Yorkshire Ambulance Service NHS
NHS Trust

Quality Committee Meeting Minutes

Venue: Kirkstall & Fountains, Springhill 1, WF2 0XQ
Date: Thursday 9 March 2017
Time: 0830 hours
Chairman: **Pat Drake**

Membership:

Pat Drake	(PD)	Deputy Trust Chairman/Non-Executive Director
Erfana Mahmood	(EM)	Non-Executive Director
John Nutton	(JN)	Non-Executive Director
Steve Page	(SP)	Executive Director of Quality, Governance and Performance Assurance
Dr David Macklin	(DM)	Executive Director of Operations
Dr Julian Mark	(JM)	Executive Medical Director
Roberta Barker	(RBa)	Interim Executive Director of Workforce and OD
Dr Philip Foster	(PF)	Director of Planned and Urgent Care

Apologies:

Dr Steven Dykes	(SD)	Deputy Medical Director
Dr Philip Foster	(PF)	Director of Planned and Urgent Care
Anne Allen	(AA)	Trust Secretary (Observer)
Suzanne Hartshorne	(SH)	Deputy Director of Workforce and OD

In Attendance:

Andrea Broadway-Parkinson	(ABP)	YAS Expert Patient
Karen Warner	(KW)	Deputy Director of Quality & Nursing
Mark Millins	(MM)	Associate Director of Paramedic Practice
Rachel Monaghan	(RM)	Associate Director of Performance Assurance and Risk
Gillian Hart	(GH)	Associate Director of Corporate Communications (Interim)
Barrie Senior	(BS)	Non-Executive Director (Observer)
Ronnie Coutts	(RC)	Non-Executive Director (Observer)
Claus Madsen	(CM)	Associate Director of Education and Learning
Keeley Townend	(KT)	Associate Director for Integrated Urgent Care (Item 6.2)
Tim Gilpin	(TG)	Associate Non-Executive Director (Observer)

Minutes produced by:

Joanne Lancaster	(JL)	Committee Services Manager

		Action
	The meeting commenced at 0905 hours.	
1.	**Introduction & Apologies** PD welcomed everyone to the meeting. She welcomed TG, Associate Non-Executive Director to his first Quality Committee.	

		Action
	Apologies were noted as above. A pre-committee presentation was delivered by Mark Millins, Associate Director of the Paramedic Practice on Critical Care Development. PD thanked Mark for an interesting and informative presentation.	
2.	**Review Members' Interests** Declarations of interest would be noted and considered during the course of the meeting.	
3.	**Chairman's Introduction** PD referred to the Spring Budget announced by Central Government, particularly referencing the relevant points for the NHS. She referred to the Trust's CQC report which had been published and had shown improvement across all domains. She passed her thanks on to KW and the rest of the team who had coordinated the inspection and the CQC team. PD reiterated that risks should be highlighted within reports or verbally as reports were being discussed.	
4.	**Minutes of the Meeting held on 8 December 2016** The minutes of the Quality Committee meeting held on 8 December 2016 were approved as a true and accurate record of the meeting subject to the following amendment. Page 9 & 10 – Expert Patient Report – ABP had noted a small number of minor amendments relating to this and she would pick these up with JL outside of the meeting. **Matters Arising:** There were no items for discussion.	
5.	**Action Log** The Quality Committee considered the open actions on the Action Log. 016/2016 – PTS waiting areas in Hospital Trusts – This item was deferred to the June meeting. An initial review had been undertaken but further analysis was required prior to being discussed at QC. Action remains open. 022/2016 – CPD training for Bank staff who did not work many shifts – This item was covered in a paper on the agenda. Action closed. 039/2016 – GP verbal request appropriately documented – This item was covered in a paper on the agenda. Action closed.	

		Action
	040/2016 – Update on discussions with York Hospital Trust – This item was covered in a paper on the agenda. Action closed. 041/2016 – Staff meal breaks update – DM reported that analysis had been undertaken for each station and further analysis was required to better understand the variances. Less than 50% of staff were getting their meal break appropriately. This would be reassessed once the rota implementation was complete and a comparison would be made. A report would be brought to the June QC. Action closed.	
6.	**QUALITY GOVERNANCE/CLINICAL QUALITY PRIORITIES**	
6.1	**Quality Governance and Clinical Quality Strategy** The paper provided a summary for quality governance and delivery of the Clinical Quality Strategy. KW referred to the Human Factors work which was taking place and advised that the Safety Huddles were now well embedded within the EOC and were now taking place in NHS 111. PD asked that future reports clarify which departments were taking part in initiatives. KS confirmed that the paediatric child restraint and the new-born restraint for use when transporting a baby or child in an ambulance had been purchased. It was noted that the Quality and Safety team were undertaking an extensive review of DATIX, the incident reporting system, to ensure that all investigations were timely and reflective of the level of incident reported. There would be a greater focus on systems for feedback and wider utilisation and sharing of learning. The number of complaints about PTS continued to decrease throughout Quarter 3 and numbers received were at the lowest levels for over 12 months. The feedback from postal surveys continued to be positive and results showed that 83.8% of respondents felt that 999 call takers listened carefully to their calls. The Critical Friends Network had been successfully launched and there had been two meetings scheduled to date with a third taking place later in the year. The Trust would like to increase the number of this group and it was actively trying to recruit in this regard. A leaflet explaining the Critical Friends Network and asking for expressions of interest was being sent with every complaint response. KW informed the Committee that the new Head of Safeguarding, Nikki Gibson had commenced with the Trust in December 2016. The Trust was developing a combined Children and Adults e-learning level 2 safeguarding course.	

		Action
	This would be complemented by specific face to face training to service lines. In terms of safeguarding referrals some concerns had been expressed over the volume from YAS by other agencies. YAS' stance remained that when a member of staff had concerns in this regard then a safeguarding referral should be undertaken. However, the Trust was looking to strengthen the information provided. DM remarked that the Trust should not aim to lengthen the process (unless there was a clear benefit to the patient) but to provide the necessary information for the Local Authority to allow them to decide what action was appropriate. KW advised that CQUINs had been agreed as part of the contract negotiations for the A&E contract and were still subject to negotiation in PTS. The national CQUINS in relation to staff wellbeing applied to both A&E and PTS and additionally the A&E contract had a CQUIN relating to a reduction on conveyance, engagement with STPs and achieving the financial control total. The Bright Ideas scheme had been updated and was being administered by the Quality Improvement Team. The first idea to progress since the scheme was relaunched was the Individual Short Subscriber Identifier (ISSI). This was a unique number for radios used by A&E operational staff and enabled them to speak to one another on the devices by dialling the unique number. This was particularly useful at an incident if further equipment was required. PD asked whether there was a reward given to the individual whose 'Bright Idea' had been implemented as a way of recognition. SP responded that the proposal was to build it in to the We Care Awards as a 'Best Idea' category. GH added that the Communications Team was considering this as part of the Trust's Recognition Strategy alongside other initiatives that would offer an immediate recognition of excellent and/or innovative work of staff. KW referred to the Care Quality Commission (CQC) inspection and subsequent reports which had been published on 1 February 2017. These had reflected an improved position for YAS across all service lines. Corporate Communications had been issued to all staff thanking them for their efforts in this achievement. The Quality Compliance Delivery Plan was being refreshed to reflect the CQC reports and work was on-going to identify the key actions and milestones.	

		Action
	KW outlined the 'must do's' and the 'should do's' for the Trust. The next step was a CQC Quality Summit which was scheduled to take place on 24 April. YAS had partnered with NHS Kirklees and Calderdale and Huddersfield NHSFT in a successful bid for the second wave of Nursing Associates. YAS would provide a placement for the recruited Nursing Associates which would give potential future nurses exposure to the ambulance sector. The work to introduce the nursing internship pilot programme had progressed to the recruitment of six nurses with an anticipated start date of April 2017. The competencies for placements within NHS 111 and the EOC had been identified and were being developed into a skills passport. The competencies for the 999 frontline placements were in development and this work was being shared and co-produced through the NAA. SP remarked that work was on-going to determine how the nurses on the internship pilot programme would fit into the multi-professional workforce at YAS. This would be informed by the Trust's future approach to urgent and emergency care delivery overall. There was national interest in this regard and the Trust would be sharing learning from this pilot. KW added that primarily this intake of nurses would be used for a specific cohort of patients: 'hear and treat' and 'see and treat'. The Quality Account was now in its first draft and the formal 30 day consultation stage with stakeholders was due to commence on 1 April 2017. JM advised that the Clinical Audit programme for 2016/17 was attached at Appendix 1 of the report. The main changes to note were the National Clinical Performance Indicators (CPI) were suspended in September 2016 until a revised national audit programme was published in April 2017. YAS continued to undertake the planned local audits to maintain oversight of clinical performance and these were attached at Appendix 2 of the report. He advised that there was a National Ambulance Service Medical Directors (NASMED) workshop the following week to review the Quality Indicators. The Myocardial Ischaemia National Audit Project (MINAP) had published the 2014/15 data with YAS showing a 78% compliance with the 150 minute call to balloon time. The report appeared to be missing a large number of cases and might not reflect the actual value. It was believed this might be attributed to poor data submission by the Acute Trusts responsible for data upload. PD asked where the recommendations went from the MINAP report.	

		Action
	JM responded that because the data was from 2014/15 it was no longer valid as YAS looked at 'live' data. There were no implications for YAS. JM referred to the Sepsis Screening Tools which had been developed in conjunction with all the regional Emergency Departments. Sepsis was a major killer in the UK and he believed that YAS was forward thinking in this regard for diagnosing and treating patients with sepsis. The Trust had now received clarity from the Home Office for the Controlled Drug (CD) License and this had provided YAS with the opportunity to simplify how CDs are procured, stored and transported across the region. PD asked that the local mortality review be taken to Audit Committee. **Action:** **The local mortality review to be taken to Audit Committee.** PD referred to the excellent performance with regard to cardiac arrest survival to discharge results and asked that a presentation be given at a Public Board on this subject. **Action:** **That a presentation on cardiac arrests and survival to discharge performance be given at a Public Board on this subject.** PD asked whether the STPs were aware that reconfiguration of stroke services within the region resulted in YAS being unable to reach the 60 minute performance target for Stroke60 from some locations. JM confirmed that Tony Rudd, National Clinical Director for Stroke, NHS England, had been made aware of the issue and YAS had attended specialised meetings in this regard. The ACQI review might provide an opportunity to turn this into a Clinical Indicator. The NICE guidance provided a three hour window from onset to treatment and it was the three hours that was the relevant clinical measure rather than the 60 minute breakdown that was currently used. He would prefer the performance measure of Stroke180. STPs would need to review what services were provided within their footprints and cross-border. PD reflected this was an important issue and that the Quality Committee should be kept appraised of developments. PD asked for a report in relation to narrative information from patient surveys. **Action:** **A report in relation to narrative information from patient surveys to be brought to the next Quality Committee.**	**JM 001/2017** **JM 002/2017** **KW 003/2017**

		Action
	PD asked about the compliance rate within Prescription Only Medicines (PoM) audit in the North Clinical Business Unit. MM responded that the North was a rural location and this could prove challenging in terms of access for audits. Work was on-going to improve the compliance in this area and he was confident that there would be an improvement going forward. PD requested that an update on the Infection Prevention and Control (IPC) Plan be brought to the Quality Committee to update on progression. **Action:** **That an update on the Infection Prevention and Control (IPC) Plan be brought to the Quality Committee to update on progression.** PD referred to incidents relating to paper loss which were mostly related to losses to Patient Care Records and requested further information in the next report. JM responded that the numbers were small and explained that information had not been disclosed but it was a system process when an email was returned from a GP surgery unopened. As the Caldicott Guardian he was satisfied that the system in place for sharing information was robust. SP confirmed that the CQC reports had been reviewed and discussed by TEG and that an action plan would be developed to address any issues and to share good practice. The CQC Quality Summit would take place on 24 April 2017 and include wider stakeholders. PD thanked KW and JM for the update. **Approval:** **The Quality Committee received the report as assurance that quality governance and clinical quality remained a key priority for the Trust and that related work streams were progressing to plan.**	**KW 004/2017**
6.2	**Service Line Assurance – NHS 111/ West Yorkshire Urgent Care** The paper provided information on the NHS 111 service line and subcontracted service West Yorkshire Urgent Care (WYUC). It was noted that call volumes in NHS 111 continued to grow year on year with an underlying growth of 6.27%. Call answer performance as at end of January 2017 was at 93% against a target of 95% and was above last year's outturn by 4%. Clinical performance remained challenging and had fallen since 2015/16 mainly due to a rise in demand but no subsequent rise in Clinical Advisors in the service. Two activities had been pursued over the last 12 months to try and aid with clinical performance: • Clinical queue management and audit;	

		Action
	• Clinical recruitment. It was noted that the clinical queue management ensured that any patients waiting for a call back were monitored and appropriately prioritised both in real time and through established audit processes. The process was commended by the Care Quality Commission in its recently published inspection report of the Trust. There had been significant clinical recruitment activity since September 2016 however this had resulted in only 195 applicants and 111 interviews, the actual number of clinical staff starting with the service had only kept pace with attrition and rising demand. Lots of work was taking place to try and increase clinical staff recruitment. A Clinical Challenge Workshop had been held with colleagues across the Trust with some good ideas generated. A project group would be set up to take forward some of these ideas. It was noted that the recent CQC inspection into the service had resulted in a 'good' rating with 'outstanding' around Innovation and Workforce planning. The service had employed a professional planner and this work resource had been shared with colleagues in A&E Operations. DM asked for his thanks to be formally noted for the work provided by this individual. The Committee heard that the service had identified three areas of focus: • Staff recognition for positive work; • Support to staff; • Raising awareness of how to raise concerns. The working environment was noted and it was explained that although call audits of the service were undertaken, the outcomes of those audits were not communicated to staff including staff being told where call audits had revealed examples of good practice. The service was changing the way it undertook supervision and call audits. Five new team leaders had been appointed to increase the supervisory presence. A recognition scheme which had been designed by staff had been implemented; this was overseen by staff and managers. Awards of certificates and badges were awarded on a monthly basis and feedback from staff had been extremely positive. An update on the contract negotiations was provided and a joint Quality Impact Assessment had been completed on the proposed settlement.	

		Action
	The Trust had received a contract settlement for NHS 111 which would allow the service to manage growth but not to be able to undertaken service developments/improvements. It was confirmed that the contract would not be agreed for WYUC until the outcome of the independent review. SP advised that the Trust was using the Quality Impact Assessment to highlight the risks to Commissioners. KT advised that the service had been creative in sourcing alternative funding to develop and improve the service. EM stated that she did not advocate signing a contract that the Trust could not deliver. KT responded that the WYUC contract would not be settled until the outcome of independent review into WYUC was known. YAS was accepted as an Early Adopter for the NHS England/Health Education England initiative to test out the ideas for national workforce competencies for staff working in Integrated Urgent Care / NHS 111. Work was underway with NHSE/HEE to shape the framework. Sickness within NHS 111 remained challenging predominantly due to the intensity of call centre work; this was being reviewed as part of the health and well-being initiatives. This included identifying ways to reduce stress and anxiety that some colleagues may feel; looking after one's own mental health training was now available for new starters to the service and a series of initiatives such as physio advice was being made available to staff. WYUC remained a challenge for the Trust and performance had declined mainly due to demand being significantly over contracted levels. The Trust was taking part in the NHS 111 Online pilot which was taking part in small postcode areas in Leeds. The service was continuing to shape its understanding in relation to the 30% clinical advice requirements by NHS England and what implications this target might have on the NHS 111 and Y&H contract. The service was working hard to try and reach the 30% target for clinical advice and was considering what could be included as clinical advice. This had been added as a risk on the risk register. PD thanked KT for a comprehensive update and she welcomed the positive CQC report in relation to NHS 111 which had been an exceptional achievement given the risks and challenges faced by the service. The risks in relation to the recruitment of clinical staff and the challenge in relation to meeting the 30% clinical advice target were noted.	

		Action
	SP added that clinical recruitment was a Trust-wide issue relating to a wider health system issue. The Trust had set up a Trust-wide working group relating to this. **Approval:** **The Quality Committee noted the update report and taking assurance on the performance across the service line and noting service developments. The Quality Committee noted the pressure on the service in terms of Clinical Staff recruitment and the challenge of meeting the 30% clinical advice performance target.**	
6.3	**Review of QIA 2016/17 CIPs** SP informed the Committee that the paper provided assurance to the QC of the progress which had been made in completing the Quality Impact Assessment (QIA) of the 2017-19 Cost Improvement Plans (CIPs) and reported the monitoring of indicators relating to the safety and quality of services. Within A&E Operations the fundamental delivery of the CIP remained focussed on efficiency and productivity improvement. Quality Impact Assessment continued in relation to new initiatives, including the use of private providers. Weekly monitoring took place to ensure that all indicators remained within acceptable parameters. It was noted that PTS transformational work continued and the issues in relation to renal patients had now been resolved. The 2017/18 CIP schemes continued to be tracked through the CIP Management Group and via indicators in the locality dashboards and the Integrated Performance Report. It was noted that the Programme Management Office (PMO) was taking an active role in supporting programme development and delivery, working closely with the Finance and Quality teams. It was noted that 34 CIP schemes had a provisional QIA and 12 had progressed to the sign-off stage. One scheme relating to a 'reduction of deep cleaners' had been given a 'Red' rating. The feeling was that it wasn't appropriate to reduce numbers at the moment and this would be kept under review and aligned with the longer term strategy of the Hub and Spoke programme. It was noted that the QIA process now included Equality Impact Assessments (EIA). PD asked whether the process would pick up a cumulative issues, ie – how many 'reds' would become an issue. KW responded that the CIP Management Group would oversee the whole programme and sense check where it felt it was necessary.	

		Action
	RM added that the PMO tracked the indicators and anomalies would be highlighted. RM explained that going forward there would be a 2-3 year CIP plan which would include transformational efficiencies and transactional efficiencies. PD thanked the team for the update. **Approval:** **The Quality Committee noted the paper and gained assurance with regard to the current position of the QIA monitoring and actions to mitigate emerging key risks.**	
6.4	**Expert Patient Report** The paper provided an update on the role and activities of the YAS Expert Patient since the last meeting. It was assumed the paper had been read but the following highlights were made. ABP referred to the successful launch of the Critical Friend Network (CFN) and provided some basic known demographic details of attendees in her report to satisfy any queries around inclusion and diversity considerations. The CFN was an on-going project and ABP was meeting with the Rebecca Mallinder (RM), Head of Investigations and Learning to discuss ideas and continue to offer support if requested in relation to the CFN. The current membership of the CFN stood at 15 and continued efforts (now taken over entirely by RM and team) were being made to promote the network and sign up further CFN members. She emphasised the need for appointed YAS colleagues to recognise the complexities and challenges of patient, carer and public involvement and engagement in such things as the CFN. She further emphasised that the experience, knowledge and staff capacity required for success should not be underestimated. Likewise, that some known recruited CFN members to date had much experience and skills sets which staff could learn from and be harnessed. She felt these considerations would be essential for CFN sustainability. In terms of the Moving Patients Safely Group ABP was continuing to work with the Head of Safety to secure patient and carer/family perspectives input. This had included requesting proactive planning of meeting dates to enable ABP as the YAS Expert Patient to attend or pre-meet if necessary. Progress on the work plan was slowly progressing. ABP reported that there was more work to be done on the Patient Facing Care Pathways Information Leaflet/Care Plans for non-conveyed patients. Details on progress had been requested by the Clinical Quality Development Forum at their April or May meeting.	

		Action
	ABP continued in her voluntary role as YAS Interim Patient Research Ambassador until the formal recruitment for this role took place. ABP suggested that there could be better engagement from the Business Planning process incorporating the patient view/voice more and it was hoped this would improve going forward. ABP advised that she was working with Kez Hayat, Head of Diversity and Inclusion and that she had attended the inaugural Diversity and Inclusion Steering Group. It was anticipated that a pending business case would be developed by Kez for YAS' Expert Patient to continue to be involved in this important agenda. ABP had met and provided the YAS' Expert Patient workplan proposals to SP, with a view to possible consideration and adoption. Further meetings were set with SP to follow this up. These were noted by the QC. PD thanked ABP for her update and reflected once again on how busy ABP had been with various projects and initiatives across the organisation. **Approval:** **The Quality Committee received the YAS Expert Patient report on actions since the last meeting for information.**	
6.5	**Significant Events/Lessons Learned** SP provided the Committee with an update on significant incidents (events) (SIs) highlighted through Trust reporting systems and by external regulatory bodies and provided assurance on actions taken to effectively learn from adverse events. SP advised that the Trust had 28 open SIs of which 7 were under investigation. All other SIs were with Commissioners to review a submitted report or await review of evidence that would provide assurance of implementation of the agreed actions. SP explained that many of the delayed response SIs related to a lack of available resource to meet the demand experienced by the service. Analysis undertaken of SIs due to delays prompted a review of the current process for reporting delayed response SIs with a key focus on what learning had arisen from each investigation. It was noted that the Trust reported SIs in line with the National Serious Incident Framework 2015. The review had strongly suggested that the current approach to incidents where the response was outside the target timeframe was too broad in scope when considered in the light of the national guidance. He advised that a Decision Tree had been developed in relation to Time Related SIs and this had been approved by the Clinical Governance Group. This would be used at the Incident Review Group to support decision-making.	

		Action
	The tool contained time thresholds for different levels of patient acuity. The Decision Tree targeted where the most learning could be gained although the Trust still collected data for all incidents. The QC noted incidents related to violence and aggression towards staff. PD questioned whether this was under reported. DM responded that the Trust had a zero tolerance in regard to violence and aggression towards staff. RM added that work was on-going to ensure that incidents were reported by staff and that these were appropriately followed up and action fed back. DM referred to the table on page 4 of the report and asked why ARP was listed on the table. SP responded this was an error and confirmed that there had been no Serious Incidents relating to the ARP pilot. SP advised that the Trust had begun issuing direct service to service letters to hospitals where extensive delays (in excess of 2 hours) had been experienced by YAS at handover. The QC considered the table which provided information of the number of extensive delays at each hospital. DM advised that it was planned to meet with the Chief Operating Officer and Director of Nursing at York Hospital Trust to discuss the issues with handover. SP advised that one Prevention of Future Death (PFD) report was received during this period. SP explained the details surrounding the case. YAS had not been informed that the inquest was taking place and no witnesses from YAS had been asked to attend the inquest. As a result of concerns raised by the family during the inquest that they were not notified that the patient was being taken to hospital, the Coroner issued a PFD report to the organisations involved to review the processes relating to this. YAS considered the report but felt that all appropriate systems and processes were in place and a response was provided from the Chief Executive of YAS confirming this to the Coroner. SP referred to an incident that had been referred to the Information Commissioners Office (ICO), the ICO considered the incident and felt it did not meet the criteria for formal enforcement action and had closed their file on the case. PD asked whether all contacts were now being recorded in relation to Freedom to Speak Up. SP confirmed this was the case and that information was being collated on lessons learned at a corporate level.	

		Action
	Approval: **The Quality Committee noted the current position and was assured in regard to the effective management of and learning from adverse events.**	
6.6	**Programme Management Office (PMO) Update** The paper provided an oversight of the Trust wide Transformation Programme as means of assurance and exception reporting of items for escalation. RM provided a brief summary of the following: • A&E Programme – There had been a slight delay with recruitment. Overall the transformation was on a positive trajectory and was being reported as Amber; • PTS Programme – The programme had slipped due to resources being re-directed to undertake the recent bid work. PTS management would be taking a view on progress once the bid work was complete. This was being reported as Amber; • Hub and Spoke Programme - The Doncaster hub had experienced delay due to the identified site not being suitable. The programme was being reported as Amber; • Urgent Care Programme – There were challenges in relation to clinical recruitment. Further review of the programme was required to clarify direction of travel following the imminent close down of some key projects. DM reported that A&E rotas were on track to be implemented as scheduled on 3 April 2017 and that the related policies had been agreed to await final approval and sign-off. He advised that the service continued with current procedural arrangements for Standby and Meal Breaks. RM explained that the PMO was supporting the development of a 2/3 year CIP plan and that support would be given to help managers to deliver these. JN asked whether there was any early indication of where costs could be reduced. RM responded that she felt that some of the processes across the organisation would produce efficiencies. This was true for both corporate processes and those distinct to service areas. PD thanked RM for the update. **Approval:** **The Quality Committee noted the update and gained assurance that the Project Management Office was assured of the effective management of the various projects and initiatives across the Trust.**	

		Action
7.	**WORKFORCE**	
7.2	**Education and Training Plan Update Report** This item was taken out of order of the agenda. The paper provided an overview of matters relating to education and training and the training plan. CM reported that 40 student places had been funded by Health Education England for the Emergency Care Assistant (ECA) to Paramedic conversion programme 2016-17 with Sheffield Hallam University. The Trust was still awaiting confirmation for commissioned numbers for 2017-18. There had been five successful students from the Pre-Degree Pilot which would commence their study in March 2017 as part of the commissioned numbers. It was acknowledged that this was a specific programme which had not been as successful as hoped. CM advised that placement requirements was a growing issue for the organisation and that YAS could not always support every request; there was a strict process related to placements. There had been a 40% reduction in CPD funding and it was difficult to mitigate this level within the Trust. YAS was in regular contact with Health Education England with regards to funding available within the Yorkshire and Humber region. To date Health Education England had not released the figures that the Trust would be eligible to drawn down upon. DM remarked that this level of reduction required a different approach including looking at alternative sources of provision and funding. He confirmed that there was no impact on in-house provision or specialist courses as yet. These would be continued to be provided at current levels. RBa added that the process for applying for CPD was inconsistent across the Trust. It was clear that some staff studying had bypassed the corporate process and budget. She confirmed that the process would be strengthened and that professional training would still continue. PD asked for a specific report in relation to this. **Action:** **To provide a report to the next Quality Committee and the process for CPD across the Trust including funding**. Discussion took place in relation to CPD training, the approval process for such and the financial implications of approval being gained from a non-centralised process.	**RBa/CM 005/2017**

		Action
	It was noted that a new governance structure for Education and Learning had been developed and would be agreed at TEG. EM suggested that some of these costs could be substantial at a local level. PD suggested this should be highlighted to the Audit Committee as a risk. CM confirmed that the team governed and oversaw training/CPD for all roles within the Trust including clinical roles. PD asked for a report to the next Quality Committee on Statutory and Mandatory compliance. **Action:** **For a report to the next Quality Committee on Statutory and Mandatory compliance.** PD thanked CM for the update. **Approval:** **The Committee noted the update and but did not gain sufficient assurance on the governance of education and training.**	**RBa/CM 006/2017**
7.1	**Workforce and OD Update** The report provided an overview of matters relating to a range of workforce issues, including education and training, equality and diversity and employee wellbeing. RBa advised there had been a poor response to the Friends and Family Test. The Staff Survey 2016 satisfaction rating had increased from 2015 to 3.38 from 3.31. The survey had been sent to every member of staff within YAS which gave the Trust a good baseline to measure from going forward. It was confirmed the response rate had been 38%. RBa referred to the Apprenticeship Levy and advised that the Digital Account had been set up. Following on from previous discussions on this subject someone from YAS' HR team was liaising with RC in this regard. YAS had a duty to ensure that 2.3% of its workforce were on an apprenticeship and that Trust was doing everything to ensure that this was achieved. CM provided a brief overview on the Visions and Values work and outlined the engagement work that had been undertaken with staff to gain feedback on the proposals. To date 7% of the workforce had been consulted and the target was 10% which he felt confident of achieving.	

		Action
	RBa advised that recruitment remained busy and the team was looking to make better use of the TRAC system to aid with effectiveness. There was now a central booking team for agency workers to enable better scrutiny in this regard. Consideration was still being given to an 'in-house' bank. The flu campaign had not been as successful as had been hoped. Work was being developed with the NAA to look at this from a wider perspective. EM emphasised the use of YAS' Charitable Fund for staff with musculoskeletal issues as there may be scope to help by referral to a treatment centre that is used by the Police. PD referred to the risks outlined in the report: • Flu vaccination; • CPD; • Apprenticeship Levy. These should be referred to Audit as risks. PD thanked RBa for the update. **Approval:** **The Quality Committee noted the update and gained some assurance by the progress made but expressed concerns in regard to Flu vaccination take-up, CPD governance and the Apprenticeship Levy.**	
7.3	**Staff Communications and Engagement Update** The paper provided an outline of progress made and tactics planned for the communications activity of the Trust. GH explained that the team had a number of vacancies which presented challenges in terms of some of the pro-active work which the team had hoped to achieve. Internal staff engagement remained a focus for the team as did external media activity and management. It was intended to make better use of social media as this was free and had the potential to reach a significant audience. GH referred to the Communication Activity Overview dashboard which was provided to TEG and TMG on a regular basis. She proposed that this would also be made available to the Quality Committee. PD thanked GH on the update and for the progress made in moving the communications agenda forward.	

		Action
	Approval: **The Quality Committee noted the update.**	
8.	**RISK MANAGEMENT**	
8.1	**Risk Management Report** RM provided an update on changes to the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) since the last Committee and on relevant Internal Audit recommendations. RM advised that a review of the BAF had been undertaken through the Board Development Meeting held on 28 February 2017. She outlined the new risks that had been added to the CRR since the last Committee: • Strategic impact of reconfigurations; • Apprenticeship Levy Utilisation; • Basic Life Support and Defibrillation training and competency; • IG Mandatory Training Compliance. JM referred to the 'Basic Life Support and Defibrillation training and competency' and explained that there had been four incidents and although reviews indicated these were isolated incidents and not indicative of the Trust as a whole it had been felt prudent to raise the risk to the CRR. PD asked for an update report on this issue. **Action:** **For an update report to be provided to the Quality Committee on the issues surrounding the increased risk rating for 'Basic Life Support and Defibrillation training and competency'.** RM highlighted those risks which were graded 'Red' and had the potential for impact on patient outcome: • Hospital Handover; • WYUC Capacity. RM referred to the reporting of physical assaults to staff; YAS had the appropriate support in place for staff. PD thanked RM for the update. PD highlighted that risks had been appropriately raised through the reports discussed on the agenda. **Approval:** **The Quality Committee noted the progress made and gained assurance from the robust processes currently in place to manage risk across the Trust.**	**SP/JM 007/2017**

		Action
9.	**RESEARCH GOVERNANCE** No items for discussion.	
10.	**ANY OTHER BUSINESS**	
10.1	**Issues for reporting to the Board and Audit Committee** PD summarised the items to be presented to the Board and Audit Committee including: • The excellent continuing work on cardiac arrest survival; • Concerns in relation to hospital turnaround times with the recognition of the discrete and significant work with partners locally and nationally; • The finalisation of a CQC action plan following the Quality Summit; • Good assurance from the service line report from 111 and recognise their good CQC report but recognise some significant challenges particularly around recruitment and also await the contract settlement; • A request for further assurance around the governance of education and training; • Apprenticeship Levy; • Flu vaccination take-up.	
11.	**FOR INFORMATION**	
11.1 **11.2** **11.3**	**IPR – Workforce and Quality** The report was noted. **Quality Committee Workplan** The workplan was noted. **Quality Committee Terms of Reference** This item was noted. The meeting closed at 1205 hours.	
12.	**Date and Time of Next Meeting:** (0830) 0900-1230 hours 15 June 2017, Kirkstall and Fountains, Springhill 1, WF2 0XQ	

CERTIFIED AS A TRUE RECORD OF PROCEEDINGS

_____ **CHAIRMAN**

_____ **DATE**