Yorkshire Ambulance Service NHS
NHS Trust

Quality Committee Meeting Minutes

Venue: Boardroom, Springhill 2
Date: Thursday, 5 July 2012
Time: 1415 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
Alison Walker	(AW)	Executive Medical Director
Paul Birkett-Wendes	(PBW)	Executive Director of Operations
Stephen Moir	(SM)	Deputy Chief Executive/Executive Director of Workforce & Strategy

In Attendance:

Karen Warner	(KW)	Associate Director of Quality
Kevin Wynn	(KDW)	Associate Director of Risk & Safety
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
Dr Dave Macklin	(DM)	Associate Medical Director
Alan Baranowski	(AB)	Locality Director, Emergency Operations (South)
Claire Geary	(CG)	Clinical Development Manager (in part)
Gareth Sharkey	(GS)	Clinical Supervisor (in part)

Apologies:

Julian Mark	(JM)	Associate Medical Director
David Williams	(DW)	Deputy Director of Operations
Adrian Haigh	(AH)	Acting Associate Director of EOC

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

		Action
	The meeting commenced at 1420 hours	
1	**INTRODUCTION AND APOLOGIES** Apologies were noted as above.	
2	**REVIEW OF MEMBERS' INTERESTS** No interests were declared during the course of the meeting	

		Action
3	**CHAIRMAN'S INTRODUCTION AND COMMITTEE WORKPLAN** The Chair welcomed everyone to the meeting. The Chair stated that there was a big agenda to work through and it was acknowledged that the work plan would need to be amended to reflect 111 if the bid was successful. It was agreed that SP would provide an update on the work plan at the September meeting. **Action:** **SP to present an update on the work plan at the September meeting** It was agreed that the Good Practice update, which was the original item number 10 would move up to item number 6 after consideration of the minutes and action log.	**SP**
4	**MINUTES OF LAST MEETING AND MATTERS ARISING** The minutes of the meeting held on 10 May 2012 were approved as a true and fair representation of the meeting. **<u>Matters Arising</u>** Page 1 - KDW stated that his title was Associate Director of Risk and Safety, not Risk and Assurance Page 5 – **Management of Controlled Drugs** - AW stated that she had requested the external audit of morphine and requested that the wording be altered to state ""a couple of minor areas for further improvement". Page 7 – **Good Practice Update** – SP asked that the action "SP to liaise with VL and team to ensure the developments to date tie in with work carried out by other teams" that had been picked up on the Action Log be added to the minutes. Page 11 – **Review of Policy and Procedure Management** – paragraph one – SP asked that the wording be amended to state "there was a challenge in providing an appropriate level of evidence to demonstrate compliance". Page 13 – **Clinical Induction – Update Report** – enter an action – SM to bring the report back to a future meeting of the Quality Committee.	
5	**ACTION LOG** The meeting worked through the Action Log, which was updated accordingly.	
	<u>CLINICAL QUALITY PRIORITIES</u>	
6	**GOOD PRACTICE UPDATE:** **Claire Geary, Clinical Development Manager** **Gareth Sharkey, Clinical Supervisor**	

		Action
	The Chair welcomed Claire Geary (CG) and Gareth Sharkey (GS) to the meeting. CG gave a short summary of her career to date. A paramedic since 2005 and a clinical team leader from May 2008, she had been appointed a Clinical Development Manager earlier this year. GS also gave a short summary of his career. He had been with YAS for 9 years and a paramedic for 5 years until his recent appointment as a Clinical Supervisor, based in Leeds. CG gave a short presentation on the Clinical Development Manager Delivery Plan, an electronic copy of which had been shared with the Committee. She stated that the main aim was consistent education across the region and a higher standard of skills for everyone, adding that good feedback had been received so far. CG stated her belief that by taking care of the foundations of the organisation patient satisfaction should increase as the staff assisting them would be better trained and therefore happier in their role. GS stated that although he had only recently been appointed he had already seen changes for the better. His responsibilities were both clinical and operational and through the mentorship process he would try to tailor his approach to meet the needs of his candidates. GS stated that he would work three full shifts with each candidate but had the flexibility to do more if needed. He hoped that this increased presence would encourage staff to improve turnaround times at hospitals, response times, etc. RR asked how CG managed the number of attendees released for training courses and how concerns would be escalated. CG replied that there had been no issues so far but it was early days so there was the potential for issues which would be considered if they arose. SP stated that the pressures were the same as they had always been but the fact that the majority of training would be closer to base should make it more flexible. He further stated that a dashboard had been designed to track training and issues. The Chair asked how an individual could record what they had attended to enable them to take responsibility for their own development. GS replied that they should record attendance in their workbooks. The Chair further stated that she wanted to see the CQC standards stop being targets and become “business as usual” and was hopeful that this approach would support achievement of this aim. The Chair stated that there were a lot of muscular/skeletal issues around the organisation’s high sickness and absence rates and asked whether there were any issues around people not accessing the relevant training.	

		Action
	CG replied that everyone had attended initial training but some still needed to attend Level 2 courses. GS stated that everyone had been taught how to lift correctly but there might be occasions when they had to lift someone awkwardly which could be causing some of the problems. SP asked if there was any support that GS required to enable him to carry out his job more effectively. GS replied that it was difficult to say as the role was new and still evolving. CG stated that she intended to meet with each of the clinical supervisors to let them know what they could expect from her and what she would expect from them. These meetings might then lead to requests for further support in various areas. The Chair thanked CG and GS for attending the meeting and leading a very useful discussion. CG and GS left the meeting. The Board members were impressed by the enthusiasm they had shown. PM stated that CM and GS had been very keen to come to the meeting to explain their roles in more detail. SP stated that the success of the roles would partly relate to skills and knowledge but it was also about cultural change and finding people with the right attitude, enthusiasm, etc. RR asked what role the clinical supervisors would be expected to play in absence management. PM replied that they would carry out return to work interviews but any formal disciplinary hearings would still be carried out by the relevant locality manager. PBW stated that his ultimate aim would be for the supervisors to be fully responsible for the people they managed.	
7	**CLINICAL GOVERNANCE AND QUALITY UPDATE REPORT** AW stated that the report provided an update on progress, issues and risks in relation to clinical governance and the delivery of the Clinical Quality Strategy which was launched at the beginning of May 2012. She further stated that an appropriate guide to the strategy was in draft for front line staff and would be launched in July 2012. She further stated that there had been a lot of positive developments. The trauma coordinators had been recruited and were in post and trauma training was almost complete. A resuscitation officer had been appointed to act as lead to the cardiac arrest project and an End of Life Steering Group was being established to coordinate the end of life agenda. AW added that the implementation of the clinical leadership framework was progressing with most of the Clinical Development Manager and Clinical Supervisor post interviews completed.	

		Action
	AW stated that key risks to the delivery of the Clinical Quality Strategy were the lack of an effective clinical supervision and leadership model and a lack of embeddedness of clinical governance and quality processes within the operational units. The Chair noted the recent inaugural meeting of the Clinical Quality Forum. She stated that from a personal point of view she thought that the Clinical Quality Forum meeting had gone well. The forum was an environment in which clinicians could be involved in discussions and work together to take forward ideas in various areas to influence the Trust's future plans. SP stated that the next meeting would be an opportunity to look at CPD and help to feed into discussions about commissioning and associated funding. **Action:** **SP to provide a report on the Clinical Quality Forum at the September meeting** KW reported that the Quality Accounts deadline had been met and the document had been sent to the Secretary of State, and posted on the official website. The Chair stated that it was a really comprehensive document, which she had found very helpful. ABP asked whether a summary document was due to be produced. KW replied that the summary was currently at design stage and was due to be produced shortly. The Quality Committee noted the progress, issues and risks as outlined in the paper and was assured that the delivery of the Clinical Quality Strategy was being monitored and was currently in line with previously agreed milestones. **Action:** **SP to submit an update report on the Clinical Quality Strategy to the September Board meeting**	**SP** **SP**
8	**SIGNIFICANT EVENTS / LESSONS LEARNED** KDW presented the report on Significant Events/Lessons Learned which covered the period 1 May to 25 June 2012. KDW stated that three Serious Incidents (SIs) had been reported during the period of the report, details of which were included in Appendix 1 of the report. He confirmed that all SIs were being reported within approved timescales. There had been no HSE letters and concerns, no significant concerns raised by CQC, no Serious Case Reviews and no requests from the Ombudsman received during the period. One letter had been received from the ICO.	

		Action
	SP asked whether Legal Services had changed their process with a single entry point for requests to address the issue raised by ICO. AA confirmed that the majority of requests had been transferred with South being the only outlier. The Chair noted the good quality of the report but queried the length of time that some actions had been open. KDW replied that they were still open as there were still concerns but plans were in place to strengthen the process. KDW reported that in Appendix 2 actions against closed incidents were kept open as far as the team was concerned so that they could be periodically monitored until completion. It was agreed that it was not acceptable for corrective actions to remain incomplete for ten months as the same problem could arise again if no action or follow up had been taken. SP agreed that although the length of time it took to conclude some actions was a source of frustration, an early review of all SIs took place and where possible actions without delay to address the immediate risks, pending completion of the official report. Following receipt of the formal report further actions might be implemented to further reduce any risks to future patients. ABP mentioned the typo on page 10 which should state 'December 2011' rather than '2012' and asked what the maximum time would be between stages. KDW replied that it was 12 weeks for non-safeguarding items but 8 weeks if safeguarding was involved. He further stated that there were various reasons why there was a delay in reporting incidents as an SI but unless it was very clear at the start there would usually be an investigation and a 'watching brief' until more evidence could be gathered. KDW agreed to look at the design of the template to try to make it more informative in relation to timescales. AA suggested that there should be an overall timescale and director owner to ensure ownership of the action. **Action:** **KDW to revise design of template.** The Chair stated her belief that the Trust had made significant improvements to its processes during the past 6 months. For example, it could challenge data now that it did not have in the past. On-going management challenge and focus on learning was important to put as many timely, preventative actions in place as possible. The Quality Committee accepted the contents and supported the actions detailed in the paper.	**KDW**

		Action
9	**INCIDENT INVESTIGATION SKILLS REVIEW** KDW stated that the report provided an update and assurance on developments, emerging issues and risks in relation to incident investigation skills. He further stated that a relatively small amount of training had been carried out to date, focussed on senior managers. He further stated that although training in investigations of incidents, complaints and claims was included in the Trust's mandatory training policy, he was reviewing the contents with Chris Sharp to ensure that it delivered what was required. KDW reported that work was on-going on the contents of an in-house bespoke training course. There would be 240 places on 10-12 days of training which should enable all managers to gain a basic understanding of the topic. He further stated that the aim was to have a pool of investigators to move across boundaries. SP stated that although the Trust needed a larger pool of people to draw from it would still need an objective view when there was a serious incident and as was the case now, for serious incidents local managers would be supported by a designated lead for the S&C or Clinical Directorate. **Action:** **KDW to present a further update at the September meeting of the Quality Committee** The Committee noted the current position and supported the proposals outlined in the paper.	**KDW**
10	**INFECTION PREVENTION AND CONTROL MID-YEAR REPORT** KW presented the report which provided a review of the progress being made in delivering the Infection Prevention and Control agenda. The period of reporting was April and May 2012. KW stated that positive developments included: the development of the work-plan and risk register for 2012-13, which would be monitored through the Clinical Governance Group; the IPC audits for which there was a robust clinical audit; training and leadership with IPC continuing to be a mandatory element of both induction and on-going training; and staff wellbeing with the Trust having an approved procedural document for the Management of Incidents. KW further stated that all minor Estates work had been completed and the outstanding major work would be completed as part of the planned capital programme by April 2013. PBW asked whether spot checks took place during hand overs as they would provide useful information.	

		Action
	AW replied that infection control nurses at hospitals reported back when they identified YAS staff not following the correct procedures. It was agreed that KW should provide additional feedback at the next meeting. **Action:** **KW to provide further information about the implementation of spot checks at next meeting** ABP asked whether there was any evidence of patient experience feeding into infection control. KW replied that there was no trend information available about this. It was agreed that the Trust would benefit from involving service users as part of the inspection for improvement team. **Action:** **KW to liaise with ABP about service user involvement** SP reported that there had been no red areas in last few months. RR expressed concern about the number of ambers in the Resilience and Special Operations section. SP agreed to pick this up. **Action:** **KW to look into the reason for the number of ambers in the Resilience and Special Operations section**	**KW** **KW/ABP** **KW**
	<u>ESSENTIAL STANDARDS OF QUALITY AND SAFETY</u>	
11	**OVERVIEW OF TRUST COMPLIANCE** KW presented the report detailing the Trust's current position in relation to compliance to the CQC Essential Standards for Quality and Safety. The report provided a description of the internal processes which were the Trust's internal mechanisms for providing assurance on compliance to the essential standards. The report outlined the current position in the CQC Quality and Risk Profile for the Trust. SP stated that overall there had been no significant changes. RR asked why several of the dials contained no data. SP replied that, as CQC were reliant on national data sets, data supplied by YAS and various additional links the timelines for provision of data varied and new data may not be available to CQC at the time of publication. SP stated that the dials relating to Outcome 6 would contain data relating to the Quality Accounts which had yet not been picked up, adding that if CQC had any concerns the Trust would usually hear about it from the inspector in regular 1:1 meetings.	

		Action
	He added that as a result of this, the Trust should already be aware of most issues before they appeared in the report. The Chair stated that all of the Trust's staff needed to take ownership of the CQC targets, as there was a risk that they could be seen as "YAS's target" rather than targets that applied to everyone that should be an everyday standard. The Quality Committee noted the current developments and was assured with regard to the compliance management arrangements.	
12	**INSPECTIONS FOR IMPROVEMENT – KEY THEMES** KW presented the paper which provided an update on the key themes emerging from the inspections for improvement. A discussion took place on the key themes and actions outlined in the paper. These included: clinical waste management; stock levels of consumables; storage of linen; sharing good practice; security; IPC and general cleanliness; awareness raising of training; and safeguarding, particularly the concern over protection of anonymity when making safeguarding referrals. KDW reported that he had seen some noticeable improvements in general cleanliness and tidiness of stations during recent months. He further stated that the Trust needed to work smartly to prevent duplication of local awareness training. PBW suggested that a central forum could be created as a place for presentations to be stored and shared. The Chair asked whether the Trust's uniform policy was up-to-date. SM replied that it was currently being revised and PM confirmed that the revised dress code had just been received for comments. AW stated that she had informed her team that they should be uniformed at all clinical meetings as if a major incident occurred during the meeting, they may need to attend. PBW asked if controlled drugs were checked during inspections. AW confirmed there was a separate audit process for controlled drugs. **Action:** **SP / PBW / KDW to meet outside the formal meeting to draft a paper of improvement issues to present at September meeting**	**SP/PBW/ KDW**
13	**COMPLIANCE REPORT – WEST LOCALITY** PM, Locality Director, Emergency Operations West presented an update on the monitoring, maintenance and improvement of CQC standards in West Yorkshire CBU. A detailed discussion took place on sickness levels and actions that were being taken to try to reduce the worrying upwards trend.	

		Action
	RR asked PM how regular checks on vehicles and equipment were carried out in West Yorkshire. PM replied that managers checked key equipment daily and crews carried out checks on their vehicles each morning. Vehicles had to be handed over to the next crew in the same condition. PM stated that although 18 new paramedics had been appointed there was still a shortfall of 33 in West Yorkshire but overtime was being managed in accordance with the vacancies. Clinical supervisors would help to fill the gaps in the management structure. The Chair asked PM to pick up on the area of dignity reps going forward in the report, adding that it would also be useful to see evidence of actions being taken which had improved things. **Action:** **PM to capture evidence of developments/good practice and include in future reports as the Committee**	**PM**
	SP asked PM how sighted he was on the timeliness of incident and complaint responses. PM replied that as he regularly met with the local “heads of” he was sighted on all of them. SP asked if PM had experienced any issues relating to safeguarding training. PM replied that he was confident that new starters were all receiving the training but not everyone in post had received level 2 training in the last year. The meeting expressed concern at the number of reds showing in the report, particularly the low percentage of CBU staff in ABL who had completed their mandatory training workbooks. It was agreed that all reds would need to be compliant by September with an exception report submitted to the meeting to be accompanied by an action plan for any item remaining red. **Action:** **PM to table an exception report at September meeting with accompanying action plan**	**PM**
	PM reported a better picture relating to performance which proved that plans to improve performance were coming to fruition. EB stated she would be interested in seeing further financial information which proved that the Trust was not over spending to meet its targets. KDW stated that were issues around the use of Prism but a new system had been purchased and during the implementation phase any pre-existing issues would be eliminated. SP stated that although this was good news it would still take about a year to roll out across the patch. The Chair thanked PM for his presentation.	

		Action
	QUALITY GOVERNANCE	
14	**QUALITY GOVERNANCE UPDATE REPORT** KW presented the report which provided an update on developments, issues and risks in relation to quality governance. She stated that the draft Board memorandum document prepared using the current Monitor template and agreed by the Board in January 2012 had been updated and attached. A further update would be produced following the current round of Board Development Meetings and receipt of the latest report from Deloitte. KW further stated that the risks relating to the FT Quality Governance framework primarily related to the complexity of the remaining key actions, although these were currently progressing according to plan. There were a number of gaps in project plans for the 2012/13 CQUINs and these were being actively pursued with designated managers via the new Trust programme management arrangements. KW stated that the requirement for safeguarding children training within 3 months of new employees starting was highlighted as part of the Quarter 4 contract quality review. The Trust was not able to report 100% compliance with this standard in that quarter and additional measures had been put in place to ensure it was achieved. This was being monitored closely and the safeguarding team is confident that the new processes will ensure that this standard is achieved. The Committee noted the developments, issues and risks outlined in the paper and were assured with regard to the management arrangements and action.	
15	**2012/13 CIP QUALITY IMPACT ASSESSMENT** KW presented the report which provided an overview of the current position and the next steps in relation to the Quality Impact Assessment of 2012/13 cost improvement programme schedules. KW stated that there was a two stage process of review: the CIP management group, which met monthly to monitor progress and review risks; and the Senior Management Group which the CIP group reported to on a monthly basis. SP stated his belief that the CIP group was fulfilling a key role in challenging assumptions and ensuring that documents contained enough relevant information. For example, the clinical hub quality impact assessment had been challenged through the group discussion as it was being developed for consideration by the Board. SP noted that a Board session was arranged on 10 July for review of key business cases.	

		Action
	Going forward the normal process would be that reviewed, signed off business cases would go to F&IC and Quality Committee for consideration on the same day before going to Board. EB stated that some business cases were still better written than others so it was important to ensure that the standard of quality impact assessments was also challenged. SP confirmed that initial assessments in business cases were being challenged by subsequent impact assessments conducted by the AD Quality, Medical and Standards and Compliance Directors. The committee noted the current position and the next steps outlined in the paper.	
16	**DELOITTE QUALITY GOVERNANCE FOLLOW UP REPORT** SP gave a verbal report on progress as the current review was still in progress.	
17	**111 – CLINICAL GOVERNANCE AND QUALITY** Discussion of this item was deferred to the September meeting by which time the outcome of the bidding process would be formally known. **Action:** **SP to include 111 presentation as agenda item for September**	**SP**
	<u>WORKFORCE</u>	
18	**WORKFORCE UPDATE REPORT** SM presented the Workforce Mid-year Update report which provided an overview of developments, issues and risks in relation to the workforce and set out the current position in order to inform that agenda and work programme of the Quality Committee during 2012/13. SM stated that detailed weekly meetings were taking place between key Executive Directors and Staff Side. This group was specifically tasked with the formal consultation and negotiation on proposed changes to the Band and Skill mix of the workforce, changes to working practices and relevant terms and conditions of employment. SM added that the Trust continued to focus upon efforts to increase the number of Paramedics in post, along with increased staffing levels with the Emergency Operations Centres (EOC). Significant progress had been made in both areas with registered and qualified Paramedics joining the Trust since November and new EOC staff entering training during July. As discussed earlier in the meeting, the level of absence within the Trust remained above target.	

		Action
	SM stated that work was underway to improve management processes, including an audit of sickness recording by the Operational Resource Teams and a monthly case conference review of randomly selected long-term sickness cases by the Deputy Chief Executive. The reviews would result in line managers and the relevant HR Professional being 'called-in' to have their progress on managing the case involved scrutinised to ensure both challenge and support. SM further stated that the key risks remained as stated. The Chair requested a focus on exceptions in the report for future iterations. **Action:** **SM to include exception reporting section in future reports**	**SM**
19	**CLINICAL LEADERSHIP FRAMEWORK PROGRESS REPORT** PM stated that the report was to inform the Quality Committee of the Clinical Leadership Framework and proposals for the future development of the clinical leaders. It was agreed that the information included in section 4.2 needed to be much clearer. Although the outcome was much better than originally envisaged, with financial savings of £1.2 m, it was difficult to see how these figures had been worked out. **Action:** **PM to meet with SP and Rod Barnes to draft a clearer format for the analysis of financial information**	**PM**
20	**HEALTH AND WELLBEING MID-YEAR REPORT** SM presented the Mid-Year Health and Wellbeing report. He reported that sickness absence was a significant issue for the Trust. The two main reasons for absence were musculoskeletal problems and anxiety/stress. AM further stated that the results of the 2011NHS Staff Survey showed no significant changes. The most important sections of the two-year Corporate Action Plan for improving workplace health were: increase of provision of stress management training, even though this had very little uptake the last time it was made available; and undertake musculoskeletal campaign/ programme – prevention and management. SM stated that the Workplace Health Group had been established as a task and finish group, with a two-year life span and would report to the Workforce Governance Group. The group would include representation from a variety of teams including Leadership & Learning, Occupational Health, Safety Systems Team and Staff side.	

		Action
	The Group would help to deliver the NHS Staff Survey action plan through 4 work streams which were: post incident care (PIC) process; stress management and reduction; musculoskeletal management and reduction; and information and resources. SM added that the post incident care process was particularly worthy of note as it had started as part of paramedic, Richard Carter's work with the safeguarding team and was being rolled out across the whole of the Trust. A detailed stress management action plan had been produced, which included: the new Post Incident Care process; a commitment to the MINDFUL employer initiative; mental health/stress management training; and a mental health/stress awareness campaign. Finally, SM covered specific actions relating to health and wellbeing which were contained in the 2012/13 Cost Improvement Programme. The Chair thanked SM for his presentation.	
	RISK MANAGEMENT	
21	**RISK MANAGEMENT UPDATE REPORT** SP stated updated information on risk management had recently been discussed in detail in the series of Board Development meetings (BDM). He further stated that a meeting of the Risk and Assurance group had taken place since the last BDM and departmental risk registers would be updated to reflect what had been discussed at a corporate level. **Action:** **SP to brief NEDs outside the committee on top clinical risks as part of wider quality briefing.**	**SP**
22	**UPDATE ON PROGRESS PRIOR TO LEVEL 2 MOCK ASSESSMENT** KDW presented the report which provided an update and assurance on developments, emerging issues and risks in relation to progress towards the NHSLA Level 2 assessment. KDW stated that the NHSLA Compliance Progress Record recorded the current compliance position against Level 1 and Level 2 of the NHSLA Risk Management Standards for Ambulance Trusts. The document identified good progress towards compliance against Level 1 and more limited progress towards compliance at Level 2. He further stated his belief that the majority of amber items at both levels would be a logistical exercise of gathering data and information that already existed. The reds were either because they were new standards or where there might be specific risks.	

		Action
	KDW stated that the evidence collated to date against Level 2 of the NHSLA Standards was not yet sufficient to satisfy the requirements at that level. Given the current position, it would be challenging for the Trust to meet the requirements of an NHSLA Level 2 assessment within the scheduled timeframe. This was for a number of reasons: • Until May 2012, the Trust did not have a compliance data management system with the capacity to store procedural documents with explicit links to associated evidence files for regulatory assessment. This had adversely impacted on the Trust's capacity to prepare for external regulatory assessment • Competing demands on those identified with responsibility as document leads • Acceptance of responsibility and local ownership of document management and collating evidence of implementation • There was insufficient evidence of implementation against a number of criterion; e.g. 1.5 Risk Registers, 4.9 Maintenance of Medical Devices and Equipment. KDW stated that the actions under way were focussed on mitigating these risks and a full review of progress and decision on next steps would be taken after the scheduled mock assessment at the end of July. The Committee noted the current position and supported the proposals outlined in the paper.	
23	**INFORMATION GOVERNANCE UPDATE** It was agreed that the report should be deferred until the September meeting when the new manager would able to provide more detail. **Action:** **SP to include as agenda item for September meeting**	**SP**
24	**ANY OTHER BUSINESS** There was no other business	
25	**ISSUES FOR REPORTING TO THE BOARD** There were no issues for reporting to the Board.	
25	**REVIEW OF MEETING ACTIONS / QUALITY REVIEW OF PAPERS** PD stated that the standard of papers was improving, but indicated that more work was still needed to strengthen the content and format of locality reports. It was agreed that there should only be two presentations at the next meeting. These would be the deferred 111 report, which would be a significant agenda item and the locality report from EOC. It was further agreed that no staff would be invited to attend on this occasion due to the 111 agenda item.	

		Action
	PD thanked those present for their time. The meeting closed at 1800.	
26	**DATE AND TIME OF NEXT MEETING** The next meeting will be held on Thursday, 6 September 2012, 1330-1530, Boardroom, SH2, Wakefield HQ.	

CERTIFIED AS A TRUE RECORD OF PROCEEDINGS

_____ **CHAIRMAN**

_____ **DATE**