Clinical Governance & Risk Management: Achieving safe, effective, patient-focused care and services
NHS Quality Improvement Scotland (NHS QIS) is committed to equality and diversity. We have assessed the performance assessment function for likely impact on the six equality groups defined by age, disability, gender, race, religion/belief and sexual orientation. For this equality and diversity impact assessment, please see our website (www.nhshealthquality.org). The full report in electronic or paper form is available on request from the NHS QIS Equality and Diversity Officer.

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# Contents

1. Setting the scene .................................................. 4

2. Summary of findings ........................................... 6

3. Detailed findings against the standards .................... 8

Appendix 1 – Glossary of abbreviations ....................... 22
Appendix 2 – Review process .................................. 23
Appendix 3 – Details of review visit ......................... 24
1 Setting the scene

This report presents the findings from the clinical governance and risk management (CGRM) peer review to the Scottish Ambulance Service. This review visit took place on 6 August 2009, and details of the visit, including membership of the review team, can be found in Appendix 3.

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

Background

NHS Quality Improvement Scotland (NHS QIS) was set up by the Scottish Parliament in 2003 and leads the use of knowledge to promote improvement in the quality of healthcare for the people of Scotland and performs three key functions: providing advice and guidance on effective clinical practice, including setting standards; driving and supporting implementation of improvements in quality; and assessing the performance of the NHS, reporting and publishing the findings. In addition, it also has central responsibility for patient safety and clinical governance across NHSScotland.

The National Standards for Clinical Governance & 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.

The national standards for clinical governance and risk management were first reviewed during 2006–2007. Peer review visits to all NHS boards in Scotland were conducted between May 2006 and May 2007 to assess performance against the standards. Local reports for each NHS board were published during the review cycle and a national overview of the key findings and recommendations was published in October 2007. NHS QIS has subsequently agreed with the Scottish Government that it will review the national standards for clinical governance and risk management at a strategic level, in each NHS board, every 3 years.

Review process

The review process has three key phases: preparation prior to the performance assessment review, the review visit, and report production and publication following the visit. (See flow chart in Appendix 2 for further detail.)

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 the cycle of development, implementation, monitoring and reviewing. These four key stages represent the continuous improvement cycle through which each NHS board can ensure that all patients 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 overall performance assessment statement for each standard will be added together for each NHS board and this information will feed into the NHSScotland health, efficiency, access and treatment (HEAT) targets, set by Ministers, in June 2010.
Each review team is led by an experienced reviewer, who is responsible for guiding the team and ensuring that team members are in agreement about the assessment reached.

**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 following organisations that monitor other aspects of healthcare in order to inform the assessment process:

- Audit Scotland
- Chief Scientist Office
- NHS Education for Scotland
- NHS National Services Scotland
- Scottish Government Health Directorates, and
- Scottish Health Council.

We have agreed that the following areas will not be reviewed by NHS QIS as they are already being reviewed as follows:

- **Criterion 1c.5:** Scottish Health Council (patient focus and public involvement assessment)
- **Criterion 3a.2:** Scottish Health Council (patient focus and public involvement assessment)
- **Criterion 3a.5:** Chief Scientist Office (research governance assessment)
- **Core area 3e:** NHS National Services Scotland (information governance assessment)

We have also agreed an operational protocol with Audit Scotland which sets out broad principles for collaborative working, primarily between NHS QIS and Audit Scotland, covering issues such as the sharing of information, communication and liaison, and avoiding the duplication of work which relates specifically to Audit Scotland’s national reporting.
2 Summary of findings

A summary of the findings, including strengths and recommendations, from the review is illustrated in this section. Overall performance is rated using the four assessment categories. The most appropriate category is agreed by the review team to describe the NHS board’s current position against each core area – indicated by the shaded areas below. A detailed description of performance against the standards is included in Section 3.

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<th>CGRM standards</th>
<th>Assessment category</th>
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<tr>
<td></td>
<td>Development</td>
</tr>
<tr>
<td>Standard 1: Safe and effective care and services</td>
<td></td>
</tr>
<tr>
<td>Core area 1a</td>
<td></td>
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<tr>
<td>Core area 1b</td>
<td></td>
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<tr>
<td>Core area 1c</td>
<td></td>
</tr>
<tr>
<td>Standard 2: The health, wellbeing and care experience</td>
<td></td>
</tr>
<tr>
<td>Core area 2a</td>
<td></td>
</tr>
<tr>
<td>Core area 2b</td>
<td></td>
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<tr>
<td>Core area 2c</td>
<td></td>
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<tr>
<td>Standard 3: Assurance and accountability</td>
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<td>Core area 3a</td>
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<td>Core area 3d</td>
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Strengths

The NHS board has:

- strong direction from the leadership team and clear vision for the future of the organisation.
- utilised technology comprehensively to strengthen its arrangements for quality.
- demonstrated a high degree of innovation and partnership working in the field of emergency planning and business continuity.
• a culture of reviewing and improving its clinical governance and risk management arrangements as evidenced in many areas.

**Recommendations**

The NHS board to:

• ensure that evaluation activity is conducted in a formal and structured manner and is supported by documentary evidence.

• ensure that consistency is achieved at a local level for clinical effectiveness and governance arrangements.
3 Detailed findings against the standards

Standard 1: Safe and effective care and services

**Standard statement**
Care and services are safe, effective, and evidence-based.

**Overall performance assessment statement:**
The NHS board is reviewing and continuously improving its arrangements 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**

**Performance assessment statement:** The NHS board is reviewing and continuously improving its risk management arrangements across the organisation.

The Scottish Ambulance Service has robust risk management systems in place that have been fully implemented and subjected to a continuous cycle of monitoring and review since the last NHS QIS CGRM review in 2006. The service has reviewed the management of risk strategy and improved it to be consistent with the Australian/New Zealand standards for risk management and it is now comprised of a strategic plan, policy and accident/incident reporting procedures 2008-2011. The reviews have also led to the implementation of an electronic incident management system, the appointment of various risk management staff and the integration of the risk management steering group to the senior management team.

The implementation of Datix, an electronic web-based incident reporting system, resulted from an evaluation of reporting delays on the existing paper-based system. It is a fully integrated system that encompasses incident management, risk registers, complaints and claims. Datix can link directly with other NHS boards; this has been piloted with NHS Dumfries & Galloway and may be rolled out further if it continues to be successful. The service rolled out Datix Web in 2007 and has made it available to all staff via the intranet. The implementation phase was supported by road shows; an extensive training programme, including e-learning packages available on the intranet; and aide memoire cards produced and distributed to every member of staff outlining the incident reporting procedures.

Datix has been continuously evaluated and reviewed since implementation. This includes recently rolling out a questionnaire to staff evaluating the use of Datix with the intention of collating results and producing an action plan. The national risk and resilience department conducted a formal review in January 2009 on the ability to perform and complete investigations after an incident has been reported. This review identified that it would be beneficial if team leaders could complete incident/near miss investigations as they are closer to the event and would be able to complete more accurate results in a timely manner. Consequently team leaders have been granted access to conduct reviews where appropriate after a discussion with the relevant manager.
Timescales for reporting and investigation of adverse/near miss incidents are audited regularly by the risk management team and reported on a quarterly basis to the risk management steering group and the Board. Weekly reports covering incidents and risks are generated from the system and sent to a cross section of health and safety staff and risk management staff to ensure appropriate action is taken and reviewed in a timely manner. The service has also taken steps to begin benchmarking its new risk management arrangements within the National Ambulance Risk and Safety Forum.

The risk management function within the Scottish Ambulance Service integrates with the national risk and resilience department. This allows for best use of resources and specialist expertise, particularly with reference to training programmes, sharing best practice and access to wide reaching networks. The service reported that following a review of its risk management arrangements in 2007, it appointed a national risk manager, a risk management systems administrator and enhanced administrative support through the national risk and resilience department. The direct relationship between the two teams is reported to enable effective exchange of information and lessons learned from each sector and across the service.

As a result of a recent review of risk management arrangements the service is integrating the risk management steering group with the senior management team meetings to ensure that risk management is thoroughly embedded into all areas of the service. The risk management steering group played a lead role in assessing the effectiveness of the risk management arrangements throughout the service. The group met on a quarterly basis and considered all aspects of risk, including a detailed review of risk registers. There is a patient safety group which is a joint group with the risk management steering group and the clinical effectiveness group that also meets on a quarterly basis. The role of the patient safety group is to specifically analyse clinical risks to the service in addition to reviewing incident and near miss reports.

It was felt that incorporating the risk management steering group into the senior management team meetings would expose a wider cross section of the organisation to discussions surrounding the management of risk that they were not previously a part of, thereby increasing the profile of risk within the organisation.

In addition to quarterly meetings, the chief executive receives a monthly risk report which states the current position of the service in relation to risk registers and corporate objectives. This is copied to executive directors and reported to the Board. Furthermore, there are quarterly reports submitted to the clinical governance committee and the audit committee for approval.

Strategic risk management objectives are determined via the delivery planning process. This sets out the service’s 3-year health plan to support the Scottish Government’s health strategy ‘Better Health, Better Care’. The service participates in an annual risk management workshop, facilitated by Deloitte. This workshop considers the effectiveness of current arrangements, identifies objectives for the year ahead and ensures linkage with the 3-year health plan. It is attended by members of the Board, including non-executives and a wide range of risk management stakeholders from across the service.

Every project, division and department within the service owns and updates their specific risk register. The risk registers are co-ordinated centrally by the risk management team and every very high risk is escalated to the corporate risk register. The corporate risk register is reviewed monthly by the Board and appropriate actions highlighted in minutes for implementation. Owners of risk registers are required to review their risk registers and risk
action plans on a monthly basis (every 2 months for project boards) and feedback to the risk management team to ensure the risks remain relevant with the appropriate grading.

**Core area: 1(b) Emergency and continuity planning**

**Performance assessment statement:** The NHS board is reviewing and continuously improving its emergency and continuity planning arrangements across the organisation.

The Scottish Ambulance Service has had a comprehensive suite of emergency plans in place since 1991; these were re-written in 1996 and have been routinely tested, reviewed and continuously improved. Specific arrangements have been developed to integrate the response to scenarios such as chemical, biological, radiological or nuclear attacks which have also been rigorously tested in multi-agency scenarios. The review team noted that the major incident plan remained dated as 1996, despite a series of reviews, thereby indicating that the plan would benefit from improved document control.

The service is strongly externally focused with the national risk and resilience department playing a lead role in a number of national committees, notably the eight strategic co-ordination groups of the Scottish Government and the UK emergency preparedness committee. It was reported that the Scottish Ambulance Service is perceived to be an innovator among the UK ambulance services and has assisted other services with their emergency and business continuity planning, and hosts an extensive range of training courses through the national risk and resilience department.

There is a detailed programme of internal and multi-agency planned exercises. The programme demonstrates that these exercises are carried out over various geographical locations and cover a multitude of topics and eventualities. After each exercise, there is a structured debrief that considers lessons learned. If changes to plans are identified as necessary and deemed relevant this is taken on board by the national risk and resilience department which ensures the appropriate changes are made and approved at the most suitable level, ie local departmental management teams, risk management steering group or Board level.

Business continuity is viewed as an integral part of emergency preparedness by the service. A framework of business continuity plans has been developed and implemented. This framework sets out the scope and purpose of business continuity to the organisation as well as the broad themes covered by the divisional level plans. The national risk and resilience department has developed a review programme to consider business continuity arrangements across the service which resulted in a revisit of each of the existing continuity plans to identify stakeholders and ensure relevance against new standards and legislation. At the time of the review visit, it was observed that there were over thirty continuity plans in place, which were created in June 2006, it was also noted that these plans were reviewed and updated in June 2009.

A specific business continuity benchmarking survey involving the fourteen other UK ambulance services was authored by the service and has been carried out. This survey has since evolved into a national work stream for business continuity as part of the UK Emergency Preparedness Board to look at mutual aid and national capabilities. In addition to this, the national risk and resilience department has also established a business continuity peer review audit tool that will be rolled out across the UK.
There are business continuity leads in each of the divisions and support functions, who assist the departmental management teams in conducting business impact analysis and evaluation exercises. The performance of the organisation with regards to emergency and continuity planning is discussed at each of the monthly departmental management meetings and various audits have been undertaken to assess the effectiveness of arrangements by internal audit. The arrangements for emergency and business continuity are also reviewed on a regular basis by the risk management steering group and by the chief executive and Board. The general manager of the national risk and resilience department submits a monthly Board report, which is also copied to the executive directors, that outlines the activities carried out over the last month, events that are scheduled to take place and information on responses to incidents and general updates.

It is clear that the Scottish Ambulance Service considers emergency and continuity planning to be integral to the continued success of the organisation and has, therefore, committed a sufficient level of time and resources to promote this within the organisation and reach a level of sustained review and continuous improvement.

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

**Performance assessment statement: The NHS board is monitoring the effectiveness of arrangements for clinical effectiveness and quality improvement across the organisation.**

The service has created a joint clinical governance policy and clinical effectiveness strategy for 2009/10–2011/12 called the framework for clinical excellence. This is an update on the previous plan that covered the period 2005–2009. It sets out how the service will continue to deliver safe, clinically and cost effective care in partnership with other agencies, including patients and the public. In addition to this strategy, a clinical effectiveness and governance programme is created annually and responds directly to current internal and external needs and priorities. The service is also establishing a new medical directorate with dedicated senior and clinical governance staff in fiscal year 2009–10. This directorate will work to further enhance the organisation's clinical focus and direction.

The service operates within the joint Royal Colleges ambulance liaison committee clinical guidelines, which is comprised of 128 research-led, evidence-based guidelines. The service contributes to the creation of these guidelines and regularly monitors compliance through its framework of clinical performance measures. The Scottish Ambulance Service has implemented 310 clinical performance measurements that have been combined into 19 overarching clinical performance indicators. These indicators are monitored by the performance and planning team alongside progress against HEAT targets and reported to the medical director, executive team, clinical governance committee, operating divisions and the Board on a monthly basis. Each locality is held accountable for results within each parameter and for compliance at a local and national level and tasked with actions on a monthly basis to support continuous improvement.

Updates on guidelines are distributed via national bulletins, team briefings, staff intranet and electronic implementation notices that are accessed and available in every responding vehicle.

The clinical audit programme, agreed on an annual basis, sets out a clear schedule of what is to be audited, the rationale for this and a reporting timetable. Evaluation evidence is brought to the national clinical effectiveness group and the clinical governance group, and
reported to the Board through approval of minutes, or if appropriate, raised as a separate item. The medical director is subsequently responsible for tasking the relevant group or individual with implementing actions from the Board or clinical governance committee.

The service is also currently expanding upon the MIDash management information software, used to produce performance management information, to create a data warehouse. The data warehouse project will enable fully flexible, real time reporting on clinical performance indicators and electronic access to patient history and outcomes, which will be invaluable in emergency situations.

Each division has a clinical governance and quality lead who reports to the head of clinical governance and in turn the medical director. Local clinical governance and quality leads are responsible for the co-ordination of local continuous improvement (or clinical development) groups, which support the local implementation and monitoring of the clinical effectiveness strategy. At the time of the visit, it was noted that not all divisions currently have continuous improvement groups and the structure for ensuring there is a group that considers clinical effectiveness at each of the divisions is under review. The review team was informed that the new ways of clinical working project group, has been tasked with including this within the remit of its project. In the meantime, the local delivery of safe, equitable and clinically effective care has been devolved to general managers and their staff in the five territorial operating divisions and the general manager in the emergency dispatch centre, who report monthly into the national clinical effectiveness group and in turn the healthcare governance committee. The review team, therefore, concluded that this reactive review did not evidence a continuous cycle of systematic and planned review of the effectiveness of the arrangements for clinical effectiveness across the whole of the Scottish Ambulance Service at this point in time.
Standard 2: The health, wellbeing and care experience

**Standard statement**
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 performance assessment statement:**
The NHS board is monitoring the effectiveness of its arrangements to provide care and services that take into account individual needs, preferences and choices.

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

**Performance assessment statement:** The NHS board is reviewing and continuously improving its arrangements with a partnership approach to access, referral, treatment and discharge across the organisation.

Since the last review, the service has continued to review and improve its arrangements for access, referral, treatment and discharge. The service demonstrated clear strategic aims, organisational leadership and reporting arrangements with respect to access, referral, treatment and discharge. A wide range of information is available to patients and carers in a variety of formats including posters in vehicles, patient information leaflets, public board meetings and information on websites. It has developed a multilingual phrasebook that allows for effective communication with individuals who do not use English as a first language, a 999 translation service and a text service for the hearing impaired.

Patient information leaflets have been developed to enhance the ‘See, Treat’ pathways that empower ambulance crews to treat a patient in their home without admitting to hospital. These leaflets were developed in consultation with patients, professionals and other key external stakeholders at five NHS boards (and NHS 24) using an easy to follow questionnaire to assess how effective the information contained in the leaflet was communicated, with changes made as appropriate. The service has also produced information leaflets for carers, including first aid leaflets for treating individuals with alcohol or drug problems, thereby demonstrating responsiveness to social inclusion issues.

The service has a fully implemented carers strategy, again developed in consultation with a wide range of external stakeholders, in addition to the service’s patient focus public involvement steering group. The strategy sets out a detailed action plan with mechanisms identified for reporting and monitoring, and clear leadership through the patient focus public involvement structure. The service is working with Carers Scotland to develop training for their employees to ensure that the needs of carers are identified and responded to on an individual basis.

Each ambulance carries posters outlining the usual procedure for treatment and transport. Individual options are also discussed with patients and/or carers prior to treatment to enable informed choices to be made; this is further supported by the use of patient information leaflets for specific conditions.

There is a clear consent policy which sets out the strategic context and includes detailed actions, targets and a flow chart to support staff in taking the appropriate action. Explicit
consent is insisted upon, except in emergency situations, and posters containing this information are displayed in all vehicles.

The service has implemented a professional to professional line following an evaluation of existing referral procedures, including feedback from GPs and ambulance crews and research evidence. The professional to professional line enables a planned review by the out-of-hours service for individuals who have not required admission to hospital. Paramedic advisors have also been established in the emergency medical dispatch centres to offer guidance to crews seeking advice and to link to other health professionals. At the time of the visit, it was reported that this has enhanced the confidence of ambulance crews to leave patients at home where appropriate.

The service uses an electronic patient record form to ensure information about patients remains up to date and that clinical guidelines are available in the practice environment and remain in line with with most current legislation. An e-learning module has been rolled out to support this, and compliance with guidelines and the consent policy is monitored on an ongoing basis through the data warehouse software.

A discharge action plan has also been established that improves prioritisation of transport, allows the inclusion of pharmacy information and more robust eligibility criteria for planned patient transport service journeys. Ambulance crews have the right to refuse discharge from hospital if appropriate care is not deemed to be available at the time of discharge and continuous liaison with local healthcare providers is maintained to ensure that this operates efficiently. Ambulance crews utilise situation, background, assessment and recommendation guidance when providing referrals to other professionals which ensuring clear and structured information is presented.

The service undertakes a range of evaluative activity to review and continuously improve its arrangements, this includes paramedic practitioner audit data to identify further areas for development in training and education, feedback from other agencies that work closely with the service (eg NHS 24), annual patient satisfaction surveys and various research projects undertaken by the research paramedics employed by the service. Results of evaluations are considered by the appropriate level of management group or committee and findings implemented where appropriate.

The review team was also pleased to note the service’s intention to tailor the Scottish Patient Safety Programme to suit the needs of the service and enable further monitoring of the service’s performance in this area.

**Core area: 2(b) Equality and diversity**

**Performance assessment statement:** The NHS board is implementing its arrangements for equality and diversity in accordance with legislation, national guidance and best practice across the organisation.

The Scottish Ambulance Service has developed and implemented a disability equity scheme and a gender equity scheme that are documented in a comprehensive manner with extensive action plans for achievement of objectives included. Annual reports are published on each scheme and contain an updated action plan with a documented status report detailing progress towards objective attainment. The service has also published its second race equity scheme which was reviewed in November 2008 and an updated action plan produced.
The service has joined the Stonewall champions programme and is working closely with this group to develop a lesbian, gay, bisexual and transgender strategy for implementation. The service reported that it has reviewed its personnel policies to ensure that they do not discriminate on the basis of age, religion/belief or sexual orientation. The service is currently examining its equality monitoring procedures to establish the best route to incorporate religion/belief and sexual orientation strands.

It is clear that the Scottish Ambulance Service ensures that its services are accessible in an equitable manner. A translation and interpretation service has been extended to cover the emergency medical dispatch centres and national headquarters. Multilingual phrasebooks are available in all vehicles to assist with communication and access to the translation service is available to each paramedic crew. Accident and emergency vehicles also contain disability tip cards providing key guidance on specific disability issues, further information is available through the cab-based terminal. The service also utilises a grid reference identification point system to place a reference tag on an address where the caller is known to have a communication issue due to a health condition or disability, allowing access to services where difficulties may arise.

The service engages with various groups through the patient focus public involvement structure. It performs an annual patient satisfaction survey of over 900 patients across Scotland and analyses the results to identify work to be done with specific patient groups that is then actioned.

Responsibility for equality and diversity is delegated to the director of personnel, who provides a monthly report to the Board. It remains the Board’s responsibility to sign off all strategies, policies and procedures relating to equality and diversity.

There is an equality and diversity steering group that meets every 2 months chaired by the equality and diversity lead and attended by representatives from across the service. The draft terms of reference for 2008–2009 states that the group will review existing equality and diversity policies, including their impact on related policies (eg recruitment) and will develop a small number of key performance indicators to monitor progress. It was reported that a yearly delivery plan is established to ensure the steering group covers a range of topics.

The service reported that there are regular evaluative discussions between the equality and diversity lead and the head of human resources and organisational development following the monthly equalities report to the Board, however these discussions are not minuted and take place in an informal manner. It was reported that these discussions led to the creation of the full time position of equality and diversity lead, however the review team could not identify specific evidence that demonstrated that this was as a result of a formal evaluation of arrangements.

It is clear that the Scottish Ambulance Service is closely monitoring the operational results of equality and diversity internally and striving for improvement in each of the six areas of fair for all. However, the review team was less able to identify evidence that demonstrated that the effectiveness of the arrangements to consider and improve the organisation’s equality and diversity procedures were being monitored and reviewed.
Core area: 2(c) Communication

Performance assessment statement: The NHS board is reviewing and continuously improving its arrangements for internal, staff and patient communications across the organisation.

Since the last review, the service has continued to monitor its communication arrangements and is now at the stage where it is reviewing and continuously improving these arrangements. A 3-year communication strategy and action plan, covering both internal and external communication, was developed in 2008. Evidence demonstrated that the service is evaluating the effectiveness of all its communication arrangements; strengths, weaknesses, opportunities, and threats analysis are included in the revised communication strategy. The review team was informed that some of the short-term strategies within the communications strategy and action plan have already been implemented; however, some others will need to wait until the overarching strategy is completed.

A consultation programme has been launched by the service to aid the development of the service’s strategic plan and vision. Information from this consultation will be used to shape the final communications plan, which is to be approved by the Board in early 2010. Evidence demonstrated the involvement of key stakeholders; a range of meetings have taken place with staff to allow them to comment. Furthermore, trade unions and members of the Scottish parliament have been invited to provide feedback on the strategy. Presentations have been given to teams within the service to increase awareness of the revised strategy.

There are a range of ways in which staff can communicate with each other within the service. National and divisional bulletins are circulated, for example the weekly bulletins from the chief executive, which inform staff of key initiatives. Information on clinical developments is communicated to staff via clinical national bulletins. The Response magazine contains articles on key projects and has a ‘human interest’ component. A review of the intranet ‘SAMSON 1’ was carried out and the intranet was re-launched as ‘SAMSON 2’ in October 2007.

Following a review by the executive team, a communications manager was employed in 2008. The communications team was then increased; this team meets with the corporate affairs manager, PR advisor and the director of human resources and clinical development as a communications forum. Local communication forums are also in place. Reporting structures ensure that the Board is kept updated on communication developments; monthly reports are provided to the director of human resources and clinical development, who in turn reports to the Board. Updates on progress with the communications strategy are provided to the Board.

The service has continued to use the staff survey to monitor feedback on internal communication. Any communication issues highlighted through the 2008 staff survey are being taken forward by national and divisional partnership forums. The review team was pleased to note that staff are updated on changes that have been made as a result of their feedback.
Standard 3: Assurance and accountability

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

Overall performance assessment statement:
The NHS Board is reviewing and continuously improving its arrangements 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

Performance assessment statement: The NHS board is reviewing and continuously improving its arrangements to coordinate clinical governance and quality assurance arrangements across the organisation.

Since the last review, the service has continued to review and improve its arrangements for clinical governance and quality assurance. The service has a joint clinical effectiveness and clinical governance strategy: the framework for clinical excellence, which contains a clear summary of the organisation’s strategic aims, derived from the seven building blocks for success in clinical effectiveness.

The clinical governance committee is a standing committee of the Board and meets on a quarterly basis. The committee receives reports from the national clinical effectiveness group, risk management steering group, emergency medical dispatch centres clinical advisory group and infection control committee. Day to day responsibility for clinical governance rests with the medical director who produces a quarterly report on clinical governance issues presented to the committee. The committee feeds back recommendations and actions to improve the arrangements for clinical governance to the medical director who then tasks the appropriate group with taking this forward.

Clinical and quality strategies are monitored in various ways. The use of key performance indicators and clinical audits dominates the evaluation cycle, however in-depth clinical research also has a significant role in supporting the clinical governance agenda. The service employs research paramedics and contributes to the wider research environment by supporting clinical trials and collaborative working with universities and other research bodies.

The service has an automated clinical reporting process that informs on over 300 clinical processes. This is reviewed monthly both nationally and locally with action plans and evaluations agreed locally. Monthly compliance reports are produced and exceptions investigated by local quality leads and clinical performance managers.

The service has implemented a new risk management system, Datix, that allows complaints monitoring to be an integral part of risk management and, therefore, considered as part of the clinical governance agenda. There are mechanisms in place for hospitals and emergency departments to feedback concerns and the service has trained staff in performing special investigations, such as case reviews and root cause analysis. The service also has a clinical
supervision policy where the frontline supervisors and trainers attend calls to ensure governance guidelines are being followed.

During 2008, the service commissioned Deloitte to audit the clinical effectiveness and governance arrangements, and the clinical governance committee subsequently approved the report. This report was in part responsible for the strengthening of the medical directorate to give improved focus on clinical governance issues, particularly at local and divisional levels.

The service further supports its clinical governance agenda by participating in national benchmarking exercises with the other UK ambulance services. In addition the service employs the LEAN methodology for evaluation techniques and service improvement and maintains membership of the Quality Scotland Foundation, and has won various quality awards such as Charter Mark, ISO9002 quality awards and the industry specific Centre of Excellence Award.

Core area: 3(b) Fitness to practise

Performance assessment statement: The NHS board is reviewing and continuously improving its arrangements across the organisation to ensure its workforce is fit to practise.

Since the last review, the service has continued to review and improve its arrangements to ensure its workforce is fit to practise. Comprehensive checks are carried out to ensure that staff have the necessary qualifications, registrations and accreditations to practise, and all staff are subject to disclosure checking. A central database is held by the education and training department for all clinical staff detailing the fulfilment of statutory requirements and also progress with continuous professional development. Systems are in place to ensure that staff renew and update their registration/accreditation to practise; the education and training department compares information on the Health Professions Council online register with its own central database. Recruitment and selection policies are in place, accompanied by a comprehensive recruitment checklist for appointing managers.

A commitment to the NHS Knowledge and Skills Framework (KSF) was demonstrated by the service. Training is available to staff on completing personal development plans and e-KSF modules have been developed to enhance understanding of this tool. Guidance is available to team leaders on the production of personal development plans.

A range of education and training programmes are in place for staff. Since the last review, the service has developed a 2-year paramedic practice programme. The paramedic practice programme meets the applicable standards set by the Health Professions Council; the paramedic practice programme board ensures compliance with this body's standards of training and education. Evidence demonstrated that the service evaluates the contents of this course, making changes when necessary. Changes are based on new developments in practice and are generated from a range of sources, for example programme team recommendations, or suggestions from patients, students and clinical representatives. Practice placement education is also incorporated within this programme; the review team was informed that education modules include the impact of law and ethics on practice. A practice placement educator is assigned to each paramedic during the first year of employment to supervise their clinical practice. One of the aims of the new ways of clinical working project is to ensure staff have the right skills; this also provides developmental and educational opportunities for staff.
The head of education and training and the senior management team are responsible for ensuring fitness to practise. The education and training department provides a report to the chief executive on a monthly basis; this report also goes to the Board. The clinical governance committee monitors procedures in place to ensure effective clinical practice, and also continuous professional development arrangements.

A range of policies and procedures are in place to enable the service to deal appropriately with staff who are potentially unfit to practise. For example, a substance abuse personnel manual outlines responsibilities for the employer and employee, and provides guidance on identifying and assessing such a problem. Evidence demonstrated that these procedures are reviewed, for example the managing employee capability personnel manual. Implementation notices circulated to staff on the use of new drugs or clinical practices, remind staff that they must ensure they are fully competent to provide care and what they must do should they believe they are not.

Mechanisms are in place to allow staff to report any issues which may adversely affect the delivery of clinical services. A whistle blowing policy has been implemented and staff can report incidents through the service incident reporting system.

**Core area: 3(c) External communication**

**Performance assessment statement:** The NHS board is reviewing and continuously improving its external communication arrangements across the organisation.

Since the last review, the service has continued to monitor its communication arrangements and is now at the stage where it is reviewing and continuously improving these arrangements. A new communications strategy has been developed that incorporates both internal and external communication, and the service is in the process of reviewing this strategy.

A range of methods are employed to enable the service to communicate with external stakeholders, for example stakeholder events, public meetings, newsletters and surveys. Furthermore, the service's website is also used to communicate externally; it contains useful information such as eligibility for patient transport and when to call 999. This website has recently been reviewed. The review team was informed that the decision to use web designers to update the website was made as a result of detailed and comprehensive strengths, weaknesses, opportunities and threats analysis. The website has been benchmarked with other ambulance service websites and was re-launched in April 2009. A new post of web and intranet communications officer was created as a result of this review; it was recognised that a dedicated member of staff was required to support effective communication and engagement through this website.

The service involves external stakeholders in the development of its services. An example of this is the review of emergency medical dispatch centres, where the views of patients and the public were sought through a participative workshop and telephone interviews. Arrangements are in place to facilitate communication with partner organisations; the joint working group with NHS 24 is an example of this.

The service is evaluating how it communicates with external stakeholders. Parliamentary forums are held with MSPs; members are asked to give feedback, for example, on how they would like to be communicated with. The service is also reviewing how it communicates
with patients. A regular review of the complaints process takes place; this is carried out with the help of a questionnaire issued to patients. The patient focus public involvement strategy has been reviewed and revised. This strategy recognises the importance of using various methods of communication, for example ‘virtual consultation’ with patient and public representatives. Efforts have also been made to ensure that external communication is accessible to all; the annual report was translated into Braille and a variety of languages on request.

Core area: 3(d) Performance management

Performance assessment statement: The NHS board is reviewing and continuously improving its arrangements for performance management across the organisation.

The Scottish Ambulance Service has continued to review and improve its extensive suite of performance management arrangements that are closely linked to its clinical governance arrangements. The performance management framework is structured around ensuring achievement of the local delivery plan and HEAT targets. The agenda for performance management is cascaded through service delivery plans, to divisional plans and further to individual objective settings, which all contain specific, measurable, achievable, relevant and time-bound objectives.

The performance manager at national headquarters has responsibility for ensuring that all performance reporting arrangements are managed effectively and includes developing appropriate tools to support managers across the service. The engagement of the Board and key senior management in performance management is widely evident through the formal meeting structure and clearly documented in minutes. There is a visible and transparent process that includes engaging key stakeholders formally on an annual basis. The senior management and executive team reviews performance on a weekly and monthly basis based on reports received from the planning and performance unit, which also report monthly to the Board. In addition to this, the medical director reports formally to the Board on a monthly basis regarding progress against key HEAT targets. On a more regular basis, an hourly performance text message is sent to operational managers with key information on performance against Category A response times; this allows for immediate changes to be made in strategy if appropriate to achieving the target. These text messages also inform a daily conference call held with the director of operations and operational general managers that considers what worked well each day, what could be improved and plan for anticipated uplifts in demand.

In the period since the last review, the service has invited the Scottish Government improvement support team to conduct a review of its approach to performance management, particularly with reference to Category A response times. This review has focused the service in developing a more robust and obvious performance management culture, that is responsive to the organisation’s needs and is led from the frontline.

This review played a key role in influencing the development of MIDash, a web-based management information tool that can produce over 100 reports on performance across the service. The service has integrated user involvement into every stage of development to ensure that meaningful and relevant information is gathered to produce reports that will enhance the service’s ability to manage performance proactively. The service has also
hosted a series of road shows at each division to provide training on the use of MIDash and create a feeling of ownership to ensure that the system was utilised to its full potential.

The performance manager at the national headquarters planning and performance unit is responsible for leading on the development of MIDash and facilitating access to management information on request to support analysis and management of performance. The review team was also pleased to note that the planning and performance unit organised the secondment of a paramedic team leader to assist with the development of the clinical reports available within MIDash to ensure useful information was made available to clinical practitioners. There has also been strong involvement of internal audit throughout the lifecycle of the MIDash project, conducting three audits on the process to ensure that progress was being made and the requirements of the organisation were being met throughout.

In addition to the adoption of the new reporting software, the service has also reviewed its local delivery structure, which, as part of the new medical directorate, has led to the appointment of dedicated divisional performance managers. This further enhances the ability for proactive engagement in performance management and the ability to influence the results in a timely manner. There are regular divisional management team meetings where performance is reviewed, together with key local objectives and fed back to the national performance manager for further discussion if necessary.
# Appendix 1 – Glossary of abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CGRM</td>
<td>clinical governance and risk management</td>
</tr>
<tr>
<td>HEAT</td>
<td>health, efficiency, access and treatment</td>
</tr>
<tr>
<td>KSF</td>
<td>Knowledge and Skills Framework</td>
</tr>
<tr>
<td>NHS QIS</td>
<td>NHS Quality Improvement Scotland</td>
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</tbody>
</table>
Appendix 2 – Review process

Prior to Visit

NHS QIS publishes standards

NHS QIS finalises and issues self-assessment document and guidance

NHS board completes self-assessment and submits with evidence to NHS QIS

NHS QIS performance analysts review the self-assessment submission and produce a pre-visit analysis report, which is sent to the NHS board for comment

NHS QIS sends self-assessment submission and analysis report to peer review team

During Visit

NHS board presentation to review team covering local service provision

Review team meets stakeholders to discuss local services

Review team assesses performance in relation to the standards based on the submission and visit findings

Review team feeds back findings to NHS board

After Visit

NHS QIS produces draft local report and sends to review team for comment

NHS QIS sends draft local report to NHS board to check for factual accuracy

NHS QIS publishes local report

Team leaders consider findings of all local reviews and NHS QIS drafts national overview

NHS QIS PUBLISHES NATIONAL OVERVIEW
Appendix 3 – Details of review visit

The review visit to the Scottish Ambulance Service was conducted on 6 August 2009.

Review team members

John Angus (Team Leader)
Non-Executive Director, NHS Tayside

Malcolm Alexander
Associate Medical Director, NHS 24

Margaret Clarke
Senior Nurse, NHS Lanarkshire

David McManus
Medical Director, Northern Ireland Ambulance Service

Helen Robbins
Head of Clinical Governance and Risk Management, NHS Grampian

Nancy Robson
Public Partner, NHS Grampian

NHS Quality Improvement Scotland staff

Anne Hanley
Team Manager

Deborah McIntyre
Project Officer
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- by email
- in large print
- on audio tape or CD
- in Braille, and
- in community languages.

**NHS Quality Improvement Scotland**

Edinburgh Office
Elliott House
8-10 Hillside Crescent
Edinburgh EH7 5EA

Phone: 0131 623 4300
Textphone: 0131 623 4383
Email: comments.qis@nhs.net
Website: www.nhshealthquality.org

Glasgow Office
Delta House
50 West Nile Street
Glasgow G1 2NP

Phone: 0141 225 6999
Textphone: 0141 241 6316