Service is at an early stage of implementation of its equality and diversity arrangements throughout the organisation. At the time of the visit, the Scottish Executive Health Department's (SEHD's) equality and diversity impact assessment toolkit was being used locally to review and undertake equality and diversity impact assessments of new and existing care and services. The Service reported that it uses its regional planning groups, service redesign structures and quality improvement groups at local level to identify the needs of specific groups of people.

Monitoring

The Service is at the early stage of implementation of its equality and diversity arrangements. The review team, therefore, agreed that the Service was not yet able to monitor its arrangements for equality and diversity.

Reviewing

The Service is at the early stage of implementation of its equality and diversity arrangements, therefore, it has not been possible to begin the reviewing stage.

Core area: 2(c) Communication

Position statement: The NHS Board is monitoring its policies, strategies and procedures for improving the way that staff communicate and engage with each other, patients and the public across the organisation.

Development

A communications strategy has been developed by the Service. The strategy has been in use for some time and was approved by the Board. The Service has a small team of staff who are responsible for corporate communications. The Service reported that staff are involved in the development of communication strategies via consultation and discussion.

Implementation

The intranet is used to communicate with staff and is updated regularly with various documents, including bulletins, notices and national guidance. The Service reported that intranet access is available in all ambulance stations and that where individual staff do not have access to the intranet, the station manager prints off documents for staff to read. The introduction of the cab-based information technology systems to all ambulances over the next 24 months will mean that ambulance staff will be able to access a variety of documentation from within the ambulance.

The review team was pleased to note the commitment of the Board to ensuring good communication mechanisms with staff. In particular, the review team noted that when the Board hold its meetings in different parts of the country, it visits ambulance stations in the area to talk directly with staff.

Monitoring

The review team agreed that the Service monitors its policies, strategies and procedures for improving the way that staff communicate. The Service uses responses from the NHS staff survey to monitor feedback in this area. In addition, feedback is sought from the partnership forum and involving people network.

Reviewing

Although the Service is monitoring its policies, strategies and procedures for improving the way that staff communicate and engage with each other, patients and the public across the organisation however, the Service has not yet begun to review these.

Standard Statement 3: Assurance and accountability

NHSScotland is assured and the public are confident about the safety and quality of NHS services.

Overall position statement

The NHS Board is reviewing the effectiveness of its policies, strategies, processes and procedures to promote public confidence about the safety and quality of the care and services it provides.

Core area: 3(a) Clinical governance and quality assurance

Position statement: The NHS Board is reviewing the effectiveness of its policy and strategy to co-ordinate clinical governance and quality assurance arrangements across the organisation.

Development

The Scottish Ambulance Service has a clinical governance policy and clinical effectiveness strategy, which are part of the overall framework for clinical excellence. The clinical governance committee, in conjunction with the medical director and the planning and performance unit, is responsible for developing and overseeing the clinical governance arrangements for the Service. The Service reported that the local continuous improvement groups are also involved in the development of the clinical governance arrangements. The review team noted the terms of reference for the clinical governance committee, which meets quarterly, however, agreed that a more formal scheme of delegation would be of benefit.

Implementation

Engaging with staff to communicate the importance of clinical governance is an important part of the Service's framework for clinical excellence. A national clinical symposium and local divisional workshops have been used to raise awareness. In addition, the Service has produced a CD of clinical effectiveness materials to complement the information already on its intranet. The Service reported that staff from the planning and performance unit also work with operational teams to assist them in this area.

Patients, the public and other stakeholders are involved widely in consultations undertaken by the Service. The Service works closely with appropriate groups of people, depending on the nature of the consultation, for example consultation on changes to the Air Ambulance Service. Patient and public involvement is also sought on particular issues through the Service's involving people group. The review team noted that the Service has a strong awareness of its responsibility to the public and as such makes efforts to ensure that they are involved in decisions which affect them and their local communities.

The review team agreed that the Service has appropriate processes in place with regard to ethical review and research governance to address the needs of the service they provide. A research and development group, which is supported by the medical director, external specialist advisors and representatives from each division, approves

all research projects. The Service reported that it does not have its own ethics committee, but that it has agreements with external ethics committees who provide support as required.

The Service reported that research governance is embedded in the Service and all staff are aware of the principles and values of the Service's research programme and that appropriate material is available on the intranet.

Monitoring

A national quality steering group, which is chaired by the chief executive and includes all executive directors and senior representatives from a number of departments, monitors the effectiveness of quality assurance within the Service. The national quality steering group meets quarterly.

The Service uses its continuous quality improvement groups to exchange knowledge, information and best practice internally. Although these groups report clinically to the medical director, they report to the national quality steering group on all other matters. The Service is actively involved in sharing knowledge, information and good practice externally with other NHS and non-NHS organisations. The review team was pleased to note the sharing of good practice both internally and externally.

Reviewing

Team leaders and experienced staff who give training to colleagues, continually assess the care delivered by their teams, and report to managers and trainers. The Service has an annual clinical forum meeting, which monitors, measures and appraises the quality of care and services provided by the Service. This group comprises specialist advisers and representatives from the local paramedic steering committees. The local paramedic steering committees act as liaison groups to evaluate local care and are chaired by senior clinical staff. In addition, divisions also undertake an annual review of their work, which ensures processes and procedures are in place and informs practice.

Core area: 3(b) Fitness to practice

Position statement: The NHS Board is reviewing the effectiveness of its policies and procedures across the organisation to ensure its workforce is fit to practice.

Development

The review team agreed that the Service has appropriate systems in place, to ensure its workforce is fit to practice. The Service has systems in place, which ensure that pre-employment and ongoing checks of staff are undertaken and that all staff are registered with the appropriate bodies.

Implementation

The Service uses the national register of paramedics to ensure that all paramedics have full state registration. Driving licences are checked annually for all staff who require to drive as part of their role. New members of staff are required to undertake Disclosure Scotland checks and additional checks to ensure they do not appear on the Disqualified from Working with Children List.

Monitoring

At the time of the visit, the Service reported that staff had a personally held continuing professional development (CPD) portfolio and that CPD is linked with the Service's appraisal system. All operational staff attend a mandatory annual training post-proficiency programme.

Staff who are assessed as being unfit to practice are assisted to understand the individual reasons for this and, where possible, given appropriate learning support and are re-examined at a later date. Where necessary, redeployment is also considered, whilst ensuring that patients are protected. The Service has a capability procedure, which addresses the situation of staff being assessed as unfit to practice.

The Service reported that ambulance staff mainly operate without direct supervision or management. The review team noted that due to the nature of the role, systematic clinical supervision is a challenge for the Service. Many of the core skills and treatments are based on protocol and clinical standards. Ambulance staff are expected to keep good clinical records and a personal clinical diary, which is reviewed periodically by line managers. Ambulance staff also participate in critical case review and are expected to share best practice and learning outcomes. Any problems or deficiency in staff skills identified outside the Service are reported to the Service via the receiving units, with whom the Service has close contacts.

Reviewing

The medical director and director of human resources are involved in the review of required competencies and training throughout the Service and in partnership with other agencies. The Service carries out a paramedic skills audit at intervals to ensure that staff are using skills appropriately and in accordance with clinical guidance.

The Service reported that it is working to strengthen relationships with higher education establishments, with the view to either offering appropriate training or assessing and awarding an appropriate qualification. For example, the Service has worked with Queen Margaret University College, Edinburgh, to deliver a paramedic practitioner scheme, where at the time of the visit, paramedics were providing out-of-hours cover in NHS Lothian and NHS Grampian.

Core area: 3(c) External communication

Position statement: The NHS Board is monitoring the implementation of its external communication strategy across the organisation.

Development

The Service has a communications strategy, which includes internal and external communication. The strategy is monitored and reviewed at regular intervals. The strategy was developed with executive team and Board level agreement.

Implementation

The Service works closely with patients, the public and other stakeholders to ensure they are informed of the work of the Service via a number of initiatives. In particular, the review team was pleased to note that project groups and boards include lay representation, to ensure the views of patients and the public are considered.

The review team noted that the communications materials used by the Service are of a high quality. The Service also has its own website which, at the time of the visit, was being updated following the appointment of a new webmaster.

Monitoring

The Service monitors its external communication as part of its standard corporate planning and development strategy. A variety of methods are used to monitor external communication, including using feedback from the involving people group, partnership forums and through an external agency, which it employs to monitor its press releases.

Reviewing

Although the Service is monitoring its external communication strategy across the organisation, the review team agreed that the Service has not yet begun the reviewing stage.

Core area: 3(d) Performance management

Position statement: The NHS Board is reviewing the effectiveness of its performance management arrangements across the organisation.

Development

The Service has appropriate performance management arrangements, which have been developed via the processes which the Service has in place for development of its health plan.

Some aspects of performance are benchmarked against other organisations, for example response times against other UK ambulance services. However, the Service reported a particular challenge in finding a suitable organisation to benchmark against.

Implementation

The Service reported that most performance information is collected as a by-product of its operational systems, for example response times for its accident and emergency (A&E) service and sickness absence.

Clinical governance is an integral part of the Service's performance management arrangements. Clinical performance is one of the four key areas targeted at the annual divisional accountability reviews.

Monitoring

Weekly performance reports are presented to management teams and the Board receives reports on a monthly basis. Performance information informs both the

annual divisional accountability reviews and the annual review for the Service. Performance information is included in the annual report.

Reviewing

When developing the Service's national health plan each year, staff review arrangements for monitoring and reporting performance against the plan. The Service's health plan is aligned to SEHD policy and the Service's key strategies. In addition, the Service has divisional plans, which reflect the Service's national plan. Annual divisional accountability reviews take place to formally review divisional plans and performance. The outcomes of these reviews are shared with the management team and reported to the Board.

Core area: 3(e) Information governance

Position statement: The NHS Board is monitoring the implementation of its systems, policies and procedures for information governance across the organisation.

Development

The Service has an information governance strategy in place and has developed its information governance structure. At the time of the visit, the Service reported that it was introducing advanced electronic systems to assist with the management of clinical and non-clinical data.

Implementation

The information management steering group has responsibility for overseeing the implementation and operation of the information governance framework for the Service. The group is directly responsible to the Board and its committee structure. The director of human resources is the director with responsibility for the day-to-day management of corporate information governance arrangements, with the chief executive being the accountable officer.

Confidentiality and security of patient information is controlled by a number of measures, including secure access to databases holding patient information available to a limited number of staff. Staff are expected to operate within clear guidelines and to ensure they follow data sharing protocols. In addition to standard IT protection, for example passwords and firewalls, the Service employs a data security officer to ensure security measures are upheld.

The medical director has been appointed as the Service's Caldicott guardian. Any breach in patient confidentiality is referred to the Caldicott guardian and the data protection lead for the Service. Patients are made aware of their rights regarding the use of their personal information via posters in ambulances and on the Service's website.

Staff are trained to deal with situations regarding use of personal information and consent. In particular, training on child protection and vulnerable adults is given. In addition, all staff have access to the relevant codes of practice and posters, and personal check cards are also used to support the use of these documents.

Monitoring

Clinical effectiveness and information and communications technology teams continuously review the consistency and integrity of information used by staff. The service reported that most information is reviewed annually. The service control systems have altering mechanisms in place to alert staff when information requires to be reviewed.

Reviewing

Although the Service is monitoring the implementation of its systems, policies and procedures for information governance across the organisation, however, the review team agreed that the Service has not yet begun the reviewing stage.

Appendix 1 – Glossary of abbreviations

A&E	accident and emergency
AMPDS	advanced medical priority despatch system
CPD	continuing professional development
EMDC	emergency medical despatch centre
CNORIS	Clinical Negligence and Other Risks Indemnity Scheme
IT	information technology
NHS QIS	NHS Quality Improvement Scotland
SEHD	Scottish Executive Health Department

Appendix 2 – Details of review visit

The review visit to the Scottish Ambulance Service was conducted on 15 June 2006.

Review team members

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Mr Vincent Shields

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NHS Quality Improvement Scotland Staff

Mrs Elaine McArthur

Project Officer

Ms Tracy Walker

Senior Project Officer

During the visit, members of the review team met with Board level, strategic and operational staff.

Appendix 3 – Timetable of review visits

Organisation reviewed	Visit date(s)
Golden Jubilee National Hospital	8 November 2006
NHS 24	17 August 2006
NHS Ayrshire & Arran	13 February 2007
NHS Borders	24 May 2006
NHS Dumfries & Galloway	8 June 2006
NHS Education for Scotland	5 December 2006
NHS Fife	1 March 2007
NHS Forth Valley	1 February 2007
NHS Grampian	6 July 2006
NHS Greater Glasgow and Clyde	27 September 2006
NHS Health Scotland	26 April 2007
NHS Highland	29 March 2007
NHS Lanarkshire	7 September 2006
NHS Lothian	17 October 2006
NHS National Services Scotland	20 December 2006
NHS Orkney	23 November 2006
NHS Shetland	10 May 2007
NHS Tayside	14 March 2007
NHS Western Isles	12 April 2007
Scottish Ambulance Service	15 June 2006
The State Hospitals Board for Scotland	18 January 2007

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