Yorkshire Ambulance Service NHS
NHS Trust

Quality Committee Meeting Minutes

Venue: Kirkstall & Fountains, Springhill 1
Date: Tuesday, 8 January 2013
Time: 0900 hours

Chairman: **Pat Drake**

Attendees:

Pat Drake	(PD)	Deputy Chairman/Non-Executive Director
Dr Elaine Bond	(EB)	Non-Executive Director
Erfana Mahmood	(EM)	Non-Executive Director
Steve Page	(SP)	Executive Director of Standards & Compliance
Stephen Moir	(SM)	Deputy Chief Executive/Executive Director of Workforce & Strategy
Dr Alison Walker	(AW)	Executive Medical Director

In Attendance:

Barrie Senior	(BS)	Non-Executive Director (Observer)
Andrea Broadway-Parkinson	(ABP)	YAS Expert Patient
Dr Julian Mark	(JM)	Associate Medical Director
Dr Dave Macklin	(DM)	Associate Medical Director
Kevin Wynn	(KDW)	Associate Director of Risk & Safety
Karen Warner	(KW)	Associate Director of Quality
David Williams	(DW)	Deputy Director of Operations
Ben Holdaway	(BH)	Locality Director, EOC
Alan Baranowski	(AB)	Locality Director Emergency Operations, South
Caroline Balfour	(CB)	Legal Services Manager
Keeley Townend	(KT)	Associate Director of NHS 111 & Urgent Care
Michela Littlewood	(ML)	NHS 111 Head of Quality Assurance

Apologies:

Paul Birkett-Wendes	(PBW)	Executive Director of Operations
Shelagh O'Leary	(SOL)	Associate Director of Organisational Effectiveness & Education

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

		Action
	The meeting commenced at 0900 hours.	
1	**INTRODUCTIONS & APOLOGIES** The Chairman welcomed everyone to the meeting and wished them a Happy New Year. Apologies were noted as listed above. The Chairman welcomed Michela Littlewood (ML), the NHS 111 Head of Quality Assurance who would be presenting an update on the NHS 111 Clinical Governance Review to the meeting.	

		Action
2	**REVIEW OF MEMBERS' INTERESTS** Declarations of interest would be noted and considered during the course of the meeting.	
3	**CHAIRMAN'S INTRODUCTION** The Chairman stated that the Trust had started the New Year with a significant number of challenges so the Quality Committee would need to ensure that quality governance remained strong and a top priority going forward.	
4	**MINUTES OF THE MEETING HELD ON 8 NOVEMBER 2012** The minutes of the meeting held on 8 November 2012 were approved as a true and fair representation of the meeting subject to the following amendments. **Matters Arising:** Page 2, section 3, paragraph 1 – last line to be amended from "added when after its publication" to "added when it was published". Page 5, paragraph 4 – sentence to be altered to state: "ABP requested an update on the status of the critical friends' network". Page 16, section 24, paragraph 6, line one – "Development" to be added between "Clinical" and "Manager".	
5	**ACTION LOG** The meeting worked through the Action Log, which was updated accordingly. **046/2012** – KW reported that all of the Trust's previous critical friends had been written to and invited to become members. In addition, working with Hester Rowell, the Foundation Trust team would be sending out questionnaires during March asking members about their specific areas of interest. The Chairman stated her belief that critical friends, who had given their time to the Trust in the past, should be contacted separately to the rest of the membership to inform them about the forthcoming questionnaire to ensure that their skills were utilised. She added that the patient experience team should take the lead in liaison with Critical Friends and KW confirmed that this was the case. ABP asked how accessible critical friends would be in the future. It was agreed that this should be discussed KW outside the meeting. **Action:** **ABP/KW to discuss future contact with and use of critical friends outside meeting.** **048/2012 & 049/2012** – EB requested feedback on these actions. SP reported that detailed discussion had taken place in the Trust Executive Group (TEG) to develop a set of early warning indicators in different localities.	**ABP/KW**

		Action
	There would be a one-page dash board for individual management units, the presentation of which would be an easily identifiable mixture of red, amber and green ratings, data definitions, criteria for escalations, The developments would be presented at the Board meeting on 29 January as part of the paper on Quality Impact Assessment. **050/2012** – BH stated that the revised 'Understanding of the EOC' statement had been approved by the Patient Group and would be in use from the following week. It was agreed that the statement should be brought to the next meeting of the Quality Committee. **Action:** **BH to bring revised "Understanding of the EOC" statement to March meeting.** AW stated that the sign off of the Trust Conveyance Policy would be through Clinical Governance Group (CGG). The only actions left open related to providing information to patients about YAS's ability to transport walking aids, wheelchairs, etc. The Policy had been considered by TEG and Senior Management Group (SMG) and the action was now closed as it was on the CGG action log. **051/2012** – SP stated that the action was closed as it was being picked up on the CGG agenda. **058/2012** – action deferred to March meeting. **059/2012** – SM stated that the information was due in February so the paper would be provided for discussion at the March meeting. **060/2012** – SP confirmed that the dashboard of indicators relating to Clinical Leadership would be ready for consideration at the March meeting.	**BH**
6	**<u>CLINICAL QUALITY PRIORITIES</u>**	
6.1	**CLINICAL GOVERNANCE AND QUALITY UPDATE REPORT** KW provided an update on progress, issues and risks in relation to clinical governance and the delivery of the Clinical Quality Strategy. She stated that the Urgent Care agenda was evolving quite rapidly and the draft strategy should be ready for presentation to the Committee and Board by March. KW further stated that one element of the Safeguarding team's monthly report to CGG related to the non-conveyance of children under the age of 2. A random sample of 30 children who were not conveyed between July and September 2012 had been analysed but without access to GP records full analysis of outcomes was unclear. The risk was jointly owned by the Safeguarding team and CGG and the action and mitigation plan was being monitored and managed by CGG.	

		Action
	EB asked whether the issue had been discussed with Clinical Commissioning Groups (CCGs), commissioners, etc. DM replied that early discussions had taken place, although he noted that the issues lay primarily with internal process. The standard was that that all children under 2 should either be conveyed or actively referred to another health professional. Whilst Trust policy was clear, discussions in CGG had identified that further guidance in the form of Q&As would be useful to staff to aid with application in specific situations. The Chairman requested a further update report, which included indicators relating to thresholds including parental refusal of a child's conveyance, at the March meeting. **Action:** **DM to present update report on Conveyance of Under-2s at March meeting.** KW stated that the lack of embeddedness of clinical governance and quality processes within the operational units had been discussed at CGG and Operations Management Group (OMG). AW confirmed that a discussion on the development of the arrangements for managing clinical governance and quality issues had not taken place at TEG on 21 December 2012. SP confirmed, however, that related issues had been discussed in TEG as part of the review of early warning indicators. **Action:** **SP to ensure development of arrangements for managing clinical governance and quality issues is added to TEG agenda for further discussion with a report to come back to the March meeting.** ABP stated that point 4.14 implied that there was an imbalance in the number of vehicles in use for bariatric incident support. DW replied that all vehicles were bariatric patient compatible but additional specialist vehicles had been purchased to enhance the service. ABP asked whether the Trust was aware of its bariatric patients' bases across the region and EB asked how the specialist vehicles as opposed to other vehicles were deployed. DW replied that further work was required in relation to training and education and the quality of cascade. SP stated that the Trust was close to agreeing an operational process whereby vehicles would be deployed appropriately.	**DM** **SP**

		Action
	It was agreed that another position statement would be required at the March meeting. **Action:** **PBW to provide further update on process for use of bariatric specialist vehicles at March meeting.** The Quality Committee noted the progress, issues and risks as outlined in the paper, and were assured that the delivery of the Clinical Quality Strategy was being monitored and was currently in line with previously agreed milestones.	**PBW**
6.2	**QUALITY ACCOUNT AND CQUIN PROGRESS UPDATE** KW provided an update on developments, issues and risks in relation to the Quality Account and the 12/13 CQUIN progress. She stated that the 2011/12 Quality Account had been published on the Trust website and outlined progress against priorities. Highlights included: a lot of work had taken place to ensure that the response from the ambulance service met the needs of local populations; the Clinical Managers were leading work to improve the current AQIs; and there had been a significant reduction in the number of complaints received in PTS with the average number each month dropping from 157 in 2011/12 to 97 in 2012/13. KW stated that good progress had been made against the 2012/13 A&E CQUINs. All targets had been achieved with the exception of: CQUIN 3: Dementia Awareness; CQUIN 2: reduction in conveyance to Emergency Departments by 4.5%; and the Emergency Care Practitioner (ECP) CQUIN (South consortia only). Negotiations relating to CQUIN 3 were on-going with commissioners and SM and his team had been working with NHS Scotland to develop a training package due for roll out shortly. DW confirmed that a stronger action plan was now in place to help support CQUIN 2. Meetings were taking place twice-weekly to monitor progress more effectively and negotiations about the impact of NHS 111 had started with commissioners. KW stated that a meeting about the ECP CQUIN had taken place with commissioners as YAS was struggling to get out-of-hours data from other providers. For Quarter 2, all PTS CQUINs apart from 1 (reduction in abortive journeys) and 3 (reduction in the longest waits) had been achieved and discussions were on going in relation to these CQUINs. EM stated that the reduction in PTS complaints was good news and asked whether a regional breakdown was available to see how effective the Unipart work had been in South Yorkshire.	

		Action
	It was agreed that further discussion on this item should be deferred until the Integrated Performance Report (IPR) section of the agenda. The Chairman asked whether joint audit relating to the new pathways was in place with YAS's partners. DM replied that the current commissioners had not supported the Trust in its attempts to obtain relevant outcome information and to date this was also the case with the CCGs. AW stated that joint audit should be kept on the agenda, as the increased level of clinical involvement through the CCGs might allow the Trust to raise the issue again. SP stated his belief that this was the type of issue that should be raised with the NHSTDA as they were keen on whole-system quality. **Action:** **SP to raise issue of support for joint audit with NHSTDA as part of the anticipated meetings between TDA and Trust Medical and Nurse Directors.** The Chairman stated that she would like to see a report detailing lessons learned from the winter plan which included patient safety and quality of care, at the next Quality Committee meeting. **Action:** **PBW to present report on lessons learned from the winter plan at March meeting.** The Quality Committee noted the developments, issues and risks as outlined in the paper and was assured with regard to the management arrangements and action.	**SP** **PBW**
6.3	**CQUIN PROPOSALS 2013/14** KW provided an overview of the process and progress for the development of the A&E CQUIN scheme for 2013/14. SP stated that a recent workshop had worked through a set of proposed indicators and several indicators from the TDA Planning Guidance. Further discussions had taken place with commissioners and the finer details now needed to be agreed. The Committee considered the Indicators being proposed. The Chairman expressed concern about the Homeless Indicator but AW confirmed that this would not be a high cost CQUIN which was derived from personal knowledge of an innovative development. It was agreed that DW should provide an update on Turnaround times at the March meeting. **Action:** **DW to provide update on turnaround times at March meeting.**	**DW**

		Action
	The Quality Committee noted the agreed process and the progress to date in developing the 2013/14 CQUINs.	
6.4	**REVIEW OF KEY QUALITY INDICATORS (IPR) / ACTION** KW and JM introduced a review of the key indicators reported in the Quality and Workforce sections of the Integrated Performance Report (IPR). The service transformation projects with amber ratings were highlighted. AW stated that the effectiveness of the patient record form scanning software remained a key risk to quality and the system was under review in terms of its longer term viability and options going forward. JM stated that the issues were wider than originally thought and had a broader impact on the wider organisation, adding that functionality might need a different solution which would bring new challenges. SM confirmed that an electronic document management system could not be implemented in HR until a software solution was found. The Chairman appreciated that this was a difficult issue and asked that the Quality Committee be kept appraised of progress. A discussion took place about complaints received relating to inter-hospital transfers. DM stated that although they were mainly internal issues he would drill down further to clarify the queries raised. SM stated sickness related absence was the key workforce issue with the biggest area of impact and a meeting of the Non-Executive Director Absence Turnaround Group would occur on 18 January. He further stated that the amber RAG rating for the completion of PDRs would also need to be addressed in Quarter 4. **Action:** **DM to provide more detailed information re inter-hospital transfer complaints at March meeting.** SM confirmed that the training plan was in place and would meet its targets for the year as long as the staff extraction rate was delivered. The Chairman noted the importance of ensuring that moving and handling was effective, given that related accidents were one of the most significant reported causes of sickness absence. The Chairman congratulated the Resilience team as they were green across the board for the first time in the IPC Audit, adding also that those areas that were constantly green should also be checked in case of complacency. EB stated that she would like to see comments from Operations about how on-going problems were being addressed.	**DM**

		Action
	EM's earlier questions about PTS improvements in South were picked up. EM stated that she would have expected to see more improvement than could be currently seen considering the amount of investment in that area. SP replied that he would ensure when Diane Williams, the Locality Director for Patient Transport Services attended the March meeting, she provided detailed analysis of the figures. **Action:** **SP to liaise with Diane Williams to ensure detailed analysis of PTS concerns and complaints is provided at March meeting.** Having considered the exceptions in the IPR, the Quality Committee was assured with regard to the management action planned and under way.	**SP**
6.5	**SIGNIFICANT EVENTS / LESSONS LEARNED INCLUDING EOC INCIDENTS UPDATE** KDW provided the Quality Committee with an update on significant events highlighted through Trust reporting systems and by external regulatory bodies and provided assurance on actions taken to effectively learn from adverse events. KDW stated that there were currently 11 open SIs which were spread across all business areas. SP stated that YAS benchmarked incidents with all Trusts as they all worked to the same policies, etc but there was a lot of scope for interpretation so internal trends were also important to consider. KDW explained in detail the top three incident categories across the Trust. These were: road traffic collisions; medicines management; and employee moving and handling patients. The Chairman asked what moving and handling training was done and whether it could be done differently to add more value. SP stated that the current training attendance rate was at a reasonable level but how and what was delivered could be reviewed. AB stated that shoulder injuries were common due to the weight of the blue bags. AW replied that a new, better designed product was shortly due to be purchased. She added that the basic items in the bag should weigh no more than a total of 11kg but recent spot checks had shown that many additional items were being stored in the bags with some of them weighing as much as 27kgs. The Chairman asked the Committee to consider how the Trust could further support staff, perhaps by linking to Occupational Health.	

		Action
	KDW stated that the Trust was on track to purchase the new blue bags in April/May 2013 for delivery in June. A meeting had taken place with SOL to discuss how all moving and handling training was currently being delivered and possible improvements and Health and Safety initiatives were also being looked at. EB requested further information about the PTS taxi usage issue. PD stated that this issue would also need to be picked up through F&IC. **Action:** **PBW to ask PTS to address taxi usage issue as specific point of concern.** The Chairman stated her belief that the timeliness of incident reporting and investigation were generally improving and the information contained in the report was increasingly useful. However, the Operational Bulletin seemed to be regularly used for briefings when face-to-face meetings with Clinical Supervisors might be more appropriate. The Chairman further stated that the Trust needed to ensure that the impact of SIs was measured appropriately and learning shared. DW stated that Clinical and Operational Quality colleagues should link to agree a process to ensure that organisational learning was communicated effectively to all staff within the Operations functions. DM agreed that the current process needed to be more robust. SP noted that all learning relating to SIs went to SMG meetings and it was expected that those present would share the information with their management teams and staff. He acknowledged, however, that the process did need tightening up, as there was limited assurance that this happened consistently. He noted that the Operational Update and other bulletins were an "add on" to dissemination via SMG and training delivery, rather than the primary method. **Action:** **SP to ensure that the current process for cascading organisational learning via was consistently supported by Managers in their respective teams.** The Committee noted the current position and was assured in regard to the effective management of and learning from adverse events.	**PBW** **SP**
6.6	**CLAIMS REPORT** The Chairman welcomed Legal Services Manager, Caroline Balfour (CB), to the meeting. CB updated the Quality Committee on the Trust's end of Q3 position on claims and provided assurance on lessons learnt. A steady increase in claims could be seen over the last decade, with 2011/12 reporting the highest number of claims received to date and 2012/13 was predicted to surpass this.	

		Action
	CB stated that work was needed on the management of Employers' and Public Liability claims and lessons learned. CB added that she would like to feed into Locality Boards to look at the claims spread across/between localities. There was also a clear overlap with the work of the Health, Safety and Risk team. CB stated that, as this was the first Claims Report she had presented to the Quality Committee, she would welcome feedback. The Chairman thanked CB for the comprehensive report. EB suggested it might be useful to share the report with the locality directors to help raise levels of awareness in their areas. DW agreed, adding that it would be useful for the Operational Management Group to see the report. A discussion took place on the possibility of the report being used as a lever to speed up the provision of information. EM stated she would speak to CB in more depth outside the meeting, adding that the organisation could be held liable if responses were delayed. It was essential therefore that the Trust kept accurate records. KDW stated he was not aware of the risks listed in section 7 being on the corporate risk register so they would need to be considered at the next meeting of the Risk Assurance Group (RAG). **Actions:** **DW to share report with Locality Directors.** **KDW to raise corporate risks in Section 7 at next RAG meeting.** **PD/SP to discuss Claims Report for a future Board meeting.** The Quality Committee noted the contents of the report, received assurance and recognised the risks highlighted.	 **DW** **KDW** **PD/SP**
6.7	**IMPLEMENTATION OF JRCALC GUIDELINES** JM outlined the proposal for the roll out of the new JRCALC clinical guidelines. He stated that their publication date had been delayed to March 2013. Issues would be monitored on an on-going basis. AW stated that face-to-face delivery of the new guidelines would take place as part of the 2013/14 clinical update training where the content required this. She further stated that, during 2013/14, the risk of clinicians working to two different sets of clinical guidelines until the new guidelines were fully implemented was time limited with a shifting balance which would be monitored by the JRCALC group through the CGG.	

		Action
	Action: **AW to bring gap analysis document to March meeting.** The Quality Committee approved the actions in the paper and agreed the proposed roll out strategy.	**AW**
7	**ESSENTIAL STANDARDS OF QUALITY AND SAFETY**	
7.1	**OVERVIEW OF TRUST COMPLIANCE** KW provided an update on the Trust's compliance with the Care Quality Commission (CQC) and the NHS Litigation Authority (NHSLA). She stated that the Trust anticipated a CQC inspection in the near future. In addition to the key themes identified at the last inspection, it was likely that they would also concentrate on several new areas, which ambulance services who had experienced a recent CQC inspection had reported. These included listening to "live" calls and interviews with EOC staff. It was agreed that BH and KW should meet to discuss the implication of the above for EOC. **Action:** **KW/BH to discuss implications for EOC of changes to CQC methodology.** KDW stated that, following its recent full compliance with Level 1 of NHSLA, the Trust had received a congratulatory post assessment report from its allocated NHSLA Assessor. Level 2 would be a big challenge with a lot of work to be done, particularly in the new area requiring assessment of clinical records. In addition NHSLA would want to see 12 months of evidence. SP asked whether the NHSLA would be progressing new assessments for the current financial year. KDW replied that it was believed that no Trust would have to go for assessment unless it requested one so YAS was currently in a low risk position. A further stock take would need to be made in the coming months as the future of NHSLA assessment evolved in the new health system. The Quality Committee accepted the report as assurance that compliance to CQC and the NHSLA was being maintained.	**KW/BH**
7.2	**QUALITY REPORT – OPERATIONS** Alan Baranowski (AB), Locality Director Emergency Operations, South provided an update on Quality and Performance in South CBU. He distributed copies of the South Yorkshire Cluster Operational Dashboard for 2012-13.	

		Action
	AB stated that South did consistently well with infection prevention and control. Completion of PDRs had been100% compliant for the first time in November 2012 and there had been a tremendous push to encourage staff to have flu vaccinations, the outcome of which was above overall Trust compliance. He further stated that Red 1/Red 2 average performance was 76% in spite of a variance to last year of +7.10% and limited funding for overtime to manage demand. The Chairman asked whether there were any particular issues about clinical care in relation to complaints and concerns. AB replied that sometimes clinical care complaints were mixed in with attitude and conduct and related to what care people thought they should have got compared with the care they actually received. However, issues were picked up and investigated quickly, which was helped by a good clinical supervisor network being in place. AB reported a significant increase in short term sickness absence during November and December with the percentage currently ranging between 8.5% and 9%. SM congratulated AB on the good performance of staff in South Yorkshire in terms of workforce issues other than sickness absence. The Chairman stated that the number of complaints not responded to in 25 days was high and asked if there was anything that could be done to help. AB stated that he was uncomfortable with the delays and believed that staff dedicated to following up complaints, etc would help reduce the current delays. He noted that much of this related to seasonal high demand. SP stated that, although organisational support was available, some of the delays were consistent through the year. He added that how to plan and manage it across the year needed further consideration by the team. He congratulated AB on his presentation and asked, from his point of view, what would trigger a response to possible issues or concerns as the organisation as a whole needed to consider this topic. AB replied that anything that seemed to be an outlier in the dash board would trigger an initial investigation. The Chairman thanked AB for his presentation.	
7.3	**INSPECTIONS FOR IMPROVEMENT** KW summarised the findings from the Trust's internal Inspections for Improvement process and provided assurance in regard to compliance with the Care Quality Commission (CQC) Essential Standards of Quality & Safety.	

		Action
	She stated that there had been a significant improvement in Outcome 8 – Cleanliness and Infection Control since inspections began. When considering Outcome 10 – Safety and Suitability of Premises, KDW reported that although security was still an issue on occasions, the majority of times he visited stations he was now challenged. He announced that all stations would have the same standard notice board from week commencing 14 January, with the Standards and Compliance team planning visits to all stations to support this. DW replied that, as maintenance would be very important, someone would need to be assigned to look after the notice board. SM replied that a nominated Clinical Supervisor had already agreed to take on this responsibility in each location. The Quality Committee noted the current position and was assured in regard to compliance with the CQC Essential Standards of Quality & Safety.	
8	**<u>QUALITY GOVERNANCE</u>**	
8.1	**QUALITY GOVERNANCE UPDATE REPORT INCLUDING QIA UPDATE** KW provided an update on developments, issues and risks in relation to quality governance. She stated that, in relation to Foundation Trust (FT) Quality Governance, YAS had responded to a number of quality related questions following the submission of the Integrated Business Plan (IBP) to the NHSTDA who now gave approval to proceed to the Monitor phase instead of the Secretary of State. KW further stated that formal reassessment of the Quality Impact Assessment (QIA) for all Cost Improvement Plans (CIPs) had taken place during September 2012. Reserve schemes had been identified and the QIA process was being reviewed, the recommendations of which would be presented to the Quality Committee in March. **Action:** **Recommendations of the QIA process review to be included on agenda for consideration at March Quality meeting.** The Quality Committee noted the developments, issues and risks as outlined in the paper and was assured with regard to the management arrangements and action.	**SP**
8.2	**DELOITTE QUALITY GOVERNANCE REVIEW** SP stated that following receipt of a proposal from Deloitte, it had been agreed not to revisit the action plan as originally proposed but to undertake a Quality Governance memorandum test instead.	

		Action
	This was a desk top exercise which would drill down into the evidence provided by YAS to support the Quality Governance memorandum and relate it back to the Monitor framework. This work would then become part of the evidence available to Monitor. A meeting with Deloitte to scope out the work was due to take place that day. Evidence collection would commence immediately with completion of the work due by the end of January.	
8.3	**NHS TRUST DEVELOPMENT AGENCY** SP provided an overview of the new NHS Trust Development Authority (NHSTDA) and its remit in relation to the Trust. He stated that the NHSTDA's remit had a strong emphasis on quality and was to provide oversight, support and performance management for all of the remaining NHS Trusts. It was also the body responsible for overseeing progress against the Foundation Trust (FT) 'pipeline'. SP outlined the ambition set out in the NHSTDA's Planning Framework which had been published for the coming year. The key areas of focus were Quality, Delivery and Sustainability. He further stated that all NHS Trusts should have an integrated plan by 31 March and the deadline for initial responses using a set of templates was 25 January. SP listed the requirements for submission by 25 January: • an overarching presentation with a narrative on the previous year and the year ahead, key challenges and needs for support and development, and identification of the reference to the priorities for improvement where there was significant variation from top performers; • a performance and activity plan; • a financial plan; • a workforce plan; and • a completed planning checklist - a 103 item document, covering quality, workforce, performance, finance, QIPP, Innovation, Health and Wealth, and the NHS FT pipeline. TDA review of initial Trust submissions and feedback/identification of further work required was scheduled for 26 January to 21 February. SP stated that a preliminary discussion had taken place at TEG the previous week which would be picked up again at the next meeting. Consultation with the Non-Executive Directors would probably be needed in relation to specific elements in the presentation. **Actions:** **TEG to agreed detailed process for managing as necessary.** **SP to provide summary of response at March Quality meeting.** The Committee noted the developments associated with the NHSTDA and their implications for the Trust and supported the proposed TEG action.	**SP** **SP**

		Action
8.4	**EXTERNAL ENQUIRIES** **a) Saville Allegations** SP presented a paper which provided an organisational response to the recent Department of Health Gateway document relating to the sexual abuse of children and young people by Jimmy Saville. SP stated that the review carried out by the Head of Safeguarding had been satisfied that current arrangements were robust but a number of areas had been identified where there was a potential to further strengthen them. The Quality Committee noted the current position and assurance with regard to key safeguarding processes and considered and agreed the proposed areas for additional action. **Action:** **Head of Safeguarding to follow up actions as outlined** **b) Winterbourne View** SP provided a verbal update on the CQC Care Home investigation and accompanying DH report which would have broad implications for care home management and ensuring that people with learning disabilities received appropriate care. SP stated that there were some relevant issues around the Mental Capacity Act and general safeguarding arrangements that the Trust needed to consider. However, the report did not target ambulance trusts with specific actions so the immediate implications were limited. The Chairman stated that the Trust's current work on Dementia also linked into this work.	**DB**
8.5	**NHS 111 CLINICAL GOVERNANCE REVIEW** The Chairman formally welcomed Keeley Townend (KT), Associate Director of NHS 111 & Urgent Care and Michela Littlewood (ML), NHS 111 Head of Quality Assurance to the meeting to provide an update on the NHS 111 Clinical Governance. ML outlined the NHS 111 Clinical Governance requirements; the national framework; and the five stages of the Patient Journey. She stated that the Regional Governance submission was a 3 stage process as follows: • Stage 1 - Written submission (24/01/2013) – part of the submission belonged to YAS and part to the commissioners; • Stage 2 - Face to Face Reviews (5-6/02/2013) – YAS would need to attend on both dates; • Stage 3 - Outcome mid-end February 2013. ML further stated that the majority of the Clinical Governance framework was the responsibility of the commissioners. The outcome could be a 'go' or a 'no go' decision but if the commissioners failed there would be no financial penalties imposed on YAS.	

		Action
	She outlined the required contents of the Quarterly Assurance report, adding that some of the items such as staff training and development were already underway. There were three domains of Key Performance Indicators. These were: Safety; Effectiveness; and Experience, which would be ranked as red, amber and green. ML stated that it would be very important for NHS 111 to integrate with the clinical governance structures already in place in YAS although there would be some specific resources to support the service line. These included the practice developers whose sole role would be audit and quality in the call centre environment. She further stated that Local Care Direct (LCD) was working hard to ensure the successful integration of governance for the elements across the integrated pathway, adding that monthly formal partnership meetings would support joined up clinical governance. ML outlined the key clinical risks, which included: • Service does not pass readiness testing; • Insufficient Clinical advisors for go live; • Performance challenges for new service; • Under deliver against high expectations; • Call volumes higher than expected; • Easter service management 2 weeks post go live is difficult; • Impact on other services of any teething problems – reputation management; and • Servicing clinical governance local groups. ML stated that the Trust would be expected to deal with 70% of anticipated calls on the date of the 'soft' go live (5 March), with 100% of calls being dealt with by the date of the public go live (19 March). KT stated that the biggest issue would be the increase in call volume that would have to be dealt with as out-of-hours calls would also need to be passed over. She further stated that the NHS 111 number would go live on 5 March but there would be limited public announcement to this effect other than in GPs' "out-of-hour" answerphone messages. The public launch on 19 March would mean the start of active communication about the changes. Information would be provided in notifications about Easter services but most national publicity would take place during the summer. SP stated that there would be a further update at the January Board meeting. The Chairman thanked ML and KT for an excellent presentation, adding that there were still a lot of internal questions to consider.	

		Action
	SP agreed that it had been a very useful update. He stated that things were progressing positively, adding that Estates and IT were doing very well. Training was currently a major commitment and an enormous amount of work was taking place around the transfer of clinical advisors, etc. SP further stated that the organisation needed to remain conscious that there were still significant risks in relation to the delivery of the project, as it was a major new service development and asked those present to continue to support the 111 team as the go live date approached. It was agreed that 111 would need to remain an agenda item for the March Quality meeting. **Actions:** **Further discussions to be arranged between Operations and 111 teams outside of meeting to consider the wider service input.** **NHS 111 to remain an agenda item for March Quality meeting.**	 **SP** **SP**
9	**WORKFORCE**	
9.1	**WORKFORCE UPDATE REPORT** SM provided an overview of developments, issues and risks in relation to the workforce. He stated that the Trust had just published its final A&E workforce plan and all staff affected by the proposals had been written to individually. Extensive HR work had taken place and Corporate Communications had provided valuable support, which had ensured that the official YAS information had been in the public domain first. SM stated that the unions had until the end of January to provide their formal response but it had been made clear to them that the Trust would aim to proceed with the changes as the consequences of not doing so were unacceptable. SM confirmed that recruitment remained on going for the NHS 111 and Band 3 A&E service lines vacancies. Training and Education were also working to full capacity There had been a 37% uptake of the 'flu' vaccination across the whole of the Trust. This was still not where YAS wanted to be but was 16% up on 2011and SM would bring a full analysis to the March meeting. **Action:** **SM to bring full analysis of staff survey to March meeting.** SM stated the key exceptions to report for the current period were: • Sickness absence remained above the Trust's 5.0% target at 6.67% Trust-wide as at the end of November (currently RAG rated as Red);	**SM**

		Action
	• PDR compliance was currently at 78% and would need to be sustained at this level throughout Q4 to ensure compliance at year end (currently RAG rated as Amber); and • Delivery of re-aligned programme of Clinical Updates / Operational Refreshers was showing a compliance level of 53.19% (currently RAG rated as Red) although the re-profiled Education & Training Plan ensured sufficient provision was in place for Q4 to achieve a Green compliance level. The Chairman thanked SM for his report and requested an update on training compliance levels at the March meeting. **Action:** **SM to provide update on training compliance levels at March meeting.** The Quality Committee noted the information contained in the paper and agreed the proposed areas for future reporting and focused scrutiny in the Quality Committee during 2012/13.	**SM**
9.2	**CLINICAL LEADERSHIP FRAMEWORK PROGRESS REPORT** DW provided an update of progress on the implementation of the Clinical Leadership Framework. He reported that most of the clinical supervisor vacancies had been covered. However, some of the posts were covered by development secondments and there still remained a number of unfilled posts although another phase of recruitment was under way. AW asked DW if he would check the vacancy information, as AB had said that all of the vacancies in South Yorkshire had been filled. **Action:** **DW to check current number of vacancies and include new data in next report.** DW stated that training and development was under way and the key issue would be to ensure that the Clinical Leadership framework became embedded in the service and regular meetings were needed with the clinical supervisors to support the importance of their role. The Chairman agreed it was important to formalise regular meetings with the clinical supervisors and suggested that the item should be taken to the Operations Group meeting for further discussion. **Action:** **Executive Director of Operations to discuss and agree regular methods of communications with Clinical Supervisors.** DW confirmed that the dash board was currently available in draft form and was being reviewed as there were a number of areas where further work was required to demonstrate progress against indicators. Formal recovery plans would be required for red rated indicators.	**DW** **PBW**

		Action
	SM challenged the wording in 3.4 that stated "No West CS's attended the first course due to cancellation of training agreed at TEG" as it needed to be clearly recorded that the request had come to TEG from the West Yorkshire locality. DW stated that next steps included: • Continued recruitment to vacant posts in line with final workforce plan numbers; • Review of clinical supervisor time commitments in Q4 to ensure full implementation of role and positive progress on dashboard metrics; • Formal sign off of final dash board and recovery plans for those metrics off track. The Quality Committee noted and was assured with regard to the implementation of the Clinical Leadership Framework.	
9.3	**COMPASSION IN PRACTICE – IMPLICATIONS FOR YAS** Consideration of the above agenda item was deferred until the March meeting of the Quality Committee.	
	RISK MANAGEMENT	
10.1	**RISK MANAGEMENT UPDATE** KDW provided an update on emerging issues and risks to provide assurance that risk was being managed effectively. He stated that 9/12 of the current key risks were showing positive movement. KDW confirmed that good progress was being made against all actions on the risk treatment plan to mitigate strategic risk 2a so the data flagging process was getting close to the point where the Trust could consider taking it off the Corporate Risk Register (CRR). A data flagging group had been formed and was starting to meet and BH, as part of the EOC review, had developed a new data flagging process to be presented to SMG. A newly emerging risk was the potential significant overspend in the PTS business area. TEG had felt that the risk was too significant to be considered within the broader risk BAF 4a and it merited specific attention as a stand-alone strategic risk. The Trust Board agreed and the risk was added to the December iterations of the CRR and BAF. The Chairman thanked KDW for the helpful summary. EB asked whether the organisation's top five risks would change due to the inclusion of the new PTS risk. The Chairman agreed that this would need to be reviewed following the meeting. **Action:** **SP/KDW to review the Trust's "top five" corporate risks in light of the addition of the new PTS risk.** The Quality Committee noted the current position and was assured in regard to the effective management of risks.	**SP / KDW**

		Action
11	**RESEARCH GOVERNANCE**	
	There were no Research Governance agenda items for this meeting.	
12	**ANY OTHER BUSINESS**	
12.1	**ANY OTHER BUSINESS** There was no other business.	
12.2	**ISSUES FOR REPORTING TO THE BOARD** • Claims overview; • Possible addition of new PTS risk to "top five" corporate risks; • Saville allegations; • Quality Governance Review; • CQUIN proposals 2013; • Quality Impact Assessment update; • Under-2s conveyance.	
12.3	**REVIEW OF COMMITTEE WORK PLAN** The Chairman stated that the Terms of Reference needed to be consolidated. It was acknowledged that the Committee Work Plan would continue to grow and that a framework was needed for each operational group. It was agreed that each operational group should provide an end-of-year report to enable PBW to produce an end-of-year report for the whole of the Operational directorate. **Action:** **PBW to produce Operational directorate end-of-year report.**	**PBW**
12.4	**REVIEW OF MEETING ACTIONS AND QUALITY REVIEW OF PAPERS** The Chairman stated that the papers had been of a good quality. She apologised for over-running, adding that she allowed discussions to take place to enable learning to be shared as there were still disparate areas between Quality and Operations. AW stated that, as she was unable to attend the next meeting, that day's meeting had been her last. It was her belief that the Committee had come an enormous distance since its inception and its members should be proud of the work it had done. The Chairman thanked AW for her comments and passed on the Committee's best wishes to her for the future. It was agreed that future meetings would commence at 0900 hours. The meeting closed at 1240 hours.	
13	**DATE AND LOCATION OF NEXT MEETING** The next meeting will be held on Tuesday, 5 March 2013 at 0900 hours in Kirkstall & Fountains, Springhill 1.	

CERTIFIED AS A TRUE RECORD OF PROCEEDINGS

_____ **CHAIRMAN**

_____ **DATE**