Yorkshire Ambulance Service NHS
NHS Trust

An Aspirant Foundation Trust

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Proforma Board Statement on Quality Governance Arrangements and table of contents for Board Memorandum

Private & Confidential
Monitor – Independent Regulator of NHS Foundation Trusts
4 Matthew Parker Street
London
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Quality Governance – Yorkshire Ambulance Service NHS Trust

In connection with the application of Yorkshire Ambulance Service NHS Trust for NHS foundation trust status, the board of directors confirm that:

- The board is satisfied that, to the best of its knowledge and using its own processes (supported by Care Quality Commission information and including any further metrics it chooses to adopt), the trust has, and will keep in place, effective leadership arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients, including:
    - Ensuring required standards are achieved (internal and external[1])
    - Investigating and taking action on substandard performance
    - Planning and managing continuous improvement
    - Identifying, sharing and ensuring delivery of best practice
    - Identifying and managing risks to quality of care

- This encompasses an assurance that due consideration has been given to the quality implications of future plans (including service redesigns, service developments and cost improvement plans) and that processes are in place to monitor their ongoing impact on quality and take subsequent action as necessary to ensure quality is maintained.

The basis of the board of directors' confirmation is set out in the attached board memorandum, dated 1 February 2013.

For and on behalf of the board of directors of Yorkshire Ambulance Service NHS Trust.

Chairman

Name: (print)…… (signature) ……

Date: …….

BOARD MEMORANDUM ON QUALITY GOVERNANCE

EXECUTIVE SUMMARY AND CONCLUSION

The Yorkshire Ambulance Service NHS Trust (YAS) Board made the development of quality governance one of its main priorities for 2011-13.

During 2011 Board held dedicated workshop sessions to focus on the arrangements in place for quality governance and to identify the priorities for future development. A number of key priorities were identified and have been taken forward over the last year, including:

- Clarifying Board definitions of quality and ensuring this is reflected throughout all strategies and plans
- Review and redefinition of Board governance and Trust committee structures
- Development of the Trust's clinical quality strategy and an ongoing focus on improving our performance against national ambulance quality indicators.
- Implementation of a new Clinical Leadership Framework.
- Establishment of the Quality Committee as a key mechanism to support Board assurance.
- The development of our performance management systems
- Development of the Board Integrated Performance Report to ensure a sharper focus on key quality issues, including metrics relating to patient safety, clinical effectiveness and patient experience, and a focus on compliance with the *Essential Standards of Quality and Safety*.
- Further refinement of our risk management strategy, systems and processes and of the Board's view of risk relating to clinical quality issues.
- An increased focus on engagement of staff and other stakeholders in the development of safe, high quality care.

The Trust is compliant with all of the *Essential Standards of Quality and Safety* and this was confirmed by the care Quality Commission following an inspection visit in January 2012.

An external review of quality governance has been commissioned from Deloitte. An initial assessment was completed by Deloitte in July 2011 and a quality governance action plan was agreed by the Board as a result of this. Further assessments of progress by Deloitte in January and July 2012 confirm the positive developments in quality governance in line with the quality governance framework.

Further development is focused over the coming months on:

- Ensuring that the benefits of the recently implemented clinical leadership framework are fully realised across the service.
- Implementation of service line management.

- Further strengthening of the performance management system, with a particular emphasis on the integration of performance management and monitoring at Board, department and individual level.
- Ongoing development of staff engagement
- Continuing to develop engagement with the Clinical Commissioning Groups

1. STRATEGY

a. Does quality drive the Trust's strategy?

- Description of the Board's quality strategy
- Detail of quality goals and how they have been developed and communicated across the Trust

b. Is the Board sufficiently aware of potential risks to quality?

- Description of the Board's approach to assessing initiatives for the impact on quality
- Description of how the Board is assured that CIPs (cost improvement plans) do not compromise the Trust's ability to meet required quality standards
- Description of how financial and operational initiatives are monitored for ongoing impact on quality (e.g. service redesigns and developments)

1a) Does quality drive the Trust's strategy?

1.1 YAS's vision and values place quality at the heart of the Trust and significant improvements in quality of care and services have been achieved since the Trust's formation in July 2006. Our *Clinical Quality Strategy*: *Delivering Excellent Services 2012-15*, sets out a framework for development, aligned to the wider Integrated Business Plan. This ensures that our plans for the delivery of safe, high quality patient care are effectively linked with operational and financial plans. Objectives in relation to the Clinical Quality Strategy are managed as part of our performance management systems and risks to delivery are formally monitored via our Risk Escalation and Assurance Process.

YAS's Clinical Quality Strategy

1.2 The Clinical Quality Strategy draws on recent developments in NHS policy as well as an internal analysis of the key issues for our service users and opportunities for further development. Its structure and content also reflect the three dimensions of quality set out in *High Quality Care for All (2008).*

1.3 In summary, the Clinical Quality Strategy comprises six key elements:
A focus on improvement in relation to a small number of priority service quality issues where evidence shows that we can make a real difference to patients within a three-year timeframe. These include key clinical service developments, including those relating to major trauma, improvement in survival from cardiac arrest and stroke care, and development of more integrated care for patients with urgent condition; a focus on clinical effectiveness through delivery of the Ambulance Quality Indicators; and priority developments relating to patient safety and patients' experience of the service.

- Ensuring we deliver higher quality care without increasing costs by eliminating waste from systems and processes
- Action to embed quality and innovation in everything we do through education, training, personal development and the development of our learning and development systems and processes
- Developing clinical leadership at all levels to support teams in the delivery of excellent care and services

- Development of measures which will enable us to track the quality of our services from the frontline to the Board and to demonstrate our continuous improvement
- An approach to communicating about the quality of our services to the general public, which demonstrates our commitment to openness and public accountability.

1.4 Our staff have contributed to the Clinical Quality Strategy through a consultation and engagement process. Views of commissioners and other health and social care providers on quality issues were also considered.

1.5 We have also worked with commissioners and other partners to align our Commissioning for Quality and Innovation (CQUIN) targets and Quality Account priorities for improvement to the key themes and objectives of the strategy.

1.6 The Clinical Quality Strategy and associated developments are disseminated to staff via the intranet and internet sites, through regular staff bulletins, staff training and management cascade. An annual implementation plan sets out the key deliverables for the Clinical Quality Strategy.

1.7 Performance measures for quality have been developed and form part of our monthly *Board Integrated Performance Report,* enabling a focus on trend analysis and emerging risks to quality. These build on national standards and measures, such as the national ambulance clinical performance indicators, as well as locally defined measures. These indicators are mirrored in departmental performance dashboards, which are reviewed through the Trust's Performance Review Group.

1.8 Delivery of clinical quality is embedded in Trust management arrangements. To provide Board assurance on effective delivery of the clinical quality, we have revised our governance committee structure in 2012 and established a Quality Committee with input from three Non Executive Directors, one of whom is the committee chair. The Quality Committee receives a report at each meeting on progress against the Clinical Quality Strategy annual implementation plan. The Committee's annual work plan also includes reports on all aspects of quality and safety, complemented with assurance reports from operational departments and clinicians.

1b) Is the Board sufficiently aware of potential risks to quality?

1.9 The Board reviews the Integrated Performance Report at each meeting, and scrutinises the key quality indicators as part of this process.
This report highlights key emerging risks to quality and also identifies specific early warning indicators as part of the Trust's monitoring of the quality impact of cost improvement schemes and other service developments. In addition, the Board and Quality Committee receive at each meeting, a report on lessons learned and briefing on significant adverse events.

1.10 The Board also receives detailed reviews of independent investigations into wider NHS service failures and has an opportunity to consider the lessons

that can be learned from these events. This learning has informed the development of quality governance arrangements in the Trust

1.11 All service developments and cost improvement schemes are required to be assessed via a process defined within the Trust Quality Impact Assessment Procedure. The existing process introduced in 2010 was updated in June 2012 and approved by the Board in July 2012.This process determines the potential impact of service developments or cost improvement schemes in terms of: costs and savings; quality and complexity of implementation. The patient risks in cost improvement schemes are reviewed by the Executive Medical Director and Executive Director of Standards and Compliance to inform decisions about scheme approval, risk management and monitoring. Key risks are escalated to the Board via the Risk Escalation and Reporting Procedure. On-going monitoring of quality impact is managed via the review of the Integrated Performance Report in Senior Management Group, with Board assurance supported through reports to the Quality Committee and Audit Committee.

1.12 Risks to quality are captured in risk registers at department and corporate level, with processes for review and escalation in line with the Trust risk escalation and reporting procedure. Risks are also considered in the Clinical Governance Group and Senior Management Group, with escalation of risks and issues from operational and other departments via the department dashboards and exception reports.

1.13 The Quality Committee undertakes detailed scrutiny of risks to quality, safety, workforce and other key aspects of governance, based on regular reports from Executive Directors, senior managers and clinicians, and informs Board consideration of these issues.

1.14 The Audit Committee provides independent assurance on the management of key risks to quality through feedback from the Quality Committee discussions, focused assurance sessions with lead directors, based on the risks, controls and assurances in the Board Assurance Framework, and reviews conducted as part of the annual Internal Audit programme.

1.15 To complement the monitoring of formal quality indicators, the Executive and senior management team conduct regular visits to front line services as part of an established ‘Listening Watch’ programme and Non Executive Directors also visit operational areas as part of their own experience and assurance process.

1.16 The Board has reviewed the Trust’s position in relation to the Quality Governance Framework through a number of workshop sessions and the external review of quality governance undertaken by Deloitte and other external reviews have also helped to inform further developments.

2. CAPABILITIES AND CULTURE

a. Does the Board have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda?

- Overview of leadership arrangements
- Description of Board's approach to challenging quality performance
- Skills assessment review

b. Does the Board promote a quality-focused culture throughout the Trust?

- Explanation of the mechanisms used to drive the quality agenda and promote and open culture
- Description of how the Trust learns from incidents and complaints

2a) Board leadership, skills and knowledge

2.1 The Trust has undertaken significant work in the last year to develop the Board composition, structures and processes. Strengthening our leadership, challenge and performance management of quality issues has been a key focus of this work.

2.2 The Board now comprises the Chairman, five non-executive directors, the Chief Executive and five executive directors. The executive directors are:

- Executive Director of Finance and Performance
- Executive Director of Operations
- Executive Director of Workforce and Strategy/ Deputy Chief Executive
- Executive Medical Director
- Executive Director of Standards and Compliance

2.3 The Board has collective responsibility for setting, maintaining and reviewing quality standards and performance. In addition, we benefit from the particular expertise of our Executive Medical Director who is a Consultant in Emergency Medicine and Pre-hospital Care; our Executive Director of Standards and Compliance who is a Registered Nurse; and one of our non-executive directors who has also worked as a senior nurse in a local NHS trust.

2.4 The Board scrutinises the quality elements of the *Board Integrated Performance Report* in detail at each public meeting. The Chairman ensures that sufficient time is allowed for this review to enable effective challenge and response. For example work to further develop the systems and structures for learning lessons from adverse incidents has been given high priority and subject to significant discussion at public Board meetings.

2.5 The Board also receives detailed reports on key aspects of clinical quality, including annual reports on Clinical Governance, Safeguarding and Infection, Prevention and Control.

2.6 The Board is responsible for setting and approving the content of the annual Quality Accounts and for signing off the final document. This provides an annual focal point for quality performance review in addition to the regular review of the *Integrated Performance Report.* Board members have particular input into the priority setting process and are able to challenge the objectives set for the year ahead to ensure they are in line with overall Trust strategy and will effectively raise standards for patients.

2.7 As part of the external audit plan for 2009/10 it was agreed that Deloitte should carry out an independent review of management capability and capacity and our overall organisational development strategy.

A number of recommendations were made in the final report (February 2010) which we have either addressed directly or have built into our organisational and leadership development plans.

2.8 Further developments to the Performance Management Strategy and Framework were introduced in 2012 to ensure that the performance management arrangements within the Trust support the delivery of the business plan objectives and other key areas of activity and enable the Trust to monitor progress at all levels. This will be supported by the systematic introduction of service line management in the coming year.

2.9 The measures used to review and monitor quality performance continue to be developed and will be aligned to the new service lines as these develop, but already senior managers are expected to report regularly to directors on key indicators of safety, effectiveness and experience and be accountable for their department's performance.

2.10 Department-level dashboards have been developed and are scrutinised on a risk assessed basis at two-monthly Performance Review Group meetings. The Board recognises the need to develop a systematic and consistent focus on quality across its operational departments and work is continuing in 2012/13 to ensure that this is fully embedded.

2.11 The Trust has sought to learn from the experiences of existing Foundation Trusts. This includes a Board development session with a member of the Airedale Board which helped us assess our readiness for Foundation Trust status and enabled individual Board members to consider their personal readiness and any further development they may wish to undertake. The Trust has also received a presentation from the Chairman and Lead Governor of North East Ambulance Service, to support greater understanding of the relationship between the Board and Council of Governors. A Board development programme is also in place and the Trust takes advantage of opportunities to learn from other organisations through Foundation Trust Network programme and other national events.

2.12 Following the Care Quality Commission inspection visit in 2011, the Board ensured a clear focus on the priorities for action arising from the inspection report. This included a review of the mandatory training programme and comprehensive review of the Trust policy and procedures for managing controlled drugs, which resulted in a significant strengthening of the arrangements in line with legislative and best practice requirements.

2b) Promoting a quality-focused culture

2.13 In 2010/11 the Board spent significant time on developing the Trust vision and values. As well as being the basis of Trust strategy, an essential part of this work was the associated communications plan to ensure that staff and managers were engaged in the process and that we achieved an outcome that reflected our shared commitment, from the Board room to the frontline, to raising the standards of care we provide for our patients.

2.14 In 2011/12 the Board has refined the organisation's goals and strategic objectives as a key element of the Trusts' 5-year Integrated Business Plan. This has formed the basis for increased staff engagement in relation to key elements of the Trust's clinical strategy.

2.15 The Trust has made it a priority to raise the profile of the Care Quality Commission (CQC) standards with staff and managers. The Executive Director of Standards and Compliance completed a series of visits to frontline and support teams across all geographic areas and functions of the Trust to discuss the expectations and challenges. This is supported by all Board members through key messages given at their own staff visits, in particular as part of the regular programme of Executive and senior management team *Listening Watch* visits to front line services. Non Executive Directors are also visit operational areas as part of their own experience and assurance process.

2.16 The CQC inspected the Trust in September 2011. At that time the CQC had minor concerns regarding Infection Prevention & Control and moderate concerns regarding Medicines Management and Supporting Staff (specifically elements of mandatory training and PDR compliance). On their return in January 2012 the CQC found significant improvements in these areas and has confirmed that the Trust is now compliant with all of the *Essential Standards of Quality and Safety.*

2.17 A particular example of how the Board has signalled its commitment to quality is by building patient stories into the agenda for every public Trust Board meeting, using video recordings or transcripts of the patients' own words. The Board is also playing a visible role in leading the Trust's Dignity and Respect campaign and promoting our YAS six point dignity code.

2.18 Our commitment to openness and accountability is well-reflected by our process for clinical incident reviews. Clinicians are encouraged to participate in clinical incident review, a process which is designed to be supportive and to facilitate the identification of individual and organisational learning.

Where a patient or family wishes it, they are kept informed at all stages of the process and in many cases senior members of the clinical team meet with patients directly to discuss what took place and what may be learned for the future. This is a key part of developing an open culture within our frontline operations which supports learning and development. One of the key areas of attention in the Care Quality Commission inspection in January 2012 was on the Trust's implementation of the Being Open principles, relating to communication with patients and families where harm has been caused by a failure of Trust care.

The Care Quality Commission concluded that the Trust had appropriate arrangements in place for sharing information with patients and relatives and that the Trust was compliant with the relevant standard.

2.19 An Incident Review Group meets every two weeks to review incidents, complaints, inquests, serious case reviews and other significant events. Lessons learned are identified in this joint forum and actions agreed. Where necessary, Clinical Case Reviews are completed with the relevant staff, to identify both individual and organisational learning from clinical adverse events. A Lessons Learned report is presented to the Senior Management Group, Quality Committee and Board every 2 months. This report triangulates information from the various sources and provides an update on delivery of actions to address key elements of organisational learning. In 2012/13 a new risk management data system is being introduced across the Trust to help to strengthen the quality of data and facilitate cross-cutting analysis of themes.

2.20 Trust plans to develop and foster a culture of quality, learning and innovation amongst our frontline A&E clinicians have been discussed by the Board. Specific developments include: a review of clinical leadership across the Trust, with the introduction of a new clinical leadership and supervisory framework across the Trust in August 2012.

The Trust is delivering a focused programme of leadership and management development to the new cohort of clinical leaders over the coming months, to ensure that they are well equipped to support delivery of quality care in their respective clinical teams. These developments are part of the wider workforce and organisational development strategy which is key to undertaking future quality improvements.

2.21 A programme of engagement meetings has been held with front line staff on the future plans for the organisation, including key clinical developments. Further extensive communication is planned for early 2013, focused on future developments set out in the Trust's Integrated Business Plan and the associated Service Transformation programme.

2.22 The Trust implemented a Dignity Awareness campaign in 2011 and an annual associated award for staff who promote patient dignity. A Trust-wide Dignity Awareness day was held in February 2013 to refresh and reinforce the campaign messages.

3. PROCESSES AND STRUCTURES

a. Are there clear roles and accountabilities in relation to quality governance?

- Description of roles and committee structures and how responsibilities are cascaded through the organisation

b. Are there clearly defined, well understood processes for escalating and resolving issues and managing performance

- Description of arrangements in place to escalate issues
- Description of how staff can raise concerns and issues
- Approach to clinical audit and how information is used to drive quality

- Internal audit approach to quality governance arrangements
- Description of how the organisation has acted on feedback received, including the resolution of complaints.

c. Does the Board actively engage with patients, staff and other key stakeholders on quality?

- Description of how the Board engages with patients, staff and stakeholders.

3a) Roles and accountabilities

3.1 Trust governance systems are set out in Trust policies and procedures, and management briefings and are summarised in the YAS Governance Handbook. The Board has overall responsibility for quality governance, with delegated responsibility for delivery of effective internal control on issues of quality and safety delegated to the Trust Executive Group.

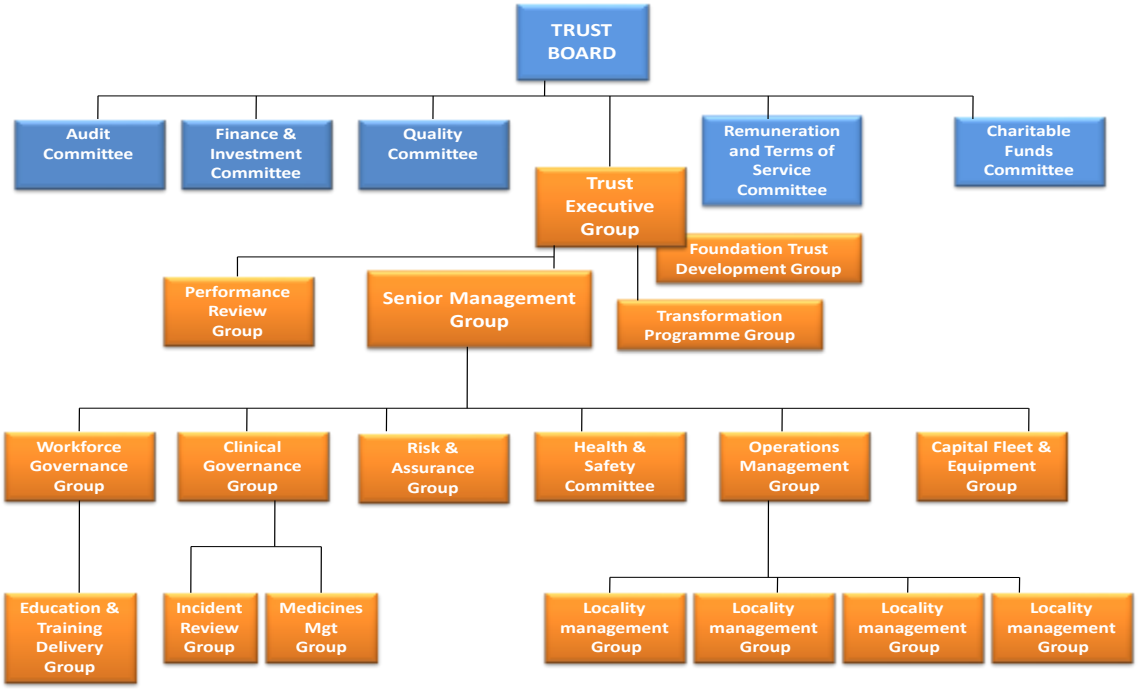
3.2 The Quality Committee is the key Committee supporting the Board in gaining assurance on the management of clinical governance and quality and receives reports at each meeting on Trust and department level compliance with quality standards.

3.3 The Senior Management Group reviews the quality indicators in the Integrated Performance Report at each meeting and receives exception reports from departments and a range of specialist sub-groups. This includes other key management groups which support delivery of safe, effective care, including the Clinical Governance Group, Workforce Governance Group and the Health and Safety Committee.

3.4 The Clinical Governance Group is chaired by the Executive Medical Director and reports to the Senior Management Group. It is the principal management group responsible for development of clinical quality. It receives and considers quality and safety reports from its sub-groups and representatives of other departments.

3.5 The Operations Management Group and Locality Management Groups are responsible for overseeing delivery of Trust strategy and policy in the operational departments of the Trust.

3.6 The Board committee and management group structure is summarised in the diagram below:



3.7 Executive clinical leadership is provided by the Executive Medical Director and on quality and safety issues by the Executive Director of Standards and Compliance. The two directors work closely together to ensure seamless leadership across the range of clinical governance and quality issues.

3.8 The organisational focus on quality is reflected in the objectives of all Executive Directors and managers. Quality is managed through the line management process, and is integral both to departmental agendas and individual performance review discussions at all levels.

3b) Escalating and Resolving Concerns and Managing Performance

3.9 The Trust has effective systems in place for escalating issues and concerns and for managing performance.

3.10 All staff are made aware of the systems for raising issues, concerns and risks as part of the corporate and local induction programmes. Local induction includes training on how to access and use the web-based PRISM incident reporting system. Supporting the PRISM system, frontline staff are also able to report incidents via our telephone incident reporting hotline. The replacement of PRISM with a new risk management data system in 2012/13 will further strengthen this process. If the concern is a management issue then staff are able to raise this in accordance with the *Raising Concerns at Work Policy*. Designated Non Executive Directors are also identified to support 'whistleblowing' processes. Staff are again made aware of this policy as part of their induction and it is available via the Intranet document library.

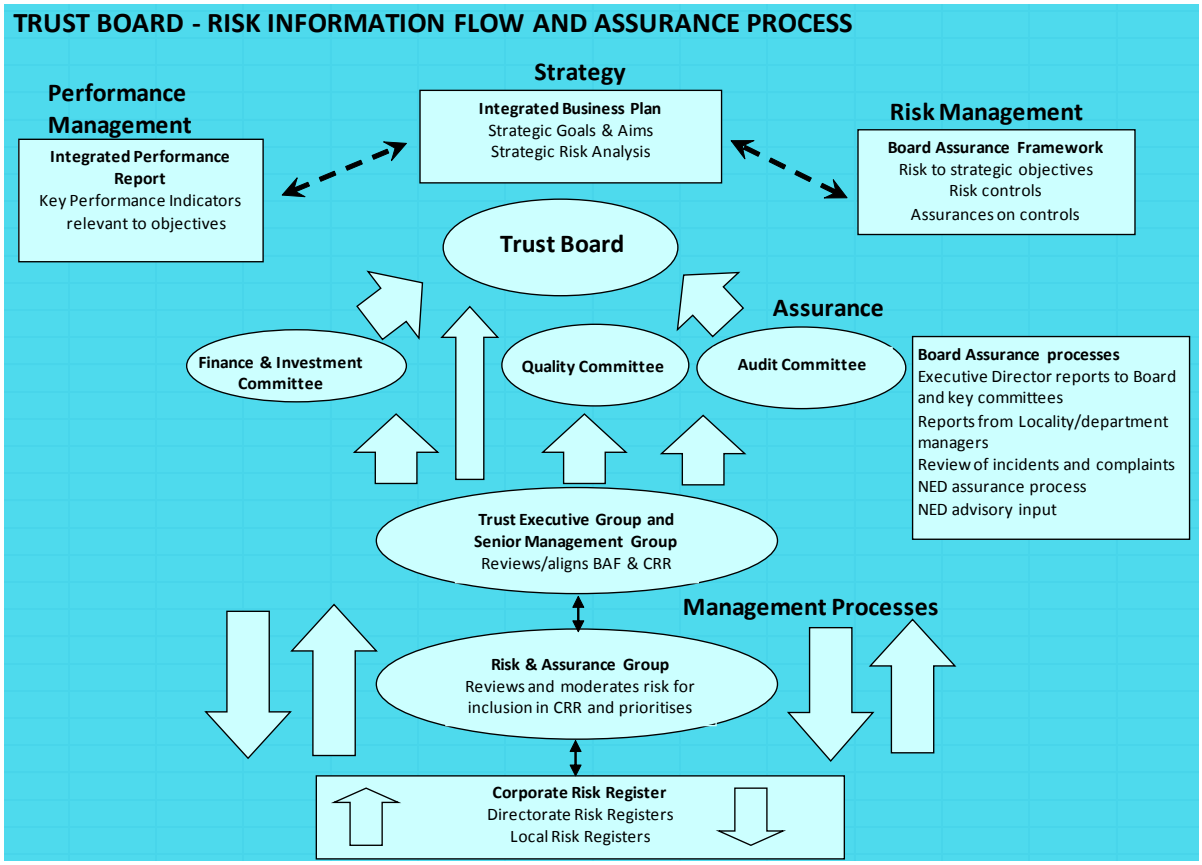
3.11 Issues are escalated through formal reports to Trust management meetings, and via assurance reports to the Board Committees. The Clinical Governance Group receives reports from relevant departments and considers emerging risks and issues.

The Senior Management Group receives formal exception reports from department managers and key management groups including the Clinical Governance Group, to support early identification of quality issues.

3.12 The Trust Performance Review Group provides a vehicle for executive scrutiny of departmental performance, and quality issues are a key focus of these discussions. Where necessary, quality issues can be escalated to this group for more detailed review.

3.13 The Board receives an Integrated Performance Report on a monthly basis. This includes a wide range of quantitative and qualitative measures of quality and is reviewed in detail, with a focus on exceptions in each public board meeting.

3.14 The Risk and Assurance Group has members from all directorates and plays a key role in reviewing escalating key risks including those relating to quality, to the Trust Executive group and Board. Risks and issues are identified, recorded and escalated according to our *Risk Escalation and Reporting Procedure.* This is summarised in the diagram below:



3.15 The Trust must be registered with the Care Quality Commission (CQC) in order to be authorised to provide its services and registration is dependent on maintaining compliance with the *CQC Essential Standards of Quality and Safety*. We are responsible for assessing ourselves against the *Essential Standards of Quality and Safety,* and for addressing any issues arising from this. Regular reports on the compliance position are reviewed by the Trust Executive Group and Clinical Governance Group.

The Trust receives a monthly external risk assessment of compliance with the standards in the form of a *Quality and Risk Profile (QRP)* from the CQC and reviews this to identify any areas of concern.

3.16 We are committed to delivering effective clinical audit in all the clinical services we provide and see clinical audit as a cornerstone of our arrangements for developing and maintaining high quality patient-centred services. Our *Clinical Audit Plan* sets out how we will use clinical audit to confirm that current practice compares favourably with evidence of good practice and to ensure that where this is not the case that changes are made that improve the delivery of care. The *Clinical Audit Plan* sets out development objectives for the short, medium and long-term. The short-term objectives focus on: compliance with regulatory requirements and national policies, guidance and best practice including the national Ambulance Clinical Quality Indicators, improving data quality and reporting systems; and staff education and training. The results of clinical audits are monitored and reported via the Clinical Governance Group.

Assurance reports on the effectiveness of the clinical audit system are presented to the Quality Committee as part of its annual work programme and it has been agreed that the Audit Committee will also receive reports on key clinical audits, to support its independent review of risk management across all Trust functions.

3.17 The Audit Committee plays a key role alongside the Quality Committee, in gaining assurance in relation to the management controls for the key risks to quality. The work of the Audit Committee is underpinned by the work of our internal and external auditors. The Trust's internal auditors are *East Coast Audit Consortium* and we have an agreed three-year strategic audit plan, which was developed with input from Board members. This includes work to examine and evaluate the adequacy and effectiveness of our governance and risk management arrangements, the system of internal control, and performance management in carrying out assigned responsibilities to achieve the goals and objectives within our business plans. Key quality audits include annual reviews of the Trust Quality Accounts, Information Governance and compliance with Care Quality Commission standards. Additional audits of quality systems in the last year included clinical governance systems, safeguarding and learning from adverse events.

Audits planned for 2012/13 include reviews of risk management arrangements, compliance with the *Essential Standards of Quality and Safety*, performance management arrangements, information governance and compliance with Monitor requirements for Foundation Trusts. Recommendations from internal audits are discussed with responsible managers and action plans agreed. These are reported to the Audit Committee along with a tracking document showing completed and outstanding actions.

3.18 Reports from the Quality Committee and Audit Committee are presented to the Board at each meeting and these provide an additional opportunity to highlight key risks or issues.

3.19 The terms of reference and effectiveness of the Board Committees are reviewed on an annual basis as part of their work plans. A review completed in January 2013 focused on the interface between the Board Committees, to ensure that there is an effective and co-ordinated assurance process in relation to all of the key risks in the Board Assurance Framework.

3.20 When people contact us to tell us about a problem we understand that they want us to respond to their concerns as soon as possible. For each person making contact with us we develop an individual resolution plan to record the issues raised and the outcome they are looking for and a timescale for resolution. Learning lessons from complaints, concerns and comments is very important to us and we track key issues, themes and trends and match these against other sources of information such as safeguarding cases, patient experience surveys, incident reports and feedback via service-user groups.

3.21 Some of the improvements we made in 2011/12 as a result of issues highlighted through complaints, concerns and compliments were:

- A number of complaints were received regarding Patient Transport Service (PTS) bookings. The Patient Relations team has identified notes which can be added to patient bookings to ensure that they are tailored to individual patients' needs (e.g. a four-person lift needed, cannot travel in a small ambulance owing to sickness). PTS managers are tasked with ensuring that planners add these notes where relevant, to reduce repeated complaints relating to poor patient experience.

- PTS managers have been reminded to keep patients informed of any updates on their pick-ups. A number of incidents have.occurred where YAS has contacted a clinic to advise of a delay, the clinic has subsequently cancelled the appointment but no-one has informed the patient.

- A number of issues have been raised by other services regarding Do Not Attempt Resuscitation (DNAR) orders e.g. photocopies of forms being refused by YAS staff or unsigned forms. The guidance on DNAR orders was re-issued to staff and the Trust continues to work with other parties to ensure that DNAR orders are prepared and communicated appropriately to YAS staff, and to facilitate the delivery of appropriate care for patients.

- Complaints and concerns have been received where members of the public felt intimidated by the driving of ambulance staff attending emergencies. To address this, in addition to an existing programme of work focused on reduction of vehicle accidents, a reminder has been issued to all Trust staff from the Lead Driving Instructor, about good driving practice and the consequences should individuals be found to have shown undue aggression towards other drivers.

3c) Engagement with staff, patients and other stakeholders

3.22 Engaging staff, patients and partner organisations is a key part of our quality strategy. This includes listening and acting on feedback and involving them in the development and delivery of our future plans.

3.23 A key forum to support staff engagement is the management time out event, which is run twice a year. These events provide an opportunity for managers to meet each other in a single location, hear from the Chief Executive and the executive team about progress over the past year and plans for the year ahead. Workshops focus on key priorities, including quality issues, and allow managers to share best practice and learn from each others' experience. These meetings help to inform key communications in local management and staff meetings.

3.24 From July 2012, we introduced a Clinical Quality Forum with a range of staff and manager representatives as well as invited members with specific clinical and quality expertise drawn from external stakeholder organisations. The Forum provides a vehicle for discussion of key clinical quality issues to inform the decisions of the Clinical Governance Group.

3.25 A new annual staff 'We Care' awards ceremony commenced in April 2012, as a vehicle to recognise and rewards achievement and innovation, and a staff 'Bright Ideas' scheme is being launched in 2013 alongside other Service Transformation Programme initiatives designed to increase staff engagement.

3.26 Work is under way to further develop and streamline processes for communication with staff, including a new regular team briefing process to supplement the existing electronic bulletins and the face to face communication via the *Listening Watch* programme and other regular Board visits to ambulance stations and other departments.
A programme of station visits by the Chief Executive and Executive Director of Operations in summer of 2012 has specifically focused on increasing the awareness and engagement of staff in relation to key clinical service developments in the 5-year Integrated Business Plan.

3.27 Our engagement with commissioners on quality includes a Clinical Quality Review Group. This is a monthly forum and is attended by the YAS Executive Medical Director, Executive Director of Standards and Compliance and PCT commissioners to review service quality and performance against CQUIN targets. Additional engagement with commissioners takes place on a regular basis through Board level dialogue, the Contract Management Board and on a wide range of operational quality issues via the Trust's locality teams.

3.28 A programme of meetings has been undertaken to develop engagement and positive relationships with the Clinical Commissioning Groups who will be key to the commissioning of Trust services in the future.

3.29 In 2012 there has been a significant focus on clinical and commissioner engagement in relation to the delivery of urgent care and of the new region-wide 111 service, which will be introduced by the Trust from March 2013.

3.30 We work closely with the Yorkshire-wide Local Involvement Network (LINk) Ambulance Group. All LINks are invited to participate in this group which is a forum for members to raise concerns to their local LINks, identify common experiences across areas and receive responses from YAS managers. When issues are specific to an individual LINk we also engage directly with them to provide detailed information and, where possible, resolve problems. The Chairman, Chief Executive and other directors participate in periodic LINks' events reporting on achievements in the past year and priorities for the year ahead.

3.31 We acknowledge the important feedback provided via our 14 Yorkshire Health Overview and Scrutiny Committees (HOSCs). Our directors and senior managers attend meetings across the region over the course of the year to report on performance and receive feedback on local issues.
All LINks and HOSCs were given the opportunity to provide input on the content of our 2011/12 Quality Accounts through a questionnaire and, where possible, meetings with Councillors or presentations to Committee meetings.

3.32 A 'Stakeholder e-News' bulletin is now circulated to key stakeholders to help update them on significant Trust developments.

3.33 We have an 'Expert Patient' who contributes significantly to the Trust Clinical Governance Group and Quality Committee, and advises on the related work programmes. The Expert Patient also facilitates links with a wide range of patient representative groups across Yorkshire.

3.34 The Trust has a Critical Friends Network made up of patients and members of the public who have said they are willing to work with us on different aspects of our service provision and development.

3.35 We obtain direct feedback from patients using the A&E and PTS service through postal and online surveys. These high-level surveys are supplemented by in-depth studies looking at the experience of particular patient groups. The Trust is also working with other ambulance Trusts, the Care Quality Commission and Picker Institute, to support the development of a national ambulance patient survey.

3.36 Information from all the above channels feeds into the Quality section of the *Board Integrated Performance Report.* It is also fed back to managers and staff and used extensively to support improvements in practice.

4. MEASUREMENT

a. Is appropriate quality information being analysed and challenged?

- Process adopted by the Board to select relevant quality information, details of what is reviewed
- Details of how quality performance information reviewed by the Board is backed up by more granular information

b. Is the Board assured of the robustness of the quality information?

- Details of Board's approach to assuring data quality

- How internal audit is used to review robustness of data and a description of how findings are followed up

c. Is quality information being used effectively?

- Examples of how quality information has led to improvements in quality
- Details of targets set and performance against targets

4a) Quality information

4.1 The development of the *Board Integrated Performance Report (IPR)* has been driven by the Board's challenge to the quality of information that it was receiving prior to April 2010. In particular, Board members set out their expectations for greater reporting on quality issues including trend and rate-based monitoring. The IPR was reviewed and refined during 2011/12. This included an external review by Deloitte focused on its fitness for purpose, and in particular whether it was sufficiently future-facing and the extent to which it supports strategic decision making. The Assistant Director of Business Planning also interviewed all non-executive directors about their information needs and comments/recommendations on the IPR. As a result of this work a number of significant improvements have been introduced to streamline the indicators, to enable a clear view of performance against targets or trajectories, to provide external benchmarks where available, to enable easier triangulation of indicators, and to highlight exceptions. It is envisaged that the Trust will continue to refine and improve the reporting process and indicators over the coming year.

4.2 To support the work on quality impact assessment of cost improvement plans and other service developments, a range of 'early warning indicators' have been highlighted for special attention in the IPR. Further work will be undertaken in 2012/13 to develop the sensitivity of these indicators and their use as part of routine management and Board monitoring.

4.3 Indicators in the IPR are mirrored in departmental dashboards which are used to support management review and action within departmental management meetings. The dashboards underpin exception reporting from departments to the Senior Management Group and inform the review and challenge by Executive Directors in the Performance Review Group. They are also used as the basis for assurance reports from departments to the Quality Committee. Further work is continuing to strengthen these departmental dashboards and in 2012/13 the Trust will develop more automated systems for production and direct access to live performance information. Pilot work is also under way to test individual performance reports for clinical staff.

4.4 Written reports are supplemented by a programme of internal 'Inspections for Improvement'. Teams of staff led by an appropriately skilled Associate Director, conduct unannounced inspection visits, focused on the delivery of Trust standards for quality and safety. Reports from these inspections are fed back to the relevant team and are reviewed in the Senior Management Group to complement other sources of performance information.

4.5 Board members and senior managers regularly engage with front line staff through department visits and 'shadowing'. They are also actively engaged with a range of external stakeholders, both through formal meetings and informal networks. Information gleaned from these engagement processes is used to inform discussions and decisions on quality, alongside the hard data in performance reports.

4.6 The Quality Committee receives reports at each meeting from corporate clinical, quality, governance and risk teams and triangulates these with information from departmental managers and individual clinicians.

4.7 The Audit Committee reviews and tests the controls and assurances in relation to each function as defined in the *Board Assurance Framework (BAF)*, including the robustness of key performance indicators and their use by management teams. An Executive Director attends each meeting to present the items on the BAF that relate to their directorates. The Executive Medical Director and Executive Director of Standards and Compliance provide assurance reports on a six monthly basis as part of this process.

4b) Robustness of Quality Information

4.8 The Board continues to show leadership on data quality and sets high standards for information management throughout the Trust. Regular reviews of data quality are commissioned from internal and external sources to inform the Board's level of confidence in data presented. Recommendations from Internal Audit review of the IPR have influenced revision of the IPR Report Generation Process including the introduction of a new template for managers defining their data definitions and quality checks.

4.9 The new risk management data system will also support improvements in quality of incident, compliant and claim data during 2012/13.

4.10 Ambulance service performance target data definitions are agreed nationally and Trust reports are audited on a regular basis to ensure compliance with agreed guidelines. There are internal data quality procedures and management audits for key reports, with sign off at Associate Director level.

4.11 Data quality for the national performance targets is also audited annually by Internal Audit and reporting of the Ambulance Clinical Quality Indicators has been subject to external peer review.

4.12 Clear procedures and data definitions are set out for internal performance reports, including the Integrated Performance Report and the IPR and Trust Quality Account are subject to management scrutiny and annual review by Internal Audit.

4c) Using information effectively

4.13 Trust performance and quality reports are prepared to a strict timetable to ensure timeliness of information provided to the Board and management groups. For most internally generated data, formal reports include data up to the previous month.

4.14 Exceptions are highlighted as part of the reporting process. Where necessary additional opportunities are organised, for example in ‘drill down’ sessions involving Non-Executive Directors or Board Development Meetings, to explore specific issues or exceptions in greater detail, and to inform additional action.

4.15 An example of how information has driven quality improvement is our Focus on hand hygiene, station and vehicle cleanliness through monthly audits in all localities. This has resulted in a steady increase in standards since the process began.

4.16 Information is also an essential element of our work to develop alternative care pathways and increase the number of referrals made by our clinicians. This has included year on year increases in referrals to specialist diabetes nurses and falls teams.

4.17 The review of regular workforce dashboard indicators at senior management level has driven an improvement in PDR completion and mandatory training attendance. Monitoring of flu vaccinations through the dashboard in 2012/13 has supported a significant increase in the rate of uptake compared to that in 2011/12.

4.18 Quality targets for the year ahead are set out in our priorities for improvement within our Quality Accounts, in the Key Performance Indicators defined in our annual Business Plan and in our CQUIN targets agreed with commissioners. The Business Plan also defines the cycle of performance management activities relating to regulatory compliance, risk and operational performance. These targets reflect the new NHS ambulance clinical quality indicators and support our continued focus on maintaining and improving our clinical performance for stroke, STEMI heart attack, cardiac arrest and other key conditions.

4.19 The *Clinical Audit Plan* sets out development objectives for the short, medium and long-term. The short-term objectives focus on: compliance with regulatory requirements and national policies, guidance and best practice including the national Ambulance Clinical Quality Indicators, improving data quality and reporting systems; and staff education and training. The results of clinical audits are monitored and reported via the Clinical Governance Group.

4.20 An action plan has been developed in relation to the Ambulance Clinical Quality Indicators where YAS is an outlier in comparison with other Trusts. Delivery of this plan is overseen by the Deputy Medical Director and progress reported to the Quality Committee.

4.21 The Trust is actively engaged in benchmarking with other services across a range of measures. This includes performance measures, the Ambulance Clinical Quality Indicators and Clinical Performance Indicators. In addition, the Trust benchmarks through national Directors’ groups on incident reporting, complaints, safeguarding and patient experience, using a range of quantitative and qualitative measures.

4.22 The Board and Quality Committee regularly review external publications to identify potential learning for the organisation. This is complemented by the regular sharing of learning across the ambulance services nationally through the Directors' groups. This includes a regular national process for learning from Coroners' Rule 43 letters.

4.23 Information is shared across the organisation to support learning and development via the Senior Management Group, and in the Operational departments through the Operations Management Group. This includes a regular 'lessons learned' report focused on learning from adverse events, as well as reports from development and audit projects. The Trust holds twice yearly management development days, to support cross directorate learning. These formal processes are supplemented by the regular publication and dissemination of quality information for managers and staff through are range of bulletins and online resources.

4.24 A Clinical Quality Forum has been established with representatives from across the Trust's patient care functions, and invited members from other NHS and higher education organisations. This forum provides an opportunity to support sharing of best practice, and for staff to contribute to the development of Trust strategy.

4.25 The Board hosts presentations on key areas of development prior to its public meetings. In recent months these have included major trauma developments, the Trust contribution to and learning from the Olympic games, urgent care developments and management of stroke patients.

5. FACTUAL ACCURACY

5.1 We have read the contents of this Board Memorandum on Quality Governance and confirm that, to the best of our knowledge, all the information is factually accurate.