



**Scottish
Ambulance
Service**
Taking Care to the Patient



Chair Tom Steele
Chief Executive Pauline Howie OBE

11 September 2018

Ms Jeane Freeman, MSP
The Cabinet Secretary for Health & Sport
St Andrew's House
Regent Road
Edinburgh
EH1 3DG

Dear Cabinet Secretary

Re: NHS Boards Governance Assurance Mechanisms

Thank you for your correspondence of 5 September 2018 on the subject.

The purpose of this response is to provide detail about how the Scottish Ambulance Service (SAS) provides assurance around its systems to review professional practice, manage any complaints in relation to this and how the Board is assured of the safety and quality of the clinical care provided. In responding, the mechanisms above will be in the context of a national organisation, working in communities rather than in hospitals and describing the general provision of clinical care rather than focussing on surgical practice.

NHS Complaints

All complaints are investigated and responded to thoroughly. This involves close links between our corporate affairs team and our regionally organised but locally delivered management structure. This ensures that the identity of any person subject to a specific personal complaint is known both centrally at a corporate level but also more importantly at a local level. In the rare event where there are a number of complaints about a single individual, this is picked up and, depending on the nature of the complaint; appropriate action to protect patients is put in place. This could mean a range of measures from supervised practice arrangements, to suspension of an individual(s) pending further investigation and referral to the Health Care Professions Council (HCPC).

Although SAS does not directly employ Consultant Surgeons, the principles to protect patients described above are followed for paramedics and other clinicians. In addition to complaints, we also regularly triangulate themes raised by complaints with those identified by internal incident reporting systems such as Datix and our review of adverse events. This allows for themes to be understood and as part of this process, where concerns about individual practice emerge, they are addressed in a fair and robust manner with patient safety as the top priority.

Surgical Safety and M&M Reviews

The specific concerns and examples in your letter do not easily translate into an Ambulance



Service context. However, a range of feedback and communication processes are in place to promote patient safety, and learning, both from best practice, and when things go wrong.

These include:

- Visits by Executive and Non Executive Directors to every Ambulance Station in Scotland annually
- Specific Patient Safety meetings between clinical leads and operational managers
- Feedback on clinical performance, patient safety clinical risk and governance from operational leads on a quarterly basis through our National Clinical Operational Governance Group which reports to our Clinical Governance Committee
- A blended approach to clinical education and learning across the organisation with nationally applied clinical guidelines and operating procedures.

Supervision of Junior Staff

- Very few SAS staff work on a solo basis. Therefore, there is typically a high degree of supervision and support available to more junior staff.
- There are specific supervisory arrangements in place for staff in training and these have to be approved by the Health Care Professions Council (HCPC).

Openness and Transparency

- Our incident reporting systems are open to all staff at all grades. All incidents are robustly reviewed and feedback is given directly to those who have raised a concern. Incidents are collated into themes, including attitude and behaviour, as well as clinical care, and reports are provided to the SAS Clinical Governance Committee at every meeting.
- Actions raised from Serious Adverse Events/Duty of Candour incidents are reported to and progress towards completion is discussed at each Clinical Governance Committee.
- Staff and patient involvement in these reviews are specifically highlighted and will become even more robust as our Duty of Candour processes mature.

Yours sincerely



Pauline Howie, OBE
Chief Executive