Yorkshire Ambulance Service NHS
NHS Trust

Quality Committee Meeting Minutes

Venue: Boardroom, Springhill 2
Date: Tuesday, 14 May 2013
Time: 0900 hours

Chairman: **Pat Drake**

Attendees:

Pat Drake	(PD)	Deputy Chairman/Non-Executive Director
Dr Elaine Bond	(EB)	Non-Executive Director
Steve Page	(SP)	Executive Director of Standards & Compliance
Paul Birkett-Wendes	(PBW)	Executive Director of Operations
Stephen Moir	(SM)	Deputy Chief Executive/Executive Director of Workforce & Strategy
Dr Julian Mark	(JM)	Executive Medical Director

In Attendance:

Della Cannings	(DC)	Chairman (Observer)
Barrie Senior	(BS)	Non-Executive Director (Observer)
Andrea Broadway-Parkinson	(ABP)	YAS Expert Patient
Shelagh O'Leary	(SOL)	Associate Director of Organisational Effectiveness & Education
Mark Hall	(MH)	Associate Director, Risk & Safety
Karen Warner	(KW)	Associate Director, Quality
Ben Holdaway	(BH)	Locality Director, EOC
David Williams	(DW)	Deputy Director of Operations
Michaela Littlewood	(ML)	NHS 111 Head of Quality Assurance

Apologies:

Erfana Mahmood	(EM)	Non-Executive Director
Dr Dave Macklin	(DM)	Associate Medical Director (Operations)

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

The meeting was preceded by a presentation for members of the Committee between 0830 and 0900. 'Improving Dementia Awareness – a blended approach' was presented by Chris Sharp, Head of Learning and Leadership and was very well received by those present.

		Action
	The meeting commenced at 0900 hours.	

		Action
1	**INTRODUCTIONS & APOLOGIES** PD welcomed everyone to the meeting and apologies were noted as listed above.	
2	**REVIEW OF MEMBERS' INTERESTS** Declarations of interest would be noted and considered during the course of the meeting.	
3	**CHAIRMAN'S INTRODUCTION** PD stated that the presentation about dementia care had been extremely informative and encouraged those present to take away copies of the information that had been provided for them. She confirmed that all future Quality Committee meetings would be preceded by a presentation at 0830 hours, details of which would be noted at the beginning of the minutes of each meeting. PD welcomed Mark Hall, the new Associate Director of Risk and Safety to his first meeting. Introductions were made around the table.	
4	**MINUTES OF THE MEETING HELD ON 8 JANUARY 2013** The minutes of the meeting held on 5 March 2013 were approved as a true and fair representation of the meeting subject to the following amendments. **Matters Arising:** Page 8, third paragraph from bottom – delete from "as the Trust could not" to the end of the sentence. Page 15 – ensure the two actions on this are on Action Log and marked as complete in May 2013. Page19, paragraph 6 – replace 'HR' with 'Workforce and Strategy'.	
5	**ACTION LOG** The meeting worked through the Action Log, which was updated accordingly. Closed items were highlighted in green. **064/2013** – SM confirmed that this formed part of the annual education and training plan. The new three-day training programme was included and positive feedback had already been received. PBW confirmed that, although numbers were small (30 out of 146 clinical supervisors), people in each CBU would be trained and qualified to use these vehicles. A discussion took place about the priority being given to the training. It was agreed that a big difference to the number of injuries would need to be seen and the Trust would need to be cognisant of the risk to staff, the organisation and patients.	

		Action
	It was agreed that this action would be closed but that a new action should be created requiring a six-monthly update. **Action:** **Executive Operations Director to provide update on roll out of training and process for use of bariatric specialist vehicles at November Quality Committee meeting.** **066/2013** – on agenda. Action closed. **074/2013** – PD/SP had discussed this and it had been agreed that the Claims Report would be scheduled for Caroline Balfour to present at the July meeting. Action remained open. **075/2013** – JM stated that work was on-going and he would provide an update at the July meeting. Action remained open. **089/2013** – SP stated progress was being made and item was tentatively scheduled in for presentation before AGM. Action closed. **090/2013** – SM confirmed that the YAS uniform policy was in line with national specifications re uniforms. Action closed. **091/2013** – SM stated that work was on-going to revise the current induction process. There had been some interim changes before a major overhaul which would include building in the refreshed Infection, Prevention and Control content. Action closed. **093/2013** – Estimated closure date changed to July 2013. **094/2013** – Action closed. PD stated it would be interesting to receive further information about Language Line, including details of what was working and what was not working. SP confirmed it was heavily used in 111. JM and BH agreed to provide an update in July. **Action:** **JM/BH to provide an update on Language Line Policy at July meeting.** **096/2013** – Estimated closure date September 2013. **097/2013** – SM confirmed some clinical supervisors had started to stagger PDRs. Further discussions on PDR policy were due to take place at the next Workforce Governance meeting. Action closed. **098/2013** – Estimated closure date September 2013. **099/2013** – EB confirmed that this had happened. Action closed. **102/2013** – SP confirmed that the discussion was due to take place on 4 June. Action closed.	**Ops Dir** **JM/BH**

		Action
	106/2013 – Committee members had read the report. Action closed. **113/2013** – SP would provide a summary of issues after that day's meeting. Action closed.	
6	**CLINICAL QUALITY PRIORITIES**	
6.1	**CLINICAL GOVERNANCE & QUALITY OVERVIEW REPORT** KW and JM presented an update on clinical governance and the delivery of the Clinical Quality Strategy. KW stated that the strategy and the implementation plan had been reviewed and revised for 2013/14 and as a result, the Clinical Governance Group's (CGG) membership and terms of reference had been reviewed to ensure that it became more operational. JM confirmed that the last few meetings had been more constructive, with Clinician representation strengthened with the addition of a member of the College of Paramedics. PD agreed that this was a good move. PD stated that, as Chairman of the Quality Committee she was happy with the recent developments. She added that there had not been much discussion about clinical governance at the locality board meetings she had attended SP replied that this was being pursued through the performance review meetings with locality teams, with specific challenge on how service lines were managing clinical governance issues, including learning from adverse events and reported patient experience. PBW stated that everyone acknowledged there was still work to do and that the dashboards had to be part of the locality board agenda. It was agreed that PBW should chase progress on this issue. **Action:** **PBW to work with locality directors to ensure clinical governance received appropriate priority at locality board meetings** SM stated that clinical manager attendance was essential to help ensure that issues around clinical governance became embedded at locality board level. JM stated that the clinical managers would need a degree of support if the organisation expected them to provide challenge at these meetings, as this had not previously been part of their role.	**PBW**

		Action
	KW stated that safeguarding children reported to the CGG on a monthly basis. One element of the reporting was in relation to non-conveyance progress draft non-conveyance of children under the age of 2. A draft conveyance referral pathway for children via the Clinical Hub had been developed and would be ratified by the EOC CGG before it was raised at the YAS CGG. JM stated that discussions had taken place about the commissioning and implementation of the Emergency Care Team for major trauma and permission had been granted for a pilot to go ahead and arrangements had progressed in good faith. However on 1 April the Trust had been informed that funding was no longer available. JM reported that he was due to attend a meeting on 20 May to see whether there was any way around this. SM stated that the Implementation Plan should contain job titles rather than names in case off staff turnover.] KW agreed to make the relevant amendments. **Action:** **KW to change names in Implementation Plan to job titles.** **Approval:** **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.**	**KW**
6.2	**CLINICAL AUDIT PLAN** JM presented an update on the current capacity issues related to the Trust's clinical audit function and the plans to address these. PD asked the Committee to ensure that the 'previously considered by' section on the front sheet was always completed correctly. If a report had not gone to another committee, it should be made clear. JM stated that the issues outlined in the paper had been debated in a variety of forums and had been brought to that day's meeting on the back of the recent Audit Committee meeting. JM confirmed that there was currently insufficient capacity to perform the audits required to gain adequate assurance for NHSLA level 2 and this had been registered as a corporate risk. He further stated that the success of the proposed reconfiguration plan was dependent on the implementation of the Emergency Care Solution (ECS) as it would significantly reduce scanning administration thus freeing staff up to carry out other tasks. JM added that completion was now likely in 2016/17 because of the later than planned for start of the ECS roll out.	

		Action
	The Trust continued to be reliant on overtime to reduce the back log of forms coming in but although it was currently managing to stay on top of reporting it was not where it wanted to be in terms of formal clinical audit. He further stated that, as the reliance on paper records reduced, things would become easier. A band 4 and a band 5 were due to be appointed which would also free up clinical expertise. He confirmed that the Trust was meeting its formal Trust level clinical audit requirements and was doing what it could in terms of small local audits that could be completed by individuals on the front line. PD asked whether the data provided by staff on higher education courses who had to do some form of audit as part of their degree was reported into clinical audit and the outcomes captured JM replied that the organisation tried to capture this information when they knew about it. PD stated that part of the signing off process should be through the PDR. In addition, this would be an untapped resource of clinical audit that the Trust could use It was agreed that clinical audit should be a standing item on every Quality Committee agenda. **Action:** **JM/SOL to look into the process for signing off audit work carried out as part of higher education courses to report back at July meeting.** **Action:** **SP to ensure clinical audit included as a standard agenda item as part of Clinical Governance & Quality Update.** **Approval:** **The Quality Committee received and were assured by the plans for delivery and implementation of the clinical audit function in the Trust.**	**JM/SOL** **SP**
6.3	**NIHCE GUIDELINE IMPLEMENTATION** JM presented an update to provide assurance to the Quality Committee that NIHCE guidance and quality standards were appropriately managed by the Trust and action plans implemented where required. JM stated that a Lead Paramedic for clinical development had recently been appointed and would have responsibility for ensuring that guidance and quality standards were appropriately assessed and action plans cascaded to relevant areas of the Trust.	

		Action
	He confirmed that new NIHCE guidance and quality standards were reported to CGG. The guidance on asthma and epilepsies in adults, children and young people had been covered in the June meeting. PD asked what would happen if recommendations in the guidance would lead to a significant cost being incurred. SP replied that, if a business case was associated with the guidance, it would be escalated through SMG to TEG. **Approval:** **The Quality Committee received assurance that NIHCE guidance and quality standards are appropriately managed by the Trust and that plans are in place to address issues regarding efficacy of implementation.**	
6.4	**REVIEW OF KEY QUALITY INDICATORS (IPR) / ACTION** SP presented a review of the key indicators reported in the quality section of the Integrated Performance Report (IPR). PD invited comments from those present. JM reiterated his earlier concerns about the withdrawal of funding for the Enhanced Care Team. SP stated that there had been a random fluctuation of the patient experience indicator on page 3.16. A national discussion was underway about the 'friends and family' ACQI as a standard bench mark across all trusts and it had been agreed to recommend to national patient experience group members that they took a consistent approach in line with DH guidance. KW stated that further analysis was being carried out around the net promoter score to give a greater understanding of the reasons for people not recommending YAS. SP confirmed that some changes had been made to the Early Warning Indictors in the version of the IPR going to Board the following week. ABP asked why the Trust had concentrated on the South consortia data when considering the patient experience PTS survey reporting. KW replied that, although this was cross-PTS from April 2013, prior to this time it had only been in the South contract. SP stated that NHS 111 would be included in next version that went to the Board. The Chairman joined the meeting at 1010 hours.	

		Action
	PD asked if there was any value in reporting near misses now that Datix was up and running. SP replied that this information was included in the general incident report but he would give further consideration to whether the Trust would be able to distinguish more clearly between incidents for future reporting. **Action:** **SP to consider whether Datix system could be used to distinguish more clearly between incidents for future reporting.** PD asked when there was duality of issue between EOC and Operations in a patient-related incident, who took ownership of the incident. SP replied that ownership was based on the allocation of the lead investigator, adding that an incident would not be double counted. PD stated that the IPC audit sheet looked much improved, with more checks. SP stated that the new Head of Safety would be in post in July and one of this person's tasks would be an objective spot checking process to give extra assurance. PD stated it was disappointing that the new containers had not made the difference it had been hoped for in reducing the number of morphine vial breakages. JM stated that, as only four vials were being carried on each trip, he too would have expected to see a reduction in breakages. The YAS pharmacist had discussed the issue nationally. The number of breakages was very high compared with acute trusts but not compared with other ambulance services. It was agreed that JM should closely monitor the situation. **Action:** **JM to monitor number of morphine vial breakages and report any new concerns back to Quality Committee** PD noted that the number of serious incidents (SI) in EOC had increased again. It was agreed that BH would incorporate each new SI into the EOC plan for further consideration. **Action:** **BH to incorporate each new EOC SI into the EOC plan for further consideration.**	**SP** **JM** **BH**

		Action
	PD stated that, although complaints in general seemed to better managed compared to 2011/12, it was disappointing that complaints about attitude and conduct had increased. SP acknowledged that this would be a priority even though it was very hard to define the underlying causes. PD asked SOL whether it would be possible to incorporate customer care training in the training plan or the corporate induction. **Action:** **SOL to consider feasibility of incorporating customer care training in training plan or corporate induction** SP stated that some of the complaints might have related to misplaced frustrations about systems, etc brought about by the pressure people worked under which should definitely be covered during induction. PD stated that, with professionalism in mind, staff should be encouraged to let go of their frustrations when they were on meal breaks, etc rather than in front of patients. SP stated that the PTS rate had gone up again, adding his belief that the majority of complaints would relate to the time that patients had to wait for their return journeys. PD stated that the standard waiting time was around 2 hours with no access to a drink, a toilet, etc, so she could understand the frustrations that this caused. It was agreed that SP would consider the PTS complaints in more depth and report back at the September meeting. **Action:** **SP to look at the PTS complaints in more depth and report back to the Committee in September.** **Approval:** **The Quality Committee considered the exceptions in the IPR and was assured with regard to the management action planned and under way (Appendix 1 IPR sections 3 & 4).**	**SOL** **SP**
6.5	**SIGNIFICANT EVENTS/LESSONS LEARNED** SP presented information and assurance to the Quality Committee on specific events and lessons learned across the Trust. SP stated that incidents relating to 111 were now being reported and the 111 Governance Team had weekly meetings to review any themes and trends identified as a result of incidents.	

		Action
	He further stated that the information on page 34 highlighted a number of issues relating to patient experience. There had been a number of discussions in the Incident Review Group about complaints relating to delayed back up and response times which would be looked at in more detail. SP stated that work had been done internally on Rule 43 letters and proposed that Caroline Balfour should bring a report to the July meeting to give full assurance on the action being taken relating to Rule 43 letters. **Action:** **SP to invite Caroline Balfour to present a report on Rule 43 letters at July meeting.** The meeting moved on to consider individual Serious Incidents. PD suggested that clinical supervisors should also be used to reinforce the message in recommendation 1 in SI 2754. She added that this should be embedded in the wording of the recommendation. SM suggested that, as a formal monthly team briefing of all clinical supervisors was due to start that month, this might be another route to take action through. PD queried the use of the word 'restraint' in the second paragraph. It was agreed that SP should revise the wording of the SI 2013/2754 recommendations. **Action:** **SP to revise the wording of the recommended actions in SI 2013/2754.** In relation to SI 2013/2676, PD asked whether the Trust had a protocol for dealing with patients known to have osteoporosis. JM replied that although there was no specific protocol, osteoporosis was covered in the Trust's training for dealing with the elderly and spinal protection. PD requested an update on actions relating to the SIs at York on page 21. JM confirmed that the proposed meeting had taken place and York had agreed that they would change their practice. JM intended to attend the final meeting to ensure everything progressed to plan. PD asked what action was being taken to ensure the completion of the overdue action on page 28.	**SP** **SP**

		Action
	It was agreed that PBW should ask David Williams and Paul Mudd to urgently revisit this action with an update to come back to the next meeting. **Action:** **PBW to ask David Williams and Paul Mudd to revisit overdue action in SI 2012/16728 and report back to July meeting.** PD asked whether the 'read and sign' procedure mentioned in SI 2012/14464 had been replicated in York EOC. BH confirmed that it was in place in both EOCs, adding that the reviewed SOP had been signed off at CGG in March 2013. EB stated that she had a couple of concerns about complaints received following the use of taxi companies subcontracted to YAS and requested more details about the number of contracts, any that had been terminated, reputational effect, etc. It was agreed that SP and KW would provide this information at the September meeting. **Action:** **SP/KW to provide detailed information re taxi contracts at September meeting.** EB stated that as delayed back up and response was mentioned in a lot of narrative she believed that a more robust EOC action plan was needed. SP replied that this was more of a general resource rather than a pure EOC issue. It was agreed that IRG would be asked to focus on the problems in more detail and SP would report back in July. **Action:** **SP to report back on delayed back up and response times at July Quality meeting.** EB expressed concern about the HSE formal notification mentioned in 12.2. It was agreed that SP and EB would discuss the specific legal requirements for staff welfare out of the meeting. **Action:** **SP/EB to discuss legal requirements for staff welfare out of meeting.** **Approval:** **The Quality Committee noted the content and supported the actions detailed in the paper.**	**PBW** **SP/KW** **SP** **SP/EB**

		Action
6.6	**NHS 111 CLINICAL GOVERNANCE UPDATE** PD welcomed Michela Littlewood (ML), NHS 111 Head of Quality Assurance to the meeting. ML confirmed that the NHS 111 clinical governance was completely integrated into the YAS clinical governance, adding that the 111 team had learned a lot over the last nine weeks. She provided a summary of feedback received. Since going live there had been 197 service to service incidents and 269 internal incidents but only 2 serious incidents. ML further stated that a major challenge was the people who refused an ambulance. The Chairman asked if there was any comparable data in relation to NHS Direct. ML replied that there was no data currently available. SP stated that the Trust would not have access to any data unless it was contained in an annual report. ML stated that call volumes had got very high very quickly. 111 could be dialled from anywhere in Yorkshire even though not all of the GP out of hour's services had gone live to date. She added that there were huge variations across the patch in terms of service demand and a lot of learning for NHS England to capture. A case study had been sent out to all call handlers, which they were expected to read and sign. ML stated that a daily clinical review was undertaken by NHS 111 clinical leads with daily reporting in place to CCG clinical leads which had massive resource implications. There was also internal review via the Trust Incident Review Group for serious cases and SI reporting and management by the established YAS processes. She further stated that End to End reviews were the main challenge to the team. The commissioners led the process but they were currently asking the 111 team to facilitate them, which was labour intensive. ML added that the 111 team was also trying to implement process review improvements. She outlined lessons learned to date, which included: • Healthcare pathway concerns regarding the patient pathway for palliative care, district nurses and paramedics on the scene. • Delays in care associated with Out of Hours capacity. • Incorrect referrals which included staff errors and Directory of Services (DoS) issues, which were improving.	

		Action
	SP confirmed that although the 111 team reported back all of the gaps in the DoS it was not up to them to decide what was included. ML stated that the commissioners owned the DoS and it was up to them to commission the services in the DoS. PD suggested that many of the issues faced by 111 as a service were the result of problems elsewhere in the wider healthcare economy. Budgets for social care, respite care, etc were being cut and social care was not a 24/7 service unless it was an emergency. ML stated that the learning from the urgent care point of view could provide phenomenal opportunities for YAS and the 111 team was working with Angela Harris and Cath James to develop their knowledge further. She further stated that on-going challenges included: reporting all feedback to the CCGs; getting timely responses; resourcing issues; getting the best out of Datix; ensuring that lessons were learned; and attendance at local and regional Clinical Governance meetings. The Chairman advised ML that the 111 team should focus on delivery of their contract requirements in the first instance, as these are onerous. She further stated that, overall, good news was coming through. Gaps in information were being identified and reflected back to the commissioners in a challenging but appropriate way. SP noted that commissioner feedback was indicating that they were satisfied that YAS was delivering a safe service. ABP asked whether ML would be working with Elaine Gibson to counter the current negative press about 111 and to implement the CQUIN relating to patient awareness. ML replied that the 111 team would be trying to manage patient awareness and encouraging people to use 999 rather than 111 when appropriate. Feedback from patients stated that they needed more information about what was 'urgent', what was appropriate for a 999 calls, etc so a national leaflet drop was planned for later in the year. PD thanked ML for a very informative and useful presentation.	
7	**<u>ESSENTIAL STANDARDS OF QUALITY AND SAFETY</u>**	
7.1	**OVERVIEW OF TRUST COMPLIANCE – REPORT FROM CQC INSPECTION** KW presented the current position and proposed future work to maintain compliance with the external regulatory bodies of the Care Quality Commission (CQC) and the NHS Legislation Authority (NHSLA).	

		Action
	She stated that the element of the Quality Risk Profile (QRP) first rated as red in the CQC's October publication of the QRPs, which related to the number of staff vaccinated against influenza, had returned to a lower risk position. **Approval:** **The Quality Committee agreed and accepted the report as assurance that compliance to the external regulatory bodies was being maintained.**	
8	**<u>QUALITY GOVERNANCE</u>**	
8.1	**CIP QUALITY IMPACT ASSESSMENT (QIA) REVIEW** SP stated that purpose of the paper was to: • Assure the Quality Committee of progress made in completing the Quality Impact Assessment (QIA) of the Cost Improvement Plans (CIPs). • Provide an opportunity for the Quality Committee to review and agree the risks and mitigations identified through the QIA process. • Report on the development and use of early warning indicators relating to the safety and quality of services. SP stated that, although the overtime scheme had been flagged amber in the last report, there was no indication that this was having a damaging impact on quality. The whole of the PTS scheme had not been implemented. It was agreed that this would need to be monitored closely while deterioration in quality had been observed although quality had not yet improved. EB stated that the paper which went to F&IC brought out a number of issues relating to staff morale, etc which might help SP to reassess the KPIs that were not improving. PD asked whether the process was more robust in the current year, as the organisation needed to get the balance right between quality and financial impact. SM stated that, rather than waiting for the annual staff survey, a pulse survey was planned shortly. SP confirmed that the Board version of the IPR would see a change in Early Warning Indicators (EWIs) in the next iteration. **Approval:** **The Quality Committee noted and commented on the key issues highlighted through the QIA process and associated plans for mitigation and agreed the risks and mitigations identified through the Quality Impact Assessment process.**	

		Action
8.2	**2013/14 CQUIN SCHEMES** KW provided an update on the proposed CQUINs for 2013/14. The new CQUINS outlined in the paper ranged across all services. Each CQUIN had a lead manager who reported to the Trust-wide management group. PD stated that she would like to receive an update report at every other meeting with exception reporting as necessary at the remaining meetings and asked if there were any unrealistic baselines. PBW replied that red performance was challenging and would need to be closely monitored. KW stated that the non-conveyance target was to be approved and agreed in Quarter 2 so she would feed back at the next meeting. **Action:** **KW to feedback on non-conveyance target at the July meeting.** EB complemented KW on her report which had been clear and easy to read. SM commended KW on the work done to get the CQUINs agreed, adding that she had done an exceptional job. PD placed on record her congratulations to KW on her hard work. **Approval:** **The Quality Committee noted the proposed CQUIN schemes for 2013/14 and was assured by the project management arrangements to deliver the CQUINs.**	**KW**
8.3	**2012/13 DRAFT QUALITY ACCOUNTS** KW presented the draft Quality Accounts for approval and recommendation to the Trust Board for sign off. She stated that every NHS Trust and Foundation Trust was required to produce an annual Quality Account which provided information about the quality of the services delivered by that organisation. Changes had been made to the regulations for 2012/13 to include mandatory reporting against a small core set of quality indicators.The indicators were closely aligned with the NHS Outcomes Framework and based on data that trusts already reported on nationally. For ambulance trusts the mandatory indicators would be: ▪ Red ambulance response times; ▪ Care of STEMI patients; ▪ Care of stroke patients; ▪ Staff views on standards of care; ▪ Reported patient safety incidents.	

		Action
	KW stated that, as it was good practice to engage stakeholders in the process of developing the content of Quality Accounts, a consultation exercise had taken place. In addition, in line with the Quality Accounts regulations the Trust's draft Accounts had been sent to commissioners, Overview and Scrutiny Committees and Healthwatch for a 30 day consultation period. Next steps would include: • Inclusion of outstanding data in the draft; • Approved final draft would go to Corporate Communications for proof reading, layout and professional design; • An electronic version would be uploaded to the YAS and NHS Choices websites by the deadline of 30 June 2013. • Printed versions to be incorporated into Annual Report & Accounts; • A summary version would be produced once the full Quality Accounts were finalised. PD invited comments from those present. SP confirmed that the feedback received to date had been generally positive and once all outstanding data had been received the summary of statements on page 48 would be revised. ABP stated that, although the draft document read really well, from a lay perspective it could be a little jargonistic. She further stated that, although it was good to produce a summary, the Trust also needed to produce alternative formats such as an easy to read version and should talk to people who had learning disabilities themselves to further advance this suggestion. PD thanked ABP for her advice and agreed that the Trust should take it on board. The Chairman checked that the patient whose story was being used on page 12 had been given permission for it to be used. KW confirmed that this was the case. The Chairman asked whether action had been taken to ensure that the Quality Accounts were produced in a Foundation Trust suitable format. SP confirmed that the report complied with all the latest DH guidance and that the audit process had been conducted in line with FT requirements. KW stated that in addition to the usual Internal Audit review, this year External Audit had also been asked to review the document.	

		Action
	EB suggested that the priorities for improvement on page 9 should make reference to which projects were supported by CQUIN funding to show the commissioners how the Trust was using this funding. EB asked whether, knowing YAS's dependency on the roll out of the ePRS system, clinical audit could be better controlled. PD stated that she would like to see an example of a Listening Watch report on page 15 to show how the Trust was picking up feedback in terms of read across, culture and professionalism. SP stated that feedback from these visits fed into SMG as a regular agenda item and was captured in the minutes. A summary report could therefore be produced. PD replied that this would be useful and asked for an update to be provided at the next Quality meeting to give a better understanding. **Action:** **SP to provide an update on learning from Listening Watch feedback to SMG at next meeting.** **Approval:** **The Quality Committee approved the 2012/13 Quality Accounts subject to the final data being added and remaining commentary being received from stakeholders.**	**SP**
8.4	**REPORT OF THE MID-STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY – TRUST REVIEW & ACTION PLAN** SP presented a report which provided an assessment of the Trust's position in relation to the recommendations in the Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry. It also set out the actions arising for the Trust and the proposed management process. SP stated that all of the recommendations had been considered and those of immediate relevance had been identified. The recommendations had been overlaid onto the existing Quality Governance action plan so all actions were captured all in one place. The combined action plan would need further revisions in terms of any recommendations emerging from NHS England, CQC, etc. PD agreed with the approach being taken, adding that the Quality Committee needed regular assurance on the progress being made. She acknowledged that there was a huge amount of work to be done. The next step would be to divide the actions up in terms of what YAS was already doing, for example refusing night transfers, with an accompanying description of how the Trust met those recommendations and those that still needed urgent implementation. SP stated that once the action plan had been approved by the Board the document would need to go to the NHS TDA and could be used to underpin some elements of the quality review process.	

		Action
	PD asked what messages were being shared with staff. JM replied that the clinical supervisors were aware of the report's main recommendations. The Chairman stated that the Trust should put responsibility on its managers to ensure that the Francis report and its recommendations stayed at the forefront of people's minds. PD suggested that a detailed article in Ops Update might be useful. KW stated that she had been discussing the learning environment with SOL in order to get things on people's radar. ABP suggested various methods by which news about the Francis report and its recommendations could be shared. These were really useful so it was agreed that she should speak to KW outside the meeting to discuss them further. **Action:** **ABP/KW to speak outside the meeting about suggestions for information sharing re Francis report and recommendations.** PD suggested that the Francis recommendations implemented by YAS in advance of the publication of the report could be used for organisational purposes as examples of how YAS cares. SP requested comments on the draft action plan by the following day so that amendments could be incorporated and the document circulated to the Board for consideration at its meeting on 21 May. **Action:** **Comments on action plan to be returned to SP by 15 May** **Approval:** **The Committee noted the baseline position and supported the proposed action plan and management process.**	**ABP/KW** **All**
8.5	**SERVICE TRANSFORMATION PROGRAMME** KW provided an update on the Service Transformation Programme. She stated that there had been a series of workshops in partnership with Unipart to develop the Executive Level (level 0) Policy Deployment matrix (PDM). This had been a good exercise which had more clearly defined the programme of work with specific and measurable deliverables and results at a strategic level. Clear project plans for the year would be produced as a result of the PDM work. KW further stated that the Bright Ideas scheme had been launched and she had received some correspondence from members of staff on the back of this.	

		Action
	SP confirmed that shortlists had been drawn up for the Head of Service Transformation role and the two vacant project manager posts. In addition, subject to the capacity review, a dedicated room was being identified for the programme so that the plans could be left out so that they were visible to work on. He further stated that, in terms of reporting arrangements, more off line discussions were needed involving the NEDs to ensure that everything was as streamlined to prevent duplication of work. A risk register was being produced for the Programme as a whole and each of the individual project groups. This would form part of the project group meeting agenda and be reported back to the main Programme group meeting. EB stated that she liked the format and asked where CIPs would sit. SP replied that there would a slight overlap. Any CIPs that were transformational in nature would be managed through the relevant part of the STP but there would still be a separate CIP Group which considered all CIPs. KW stated it was intended that individual project groups would have a clear focus and take ownership of their individual CIPs but the CIP Management Group, which reported into SMG and TEG, would continue to oversee the overall CIP progress. **Approval:** **The Quality Committee noted and was assured by the progress to date and supported the next steps in the establishment of the Service Transformation Programme.**	
9	**<u>WORKFORCE</u>**	
9.1	**WORKFORCE UPDATE REPORT** SM provided an overview of matters relating to various workforce issues, including: education and training, equality and diversity and employee wellbeing. He stated that the industrial action around the cessation of the official recognition of Unite the Union on 2 April had not had any significant adverse effect and had not compromised patient safety. SM highlighted the work taking place with the army in relation to the Ministry of Defence (MOD) Student Paramedic development. It had been a positive opportunity for YAS and the approach had been highlighted to the other ambulance trusts at a national conference hosted by HM Army at Sandhurst on 2 May 2013. He stated that the Recruitment Services Team continued to manage an extremely high volume of job applications. There were currently 190 people in various stages of pre-employment checking.	

		Action
	The formal Occupational Health recruitment process had been completed and a paper was due to go to F&IC that afternoon. A second 'deep dive' meeting had been held by the Board Absence Turnaround Group with some marked progress evident. PD congratulated those involved on their success. SM stated that a second successful 'values based' recruitment assessment centre, which was relevant to the Francis discussions, had taken place, attended by the Chairman. The next assessment centre was due to take place on 18 May and Non-Executive Board Members were welcome to attend to review the new approach to recruitment. The Chairman congratulated the NEDs on their success in the Absence Turnaround Group. She stated that it was the responsibility of managers to drive things forward in the areas that were now achieving and she would only expect further NED involvement in the areas that were still not achieving. PD agreed that it had been a good exercise. **Approval:** **The Quality Committee formally reviewed, was assured by and scrutinised the Workforce Update Report for April 2013.**	
9.2	**ANNUAL TRAINING PLAN 2013/14** SOL provided an overview of the planned Education and Training activities of the Trust. Training needs across the service had been collated and were attached in Appendix 5. The demand for formal training and development had exceeded what was available so it had been decided to provide a two year plan to balance the competing needs for training whilst recognising the premium of staff release. Where demand had exceeded availability a quality impact assessment had also been completed. The focus in 12/13 was on delivery of the formal education and training in the Workforce Plan. SOL further stated that the training needs analysis form for Statutory & Mandatory (S&M) training had been revised and was attached PD stated that it was a good paper, which provided accurate and up to date information about Training and Education for the first time. The Committee needed to be assured it was an achievable plan. SM stated that PBW had given the commitment of his management team that they could cope with the extraction levels.	

		Action
	PBW also noted that the current rota review would also support greater release for training in future years. The Chairman asked how SOL and her team would engage with staff to ensure that they kept up with their development as it was her belief that the onus needed to be placed more on the individual than had been the case historically. SOL replied that all training requirements should be recorded in individuals' PDRs. PD asked why certain people kept managing to avoid doing their moving and handling training, as this was unacceptable. SM replied that the S&M training provision was specifically targeting individuals who were not accessing training. PD noted that she no longer wanted to see the first option in periods of peak demand to be to cancel training. PD stated that the key issue would be to ensure that all changes to the plan were risk assessed. SOL stated it was very helpful to have a Training & Development sub group to take changes forward during the course of the year. SP stated that SOL had done a really good job in drafting the plan. Although it might look on paper as if there was less training for staff than in previous years, it was realistic, achievable and risk assessed. PD thanked SOL for the efforts that had been put in to gathering the information and writing the report. **Approval:** **The Quality Committee reviewed and was assured by the content of the report.**	
9.3	**CLINICAL LEADERSHIP REVIEW & ACTION PLAN** PBW outlined the process undertaken to conduct the review of the Clinical Leadership Framework including the key findings and feedback from each Locality. He stated that the outcome of the work was to make short, medium and long term recommendations to address gaps in implementation against the principles outlined in the framework. PBW stated that prior to undertaking the review he had done a lot of background work and had met with clinical supervisors all over the patch. He had asked them to analyse what they were currently doing to enable him to develop a good understanding of the current picture. The findings had been cross-referenced with the Francis report, etc.	

		Action
	He further stated that the framework as a concept was valid but it had not yet had the opportunity to fully embed for a variety of reasons, one of these being that clinical supervisors had been filling the gap between support services and themselves. PBW stated that, in essence, there were 25 short, medium and long term measures. The ethos was to change the dynamic so clinical supervisors interacted with front line staff on a daily basis and to give them the empowerment and authority to do their job effectively. For example, by addressing staff development needs by stepping people down. EB stated that there was an inherent risk if too many people were stepped down at any one time. PBW replied that this was highly unlikely but any impact on delivery would be managed by ROC who would ask the relevant clinical supervisor to delay the request, as there were not enough resources. As a variety of concerns were expressed, PD suggested that PBW should undertake an audit and an impact assessment. **Action:** **PBW to undertake a baseline assessment, impact assessment and audit of the proposal for clinical supervisors to be able to stand down staff to address development issues.** PD requested an update on the current recruitment process. SM replied that recruitment had been under way for a while and there was no excuse for positions not being filled. It was agreed that PBW should chase up progress in relation to the recruitment process to enable an update to be presented in July. **Action:** **PBW to chase up progress re Clinical Supervisor recruitment process to enable an update report to be presented in July.** It was acknowledged that the majority of clinical supervisors had been used operationally in recent months rather than dedicating the majority of their time to their clinical supervisor role. KW stated her belief that the original role description needed to be reworded along the lines of “the clinical supervisor’s main role is…… and on occasions they will need to do …….” PD complemented PBW on a good piece of work. She stated that she would like to monitor the action plan through the Committee, as it was hugely important to get the implementation of the Clinical Leadership framework right. In addition, she expected to see significant progress in recruitment by the July meeting.	**PBW** **PBW**

		Action
	Action: **SP to include monitoring of Clinical Leadership framework action plan as agenda item for July meeting.** It was agreed that PBW should provide formal feedback on actions that were being taken to the staff he had spoken to when carrying out the review. In addition, more general feedback should be shared with all clinical supervisors. SM suggested that the Chief Executive could provide feedback during the Team Brief sessions the following Friday. **Actions:** **PBW to provide formal feedback on recommended actions to the clinical supervisors he originally spoke to.** **SM to ask Chief Executive to provide a general update as part of the forthcoming Team Briefing to clinical supervisors.** **Approval:** **The Quality Committee supported the recommendations and associated timescales outlined in the paper.**	**SP** **PBW** **SM**
9.4	**BOARD ABSENCE TURNAROUND GROUP – PROGRESS REPORT** SM provided the Quality Committee with a brief overview of progress achieved to date by the Board Absence Turnaround Group. As a detailed discussion had taken place earlier in the meeting the Committee noted the details of the report but there were no comments forthcoming. **Approval:** **The Quality Committee formally received and was assured by the progress being made by the Board Absence Turnaround Group.**	
	RISK MANAGEMENT	
10.1	**RISK MANAGEMENT UPDATE REPORT** SP provided an update on emerging issues and risks to provide assurance that risk was being managed effectively. He stated that the report focussed on the risk registers in existence across the Trust below the level of the Corporate risk register. The Management Group/Committees' risk registers were working well and the Directorate risk registers were working reasonably well. However, the department level risk registers were variable. It was agreed that the locality presentations scheduled for during the year could capture some issues as locality directors should be asked to identify risks and explain how well the risk registers were working.	

		Action
	It was acknowledged that the Quality Committee would also need to be aware of the risks and potential risks that were outlined at the end of Board papers. **Action:** **SP to inform locality directors that a review and explanation of their departmental risk registers would be expected to be included as part of their presentations to Quality Committee.** SP stated that a review was currently underway which would look at all levels of risk registers and the possibility of building them into Datix which should make them easier to access and read across. **Approval:** **The Quality Committee noted the current position and was assured in regard to the effective management of risks.**	**SP**
11	**RESEARCH GOVERNANCE** There were no reports to consider.	
12	**ANY OTHER BUSINESS**	
12.1	**ANY OTHER BUSINESS** There was no other business.	
12.2	**ISSUES FOR REPORTING TO BOARD & AUDIT COMMITTEE** SP would continue to summarise the key issues for Board reporting for consideration by PD.	
12.3	**REVIEW OF COMMITTEE WORK PLAN** SP stated that PD and he had reviewed the Committee workplan. There had been no additions but comments and suggestions were always welcome for integration into the plan.	
12.4	**REVIEW OF MEETING ACTIONS AND QUALITY REVIEW OF PAPERS** PD stated that for reports to be fully compliant the new front sheet should be used and completed in full. Any reports accompanied by an incomplete cover sheet would in future be returned to the author. She further stated that, although there had been a lot of reading to do to prepare for the meeting, the papers were of a good standard. The Committee agreed that the additional time for the NHS 111 presentation had been needed and the update had been very useful. The 0830 presentation had been very informative and Committee members looked forward to future pre-meeting presentations. PD thanked everyone, especially ABP, for their input.	

		Action
	It was PBW's last Quality meeting and PD thanked him for his input over the past 12 months, complimenting him on the output of the Clinical Leadership review, his last major piece of work. PBW thanked PD for her comments. The meeting closed at 1250 hours.	
13	**DATE AND LOCATION OF NEXT MEETING** Tuesday, 9 July 2013, 0900 hours, Boardroom, Springhill 2 with a pre-meeting presentation at 0830 hours.	