Scottish Ambulance Service
Working in Partnership with Universities

NHS SCOTLAND

NOT PROTECTIVELY MARKED

PUBLIC BOARD MEETING	**29 May 2024** **Item 17**
THIS PAPER IS FOR NOTING	
CLINICAL GOVERNANCE COMMITTEE MINUTES OF 12 FEBRUARY 2024 AND REPORT OF MEETING HELD ON 13 MAY 2024	
Lead Director **Author**	Stuart Currie, Chair of Clinical Governance Committee Pippa Hamilton, Acting Board Secretary
Action required	The Board is asked to note the minutes and report.
Key points	In compliance with the Service's Standing Orders, the approved Committee minutes are submitted to the Board for information and consideration of any recommendations that have been made by the Committee. The minutes of the Clinical Governance Committee held on 12 February 2024 were approved by the Committee on 13 May 2024. An update of the meeting held on 13 May 2024 is also attached for the Boards information.
Timing	Minutes are presented following approval by the Committee. The Board will receive also received a written update of the most recent Committee meeting.
Link to Corporate Ambitions	The Clinical Governance Committee has responsibility on behalf of the Board to ensure that the appropriate work is undertaken to assess clinical governance within the Service and provide assurance to the Board that the governance arrangements are safe, effective and person centred.
Link to NHS Scotland's Quality Ambitions	The Clinical Governance Committee remit is to monitor good clinical governance to ensure safe, effective and person centred care across the Service.
Benefits to Patients	The Service practices the principles of good clinical governance to ensure that safe, effective and person centred care exists across the organisation to deliver high quality care to patients.
Equality and Diversity	No issues identified.

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MINUTE OF THE NINETY FIRST (94th) CLINICAL GOVERNANCE COMMITTEE AT 10.00AM ON MONDAY 12 FEBRUARY 2024 VIA MICROSOFT TEAMS

Present:	Stuart Currie, Non-Executive Director (Chair) Liz Humphreys, Non-Executive Director and Whistleblowing Champion Irene Oldfather, Non-Executive Director *(until 12:00)* Carol Sinclair, Non-Executive Director Maggie Watts, Non-Executive Director
In Attendance:	Alan Martin, Patient Experience Manager Andrew Carruthers, Clinical Quality Lead West Cheryl Harvey, Associate Director of Education and Professional Development Dave Bywater, Lead Consultant Paramedic Iona Crawford, Interim Dementia and Mental Health Lead *(for item 5.3 only)* James Ward, Medical Director Keith Colver, Clinical Governance Manger – Guidelines Sarah Freeman, Head of Infection Prevention and Control Shereen Cameron, Patient Safety Manager Michael Dickson, Chief Executive Niki Kendall-Wilson, Interim Committee Secretariat (notes) Julie King, Service Transformation Manager Paul Watson, Clinical Governance Manager, Medicines and Equipment Martin Robertson, Patient Representative Tim Parke, Associate Medical Director Wendy Quinn, Deputy Regional Director West
Apologies:	Anne Hendry, Patient Representative David Robertson, Regional Director West Emma Stirling, Director of Care Quality and Professional Development Tom Steele, Board Chair

ITEM 1 WELCOME AND APOLOGIES

Stuart Currie welcomed everyone to the meeting. Maggie Watts introduced herself as the new Non-Executive Director and noted this was their first meeting of the Clinical Governance Committee.

Apologies were noted as above.

ITEM 2 DECLARATIONS OF INTEREST RELEVANT TO THE MEETING

No new declarations of interest were noted.

Standing declarations of interest were noted:

- Irene Oldfather in her position of Director, Scotland Health and Social Care Alliance and Vice Chair of Domestic Advisory Group (DAG) on the Trade and Cooperation Agreement (TCA) with the European Union.
- Carol Sinclair in her position as Trustee of Scotland's Charity Air Ambulance and Strategic Data Adviser, Digital Health and Care, Scottish Government
- Stuart Currie - Board Member of State Hospital Board and Vice Chair of the Independent Review of Inspection, Scrutiny and Regulation of Social Care in Scotland by the Scottish Government.
- Liz Humphreys - Non-Executive Director, Public Health Scotland, and Trustee Scottish Association for Mental Health.
- Martin Robertson, Patient Representative, declared an interest as a member of Voices of Experience (VOX) Scotland.

ITEM 3 MINUTES OF MEETING HELD ON 13 NOVEMBER 2023

The minutes of the meeting held on 13 November 2023 were reviewed and approved as an accurate record of the meeting.

One amendment request was approved, this was on the wording of Page 3 paragraph 6 regrading Tim Parke's quotes:

"Tim Parke advised that good trauma care has been estimated to potentially save £4 billion in life-time long term care costs across the NHS England, and early antibiotic administration halves a patient's time in hospital by significantly reducing risk of costly infection."

No objections noted.

ITEM 4 HOT TOPIC – REALISTIC HEALTHCARE IN SAS

Jim Ward provided Committee with a comprehensive and informative presentation on Realistic Healthcare In SAS.

Members noted and discussed the presentation.

Discussion led to the drivers for change, the Chair agreed that using negative feedback is not always the best way to initiate change. Reframing what improvements look like can be more impactful ie asking patients what they what opposed to what the service can do for them. All noted there were financial implications and system pressures associated with the challenges in wider adoption and exploration of this improvement approach.

The group noted that education and training was to be considered as part of this, including partnership boards. Martin Roberston highlighted the significance of power dynamics in healthcare and empowering patients to make the best decision for them reflecting on feedback from patients who are not given clear information in relation to their rights to refuse; giving an example that a patient can refuse conveyance to hospital, but this doesn't mean they are necessarily refusing treatment overall. Martin highlighted that many patients knew the impact of hospital and the environmental factors that can exacerbate their own

condition detrimentally, reflecting on his own dementia and awareness that he had the right to be treated within his home should he deem this the best option for his health. Martin added this should be advocated more by clinicians to help empower patients chose the best care for them. Dr Ward agreed noting his experience in training junior doctors and GP Registrars in how to listen to patients opposed to talking at them without fully understanding their wants and expectations are. Dr Ward also noted that this can realign the pressure on clinicians to provide an absolute solution and balance expectations from both patient and physician.

Carol Sinclair echoed this point adding that Healthcare Professionals may find this challenging in comparison to the 'usual' dynamic of practice/consultation, she reflected on her previous work with Dr David Riley within NHS Greater Glasgow & Clyde and his training of healthcare professionals where he asked them to rethink consultations with the patient and focus on the driver as 'where does the patient wants to get to'. Carol acknowledged that it was a challenging time for healthcare however stated that adversity created the conditions to initiate change and suggested that this would perhaps enable the service to embrace this opportunity of traction around quality improvement driven by patient reported outcomes and experiences opposed to process driven metrics.

Jim stated that the quality improvement work was under way with NHSGG&C, in particular, with the falls pathways to try and understand the variation in patient demographics and working with the Social Care Partnerships, looking at different levels of conveyance; the drivers for hospital admittance; and other opportunities locally to mitigate where conveyance and hospital admittance is perhaps not the right care for the patient overall. Julie King discussed the Pathways work within the Clinical Services Transformation team update and noted this underpinned SAS efforts to initiate this change and wished to reassure the members that there was a focus on the positive feedback to staff also. The group acknowledged that often change was initiated from negative feedback opposed to what is working/positive feedback.

Discussion and reflections ensued with committee members in agreement that the benefits of realistic health were evident and supported this work in activating change from a different angle. SAS CEO Michael Dickson noted this was part of a wider critical piece of work for not only SAS but NHS Scotland. Noting that the healthcare system was extremely complex to navigate and often the service put the responsibility on the patient to try and understand /navigate it. The service needed to rethink how to enable patients to make better, more informed decisions by creating an environment for senior leaders to help make these changes happen and work more collaboratively rather than competitively from target-based drivers.

Dr Jim Ward noted that the SAS funding allocation from Scottish Government had been doubled over the last three years due to SAS activity seeking involvement to these Realistic Medicine conversations which were initially only available to territorial boards.

The Chair thanked Dr Ward and members for the contributions.

ITEM 5 PATIENT CENTRED CARE

ITEM 5.1 PATIENT EXPERIENCE AND LEARNING FROM ADVERSE EVENTS (Including SAER Internal Audit Action Plan)

Alan Martin highlighted and discussed key points from the report:

- Compliance performance remains positive
- Noted that volume of complaints received are steady but are overall less than last year and pre-covid
- Attitudes & Behaviours (A&B): Highlighted that in reality SAS have some of the lowest figures for A&B complaints, however it was recognised, on discussion with Emma Stirling, who has discussed this at the Board, that further understanding on the associated factors relating to A&B could be reflected on via the Learning from Event Group and the creation of SMART targets. Initial conversation had taken place and the LFEG had welcomed guest Dr Paul Bowie to discuss Humna Factors, noting that there are often misconceptions about understanding the root cause of A&B issues. The group had proposed using training via Education & Development Team, to teach staff how to recognise when communication is breaking down with a patient and how to restore it. The LFEG would report back to the committee once explored further.

Members thanked Jim, Alan and Shereen for the update.

Feedback from members:

- Carol Sinclair requested that the detail and layout of the paper is reviewed:-
    - with the coversheet to align to the appropriate corporate and clinical risks, it was noted that there were no corporate risks mentioned in the cover sheet.
    - Current Status Overview section to be moved to nearer the beginning to improve the wider context for the reader.
    - Develop and refresh the PFPI section of the paper regarding the challenges and context of the service co-design projects.
- Martin Roberston queried PPI engagement noting not all Boards have this wider engagement and representation across the variety of forums that govern and discuss services. Martin looked for assurance that a cross-section of patient representatives was being sought for co-designing and that this included how to assist all abilities and ages in giving feedback. Shereen agreed and highlighted that the LFEG did have a well established and active PPI member who is also now a member of the Patient Safety & Risk Group as the feedback and engagement from patients was crucial.
- Martin also queried how staff were supported and if counselling was automatically offered. Michael confirmed that the service did not mandate counselling as this was not the right support for everyone however staff were offered an extensive resource of support both internally and externally via partnership charities. The service approached this from a person-centred perspective and was currently building upon a culture of openness that welcomed self-referral and advocated reaching out for support, this was reinforced in the staff bulletins via email and on @SAS.
- Maggie Watts asked for more information on the process of triaging SAERs and how complaints were fed back to crews or staff involved, querying if there was a balance of feedback and inclusion of compliments and positive results. Shereen confirmed that all feedback is reviewed as it was reported. The internal audit identified capacity for improvement ion this process and as result the, as part of the adverse events framework, they were looking to introduce a Multi-disciplinary Team (MDT) approach to without adding too many layers of additional bureaucracy. This team would review all feedback to gain a wider understanding of the bigger picture, and what level of review/action was required.
- Irene Oldfather asked for reassurance on the SPSO response times noting response delays dating back to 2021. Michael reminded the committee that investment had been approved at a recent Board to reduce the backlog of complaints and initial data

reflected this was improving however acknowledged that delays were unacceptable. Michael noted the positive and close working relationship SAS had developed with the SPSO and that the Board were committed to evaluate its approach to complaints and learning.

Actions:

1. **All Report authors to ensure that Corporate and Clinical Risks are noted on the cover sheets.**

2. **Shereen Cameron and Alan Martin to review Patient Experience And Learning From Adverse Events report in relation to:**
    a. ***including aligned Corporate and Clinical Risks;***
    b. ***Current Status Overview section to be moved to nearer the beginning to improve the wider context for the reader.***
    c. ***Develop and refresh the PFPI section of the paper regarding the challenges and context of the service co-design projects.***

3. **Learning from Event Group to report back on learning outcomes from Attitudes & Behaviour complaint review.**

ITEM 5.2 CLINICAL RISK REGISTER

Dave Bywater presented the Clinical Risk Register to members and advised that all updates to the Clinical Risk Register since the last Committee meeting were highlighted in red and advised that all risks had been reviewed and updated prior to presentation to Committee.

It was noted that 7 risks were presented to committee.

3 risks were categorised at 'Very High':

- CR 4638 – Very High -Hospital Handover Delay (a corporate & clinical risk)
- 5611 – Very High -SAS SAER processes
- 5516 - Very High -SAS Medicine Management Infrastructure

The committee acknowledged the updates, feedback from Carol Sinclair requested that the updates on risks were more detailed referring to risk 4638 highlighting that 'remains same' did not give assurance as to what action had been undertaken. Dave explained that work was underway however challenges in relation to progress on this risk action were out with SAS control however this will be noted as part of the update going forward.

Carol also requested that the risks were listed on the cover sheet.

[The committee paused for a 10 minute comfort break]

ITEM 6 PATIENT SAFETY

ITEM 6.1 CLINICAL GOVERNANCE AND PATIENT SAFETY REPORT

Keith Colver presented the Committee with a report which provided an overview and assurance of current Clinical Governance and Patient Safety activities.

Keith highlighted key points:

- PGD Compliance: Noted significant progress in compliance rates however indicated long term aim and dynamic for achieving 100% compliance would not be achieved in the current model and team were working to develop data linkage and measurement with the electronic patient record (ePR) to match PGD users to the PGD medicines administration. Current efforts included working with regional teams to encourage and maintain progression towards 95% compliance.
- ScotSTAR Guidelines Test of Change: Noted this had been in development for a number of years and was currently being led by Richard Price and Dr Andrew Cadamy. 40 of the ScotSTAR guidelines were now on JRCALC, this was part of a wider program to align the ScotSTAR guideline governance process with the clinical governance framework.

Liz Humphries queried the Patient Guideline Direction (PGD) compliance and wondered why staff absence was a factor in achieving 100% compliance, Keith confirmed this was due to the current process of collecting and sharing data with the app owners (Class Publishing), SAS could only share email addresses therefore some staff that were still counted within the data were staff who were on long term absences ie Maternity Leave. These are flagged by Class Publishing as non-compliant as they have not been signed off but in reality, the Clinical Governance Team are aware, when reviewed, that this is not accurate. Keith reiterated the long-term plan in developing the sign-off process would work to eliminate these inaccuracies.

Carol Sinclair thanked Stephen Massetti for the progress and improvements made within the NRRD update wishing to give enhanced assurance to the committee that the Resilience Committee minutes are now reported to the Audit & Risk Committee and this added to the quality discussions. Carol did query if the Community Resilience section in the Clinical Governance and Patient Safety Report, could be developed to include more nuanced information on response and resilience noting that from a recent visit to Shetland she was briefed on the different types of Community First Responders (CFRs) and volunteers which isn't apparent from the reports. Michael acknowledged the comments and discussed the complexities in the SAS relationship with Volunterers and CFRs. Michael wished to assure the committee that there was a wider piece of work commissioned to review this and development an equitable programme for all CFRs and volunteers.

Martin Roberston queried, via the group chat function, as to why is dementia and the new SIGN guidelines were not in the list available on JRCALC. Keith responded that the report reflected all the guidance SAS published on the JRCALC App - this was a mix of JRCALC guidance and SAS guidance. With regard to SIGN and NICE, Keith noted the ambulance service(s) did try to have representation on key guideline groups, this allowed the service (SAS) to highlight ambulance care needs which then in turn is fed back into the core JRCALC guidance. Keith proposed meeting Martin offline with the SAS Dementia leads to see if there is anything that was critical to be highlighted to SAS clinicians.

Members noted the update provided.

ITEM 6.2 WHISTLEBLOWING QUARTERLY REPORT

Andrew Carruthers presented the paper and apologised for the second version being circulated so close to the meeting date.

Key points raised by Andrew were that the team are working to create and develop robust processes and procedures in relation to whistleblowing. This had identified:

- Further development of governance processes in relation to actions and recommendations-Andrew aims to provide an update report at the next meeting.
- Accuracy in aim reporting when it comes to handling performance; Andrew elaborated this appears to be due to a limited workforce who manually undertake this. The team were reaching out to other Boards to understand their management processes to see where improvements could be made.
- Confidential Contact & Peer Review Network established with a new meeting now expedited. The Board has recruited three new confidential contacts since the last committee meeting.

Liz Humphries thanks Andrew and stated she was the Non-Executive Whistleblowing Champion for SAS and was delighted with all the progress and work ongoing in this space. Liz added she also works with Public Health Scotland as Whistleblowing Champion and is now working on Psychological Safety in relation to this workstream and will import any beneficial progress from this to SAS.

The Chair acknowledged this progress and stated that it was crucial to have a culture of openness and space where people can speak up. These ongoing discussions that include Staff Side and Workforce colleagues clearly were working to make it more clear on the differences between grievances and whistleblowing.

[Andrew Carruthers left the meeting]

ITEM 7 EFFECTIVENESS

ITEM 7.1 INFECTION PREVENTION AND CONTROL UPDATE REPORT

Sarah Freeman presented Committee with an update on Infection Prevention and Control work since the last Committee meeting.

Sarah highlighted a typo within the report under the ‘peripheral vascular catheter insertion bundle’ section, the figures were last quarters.

The Committee noted the update presented and thanked Sarah for the paper.

ITEM 7.2 EDUCATION UPDATE

Cheryl Harvey presented the paper which provided an update on the developments within the Education and Professional Development Department which covered the undernoted areas:

- Challenges in Learning in Practice (LiP), it was noted the department were taking a concerted effort to increase the Ambulance Care Assistant (ACA) numbers.
- Progression of work ongoing within the Tech to Paramedic programme, this is supported by NSS who were providing Project Management, this was funded by Scottish Government.
- Practice Education: SAS were working with Healthcare Associated Infection (HAI) partners on enhancements.

Carol Sinclair noted it was challenging to quantify the level of risk associated with the various activity within the department, particularly the issues of recruitment and the offsetting of skill mix regionally; and the low number of paramedic mentors. Carol stated she understood that some of these risks may be aligned and presented to Staff Governance by workforce colleagues however asked how these clear risks was being collaboratively managed and reported, noting the intrinsic relationship of Workforce and Education. Carol proposed these might be better brought to the attention of the Integrated Governance Committee. Cheryl stated that recruitment was reported by Workforce however agreed it did impact the education department resources, programmes of work and risks.

Cheryl confirmed that the paramedic job description did state that contributing to being a practice educator was part of the role however the reality of getting staff to fulfil this was challenging in the current climate.

Michael agreed with Carol and the parallel nature and impact of workforce with the SAS education programmes. He suggested that utilising SAS University partnerships may be a solution in providing better support and mentorship.

Actions:

4. **Cheryl Harvey to discuss the escalation and reporting of the combined risks within the Education department with the Workforce Director.**

ITEM 7.3 CLINICAL SERVICES TRANSFORMATION PROGRAMME UPDATE

Julie King introduced the paper which provided an overview of the work underway across a range of workstreams within the Clinical Services Transformation portfolio which included highlight reports aligned to the undernoted portfolios:

- Integrated Planned, Urgent and Unscheduled Care
- Preventative and Proactive

Committee discussed and noted the report.

Julie highlighted that there was an action from the Integrated Joint Chairs (IJC) Group to feedback on what actions were taken for winter preparedness, and noted the department were not in a position to fully evaluate the impact currently, but this would be reported to the committee when available but hoped that the reports presented provided assurance that the Board maintained a focus on supporting frontline clinicians not just within SAS but within the partnerships from territorial boards to health and social care partnerships.

Dr Jim Ward wished to highlight the Care Home Aide Memoire had been distributed on JRCALC and this had received 3000 clicks of engagement via the app (75% of clinical workforce). This needed to be recognised as significant.

Julie King wished to thank the wider Clinical Teams who enabled the work within the directorate and was at the forefront if the progress.

ITEM 8 COMMITTEE GOVERANCE

ITEM 8.1 Self- Assessment Action Plan Progress Update

Committee noted the current position on Clinical Governance Self- Assessment Action Plan Progress Update.

Liz Humphries queried action 2 (marked as completed) and stated that this action derived from a comment from Liz during the self-assessment. The action didn't reflect what Liz was referring to which was for the reports expand and detail more a of a tracked plan in the reporting style, not by a separate paper. Carol Sinclair suggested this could be taken forward as part of the Board Assurance Framework as the suggestion would be applicable across the wider Corporate/Board Assurance reports. No objection noted.

ITEM 8.2 Committee Draft Workplan 2024

Stuart Currie advised members that the presented work plan was for approval.

Irene Oldfather requested that 'standards' were added to the item within the Communities & Place Portfolio: Mental Health Update. Members approved the draft plan pending minor changes to the Mental health Update, as suggested by Irene Oldfather.

Action:

5. **Secretariat to update work plan with the inclusion 'standards' to the item within the Communities & Place Portfolio: Mental Health Update.**

ITEM 8.3 ACTION TRACKER

The undernoted update was provided to Committee on item 2023/08/05.1:

Extension to May 2024 for actions 2023/08/05.1 and 2023/11/11 (2) were granted.

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

2023/11/04	Hot Topic – Major Trauma Update
2023/11/05.2	Clinical Risk Register
2023/11/06.1	Clinical Governance and Patient Safety Report
2023/11/06.2	Duty of Candour Annual Report
2023/11/07.2	Education Update
2023/11/07.3	Clinical Services Transformation Programme
2023/11/08.6	Clinical Governance Workplan
2023/11/10	AOB – Future Committee Meetings
2023/11/11 (1)	Restricted – Patient Experience and Learning from Events

ITEM 9 ITEMS FOR NOTING

Stuart Currie advised members that items 9.1 to 9.3 were the approved minutes of each Committee Sub Group and are presented to each Committee meeting for information.

ITEM 9.1 CLINICAL ASSURANCE GROUP MINUTES

The Committee noted the minutes.

ITEM 9.2 MEDICINES MANAGEMENT GROUP MINUTES

The Committee noted the minutes.

ITEM 9.3 NATIONAL CLINICAL OPERATIONAL GOVERNANCE (NCOGG) GROUP MINUTES

The Committee noted the minutes.

ITEM 9.4 RESEARCH DEVELOPMENT AND INNOVATION GROUP MINUTES

The Committee noted the minutes.

ITEM 10 ANY OTHER BUSINESS

None to note.

Stuart Currie thanked everyone for their attendance, discussion, and comments throughout the meeting and to all authors of the reports which allows committee to take significant assurance from the work being undertaken.

Date of next meeting May 2024 10:00

The meeting closed at 12:46.

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Board Update – Clinical Governance Committee 13 May 2024

The Clinical Governance Committee met on Monday 13 May 2024 and discussed the following:

Hot Topic – Advanced Airway Guidance
Committee received a presentation from Dave Bywater, Acting Director of Care Quality and Professional Development and Dr Gareth Clegg, Associate Medical Director. Committee noted the presentation which highlighted that the Scottish Ambulance Service currently includes endotracheal intubation (ETI) as part of the core skill set of all trained paramedics. ETI is used almost exclusively for the management of patients after out-of-hospital cardiac arrest (OHCA). Recent literature suggests that intubation of OHCA may not result in improved outcomes when compared to other less technically demanding methods of airway management e.g., supraglottic airway devices. It was noted that other services across the UK are abandoning the ubiquitous use of ETI. Members noted and discussed the presentation which outlined the 3 options for future advanced airway management within the Service. Members noted that a paper on this subject had also been presented to and was being considered by the Clinical Assurance Group. It was agreed by Committee that further discussions would take place prior to final decisions being made.

Adverse Event and Duty of Candour Policy
Members noted and approved the policy presented which had been developed to provide assurance that the organisation has clear, robust processes in place for the management of adverse events and detailed the requirements for compliance with Duty of Candour.

Clinical Risk Register
Members reviewed and approved the Clinical Risk Register and noted that 5 risks were presented, 3 were categorised at 'Very High' (CR 4638 (Hospital Handover Delays); 5611 (SAS SAER Processes); 5516 (SAS Medicines Management Infrastructure).

Clinical Governance & Patient Safety Report
Members welcomed the report and took assurance from the overview provided in relation to current Clinical Governance and Patient Safety activities. Members noted that following the recent update to the Clinical Governance Framework a development session will be held to assist National Clinical Operational Governance Group (NCOGG) members to develop and agree a reporting framework to reflect and provide assurance on current clinical practice. It was highlighted that the output from the work would be presented to the next Clinical Governance Committee meeting.

Items Approved – Committee approved the undernoted items presented:

- Clinical Governance Committee Annual Report 2023/24
- Clinical Governance Committee Sub Group Annual Reports
- Terms of Reference of Clinical Governance Committee and Sub Groups

Items Noted – Committee noted the undernoted items presented:

- Mental Health Update
- Infection Prevention and Control Update
- Annual Infection Prevention and Control Work Programme
- Education Update
- Clinical Services Transformation Programme Update
- Clinical Assurance Group Minutes
- Medicines Management Group Minutes
- National Clinical Operational Governance Group Minutes
- Public Protection Assurance Group Minutes
- Patient Safety and Risk Group Minutes