South East Coast Ambulance Service NHS
NHS Foundation Trust

Date of Report: 19/05/14 Agenda Item: 41/14

Report to	:	**Trust Board of Directors**
Date of Meeting	:	**29 May 2014**
Subject	:	**RMCGC Summary Report to the Board**
Report from	:	**Christine Barwell, ARC Chairman**
Purpose	:	**For Information**

Summary		The Board is asked to note the summary report from the RMCGC meeting on 8 May 2014.
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Risk and Assurance	:	N/A

Date issued	:	19.05.14
Review by	:	Christine Barwell, Chair RMCGC
Originator	:	Clare Mitchell, Company Secretary

South East Coast Ambulance Service NHS Foundation Trust

Trust Board Report

Risk Management and Clinical Governance Committee Update

1. Introduction

1.1 This report provides a summary of the business discussed at the Risk Management and Clinical Governance Committee (RMCGC) meeting held on 8 May 2014.

2. Summary

2.1 The Committee discussed the Quality Account Progress Report, which summarised performance against the 2013/14 Quality Measures. The Committee expressed concern that Quality Measure A (infection control) had not been achieved. Compliance with this measure should increase now that the Trust had moved to REAP 1. This would be monitored at the next meeting.

2.2 The Committee received the results of the 999 patient satisfaction survey. The results of the survey were very positive, with 97% of patients being satisfied or very satisfied with the service. The results would be communicated widely to staff. Further work would be undertaken to evidence whether or not there was a correlation between low staff survey results and poor patient care. While this had been shown to be a concern in the acute sector it did not appear to be the case in the Ambulance sector.

2.3 The Committee received a report on the clinical impact of paramedic staffing gaps. The report set out the potential risks and the mitigations in place to manage them. These risks would continue to be monitored by RMCGC. The risk of being unable to recruit sufficient number of paramedics was rated as 20 on the Corporate Risk Register. A recruitment update was included within the paper which showed

positive progress against the target of recruiting 200 paramedics and 150 ECSWs in 2014/15. It was agreed that this issue would be brought to the Board's attention.

2.4 The Committee noted that the Trust was not yet achieving its initial internal target of scanning 90% of PCRs by 10 days post the incident date. The aspiration was to scan 95% of PCRs by seven days posts the incident date. The Committee asked for information on the resources that would be required to achieve this target prior to the introduction of an EPCR.

2.5 A report on performance against Clinical Performance Indicators was received.

In future data should be provided on the Trust's performance relative to other Trusts. The Committee discussed performance against the stroke targets and the potential impact of service reconfiguration on achieving the target of transporting stroke patients to a hospital that could provide definitive care within 60 minutes. The relevance of this target was also subject to question if audit data showed that patient outcomes were improved by travelling further to a specialist unit. The Medical Director was asked to identify those aspects of the stroke care bundle that the Trust should concentrate on improving. The Committee proposed that the Board should receive an update on the causes of and treatments for stroke at a development session to improve members' clinical understanding.

2.6 The Committee discussed the clinical governance implications of a business case to introduce a new medicines supply model into the Trust. The case outlined a number of options. The Committee endorsed the option recommended by the Executive Team. The Committee's view was this was the only option that was acceptable from a clinical governance perspective.

2.7 The Committee noted reports on the Trust's compliance with best practice guidelines and clinical pathways.

2.8 The Committee received an update on safeguarding and the final summary report on the domestic abuse referral pilot. Referral rates had increased by 204% in 2013/14 compared to the previous year. This was delaying the logging of referrals on the Trust's database but was not delaying onward referrals. The Executive were asked to consider how best to resolve the internal backlog.

2.9 The Committee received a paper summarising progress to date with the development and implementation of the quality impact assessments of the Trust's cost improvement programmes for 2014/15. All but one were rated as low risk.

2.10 The Committee approved the formal Complaints and PALS annual report for 2011/12 and discussed the Patient Experience Report for February to March 2014. There were a significant number of overdue responses to complaints about PTS and this was not acceptable. The Executive were asked to resolve this issue and to bring a report on any complaints that had been outstanding for over six months to the next meeting. The Committee approved the revised Complaints Policy subject to some minor amendments.

2.11 The Committee noted that the Trust had assessed itself as compliant with all the quality markers in the Quality Governance Framework (QGF). Compliance would be reviewed against any changes to the QGF in 2014/15.

2.12 The Committee reviewed a proposed dashboard of key performance indicators. It was agreed that a revised version would be considered at the next meeting.

2.13 The Committee received an assessment of the clinical impact of Red 1 and Red responses of over 19 minutes. Based on the small sample of data reviewed, stroke was identified as the condition where there was the greatest potential for an adverse impact on care by significantly delayed responses, particularly in Sussex. The exercise would be undertaken regularly with a larger data set. The Committee noted the clinical audit tail review process used in NHS 111.

2.14 The Corporate Risk Register (CRR) was reviewed. Three new risks were noted as follows:

- Risk ID 224 – Medicines management distribution
- Risk ID 223 – Failure to meet the CQC action plan for medicines management
- Risk ID 225 – Failure to report on and use safeguarding referral data

The following risks were approved for removal from the CRR:

- Risk ID 2 – Fraud and theft
- Risk ID 157 – Non-compliance with Level 2 of the Information Governance Toolkit Assessment
- Risk ID 175 – Compliance with the Standing Financial Instructions
- Risk ID 216 – NHS Pathways v7.0.4 – Implementation delay
- Risk ID 219 – CAD stability (business as usual)

2.15 The Committee noted the report on risk management KPIs. The number of medication errors had exceeded the expected parameters. Further guidance would be issued to operational staff via the bulletin.

2.16 The Committee received the report on SIRIs including root causes and action learning points for each closed SIRI. The Committee thanked all those who had contributed to resolving the backlog.

2.17 The Committee noted a report on the Trust's position relating to Employer Liability, Public Liability and Clinical Negligence claims.

2.18 The Committee noted that the Trust had achieved Level 2 of the Information Governance Toolkit. This was a considerable achievement as it required 95% of all staff to have successfully completed their IG training.

2.19 The Committee received the action plans drawn up to address concerns raised by the CQC relating to the timeliness of SIRI investigations and compliance with the medicines management policy. Progress against the action plans would be monitored by the Compliance Working Group and reported to the RMCGC.

2.20 The Committee noted a report on the Trust's Care Quality Commission Quality Risk Profile and a briefing on the CQC's proposals for improving how they monitor, inspect and regular ambulance services. Further information on the proposed new inspection process would come to a future meeting.

2.21 The Committee received a full list of projects being dealt with by the IT department. It was noted that there was considerable demand for IT support and this list had grown over time. The Executive were requested to decide on organisational priorities and to determine an authorisation process for new IT projects.

2.22 The Committee noted NHS 111 clinical governance monthly report and thanked the Executive for the considerable improvement in performance.

2.23 Reports of activity were received from the following groups:

- Inclusion Working Group
- Compliance Working Group

2.24 The Committee approved the following policies:

- Equality, Diversity and Human Rights (new)
- Medicines Management Policy (revised)
- Policy for Clinical Guidelines (revised)
- Clinical Audit Policy (revised)

3. Recommendation

3.1 The Board is asked to note this report.

Christine Barwell

Chair, RMCGC