Yorkshire Ambulance Service NHS
NHS Trust

Quality Committee Meeting Minutes

Venue: Boardroom, Springhill 2
Date: Thursday, 10 May 2012
Time: 1330 hours

Chair: Pat Drake

Attendees:

Pat Drake	(PD)	Non-Executive Director (Chair)
Elaine Bond	(EB)	Non-Executive Director
Richard Roxburgh	(RR)	Non-Executive Director
Steve Page	(SP)	Executive Director, Standards & Compliance
Stephen Moir	(SM)	Deputy Chief Executive/Executive Director of Workforce & Strategy

In Attendance:

Julian Mark	(JM)	Associate Medical Director
Karen Warner	(KW)	Associate Director of Quality
Kevin Wynn	(KDW)	Associate Director of Risk & Assurance
Glynis Learnmouth	(GL)	Assistant Director, OD – Workforce
Andrea Broadway-Parkinson	(AB-P)	YAS Expert Patient
Paul Mudd	(PM)	Locality Director Emergency Operations West
Anne Allen	(AA)	Director of Corporate Affairs & Trust Secretary
Michael Long	(ML)	ECP, Selby (in part)
Peter Shaw	(PS)	Community Paramedic, Leyburn (in part)
John Arnell	(JA)	Acting Clinical Manager (NY) (in part)
Vince Larvin	(VL)	Locality Director, Emergency Operations, N&E Yorkshire (in part)

Apologies:

Alison Walker	(AW)	Medical Director
Paul Beasley	(PB)	Associate Director of EOC
David Williams	(DW)	Acting Executive Director of Operations

Minutes produced by: (MG) Mel Gatecliff, Executive Support Officer

		Action
	The meeting commenced at 1330 hours	
1	**INTRODUCTION AND APOLOGIES** Apologies were noted as above. It was agreed that the presentations which formed items 9 and 11 would be discussed at the start of the meeting.	
2	**REVIEW OF MEMBERS' INTERESTS** No interests were declared during the course of the meeting PM advised the meeting that he was on call and might need to leave early. (He subsequently left the meeting at 1350)	

		Action
3	**MINUTES OF LAST MEETING, MATTERS ARISING AND ACTION LOG** The minutes were approved as a true and fair representation of the meeting. **Matters Arising** Page 3 (6) Patient Experience Developments. Line 2 – typographical error – "had been had been" – the duplication was deleted. Page 5 (9) Quality Governance Overview Report. Paragraph 2 – typographical error - "buy" was replaced with "by". **Action Log** The meeting worked through the Action Log, which was updated accordingly. SP reported that comments had been received on the work plan and that these were now incorporated. It was agreed that this would be submitted to the Board for sign off. PD queried the current position in relation to patient experience developments. KW noted that further work was required to develop active patient involvement in relevant Trust developments including involvement of the Critical Friends. It was agreed that the Patient Experience work plan would be presented at a future Quality Committee meeting and that this should incorporate the training and support of volunteers. PD requested that consideration be given to the expenses, etc that would be incurred if volunteers were going to be used going forward. In relation to the timing of future meetings, PD confirmed that if there was no NED meeting in between the Quality Committee and Finance and Investment Committee, the Quality meeting would commence at 1330. Members should therefore assume that Quality meetings started at 1330 unless otherwise notified.	
	CLINICAL QUALITY PRIORITIES	
4	**CLINICAL GOVERNANCE AND QUALITY UPDATE REPORT** KW stated that the report was intended to give an overview of developments relating to the clinical quality strategy and the associated implementation plan. A monitoring tool was presented which will be used to track the progress of each element. KW added that she would report on progress regularly to the Quality Committee so that success could be gauged against the key indicators. PD stated that it was an excellent document. EB agreed, and said that she would appreciate the opportunity to receive updates on new risks and be able to drill down against these risks SP stated he would find it very useful to have more information about milestones and projected completion dates.	

		Action
	RR agreed, stating that as March 2013 was a long way off he would appreciate a break down into more detail. PD stated that she felt better assured about the current position, as it was better to know that there were challenges so at least the Board knew what they were aiming for.	
5	**SIGNIFICANT EVENTS/LESSONS LEARNED** KDW stated that the intention of the report was to provide a briefing on all significant adverse events highlighted through the Trust reporting systems and by external regulatory bodies. Appendix 1 included a breakdown of serious incidents; Appendix 2 picked up on lessons learned; and Appendix 3 provided an over view of significant reporting and review timescales, etc. PD asked how long it took between the occurrence of an incident and it being reported. SP replied that 2.10 picked up this point and the Trust was performing well in the management of SIs and adherence to the reporting timescales. KDW stated that Appendix 3 showed that, since August 2011 no extensions had been requested from the commissioners. PD asked whether actions taken were kept on the log until lessons were implemented. KDW replied that actions would remain on the log to revisit even when an item was closed so the Trust could check further down the line that actions were still being followed through. SP stated that the team had really tightened up on the area in the past 12 months and were now very outcome orientated. KDW stated that development of managers' investigation skills was a priority, adding he was currently working with EOC to address the increasing number of response SIs. PD stated she would be interested in a report coming to Quality Committee to tie up the loop. AB-P asked why there was a delay in "Being Open" (3.7). KDW replied that each case was looked at individually to assess how best to apply the being Open principles to each family. KW stated that the IRG collectively discussed cases in detail and to date all families had been contacted. AB-P asked whether there was a protocol to follow. SP confirmed that there was but that this was based on principles which needed to be interpreted for each situation, to ensure that communication with the family was handled appropriately and with sensitivity. The Quality Committee supported the recommendations detailed in the paper.	
6	**NHSLA SOLICITORS' RISK MANAGEMENT REPORT ON CLAIMS** AA stated that Caroline Balfour (CB) had written the report which provided an update on the key themes and developments in relation to the NHSLA Solicitors' Risk Management Report on Claims Analysis and Annual Review.	

		Action
	The analysis had been carried out in the 2010/11 review period. Ambulance trusts had a far lower level of claims in the category than Acute trusts but YAS had received 2 of these reports in the period under review. AA stated that the main purpose of the reports was to learn from the review and to implement that learning. It was noted that the current Trust claims management systems addressed the national report recommendations and that learning from claims took place before the claim was closed. The Committee received the report and agreed to receive further update reports in the future.	
8	**CLINICAL AUDIT AND NIHCE GUIDELINE REPORT** JM presented the report which provided an update and assurance on developments, emerging issues and risks in relation to clinical audit, including NIHCE recommendations. JM stated it was pertinent to raise the issues recently encountered with document processing and the ability to perform clinical audit in the organisation. He reported that the Readsoft software had been introduced in March and had not functioned effectively so patient data forms could not be automatically processed. JM stated that he was due to lead an investigation into what had happened further down the line and action plans were in place to ensure reporting was on time in the future so things should be back up to speed by the end of May. JM stated he was working with the software manufacturer to rebuild the system. In the meantime a mitigation plan had been agreed with TEG to target additional resources at manual scanning. This would ensure that clinical AQI reporting was not affected. JM added that clinical audit capacity was affected by this issue and by other pressure on costs and that this affected the ability of the department to support local clinical audit activity. SP note that as the electronic care solution was rolled out across the Trust some time should be freed up. JM confirmed that there should also be a tangible reduction in paper reporting over the next 2 years. JM also reported that clinical audit wanted to move the whole team on to one site to enable them to flex working practice to meet demands. JM confirmed that he had already spoken to the Audit Committee about clinical audit and it had been escalated as a corporate risk in November 2011. SP would include the item in the report from Quality Committee and AW could speak about it in detail. **Action:** **SP/AW to raise the item at the next Board meeting under Quality Committee report**	**SP/AW**

		Action
	JM noted that no new NICE guidance pertinent to the Trust had been published. He added that the new JRCALC was about to be published and would contain significant changes. RR stated he would have expected a programme of work relating to its recommendations to come out of the clinical audit programme. PD replied that this needed to be part of the process coming out of the Quality Committee. **Action: JM to include recommendations and improvements arising from clinical audit in future reports to the Committee.**	**JM**
8	**MANAGEMENT OF CONTROLLED DRUGS** JM presented the report which provided an update and assurance on development, emerging issues and risks in relation to the management of controlled drugs in YAS. JM reported that YAS had changed the way in which it handled morphine in December 2011 because of concerns about the previous process which had been far too complicated. However, following the simplification of the process there had been an increase in the breakage of vials whilst removing them from the containers in the morphine safe. JM added that alternative containers had been sourced and trials had been conducted at two stations with good results so the new morphine vial containers were currently being procured for roll out across the remainder of the Trust. JM reported that the SHA Chief Pharmacist had carried out an external audit of morphine on 3 May, using the CQC morphine management assessment tool. Although there were a couple of areas to tighten up on, the SHA was happy with the YAS processes. PD stated that she had found the morphine incidents by type graphs at the end of the report very useful and asked JM to continue to provide updated graphs for the foreseeable future. The Committee noted the contents of the report.	
9	**GOOD PRACTICE UPDATE - PRESENTATION** The Chair welcomed Vince Larvin (VL) and his team to the meeting. **Peter Shaw** (PS), Community Paramedic – Community Paramedic Role at Leyburn Medical Practice. PS presented a summary of his Community Paramedic role which had commenced 10 years previously. He stated that, as trust in his abilities had grown over the years, so had the responsibilities he undertook in his role. PS reported that he could see, triage and treat within and outside the medical practice. He currently responded to all types of emergencies within the medical practice and local rural community, including minor injury assessment, treatment and the carrying out of home visits on behalf of GPs.	

		Action
	During the past 12 months he had stood down about 25 ambulances and called out a doctor instead. VL confirmed that the role had made around £25k of savings each year. PD asked what could be done to improve the service on offer. PS responded that full autonomy over minor injuries out of hours would add value as it would mean that patients did not have to travel a long way for treatment. It was agreed that this should be pursued with the Clinical Directorate team. **Action: VL to liaise with JM to discuss the issue of autonomy for minor injuries treatment out of hours.** SP commented on the potential for similar roles to be appointed to other areas. PS agreed, stressing that the role would need to be adaptable to fit local needs. He added that cover when he was on holiday would also be of great value and the importance of this to building sustainable service models for the future was noted. **Michael Long** (ML), Emergency Care Practitioner – Emergency Care Practice ML presented a summary of his role as an Emergency Care Practitioner, based in the Selby area. ML stated that during winter 2011 he had worked with NY and York PCT to assist with the provision of out-of-hours home visits. Information was provided by the GP OOH service who would call with patient and brief triage details. Patients would then be visited and an assessment performed although the GPs took overall responsibility for the patient outcome and treatment. Call volume was low but this enabled the team to respond without affecting their overall service provision. ML concluded that the trial worked well and might be expanded into a wider geographical area. ML further stated that in March 2012 his team had been asked to help develop and run a static city centre treatment facility on Friday and Saturday nights in York and Scarborough to help reduce unnecessary ED admissions, adding that a similar scheme was being considered for Leeds city centre. ML explained that the initiative was born on the back of a successful partnership with St John's Ambulance at York's New Year Eve celebrations. He stated that clubs/pubs reported incidents and the team responded accordingly. Treatment would be either on site or at the static unit or on occasions they had used the St John Ambulance transport to take individuals to hospital so there was no DMA involvement. ML stated that public feedback had been positive and York City Council had been very supportive. The team dealt with 4-5 call outs on average per night, with the maximum incidents being 10 in one evening, 2 of which were admitted. PD asked how exposed the team was to violence and aggression.	**VL/JM**

		Action
	ML replied that he had only had one experience of a violent drunk. The Committee agreed that the scheme needed commissioner buy in but that it had the potential to be used for promotion of good sexual health, healthy drinking schemes, etc in addition to its original aims. SM reported that the Trust Executive Group had already picked up on the scheme and had formally requested through the CEO the provision of a business case for funding for additional units. **John Arnell** (JA), Acting Clinical Manager (NY) – Clinical Reporting Framework/Clinical Performance Indicators KPI Assurance Process JA presented a summary of the proposed new Clinical Reporting Framework which was thought to capture all the elements required for reporting at CBU and Locality Board level. It also aimed to inform action planning for areas of improvement. The report was split into three areas – clinical performance, risk and training. JA confirmed that that one month's data had now been analysed and going forward Clinical Audit would provide the information on a monthly basis. All the information had been brought into one document and the data analysed in terms of themes and trends. PD asked how the framework linked with the Clinical Governance Framework. EB asked how JA would ensure that it was not siloed and RR asked how the framework would be shared. SP replied that a dashboard, which had been fairly generic to start with, had been set up during some performance review sessions. JA had then tailored it to the specific aims of the unit although more work was needed to fine tune the framework and see how it could be used in practice.	
	ESSENTIAL STANDARDS OF QUALITY AND SAFETY	
10	**OVERVIEW OF TRUST COMPLIANCE** KW presented the report which provided an update on issues, developments and risks in relation to the Trust Compliance to the CQC Essential Standards of Quality and Safety. She reported that, following its assessment in January 2012, YAS was fully compliant. The Trust had previously used the "provider compliance assessment" document provided by CQC and would continue to use the document going forward. KW stated that CBUs were expected to monitor compliance using their department dashboards. She added that a standard reporting template would be used from this month. KDW stated that there had been a notable improvement in premises in recent internal inspection visits whilst acknowledging the key areas for further work in 4.11.	

		Action
	SP stated that there was variation across the patch and the Committee would need further information about each of the risks. PD stated that she would find operational groupings more useful than alphabetical order.	
11	**COMPLIANCE REPORT – NORTH/EAST CBU** **Vince Larvin** (VL), Locality Director Emergency Operations, North & East Yorkshire – presented an update on monitoring & maintenance of CQC Standards in North/East CBU VL stated that Hull East Riding and North Yorkshire had combined their self-assessment tools and explained the progress made against each of the standards. VL stated that compliance with CQC standards was managed and monitored at Locality meetings where robust action plans were put in place to prioritise and focus on key targets that fell below the required standard. RR acknowledged that the information was at CBU level and asked, in terms of individual stations, what information was available to red flag problems. VL replied that his two Heads of Operations reviewed indicators on a regular basis at their weekly senior management meetings. SM stated he was pleased to see the tools being used by locality teams, adding that he was certain this could be built upon. PD agreed that a lot of positive work had taken place, and suggested that it would be good to follow up the work away from the meeting for further development, to ensure that it ties together with that in other CBU areas and the work being carried out corporately by SP's and SM's teams **Action:** **SP to liaise with VL and team to ensure the developments to date tie in with work being carried out by other teams** PD asked whether dates of hygiene audits were published in advance as she would be concerned if audits were returned at 100% each time they took place. SP noted that there was an external assurance element through the internal unannounced inspections. VL also stated that management teams were going to do cross checks so complacency did not set in. The committee members were concerned that some standards shown as green were not truly green as e.g. Trauma Kit training and CRB checks and it was agreed that this would be reviewed at Trust level. **Action:** **SM to review RAG rating of workforce indicators**	**SP** **SM**

		Action
	SP commented that consideration should be given to learning and themes from incidents and complaints at CBU level, to inform learning processes in the wider organisation. Further consideration should also be given to how best to work with other CBUs across other organisational areas to bring about standardisation. PD stated that quality and clinical governance, including lessons learned, should be standard within Operational management agendas. SP replied that he was currently discussing this process and the link to corporate clinical governance functions with DWi.	
	<u>QUALITY GOVERNANCE</u>	
12	**QUALITY GOVERNANCE UPDATE REPORT** SP presented a report which provided an update on developments, issues and risks in relation to quality governance. He reported that a further assessment on FT quality governance was due to take place with Deloittes in June. RR stated that he had attended a Monitor meeting in Manchester the previous week which highlighted the importance of quality impact assessment of CIPs. SP reported that work was progressing on identification and risk assessment of CIPs and that he had proposed to use one of the June Board workshops to work through quality impact assessments. SP stated his hope that by the time that the Board workshop took place information would be available about all the schemes to enable the whole picture to be presented to the Board. SP reported that it had been highlighted via the Quarter 3 contract quality review, that YAS was not fully compliant with a requirement to ensure that all clinical staff receive safeguarding training within 3 months of taking up post. The Trust was not able to report 100% compliance so additional measures had been put in place to ensure that it was achieved. New starters are now allocated their work book on their first day of employment so they can complete it without delay. This KPI has been added to the TEG workforce dashboard.	
13	**QUALITY ACCOUNT PREPARATION** KW reported that the draft quality account was still in its consultation period with its closing date being Friday 11 May. KW stated that she would build in the comments received and bring the final document back to the Board in June.	

		Action
14	**CQUIN PROGRESS 2011/12 AND SCHEMES FOR 2012/13** SP provided an update on progress in relation to the CQUIN schemes for 2011/12 and an overview of the agreed schemes for 2012/13. He reported that commissioners had highlighted some issues for further clarification for 2011/12 schemes, and a response was being prepared. SP stated that he had attached all the 2012/13 CQUIN schemes as appendices. He reported that the first programme management meeting had taken place the previous week. SP highlighted that the detail of all of the PTS schemes were still not finalised. He noted that the biggest risk in the A&E schemes were the CQUINs relating to rural pilots and reduction in conveyance because of the scale of the projects and need for tight project management in line with the agreed reporting milestones. SP added that he was due to discuss the issues at a meeting DWi the following day. PD asked whether additional work would be carried out around the dementia plan beyond the CQUIN itself. SP acknowledged the importance of this and confirmed that other work was also being taken forward in partnership with other agencies.	
15	**2012/13 CIP QUALITY IMPACT ASSESSMENT** It was noted by the Committee that this was work in progress as it was an area that needed further development and improvement. Building on RR's comments from an earlier meeting, EB stated that there did not appear to be a fully joined up process re the CIPs in relation to Board. SP gave assurance that the process in relation to finances and quality was joined up via the Executive team but that work was still ongoing prior to the proposed Board workshop session. EB stated her belief that the CQUIN format was excellent. She added that the generic business case template could be improved and could learn from the CQUIN's template which was shorter with less narrative.	
16	**REVIEW OF POLICY AND PROCEDURE MANAGEMENT** KDW provided an update on the current position on policy and procedure management and progress towards compliance at Level 2 of the NHSLA Risk Management Standards for Ambulance Trusts. He summarised the actions taken to-date and the risks relating to outstanding work. This would be discussed by the Trust Executive Group at their meeting the following day, to agree the further action required. SP noted that the report highlighted some criteria where evidence was available in the Trust but not in KDW's file in a format which could be used with an assessor.	

		Action
	In other cases evidence may not exist at this stage and this also needed to be identified for priority action. SP acknowledged that there was a challenge in the level of evidence that the NHSLA required for level 2, but that he believed that it was still achievable at this stage. **Action:** **SP to provide a further update and assessment of progress for the July Quality Committee meeting** KDW confirmed that he had designed a wider template to use for general procedural documents beyond those in the NHSLA framework. He also confirmed that a data management system had been procured and an assurance co-ordinator was due to start shortly to support this work.	**SP**
17	**111 – CLINICAL GOVERNANCE AND QUALITY** SP presented a report which provided an overview of key aspects of the Trust 111 service tender submission relevant to the remit of the Quality Committee. It provided an opportunity for the Committee to consider and gain assurance with regard to the rigour of the proposed governance arrangements. PD suggested that the paper should be discussed in greater depth at the July Quality Committee meeting. Committee members have access to the full 111 submission via a secure website, but PD also drew attention to the highlighted sections in 3.2 of the report to ensure that the Committee were aware of the areas that they needed to be most familiar with. **Action:** **SP to provide further information at the next meeting to enable more in depth discussion.** SP stated that YAS would find out prior to the next meeting whether it had been successful in its tender for the contract. The team was therefore going to start some of the pre work for mobilisation so it was ready to hit ground running if it got the contract. The Committee recorded its thanks to the people involved in writing the submission for the long hours and effort they had put in.	**SP**
	<u>WORKFORCE</u>	
18	**WORKFORCE UPDATE REPORT** SM presented a report which provided an overview of developments, issues and risks in relation to the workforce. SM reported that the Workforce Strategy for 2012-17 was formally approved by the Board in March 2012 and was in the process of being published.	

		Action
	He added that the Trust had met its statutory obligations in relation to equality and diversity, the Trust's training plan was in draft form awaiting approval, a further 6 policies had recently been updated and approved and a revised disciplinary policy would be approved by TEG the following day. SM stated that the inaugural WE CARE awards ceremony had gone well. He added that the staff survey results were due shortly and the restructuring of the Workforce and Strategy directorate was continuing with interviews currently taking place for new Associate Directors of HR and Organisational Effectiveness and Education. EB stated her belief that more visibility was required on workforce issues, as in business cases they did not seem to be highlighted as well as they could be. The Committee thanked SM for his useful summary of the workforce developments and noted the progress across a number of key areas.	
19	**CLINICAL LEADERSHIP FRAMEWORK PROGRESS REPORT** As PM had left the meeting, SP presented his paper which provided an overview of progress in implementing the new Clinical Leadership arrangements with the Trust's Emergency Operations (A&E) services SP stated that the team had looked at the benefits that the organisation would expect to see and how it would measure them. He added that progress was being made, with full implementation expected to commence in late June/early July. In the meantime work was under way to ensure continuity between the old and new arrangements. The meeting moved on to discuss support arrangements. SP stated that KW had led on the clinical leadership skills training from Bradford University which was evaluating very positively. Internally, the paperwork to support the supervision process was looking good. SP added that, although initial project management arrangements had not been sufficiently robust, good progress was now being made and the obvious risks were being managed. SM stated that the staff appointed to the new roles were very enthusiastic and wanted to do a good job. He added that the best poster presentations being developed as part of the clinical leadership course would be presented to the Trust Board for their information. PD noted the positive progress but expressed her disappointment in the contents of paper which was missing certain useful information and this was echoed by other NEDs. RR also raised concerns about the current policy of protected pay. SP stated that the Executives currently had to work within the Agenda for Change. PD requested a better standard of written report for next time and SP agreed to relay this feedback to PM.	

		Action
20	**ANNUAL TRAINING PLAN 2012/13** SM introduced the report which gave an overview of the proposed education and training plan for 2012/13 and provided details of costs and release required. SM noted that there was a range of statutory training that had to be delivered plus a number of other items that would need to be prioritised. SM stated that a revised version of the plan would be going to TEG on Friday 11 May. GL stated that the plan would be delivered in a phased way with a reduction in delivery in August and December. Not all of the training would be delivered face-to-face. SM stated that the release of the 2012 version of JRCALC, which contained significant changes, would require some face to face training of staff.. SM reported that the process by which training plan decisions were made was being tightened up from a quality perspective e.g. AW or SP as professional leads must now be part of the decision process. PD stated that, as yet, she did not fully understand the CPD requirements and requested some clarity at a future meeting. She would also be interested in the long term plans and costs of training contained in the IBP. EB asked whether a learning contract was in place whereby individuals committed themselves to stay with YAS for a certain period of time or have to pay the investment back. GL replied that learning contracts were in place for certain qualifications eg accountancy but it was not a general policy.	
21	**CLINICAL INDUCTION – UPDATE REPORT** GL stated that historically a separate Clinical Induction had not been considered as specialist items had always been covered in operational basic training courses, the length and content of which were dependant on the role. A local induction check list did exist but this was not specifically clinical. PD asked how competency would be evidenced. SP replied that supervisors would be responsible for meeting with staff and agreeing development needs, etc. The Clinical Development Manager's job would be to carry out a set number of clinical competencies in the field to complement class room training. Information would be entered on to the Oracle learning system for reporting purposes.	
	RISK MANAGEMENT	
22	**RISK MANAGEMENT UPDATE REPORT** KDW presented a report which provided an update and assurance on developments, emerging issues and risks in relation to patient safety. KDW stated that the latest version of the Board Assurance Framework had been subject to a comprehensive executive and non executive review.	

		Action
	KDW stated that all corporate risks had been translated onto the Board Assurance document with a number of corporate risks being archived and new risks being added. SP stated that during the TEG review session the executives had examined the register in depth, removing duplications so they could they concentrate on major risks. PD congratulated KDW on the revised document, adding that it was now much easier to read. EB and RR agreed with the Chair's comments with RR adding that the Committee would need to identify the top risks relevant to its remit. KDW replied that he would like to present updates in the format of heat maps containing all of the risks and their movement since last report, to support prioritisation of Committee attention. The Committee agreed that this was a good idea.	
23	**ANY OTHER BUSINESS** There was no other business	
24	**ISSUES FOR REPORTING TO THE BOARD** It was agreed that the reported risk to clinical audit arising from the problems with patient record scanning software would be highlighted.	
25	**REVIEW OF MEETING ACTIONS / QUALITY REVIEW OF PAPERS** The Chair confirmed that the timeliness and quality of papers was good, adding that actions had been picked up during the course of the meeting. The clinical staff presentations had been very useful and it was agreed that this process should be continued, although it was recognised that the timing of these items would need to be managed more tightly. The meeting closed at 1730 hours	
26	**DATE AND TIME OF NEXT MEETING** The next meeting will be held on Thursday, 5 July 2012, 1330-1530 hrs, Boardroom, SH2, Wakefield HQ.	

CERTIFIED AS A TRUE RECORD OF PROCEEDINGS

_____ **CHAIRMAN**

_____ **DATE**