ABM University Health Board	
Date of Meeting: 5th April 2018 **Name of Meeting: Quality and Safety Committee** **Agenda item: 10.1**	
Subject	*Clinical Governance for the Emergency Medical Retrieval and Transfer Service (EMRTS)*
Prepared by	Liz Stauber, Committee Services Manager
Approved and presented by	Hamish Laing, Executive Medical Director

1.0 Situation

This reports sets out the update to the Quality and Safety Committee with regard to clinical governance for the Emergency Medical Retrieval and Transfer Service (EMRTS).

2.0 Background

The EMRTS service provides advanced decision-making and critical care for life or limb-threatening emergencies which require transfer for time-critical treatment at an appropriate facility.

Hosted by ABMU Health Board, the all-Wales service went live in April 2015 and a governance sub-committee was established shortly after which reports to the Audit Committee.

The hosting agreement with the commissioner (Emergency Ambulance Services Committee [EASC]) requires that matters of clinical governance are considered by the host's Executive Medical Director on behalf of the host's Chief Executive and shared by the Executive Medical Director with the all-Wales Medical Directors' Group and the Delivery Assurance Group for EMRTS at EASC. This is in place.

Following correspondence with Welsh Government, it was agreed that clinical governance updates would also now be provided to ABMU's Quality and Safety Committee.

3.0 Assessment

The EMRTS Governance Sub-Committee met on 14th February 2018 at which it received the clinical governance report for quarter three (October-December 2017).

Members heard that no concerns had been escalated to the external clinical advisory group (ECAG) for review and no clinical concerns had been raised with EMRTS for action. The service had undertaken regular clinical governance days with topics including morbidity and mortality, information governance and cardiac arrest.

Following a morbidity and mortality session, a 'lessons learned' bulletin is circulated. The most recent iteration had a particular focus on elderly trauma patients as this patient group is often challenging to diagnose and treat. In addition, there was also learning shared in relation to airways and breathing as well as medication.
It was noted that the service has a customised DATIX form for ease of reporting and a mobile phone application is also now available. The entries for the quarter comprised:

- 14 internally reported incidents;
- One externally reported incident/concern;
- 12 equipment defect reports;
- One formal complaint;
- 13 written compliments.

Appended to the clinical governance report were updates regarding blood and anaesthesia activity. The blood report informed the committee that critical care practitioners were nearing completion of a transfusion module to enable them to prescribe and administer blood products in the absence of a medical practitioner and a detailed summary of blood product use, including compliance with service key performance indicators, was to be completed in April 2018. With regard to anaesthesia activity, it was noted that compliance with time targets on scene remained static but this was an area for ongoing surveillance and improvement. Work was continuing to better capture 'off scene' times as well as time taken for the aircraft to lift in order for consideration to be given to revising target times if appropriate.

As part of the discussion of the report, it was noted that consideration was needed as to how to share learning from issues and incidents nationally so other organisations could benefit, but there was no specific fora for this. However, members of the team were to spend time with an English air ambulance charity to provide support and learning as it took ownership of a new helicopter.

Clarification was also sought as to whether the issue relating to blood samples taken prior to hospital arrival from as yet unidentified patients had been resolved. As it had not, the Executive Medical Director undertook to write to his counterpart at the relating hospital to determine what action was required to address this.

4.0 Recommendations

The Quality and Safety Committee is asked to note the report.