Yorkshire Ambulance Service NHS
NHS Trust

Quality Committee Meeting Minutes

Venue: Boardroom, Springhill 2
Date: Tuesday, 9 July 2013
Time: 0900 hours

Chairman: **Pat Drake**

Attendees:

Pat Drake	(PD)	Deputy Chairman/Non-Executive Director
Dr Elaine Bond	(EB)	Non-Executive Director
Erfana Mahmood	(EM)	Non-Executive Director
Steve Page	(SP)	Executive Director of Standards & Compliance
Dr Julian Mark	(JM)	Executive Medical Director
David Williams	(DW)	Acting Executive Director of Operations

In Attendance:

Barrie Senior	(BS)	Non-Executive Director (Observer)
Andrea Broadway-Parkinson	(ABP)	YAS Expert Patient
Dr Dave Macklin	(DM)	Associate Medical Director
Karen Warner	(KW)	Associate Director of Quality
Ben Holdaway	(BH)	Locality Director – EOC
Shelagh O'Leary	(SOL)	Associate Director of Organisational Effectiveness & Education
Graeme Jackson	(GJ)	Associate Director of Human Resources
Claire Ashby	(CA)	Head of Safety
Mark Millins	(MM)	Lead Paramedic for Clinical Development
Caroline Balfour	(CB)	Head of Legal Services
Fiona Hibbitts	(FH)	Delivery & Development Manager, NHS TDA (Observer)
Graham Prestwich	(GP)	Lay Member for PPI, NHS North Leeds CCG (Observer)

Apologies:

Nick Cook	(NC)	Interim Executive Director of Workforce & Strategy
Mark Hall	(MH)	Associate Director Risk & Safety

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. 'Urgent Care Developments' was presented by Angela Harris, Lead Nurse Urgent Care and Dr Philip Foster, Clinical Director NHS 111 & Urgent Care 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. As representatives of the NHS TDA were observing the meeting, introductions were made round the table. PD stated that Graham Prestwich (GP), lay member P&PI, NHS North Leeds CCG had been invited to the meeting to enable him to see how the YAS Quality Committee worked.	
2	**REVIEW OF MEMBERS' INTERESTS** Declarations of interest would be noted and considered during the course of the meeting.	
3	**CHAIRMAN'S INTRODUCTION** PD placed on record her thanks to Dr Phillip Foster and Angela Harris for their excellent Urgent Care presentation. She stated that there had been an unannounced CQC visit the previous week. The inspection had been very thorough and SP would provide further details later in the meeting. PD reported that she had attended a stakeholder engagement event on 27 June and had been impressed by the significant number of individuals who attended the event as a part of community groups. PD further stated that she had been concerned that 1½ hours for questions might have been too long but it was actually not long enough. The Healthwatch representatives had found the event very helpful and it was hoped it would be the first of many such events. ABP stated her belief that it had been a positive and worthwhile day and a true step forward in engagement. She had, however, a number of observations for improvement for future events and had shared these with the organising team. SP stated that the workshops and presentations had been well-received. The Q&A session had been very lively with a wide variety of thought provoking questions.	
4	**MINUTES OF THE MEETING HELD ON 14 MAY 2013** The minutes of the meeting held on 14 May 2013 were approved as a true and fair representation of the meeting subject to the following amendments. **Matters Arising:** Page 13, paragraph 7 – "and to implement the CQUIN relating to patient awareness" to be added at the end of the sentence. Page 17, paragraph 2 – current sentence to be replaced with: "EB asked whether knowing YAS's dependency on the roll out of the ePRF system, clinical audit could be better controlled."	

		Action
5	**ACTION LOG** The meeting worked through the Action Log, which was updated accordingly. Closed items were highlighted in green. **093/2013 - Review of Key Quality Indicators (IPR) / Action** Meeting scheduled to pick up issue. Action closed. **096/2013 / 098/2013 / 114/2013** Estimated closure date not yet reached. Actions remain open. **115/2013 – Action Log** BH and JM had discussed the matter and a meeting with BigWord had been set up to compare like for like re quality and cost. A further report would follow this meeting. Action remains open. **118/2013 - Clinical Audit Plan** Although JM and SOL had reviewed the process there was still some work to be done as information was being captured in different ways. Self-funding students were agreeing to share information if using Trust data. An update to follow in September. Action remains open. **120/2013 - Review of Key Quality Indicators (IPR) / Action** SP confirmed that the Trust should be able to use the new Datix system to highlight incidents and near misses and options were being explored. New Head of Safety would look at this in more depth and changes should be on stream by September. Action remains open. **122/2013 - Review of Key Quality Indicators (IPR) / Action** Presentation at that day's meeting. Action closed. **123/2013 - Review of Key Quality Indicators (IPR) / Action** SOL confirmed that the whole induction process was being revised and she would ensure that customer experience was integrated throughout. Action closed. **124/2013 - Review of Key Quality Indicators (IPR) / Action** Estimated closure date not yet reached. Action remains open. **127/2013 – Significant Events / Lessons Learned** New simplified back up procedure is written but still has to go through Clinical Governance Group for sign off with further update report to come back to September Quality meeting. Estimated closure date extended to September. Action remains open. **128/2013 - Significant Events / Lessons Learned** Estimated closure date not yet reached. Action remains open. **129/2013 - Significant Events / Lessons Learned** See action 127/2013 above - estimated closure date extended to September.	

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	131/2013 - 2013/14 CQUIN Schemes KW confirmed that work was on-going with the CQUIN target due to be set in Q2. Action closed. **132/2013 - 2012/13 Draft Quality Accounts** SP confirmed this was a standing SMG agenda item with learning from each visit detailed in the minutes. Themes would be fed back to managers, staff and Quality Committee on a quarterly basis to allow for a full audit trail. Action closed. **133/2013 - Report of the Mid-Staffordshire NHS FT Public Inquiry - Trust Review & Action Plan** ABP confirmed that KW and she had discussed the item outside the meeting and she had submitted a paper to KW. Action closed. **135/2013 - Clinical Leadership Review and Action Plan** Estimated closure date not yet reached. Action remains open.	
6	**CLINICAL QUALITY PRIORITIES**	
6.1	**MID STAFFORDSHIRE PUBLIC INQUIRY – REVIEW OF RECOMMENDATIONS AND ACTION PLAN** SP stated that, following initial review of the Francis Report, a number of issues where immediate action could be taken had been identified. There were other areas that were likely to have relevance to YAS as an organisation but national body input would be required before any actions could be implemented. The Quality Governance Action Plan incorporated the immediate actions. Key areas included: Board leadership; organisational culture; openness and candour; standards of care; and staff feedback and learning. SP further stated that the email he had received from ABP had been very helpful and would help to develop the action plan further. He confirmed that the action plan, which had been submitted to the NHS TDA, was now in delivery and monitoring mode and had been shared with members of SMG. SP outlined progress against the Action Plan to date, adding that, as the Trust implemented new initiatives, it wanted to consult staff more regularly than the current annual survey. SP confirmed that the CEO was holding regular face-to-face meetings with the clinical supervisors which included presentation of the monthly team brief. He added that the Francis Report's recommendations had been heavily shared during those meetings. JM confirmed that, going forward, he would also be attending the monthly meetings which provided a great opportunity to gather feedback on day-to-day business in addition to the Francis Report recommendations.	

		Action
	BH stated that the meetings were also linking to the EOC management team to ensure that joint messages were received. EB noted that 16 actions were due for completion during July and asked whether the Committee could gain assurance that they were on track and could be delivered. JM replied that many of the actions were not distinct but were interlinked as they related to embedding culture, feedback, etc. PD stated she would like to see outputs against the blue, completed actions. For example, had any 'bright ideas' been received. SP replied that this would be a standing item at each meeting of Transformation Programme Management Group (TPMG) where there would be a full review of each bright idea and action agreed. KW confirmed that 23 'bright ideas' had been received to date. **Approval:** **The Quality Committee noted the progress, issues and risks as outlined in the paper and were assured that the delivery of the Quality Governance Action Plan was being monitored.**	
6.2	**CLINICAL GOVERNANCE AND QUALITY OVERVIEW REPORT** JM stated that the Clinical Quality Strategy, launched in May 2012, was a 'living' document which looked to 2015 and beyond. The strategy had been reviewed to ensure it was fully aligned to the Service Transformation Programme and highlighted the focus on creating and maintaining an effective values based culture which fostered safe harm free quality care with professional behaviours in all staff. It also re-focussed on effective clinical leadership and supervision, staff engagement and communication as key priorities for the coming year. As the strategy had considerable overlap with the Quality Governance action plan it was therefore proposed that the Clinical Quality Strategy implementation plan was incorporated into this action plan to provide a single comprehensive action plan. JM outlined progress against the Strategy's priorities. He stated that, as discussed earlier, the Enhanced Care Team (ECT) had not been commissioned and Yorkshire Air Ambulance had confirmed that they were not currently able to fund the entire pilot. However, the Ministry of Defence were keen to get back in the field and saw this as a possible opportunity with DM leading the discussions.	

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	EB requested additional information in relation to item 4.3. It was agreed that JM would discuss this with EB outside the meeting. **Action** **JM to provide EB with additional information re item 4.3 outside meeting.** PD asked what work had been done to mitigate reputational loss with the acute trusts. JM replied that the doctors had all received letters of apology and had been remarkably understanding. However, acute trusts were less likely to be as willing to release clinicians in the future so there could be problems going forward It was agreed that, as a formal response had not been received from the specialist commissioning unit, JM should follow this up again. **Action:** **JM to chase specialist commissioning unit for formal feedback on their decision to withdraw the funding for the ECT.** KW confirmed that the Quality Account had been completed for 2012/13 and had been published on 30 June 2013. SP stated that he would share the safeguarding peer review exercise report with Quality Committee colleagues on receipt. Positive feedback had been received on the day and it had been a constructive exercise and model for peer reviewing other areas of ambulance services. EB stated that 4.5 seemed to be light in terms of what was happening in the area of patient experience, adding that NED involvement in the Healthwatch event was also not mentioned. KW replied that this had been a timing issue. SP stated that the September meeting was due to receive a mid-year patient experience report, adding that there was due to be a patient experience presentation before the July Public Board Meeting. ABP stated that she was always pushing for engagement and hoped that she was not seen as too critical at times. PD replied that ABP's efforts as a critical friend were greatly appreciated by the Trust. SP stated that ABP and he were due to meet later that week and he would present the outcomes at the September meeting	**JM** **JM**

		Action
	Action: **SP to present outcomes of meeting with ABP re patient experience, etc at the September meeting.** EB asked whether the review of key risks in the report duplicated the information on paper 10.1. SP replied that the report tried to draw out specific risks in each area of business whereas Paper 10.1 was more about generic risk management and processes. **Approval:** **The Quality Committee approved the changes to the Clinical Quality Strategy, and was assured that the delivery of the strategy was being monitored and was currently in line with agreed milestones.**	**SP**
6.3	**REVIEW OF CLINICAL QUALITY STRATEGY - PRESENTATION** JM and KW presented an update on the Trust's Clinical Quality Strategy. JM stated that by 2018 integrated provision across emergency and urgent care would mean that more patients could be treated at home which would lead to improved patient satisfaction. It was hoped that YAS would become a key provider in urgent care solutions reaping the benefits of 111 DoS, ECS and alternative pathways. Reducing the amount of emergency need and moving patients into planned care would mean that more patients were treated in the right place. KW stated that the clinical quality strategy, which set out the key priorities for 2013-15, would help YAS to reach its objectives. The strategy was a key part of the Integrated Business Plan which set out key clinical quality priorities and focused on evidence based practice, national priorities and the most important issues for the people who use YAS' services. She further stated that becoming an FT would be a catalyst for YAS' service transformation journey. The organisation would be stronger after going through the rigorous authorisation process with resilient performance and quality embedded throughout all its processes and procedures. The Trust would also be financially stable with enhanced governance arrangements and access to all its communities through membership and its volunteers. JM stated that the key message was to get things right for every patient every time. Key priorities were therefore: ▪ Reduction in major trauma mortality; ▪ 50% improvement in cardiac arrest survival;	

		Action
	▪ Improved clinical decision making; ▪ Improved Safeguarding of children and vulnerable adults; ▪ Continuous improvement in AQIs; ▪ Using feedback from patients; ▪ Increased partnership working; ▪ Delivery of PTS and A&E CQUINs. JM stated that there were opportunities within urgent care, by using feedback from patients, to develop partnerships and work collaboratively with other people to improve patient-centred professionalism and ensure high quality care without increasing cost. He further stated that the underlying principles were: ▪ Focus on improvement in quality of care; ▪ Embedding patient-centred professionalism; ▪ Deliver high quality care without increasing costs; ▪ Recruit and train the best people we can; ▪ Develop clinical leadership to deliver excellent care; ▪ Measure, manage, report and improve. JM outlined YAS' response to the Francis Report which was listed under the headings of: ▪ Culture and Values; ▪ Patient-centred Professionalism; ▪ Measurement; ▪ Improvement; ▪ Openness; ▪ Skilled and Capable Workforce. Patient-centred professional practice was important as the Trust needed to understand every patient and their problems and unique issues. It would be a big challenge to move across to this type of care and would involve developing and supporting people to have the confidence and ability to make their own decisions. JM stated that the Trust had worked hard to improve the quality of care for patients and 2012/13 achievements included: ▪ Improved patient experience; ▪ Improvements in quality of care for patients in rural settings; ▪ Improvements in training in Dementia Care; ▪ Development of the 'safety thermometer'; ▪ Enhanced public awareness; ▪ Reducing long waits in PTS. KW stated that YAS would continue to listen to its patients and staff with a series of pulse surveys. Next steps would include a focus on safety, which must always come first; compassion; learning; and the Francis Report and its recommendations. ABP thanked JM and KW for their excellent report and asked when the pulse surveys were due to start.	

		Action
	KW replied that it should be within the next quarter, adding that there would also be a series of focus groups over summer period. She further stated that the question time format of the Francis Report section at the recent management conference had been recorded and the film would be edited and shown at the start of the focus groups to set the scene. JM stated that the organisation needed to understand its markers of success, as patients would sign post themselves to a more appropriate place if they were unhappy with the service on offer. He further stated that end of life care was currently disjointed and needed to be a better co-ordinated patient-centred experience. EM stated that she was happy to see paramedics' professionalism as a development principle for the first time and would like to see it pulled together into a cohesive strategy going forward. JM agreed with EM that this would be vitally important going forward. PD stated it was important that YAS, not only ensured that its paramedics had the confidence and competence required to drive the profession forward, but also understood why this was needed. She thanked JM and KW for an excellent presentation. **Approval:** **The Quality Committee was assured by the review and further development of the Trust's Clinical Quality Strategy.** DWi and CB entered the meeting at 1025 hours.	
6.4	**REVIEW OF KEY QUALITY INDICATORS (IPR) / ACTION** SP invited comments from Committee members on the May 2013 IPR, sections 3 and 4. SP stated that there had been a fairly high level of complaints about the new NHS 111 service in April, as would be expected for a brand new service. In May this dropped to within the Trust's range for other service lines. The service was now fully live for all out of hours' (OOH) providers. 92.6% of calls were answered in 60 seconds in May and had improved further in June, which was a good indicator that the call centre was working well. SP confirmed that the Trust was happy with its progress to date. It was the biggest single contract nationally and holding up well on patient safety and the main KPIs. The 111 team was now working on a service optimisation programme and holding extensive discussions with the commissioners in relation to wider system problems.	

		Action
	However, in spite of its good progress to date, there was still quite a lot of work to be done to get the maximum benefits out of the service. PD stated that patient safety continued to be paramount and asked whether the drop in patient related incidents in 3.5 was a seasonal adjustment. SP replied that, in relation to NHS 111, there had been a high number of incidents at the 'go live' point so it was expected that this number would drop. In relation to A&E incidents, he suspected that this was due to seasonal adjustment. EB noted that the number of breakages in 3.6, 'morphine related incidents' remained high. JM replied that changes had been made to the holders used and the way in which paramedics carried morphine, with only two vials now being allowed on a vehicle at any one time. This had already made a difference and he was happy that the breakages were true accidental breakages. EB stated that 3.18, 'PTS Patient Experience', looked out of date in terms of collation of data. It was agreed that KW would follow this up. **Action:** **KW to follow up information in 3.18 and report back to EB.** EB asked whether there was a plan for 111 in relation to 4.3, PDR's performance going forward. SP acknowledged the current low level of completion but stated that work was on-going. There had been good engagement of staff to date which now needed to be formalised into individual PDRs, etc. DM stated that the drop in sessions which had taken place as part of the service optimisation programme had been well attended and would be a valuable starting point. SP stated that CQC had reported back positively on 111 staff engagement the previous week. EB stated that absence by directorate had dropped to under 5% which was really good. She noted that Finance was currently an outlier but that it should be able to get back on track. PD stated that the numbers had reduced mainly through the management of long term illness and various individuals, but the sustainability of the new lower levels remained to be seen. She further stated her belief that there should need to be no more than two further deep dive meetings with NED engagement before the sickness management became part of business as usual.	**KW**

		Action
	DWi stated that sickness management was a constant pressure and although the managers were working hard to maintain the lower sickness levels, it was not easy with seasonable variations, etc. PD stated her belief that there should also be better support from Occupational Health to support staff going forward with the introduction of the new OH provider. PD stated that in 3.10, 'Safeguarding', the increased number of child referrals was good news as was the fact that response time to complaints was improving. She congratulated those involved. She stated that 3.17, the 'family and friends' test, was a significant unknown area. SP confirmed that work was in progress to enable a greater understanding of the scores, as there was not currently a consistent approach in the ambulance sector. PD stated that showing sickness absence in terms of cost and days was more meaningful and congratulated GJ on the revised format. **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 May 2013 sections 3 & 4).**	
6.5	**IMPLEMENTATION OF JRCALC GUIDELINES** JM stated that overall there were no monumental changes in the new 2013 JRCALC guidelines, as they contained mainly updates and minor variations. A gap analysis had been carried out to identify the differences between current Trust practice and the new guidelines. The implementation date for the 2013 guidelines was 1 July and the clinical directorate and the education department had been working closely on a strategy to roll out the new information to clinical staff. JM stated that MM had run a series of road shows throughout the region which had been well attended and well received. The Trust was keen to learn from lessons in the past. Staff queries would now go to a dedicated email facility which would ensure one consistent answer from the clinical directorate which would be posted on the FAQ page on YAS 24/7 so all staff within the Trust would have access to it. As a key aspect of the information roll out was consistency the gap analysis documents would be posted on YAS 24/7 and to form the basis of any training session. EB asked how the Trust would assess staff understanding following roll out of the new guidelines. JM replied that it was part of the clinical leadership function.	

		Action
	DM stated that the Trust would face a challenge to ensure that the clinical supervisors' level of knowledge was at an appropriate level so that they could ensure that their team members' knowledge was up-to-date, adding that there was still work to be done in this area. JM stated that new drugs use was also being audited. PD asked JM to provide an update report at the November meeting to enable the Quality Committee to gain assurance that the roll out process had been successful. **Action:** **JM to present JRCALC implementation update at November Quality Committee meeting.** JM placed on record his appreciation of MM's work on the JRCALC implementation at a national level as well as for YAS. PD echoed the thanks, adding that it was good to hear about areas in which YAS was taking a lead. **Approval:** **The Quality Committee approved the actions taken so far and agreed the JRCALC implementation plan.**	**JM**
6.6	**SIGNIFICANT EVENTS/LESSONS LEARNED** SP presented information and assurance to the Quality Committee on specific events and lessons learned across the Trust. He outlined the sources of significant events and lessons learned within the scope of the report and amendments to its format. Section 3.1 on page three of the report contained information about new Serious Incidents (SIs) reported to the commissioners between 1 May and 21 June 2013 and section 3.2 contained an update on previously reported SIs. SP stated that there had been a number of instances of falls whilst in care over the past 2-3 months. As a result, DWi had pulled together a safety alert which had been issued to all areas. There would also be additional engagement with the clinical supervisors in supporting the process, an equipment review and a review of the content of patient moving and handling training. SP stated that section 4 of the report contained a new format for presenting incident data. PD stated that this was much improved. He explained the background to the HSE notification received in May 2013, details of which were contained in section 12 of the report and following which YAS had been issued with a notice of contravention.	

		Action
	He stated that this was the first HSE notice received by the Trust for a long time. However, the necessary actions were in train and he was confident that the matter could be quickly closed. JM stated that a major challenge was the regional and local variations from one acute trust to another and PD stated her belief that the matter needed to be referred to NHS England. EM was concerned that the delayed response text on page 7 of the report seemed to suggest that, due to the movement of staff rotas, the Trust did not have enough resources to deal with the call and this was not the first time that this had happened. She asked when the last rota review had taken place. DWi replied that it had been 2 years ago and although rota reviews should not take place every two years, the last one had not worked as effectively as was anticipated. EM asked whether the rota would be Quality Impact Assessed. DWi confirmed that it had been and the evidence supported the changes. SP stated that the whole piece of work and the analysis underpinning it had been done differently this time around. EB stated that there seemed to be a long time between the date of the incident and when it was reported for the first two new SIs. SP replied that the delays were exceptional, caused by discussions with commissioners in relation to whether and where in the system incidents should be reported, who picks up whole system issues, etc. PD asked if there was a delay in the future that an exception note should be added at the bottom of the form. **Action:** **SP to ensure exception note added to the form if SI reporting delayed beyond 24 hours going forward.** EB asked whether the Trust had a split in its reporting system to show whether errors in data were DoS or call handler errors. DM confirmed that this was the case with SP adding that call handler issues were picked up in real time. ABP asked whether the Trust ever carried out a cost benefit analysis of how policies were implemented and their impact on patient experience as the need to maximise capacity on PTS vehicles did not always leave room for escorts, etc. PD suggested that SP should look into the feasibility of doing this.	**SP**

		Action
	Action: **SP to look into the feasibility of carrying out cost benefit analysis of the impact of policies on patient experience, etc.** ABP asked whether any work was being planned on the implementation of CCTV in PTS vehicles. SP stated that the use of CCTV, which could be activated by a member of staff in the cab if they encountered violence or aggression, was a complex area. Whilst the Committee members appreciated the benefits of being able to use CCTV it was agreed that it was not an appropriate time to discuss the matter in greater depth. In summary, PD stated that, although she liked the more succinct report, the new graphs, etc she would like to see more information. She was concerned about staff violence increasing and would like to receive more information about this issue at the September meeting. **Action:** **SP to provide further information about the increase in staff violence at the September Quality meeting.** **Approval:** **The Quality Committee noted the content and supported the actions detailed in the paper.**	**SP** **SP**
6.7	**CLAIMS AND INQUESTS REPORT** PD welcomed Caroline Balfour (CB), Head of Legal Services, to the meeting to update the Quality Committee on the year end 2012/13 position on claims and inquests and their future management. CB stated that there recently had been a visible increase in claims, the majority of which were employer's liability claims. The Legal Services team was working closely with the Operations Management Group (OMG) to try to minimise the number of claims. SP confirmed that the new carry chairs were now in use and the new equipment bags had now been ordered. DM stated that the first delivery was due to arrive early autumn, adding that he would provide Quality Committee with an update on the roll out at its meeting in January 2014. EM stated that claims management from a legal point of view was crucial to her and asked whether the quality of witness statements and the general management of the process had improved, as she understood the pressures that CB and her team were under.	

		Action
	CB replied that the information had to be managed on an individual basis, as evidence of investigations, etc was frequently still lacking. DWi confirmed that OMG had drilled further down into the issue and it had been agreed that this would become a standing agenda item. **Action:** **DWi to include claims management as OMG meetings standing agenda item** EM stressed that the quality of evidence was key. The legal team should not have to look into things piece meal and she would like to see an action plan relating to system improvements as she personally needed more assurance. It was agreed that EM would discuss the matter with DWi outside the meeting with a report to come back to the next meeting. **Actions:** **EM to discuss the management of claims with DWi outside of meeting with update report to come to September meeting.** DM stated his belief that individual members of staff needed to fully understand their responsibilities from an operational management perspective. For example, did everyone understand how to prepare a witness statement? JM stated that the ability to prepare a witness statement came down to personal development and experience and was not just taught. EB acknowledged JM's statement but added that provision of good and bad examples would help in the interim period. SP confirmed that some generic investigation skills and report writing training was shortly due to go live. PD stated that the Committee would need a further update report at its January meeting and the information would need to be shared with both the Audit Committee and the Board in the Quality report. **Action:** **CB to provide a further update at January 2014 meeting.** **SP to share CB's update report with Audit Committee and include details of the report in the Quality Committee update to the Trust Board.** CB stated that the review of Rule 43 letters issued to ambulance services across the country was published every 6 months. She had attached details of the latest review at Appendix C and confirmed that YAS was leading at NASMeD on a national framework for Coroners in areas where there was disparity across trusts.	**DWi** **EM** **CB** **SP**

		Action
	PD stated that this was positive news. **Approval:** **The Quality Committee noted the contents of the report, were assured that claims and inquests were effectively managed, and recognised the future risks.** PD thanked CB for an informative and useful presentation.	
7	**ESSENTIAL STANDARDS OF QUALITY AND SAFETY**	
7.1	**OVERVIEW OF TRUST COMPLIANCE AND REPORT ON INSPECTIONS FOR IMPROVEMENT** SP provided an update on the findings to date of the previous week's unannounced inspection visit from CQC. The three-day inspection had involved a team of inspectors, with specialist support from an expert patient and pharmacist. They visited a number of stations, training facilities, A&E Departments across the region, and the EOC and NHS 111 call centres at Wakefield. The inspection had involved extensive conversations with patients, carers, staff and managers, observations of practice and review of supporting documentation. SP noted that the initial feedback was provisional pending completion of the inspectors' internal review process and publication of the written report and shared some of the initial feedback in relation to the six outcomes which formed the focus of the visit: **Outcome 1 – Respecting and involving people who use services** • Positive feedback from talking to patients, YAS staff, other NHS staff and observation of practice. Excellent, caring approach to patients and Trust well engaged with service user representatives. • Some negative comments relating to waiting times for return PTS journeys and vehicle comfort. **Outcome 4 – Care and welfare of people who use services** • Inspectors found evidence that care delivered was good and staff appeared knowledgeable and informed, clear about their roles and how to access support if necessary. • The ECA role appeared well planned and implemented. • Processes for reporting of incidents appeared clear. **Outcome 7 – safeguarding people who use services from abuse** • Very good policies and procedures in place and staff aware of how and when to use them. • Positive feedback about the specialist safeguarding team and Trust developments and communication with other agencies and wider networks.	

		Action
	Outcome 9 – Management of medicines • Positive feedback on Trust policies and procedures for CD and other medicines management. • They recorded a number of observations from stations about variation in practice for checking and auditing of drug stocks. • Further information was requested and the standard would be subject to further review by the CQC pharmacist. • Low level of non-compliance might be forthcoming. **Outcome 14 – Supporting workers** • Staff feedback from EOC and 111 call centres was very positive, training was good and staff felt supported. • Feedback from road staff was more mixed, with issues about consistency of clinical supervision and quality of the PDR process highlighted by some staff. • Good evidence in relation to training and development • Some perceptions that feedback from corporate departments could be improved. • Positive feedback from staff of other NHS Trusts. • Overall positive although further information to be provided to CQC on progress in embedding the Clinical Supervisor supervision and PDRs. Outcome of standard as yet unknown. **Outcome 16 – Assessing and monitoring the quality of service provision** • Positive feedback on the evidence provided in support of this outcome. • Good evidence of auditing and monitoring. • Query about frequency of staff survey and the plan for development of monthly staff 'pulse survey' was discussed In summary, overall feedback was fairly positive although there were some issues around the management of medicine and supporting workers about which more information was being provided. PD stated that the Trust remained cautiously optimistic and a report would go forward to both the Trust Board and the Audit Committee. **Approval:** **The Quality Committee agreed and accepted the provisional report as assurance that compliance to the external regulatory bodies was being maintained.**	
7.2	**LOCALITY ASSURANCE REPORT – EOC – INCLUDING SERIOUS INCIDENT REVIEW** BH presented the locality assurance report for EOC which included a Serious Incident review. He stated that the drivers for change in the on-going management review, restructure and rota review included: continual performance improvement; improving culture and quality within EOC; and increasing efficiency and productivity as the current model had been expensive.	

		Action
	BH outlined achievements to date, which included: • Restructure of Management Team had been completed; • Rota Review was complete and live; • Team Working was complete and live; • Reinvestment in front line EOC staff was partially complete; • CIP delivery over 5 years. Year 1 was delivered and everything was on track for year 2. BH stated that a skills gap analysis had been carried out in the Clinical Hub with a training plan to follow and confirmed that the 1555 incidents closed in July by the Clinical Hub were the highest ever amount. He stated that there had been 3 Serious Incidents (SIs) in January 2013, 2 in February, 2 in March and zero between April and June. Lessons had been learned from the SIs earlier in the year and actions implemented. There were currently 4 amber and 2 red risks on the EOC risk register with Treatment Plans (RTPs) in place for all of the risks. In addition, the EOC risk register was reviewed quarterly at the EOC management and the Risk and Assurance Group (RAG) meetings. In relation to CQC Standards, PDR completion currently stood at 70% in comparison with a rate of 78.36% Trust wide. BH stated that in comparison with the Trust sickness target of 5%, EOC's levels were: March, 7.22%; April, 6.6%; May 5.7%; and June, 5.7% (short term 4.82% and long term 0.96%). In conclusion, BH reported that the Trust had been awarded the Accredited Centre of Excellence (ACE) status from the International Academies of Emergency Dispatch (IEAD) for its emergency call handling and dispatch and was just one of 174 emergency services currently accredited. As both of the YAS EOCs in Wakefield and York had been accredited the Trust had actually achieved multi-site centre of excellence status. PD thanked BH for a comprehensive report and noted the positive progress and developments since the last report.	
8	**<u>QUALITY GOVERNANCE</u>**	
8.1	**QUALITY GOVERNANCE UPDATE REPORT** KW presented an update on developments, issues and risks in relation to quality governance and progress against the plan. She confirmed that following the final external assessment of the Trust's quality governance arrangements in relation to the framework set out by Monitor, Deloitte had given the Trust a compliant score of 3.0 which was an enabler to progress to the Monitor phase of the Foundation Trust application process.	

		Action
	The Quality Visit was due to take place on 6 August 2013 and it was anticipated that the desktop Quality Challenge exercise would be in the weeks following this visit. KW confirmed that the project management of CQUINs continued to be through a single management group. In A&E all milestones for delivery were on track with the exception of CQUIN 6 (improvement in combined Red performance in four underperforming CCGs). An action plan had been developed and discussions were taking place to progress the modelling work. The 13/14 CQUINs for PTS were separately negotiated with each commissioning consortia and reflected local area priorities. The South and North CQUINs were still not signed off although work was progressing to achieve the milestones. Risks therefore remained relating to the delivery of some elements of the CQUIN schemes although no new risks had been identified. PD stated that the risks needed to go into report to the Audit Committee. **Action:** **SP to ensure risks against CQUIN delivery were included in update report to Audit Committee.** **Approval:** **The Quality Committee noted the developments, issues and risks as outlined in the paper and was assured with regard to the management arrangements and action.**	**SP**
8.2	**CIP QUALITY IMPACT ASSESSMENT (QIA) REVIEW** SP provided an update on the Quality Impact Assessment (QIA) of the Trust's Cost Improvement Plans (CIPs). He stated that the report built on the progress made at the last Quality meeting. The CIP management group, which was now chaired by the CEO, had reviewed the schemes being taken forward into 2013/14. SP further stated that KW had undertaken a full review of all the QIAs, ensuring the schemes taken forward for 2013/14 had been assessed. Schemes implemented during 2012/13 had received a post implementation assessment to ensure there was no effect on the quality of the services as a result of these schemes. In addition, following the update of Trust-level early warning indicators in the IPR, work continued to introduce the A&E Locality, PTS Locality and EOC early warning dashboards which would be used in local operational teams and as part of the Performance Review Framework from July onwards.	

		Action
	Key risks to quality and safety were recorded in the individual QIA forms and summarised in the table attached at Appendix 2. KW stated that items 5.3 to 5.7 in the report (Clinical leadership, reduction in overtime, A&E skill mix, EOC and PTS transformational work) highlighted specific schemes as part of the review process. The Committee agreed that the report contained a useful summary. EB asked where the Transformation Project Group sat in relation to QIAs, etc. SP replied that the group oversaw all the Trust's transformation work, although it did not have a specific role in relation to QIA. **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.**	
8.3	**SERVICE TRANSFORMATION PROGRAMME UPDATE** KW provided an update on developments, issues and risks in relation to the Service Transformation Programme which included provision of a copy of the regular dashboard to provide a high level view of the overarching programmes. KW stated that the nine project groups were now well-established with Executive Director sponsorship. Robust project plans with clear milestones were emerging and were monitored through the Transformation Programme Management Group (TPMG). The policy deployment approach had progressed and each group now had a policy deployment matrix specific to their work streams (PDM level1). PTS was currently the only project moving to level 2. KW confirmed that a programme management office was being established in the Rosedale room at YAS headquarters. The Head of Service Transformation had been appointed and was due to commence in post 2 September 2013. She stated that the risks associated with the programme would be managed by both project and programme level risk registers. PD stated that, looking at the key risks, it was her belief that the majority of them belong to Finance and she asked whether a report went from TPMG to the Audit Committee. SP replied that the report would go to the Audit Committee via the RAG group.	

		Action
	Approval: **The Quality Committee noted the developments, issues and risks as outlined in the paper and was assured with regard to the Transformation Programme management arrangements and action.**	
9	**<u>WORKFORCE</u>**	
9.1	**WORKFORCE UPDATE REPORT** It was assumed that all of the Committee members had read the report so GJ and SOL invited questions from those present. PD stated that she would like to see a specific diversity and inclusion report, which picked up the issues raised at the 27 June Stakeholder event, at a future meeting. **Action:** **GJ to present diversity and inclusion report at a future Quality meeting.** EB requested further information about the Emergency Care Assistant pass rates outline in section 6.1. SOL replied that a specific pass rate had not been applied and the 93% pass rate was actually higher than expected. GJ stated that the calibre of candidates had already improved. The values based recruitment had been equality and diversity impact assessed and the results had been good. PD thanked GJ and SOL for presenting the update. **Approval:** **The Quality Committee formally reviewed, scrutinised and was assured by the progress reported in the Workforce Update Report for April 2013.**	**GJ**
9.2	**HEALTH AND WELLBEING MID-YEAR REPORT** GJ apologised for the late submission of the report. GJ stated that he had hoped the overall level of sickness in the Trust, which currently remained at 5%, would be under this level. However, the general downward movement remained encouraging. GJ provided an update on the new Occupational Health (OH) contract. Following the recent tender exercise, the Trust had approved People Asset Management (PAM), as the preferred bidder. A due diligence exercise had commenced and would be followed by final contract negotiations over the next two months. The contract award should therefore take place by autumn 2013 with a three month mobilisation period.	

		Action
	GJ outlined the new process that would be followed when staff phoned in sick, adding that following early discussions with the new OH provider, fitness testing should also form part of recruitment centres by the autumn. It was agreed that questions should be brought to the September meeting, to be answered by the Employee Wellbeing Advisor. **Action:** **Questions on Health and Wellbeing to be brought to September meeting to be answered by Employee Wellbeing Advisor.** ABP stated that she did not get chance to say good bye to the former Executive Director of Workforce and Strategy, Stephen Moir, and asked for her best wishes to be passed on to him. **Approval:** **The Quality Committee formally reviewed the Health and Wellbeing report and was assured by progress being made.**	**All**
9.3	**CLINICAL LEADERSHIP REVIEW & ACTION PLAN** DWi stated that the YAS Clinical Leadership Framework concept was developed during 2011/12 in recognition of the need to support operational teams to enhance quality of care and improve outcomes. The initial logic of 144 clinical supervisors was based upon an assumption of 2200 frontline staff and assuming a ratio of staff at 15:1. However, the A&E frontline numbers of 2106 had been agreed within the workforce plan and following review the new requirements based on a supervision ratio of 1:16 were 124 clinical supervisors. DWi confirmed that there were currently 122.45 Clinical Supervisors in post, including those in development posts. 98 were substantive leaving 26 posts currently filled with staff on a development basis. It was therefore recommended that 20 of the current development posts were filled substantively, leaving 6 as permanent development positions which would allow a development opportunity for talented staff wishing to progress in a structured way. He further stated that a plan was being finalised that would ensure timely recruitment of the required number of Clinical Supervisors and provided an outline of the high level recruitment plan. DWi added that, by moving to the revised Clinical Supervisor number of 124, Operations would be able to deliver a recurrent CIP of £619k. JM welcomed the recruitment of the new clinical supervisors because of the current gaps in provision and asked how the gaps would be filled until such time as all of the vacancies were filled. DWi replied that although the rota review would help there was still a long way to go.	

		Action
	EM asked whether the changes had been Quality Impact Assessed. SP replied that JM and he had worked closely with DWi to review the plans and the ratio of 1:16 against 1:15 was not critical so the Trust did not expect a negative impact on quality. The key issue for quality was ensuring full implementation of the role in practice. EB asked whether any negative feedback had been received in relation to the implementation of the project. JM replied that some areas of South Yorkshire were over-staffed whereas East Yorkshire was massively below the correct ratio so complaints were being received about lack of supervision, etc. PD stated that her main concern was the length of time it had taken to recruit to the vacancies and asked whether the skill gaps in the development roles had been filled so that the current incumbents were competent to fulfil that role. SP replied that a structured development and assessment process was in place which ensured that skill gaps were being filled, adding that the six development roles would have a different feel to them to those currently in place. PD thanked DWi for his update, stressing that the Committee would continue to require updates at every meeting because of the importance of the clinical leadership framework to the organisation. DWi left the meeting at 1215 hours. **Approval:** **The Quality Committee approved Clinical Supervisor numbers to be set at 124; agreed to the establishment of 6 development Clinical Supervisor posts; and agreed how the Clinical Leadership Framework would be assessed.**	
	RISK MANAGEMENT	
10.1	**RISK MANAGEMENT UPDATE REPORT** SP stated that the Board Assurance Framework (BAF) had been reviewed and the refreshed version would be presented at the following week's Audit Committee meeting. He further stated that the Trust's risk registers were being reviewed and revised and would soon be input on to the new Datix system. The organisation would continue to refine the Datix outputs as knowledge of the system increased. SP added that the Trust's NHSLA status had been reviewed and due to uncertainty around the assessment process for the coming year it had been recommended that Level 1 was maintained until a new process was announced by the assessing body.	

		Action
	Approval: **The Quality Committee noted the current position and was assured in regard to the effective management of risks.**	
10.2	**INFORMATION GOVERNANCE UPDATE REPORT** SP presented the Information Governance (IG) update report. He outlined the contents of the first section which contained information about the IG Toolkit and progress in relation to issues with record management, etc. SP stated that, although the Trust needed to ensure that all proposed actions in the ambitious IG plan were deliverable, he was delighted with the progress that Caroline Squires (CS) had made during the past twelve months. JM placed on record his appreciation of the work that CS had put into clarifying the 26 Caldicott2 recommendations. He expressed concern about the duty outlined in recommendation 1 (section 2.4) to share patient information, as this could be difficult to implement for YAS as an ambulance service. JM further stated that recommendations 7 and 8 (section 5.5) would mean that the onus would fall back on the patient to refuse permission for their personal confidential information to be used. PD stated that the majority of issues faced by the Trust would relate to the safeguarding client groups. DM stated that it would be important to share only relevant information rather than all of the information about people. JM stated that the Trust should be able to work with Healthwatch quite proactively, adding that producing an audit trail of everyone who had accessed a person's record would be more difficult for acute trusts. PD stated her belief that the recommendations were a positive move. **Approval:** **The Quality Committee noted the current position and was assured in regard to the effective management of information governance.**	
11	**RESEARCH GOVERNANCE** There were no reports to consider.	
12	**ANY OTHER BUSINESS**	
12.1	**ANY OTHER BUSINESS** There was no other business.	

		Action
12.2	**ISSUES FOR REPORTING TO BOARD & AUDIT COMMITTEE** SP would summarise the key issues for Board reporting for consideration by PD.	**SP**
12.3	**REVIEW OF COMMITTEE WORK PLAN** PD stated that the Committee had achieved the workplan for the current meeting, adding that SP and she would continue to review the workplan between meetings.	
12.4	**REVIEW OF MEETING ACTIONS AND QUALITY REVIEW OF PAPERS** PD apologised for over running, adding that it had been essential that all of the important issues on the agenda had been allocated enough time to be thoroughly covered. She stated that the papers had been of a good standard with the risk orientation now clearly in each of them. It was noted that there would be further TDA observers in attendance at the meeting on 10 September. The meeting, which was due to commence at 0900 hours, would be preceded by a presentation at 0830 hours. BH placed on record his apologies for the September meeting. The meeting closed at 1255 hours.	
13	**DATE AND LOCATION OF NEXT MEETING** 12 September 2013, Boardroom, Springhill 2, WF2 0XQ.	