CANDOUR

ISSUE 22 - June 2002

The newsletter of the Joint ASA/JRCALC Clinical Effectiveness Committee and the ASA National Clinical Effectiveness Programme

JRCALC
JOINT ROYAL COLLEGES AMBULANCE LIAISON COMMITTEE

ASA

In this Issue:

National Clinical Audit Update

Following the feedback from the seminars version 2 of the CHD software is now ready. This version does not replace the existing database but enhances it in a number of ways to provide more functionality.

Over the summer the ASA and JRCALC will use the data already submitted to draft the initial reports for feedback to ambulance services.

There is ongoing development work in collaboration with the Myocardial Infarction National Audit Project (MINAP) and the Central Cardiac Audit Database (CCAD) to ensure all the audit systems are integrated in the future.

Work is also starting to develop the dataset and objectives for a national audit of outcome from out-of-hospital cardiac arrest in line with the NHS Coronary Heart Disease Information Strategy.

To follow all the developments with the project visit the website at www.asancep.org.uk/ami.htm

JRCALC Clinical Guidelines on the NHSnet

The JRCALC Clinical Guidelines circulated on CD-ROM to all ambulance service NHS Trusts in January 2002 are now available on the NHS net at a dedicated site run by the Emergency Medicine Research Group (EMeRG) at The University of Warwick.

nww.warwickuniversity.nhs.uk

Please note you will only be able to view this site if you have access to the NHSnet either through a personal subscription or through the your Trust's intranet connection. If you have any questions about access to the JRCLC guidelines please contact:

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Emergency Medicine Research Group
Centre for Primary Health Care Studies
University of Warwick
Coventry
CV4 7AL
Tel: 02476 573954
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The Commission for Health Improvement Clinical Governance Reviews: Ambulance Service Experience and Implications

On 22nd March 2002 the ASA held a one-day seminar, at the request of the ASA National Council, to raise awareness of the Commission for Health Improvement's Clinical Governance Review (CHI-CGR) process and to share the experiences of those ambulance trusts currently under review.

Introduction

Peter Innes, Chair of the Joint ASA/JRCALC Clinical Effectiveness Committee, and Chair of North East Ambulance Service NHS Trust, who will commence their CHI-CGR in mid-June, introduced the day to over eighty delegates. He stated the objectives of the day were to hear more about the process from CHI, hear the experiences of a CHI Assessor and of those services currently undergoing their reviews, to determine how the review fits with other assessments and to provide feedback both to services and to CHI to further inform the development of future review processes.

The CHI Review Process and Outcomes

The first presentation was from Mr Jo Setters, Development Manager for CHI and leading on ambulance services, and covered the work of the Commission. He stated CHI's aims were to:

- Drive local change and not enforce it from above
- Be patient centred
- Be open and accessible

As well as the clinical governance reviews CHI's work includes national studies around the various National Service Frameworks and investigations into organisations experiencing difficulties. CHI will soon form part of the new Commission for Health Care Audit and Inspection as announced in the Spring 2002 budget and following the Kennedy Report (Bristol Inquiry), with added powers and reporting directly to parliament and not the Secretary of State or the Department of Health.

The clinical governance review process itself is not designed as a service review but to determine whether each trust can ask questions of itself. Assessments of specific clinical quality are very complicated and are therefore avoided, so the focus is very strongly on the process of self-assessment – is there evidence of written policies and have they been implemented?

Information on the review process and the associated tools can be accessed from the website www.chi.nhs.uk

Ambulance Service Assessor's View

The second presentation was from Dr Tracey Cooper, Associate Director of Education and Training for the NHS Clinical Governance Support Team, part of the NHS Modernisation Agency.

Tracey outlined how expertise from ambulance services had gone in to the development of the CHI-CGR assessment tools to ensure the questions asked and the process as a whole was more tailored to the specific needs of the ambulance service. The first three reviews of ambulance services would act as learning sites to inform CHI of any changes required to the review process, and subsequent reviews would also add to the continuous development of the tools used.

Tracey then went on to explain how the CHI-CGR uses clinical teams to assess the process through examples and is not a full service review, and the process is assessed using the "seven pillars of wisdom"

Figure 1. The "Seven Pillars of Wisdom"

She then described the timetable in more detail starting with the three-month pre-review phase of data collection from both internal and external sources and covering other assessments such as CNST etc. This data is aligned to the components of the review and a summary analysis is produced.

- Weeks 1 to 5 involve completing the Fact Finding Questionnaire – a very important source of data for the review
- Weeks 6 to 7 involve the first visit to the Trust as part of a two-way process to learn about the organisation and to allow the Trust to comment on the summary analysis and its evidence.
- Week 8 is the review week itself with formal verbal feedback given at the end. The review team for the week-long visit would have at least one member who had expertise in the prehospital field.
- Weeks 9 to 17 involve the continuing analysis and production of the report, before an action plan is drawn-up and approved by the Strategic Health Authority.

Experiences from Ambulance Service NHS Trusts

The next set of presentations focused on the experiences of those services currently undergoing their CHI-CGR's and an example from Scotland where a similar process has been completed.

Brain Chambers of **Hereford & Worcester Ambulance Service NHS Trust** opened by asking the question – Is there life after the 8-minute standard?
He stated there definitely was and the since CHI had announced there impending visit it had had the following effects within his service:

- Focused minds on the Trust Strategic Plan
- Forced the Trust to look at its internal structures and policies
- Facilitated sharing of work within the ambulance service

On a practical note he advised services to choose their co-ordinator well as the workload and skills required would need to be flexible. Brain then passed to his co-ordinator, Sonia Bridge-Jones who relayed what it is like to be CHI'ed – "Hell on Earth!".

Not having been reviewed at the time of the seminar, Sonia described the logistics of providing information for the pre-review phase including four-years worth of data, apart from the questionnaires. This includes all incidents attended, time of allocation, response times, age and sex of patient, and destination hospital. Information is required from human resources, clinical audit, effectiveness, governance, risk management, training and information technology.

Secondly she focused on the requirements of the Fact Finding Questionnaires – three of them – one for each of the Emergency Service, Patient Transport Service and Doctors Urgent Services and the other ad-hoc requests for information.

Kate Turner, an NHS Management Trainee with **East Anglia Ambulance Service NHS Trust**, described a similar picture. She emphasised that the review must be seen as something positive for the Trust and the feedback gained from an 'outside' organisation had added a different perspective. She stated that the CHI-CGR was a chance to:

- Show commitment and understanding of clinical governance agenda
- Show positive examples of practice within the organisation
- Become a learning organisation and make improvements

Figure 2. "Prepare yourself!"

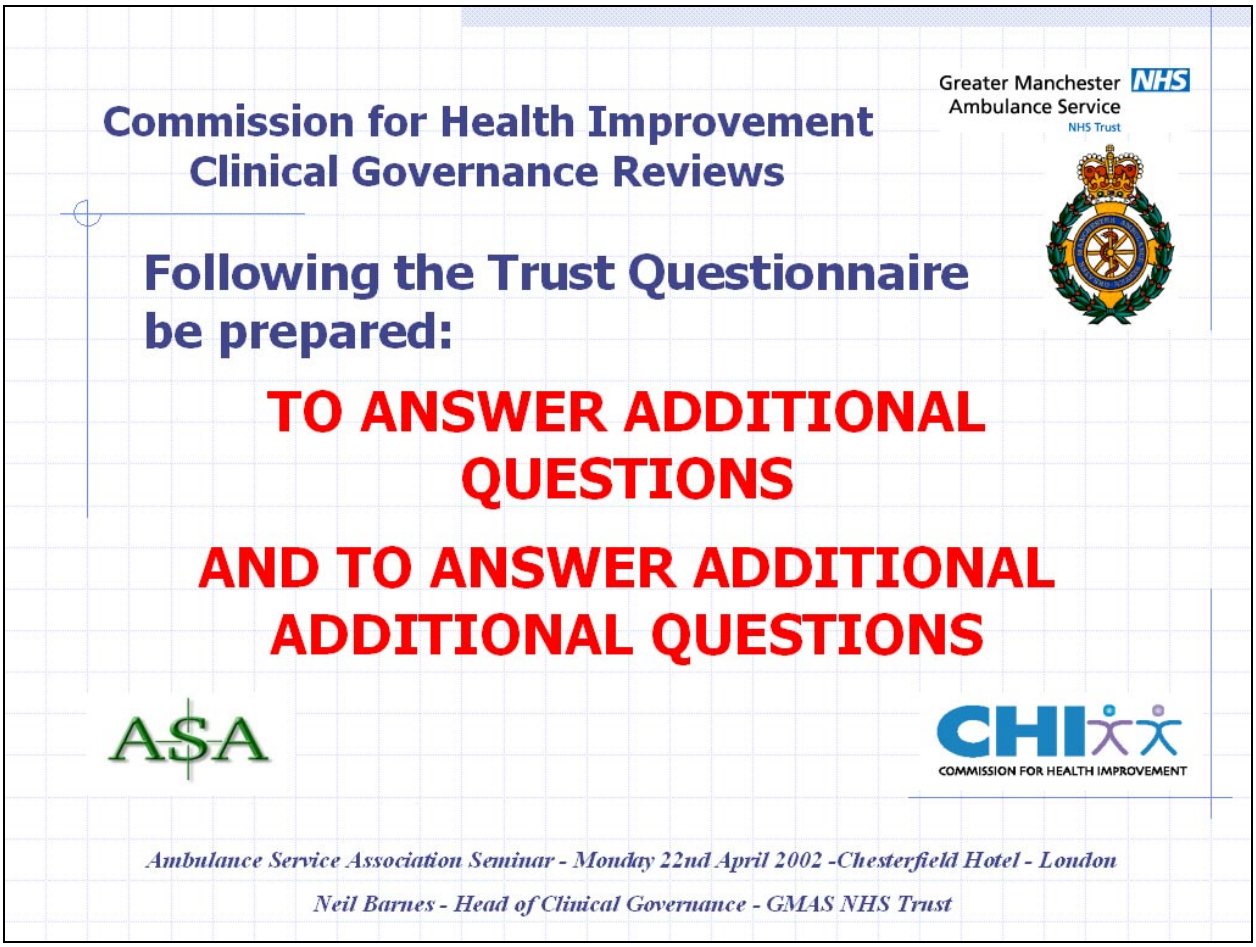
Neil Barnes, Head of Clinical Governance **Greater Manchester Ambulance Service NHS Trust**, who had only just finished their review week, gave the next presentation – "How to survive a CHI-CGR".

Again Neil emphasised that the CHI-CGR is both a challenge and an opportunity. He advised that although the data is collected for CHI to review it proved very useful locally as well and that due to the logistics involved he recommended appointing:

- a project manager to oversee the review process on behalf of the Trust
- an executive lead to ensure the issues are communicated and that they can influence change
- an information lead to communicate with CHI and internally to ensure there is understanding on both sides

Like the others before him Neil warned of the demands for information.

Figure 3. "Ask more questions than Chris Tarrant"

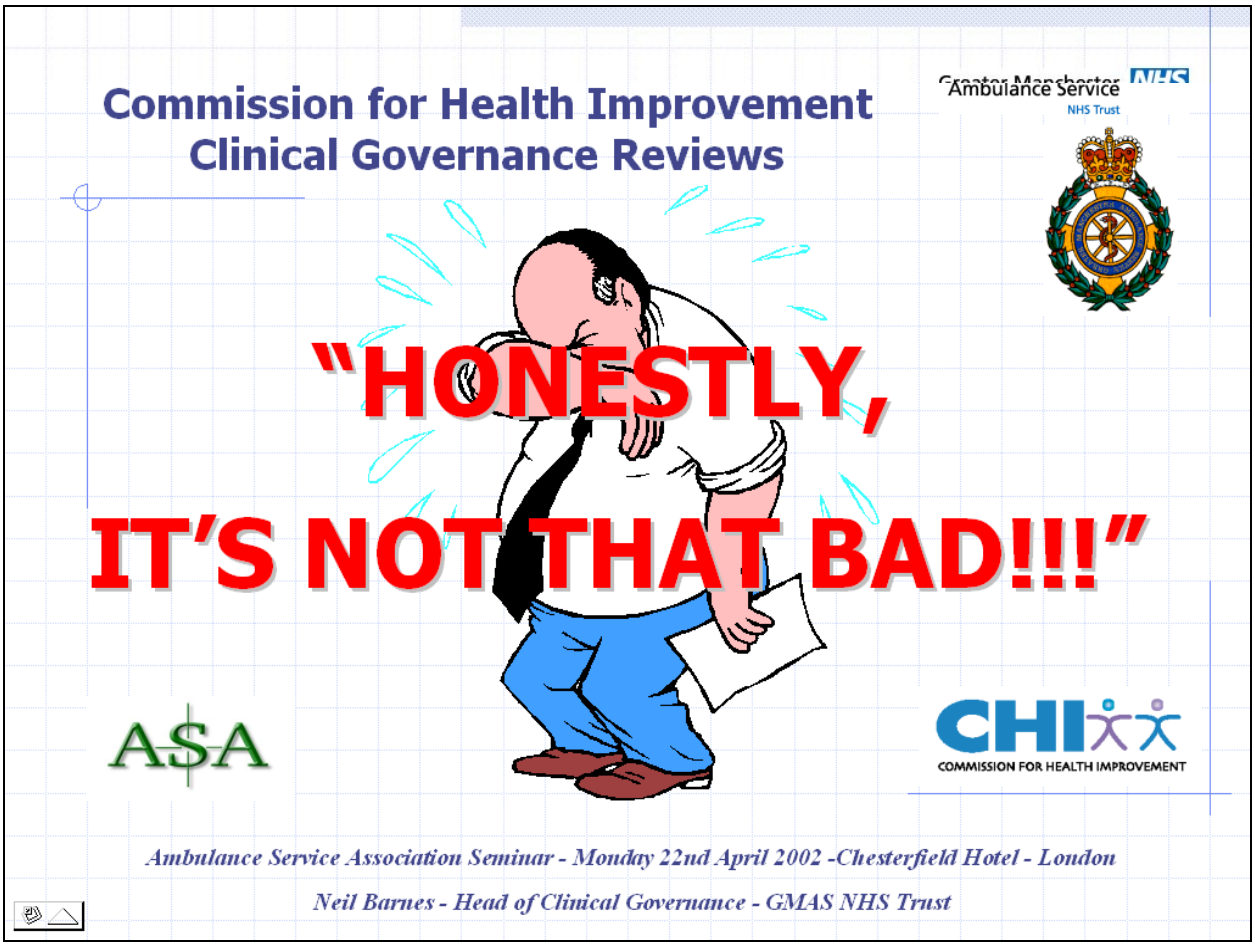


Neil then described the timetable leading up to the review week. The review team will arrive on the evening before-hand and will require an information pack. The team itself consists of a review manager and eight reviewers working in pairs gathering information through interviews and observation.

There were 75 informal interviews that were non-threatening, relaxing and well conducted. The following areas were observed during the week:

- Control
- NHS Direct
- Ambulance stations
- A&E departments
- PTS
- IT
- Clinical Audit
- Training
- Finance

Figure 4. "Is it over yet?"



The formal feedback concentrated on the strengths and weaknesses found and initiated the plans for the Action Planning Workshop to follow the publication of the final report.

Neil emphasised that the review is not an inspection of individual performance and that staff must be made aware of this and contribute fully in an open and honest manner so that the Trust can learn and adopt a positive approach. This process provides the ambulance service with a mandate for change – an opportunity not to be missed.

The seminar then popped north of the border to hear how the **Scottish Ambulance Service** experience differs. Bill Mason, Continuous Improvement Manager, described how the Clinical Standards Board for Scotland (CSBS) differed from CHI albeit with the same objectives.

The CSBS is part of the quality circles in Scotland is therefore continuously involved in developing practice with health organisations. The standards are mandatory and are set before the review which itself is seen as a partnership.

The review includes a self-assessment, similar to CHI's "seven pillars of wisdom". Scottish Ambulance Service provide evidence and comment on a draft which contains no surprises, confirms areas of best practice, and suggests areas for improvement – with offers of support from

the CSBS. By 'passing' the review it has strengthened the position of the ambulance service within the NHS in Scotland, and this can now be used to dictate the pathways of care from the prehospital phase.

Links with other performance management processes

The final presentation came from West Midlands Ambulance Service NHS Trust. Steve Ellicker, NPSA Co-ordinator, outlined the pilot of the National Patient Safety Agency insisting it was not about blame but establishing whether current systems are working. The safety of patients is of paramount importance and a blameless culture of learning underpins clinical governance.

He stated we could learn from the Civil Aviation Authority where it is a disciplinary offence *not* to report an adverse incident thereby encouraging reporting. In terms of the NPSA pilot random cases are reviewed on a weekly basis to obtain a root cause analysis. The reports, which have to be completed within 45 days, are graded into the specific NPSA categories. Currently all reports – Red, Amber and Green – are reported, however in the future it is likely only 'Red' reports will be submitted to the NPSA. Steve then described the links with the Medical Devices Agency, Medicines Control Agency, NHSLA and CHI.

Results of the pilot, also involving North East Ambulance Service, will be reviewed by all ambulance services to confirm national conformity to the types and numbers of incidents reported. It will then be rolled out nationally on a regional basis from late summer 2002. Each Trust will have to appoint an NPSA Co-ordinator and there will be regional workshops to train staff in root cause analysis.

Steve Edwards, Clinical Governance Manager, then described the work of the ambulance service standards working group of the Clinical Negligence Scheme for Trusts as part of the NHSLA. The on-going process will ensure there is no conflict with any other standards being set by external agencies. Steve outlined the areas future standards could encompass, including: response times, thrombolysis, consent, obstetrics & gynaecology, paediatric emergencies, patient documentation, air ambulance, JRCALC guidelines, NHS Direct, treat & refer guidelines, handover of care, and first responders.

The day closed with all the speakers answering questions from the floor in a panel session. The consensus was that it had been a very successful and informative day and one that should be repeated on a regular basis to ensure all ambulance services continue to share their experiences of the CHI-CGR process. It was suggested that services should share the workload in developing policies and procedures to prevent anyone reinventing the wheel and to reduce variation in practice.

A further five ambulance services commence their CHI-CGR's in June 2002 and from then there will be a number starting every month until April 2003.

Thanks to Neil Barnes and Greater Manchester Ambulance Service NHS Trust for allowing Candour to reproduce some of the slides used in his presentation.

Copies of the presentations and details of the CHI Clinical Governance Review Process and Information for Ambulance Services is available from the website www.asancep.org.uk