Yorkshire Ambulance Service NHS
NHS Trust

Quality Committee Meeting Minutes

Venue: Boardroom, Springhill 2
Date: Tuesday, 10 September 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

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
Mark Hall	(MH)	Associate Director Risk & Safety
Ben Holdaway	(BH)	Locality Director – EOC
Graeme Jackson	(GJ)	Associate Director of Human Resources
Joanne Halliwell	(JH)	Associate Director Operations - PTS
Mark Inman	(MI)	Head of Operations – Humber
Peter Wood	(PW)	Non-Executive Director – NEAS

Apologies:

Nick Cook	(NC)	Interim Executive Director of Workforce & Strategy
David Williams	(DW)	Acting Executive Director of Operations
Shelagh O'Leary	(SOL)	Associate Director of Organisational Effectiveness & Education

Minutes produced by: (AW) Andrea Wort, Executive PA

The meeting was preceded by a presentation for members of the Committee between 0830 and 0900. 'A Locality response to Mid Staffordshire Public Inquiry' was presented by Mark Inman, Head of Operations – Humber.

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	The meeting commenced at 0900 hours.	
1	**INTRODUCTIONS & APOLOGIES** PD welcomed everyone to the meeting and apologies were noted as listed above. As an observer was present introductions were made round the table. Peter Wood (PW), Non-Executive Director, NEAS introduced himself.	

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2	**REVIEW OF MEMBERS' INTERESTS** Declarations of interest would be noted and considered during the course of the meeting.	
3	**CHAIRMAN'S INTRODUCTION** PD informed the Committee that feedback had been received from the NTDA, following their observations at the last Quality Committee held on 9 July 2013, which will be shared and contains only minor issues. These issues had already been highlighted by the Committee in that meeting due to on-going development needs relating to risk registers and other organisation governance processes identified at a local level by MH. The feedback also included a number of areas of good practice. On balance PD congratulated everyone on the quality of papers presented and on the level of discussion and debate. She particularly thanked the Non-Executive Directors and SP for his support. PD also informed the group that a meeting was scheduled to take place on 12 September involving Keith Willets, Director of Urgent and Emergency Care and Dame Barbara Hakin, Deputy Chief Executive, NHS England around the Urgent Care agenda. PD confirmed the Trust was still awaiting the final CQC report following their unannounced inspection in July 2013, and noted that a paper on the patient safety report produced by Don Berwick KBE was included in the committee agenda.	
4	**MINUTES OF THE MEETING HELD ON 9 JULY 2013** The minutes of the meeting held on 9 July 2013 were approved as a correct record of the meeting.	
5	**ACTION LOG** The meeting worked through the Action Log, which was updated accordingly. Closed items were highlighted in green. **096/2013 and 098/2013 – Year End Quality Report, A&E Operations** Both actions on track, to be reported in November 2013. **114/2013 - Action Log** Update to be provided in November 2013. **115/2013 – Action Log** BH informed the Committee that a short trial had been held with Big Word an alternative provider, but BH reported that a better evidence base for changing providers was needed. Language Line had been contacted regarding their contract offering. They are not part of the national framework that YAS recognise but are the largest provider to ambulance services. Alternative providers were still being reviewed and options are still under review. BH informed the Committee that the Language Line contract had been extended for a further three months. PD suggested this was removed from the Quality agenda and placed on Finance & Investment under contracts and managed through the Procurement process.	

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	118/2013 – Clinical Audit Plan Item to be removed from action log as included in agenda. **120/2013 – Review of Key Quality Indicators (IPR) / Action** Item to be removed from action log as included in Lessons Learned report. **127/2013 and 129/2013 – Significant Events / Lessons Learned** Items to be removed from action log as included in Solo Responder back-up paper. **128/2013 – Significant Events / Lessons Learned** Item to be removed from action log as included in Sub-contractor governance paper. **135/2013 – Clinical Leadership Review and Action Plan** This item was not covered in the agenda paper but PM agreed to provide a verbal update during the agenda item. **141/2013 – Clinical Governance and Quality Overview Report** Item to remain on action log as not met. **142/2013 – Clinical Governance and Quality Overview Report** Feedback provided at Board as the Chief Executive had received feedback from specialist commissioners. PD requested this item is removed from the action log and that any progress in discussion with Commissioners continues to be included within the Clinical Governance report. **143/2013 – Clinical Governance and Quality Overview Report** A meeting had been held between SP, AB-P, along with KW, Hester Rowell and Karl Portz. AB-P confirmed the meeting went well with discussion on a couple of issues and worked to a few actions. The complaints policy was discussed. There were also opportunities for equality and diversity frameworks to influence policy and practice. It had been agreed that work plans would be shared. The new role of Head of Stakeholder Engagement that was soon to be advertised was also discussed. This role will help make the connection better between some of these strands of work. KW confirmed another health watch event will be held next year. PD suggested that AB-P continued to hold these productive meetings between now and then. AB-P advised that the friends and family test had been discussed. The Quality Accounts next year will have a review of content and structure, and will involve the external auditors Deloitte to ensure FT ready. AB-P appreciated the meeting as productive. **145/2013 – Implementation of JRCALC Guidelines** Item to be removed from action log as included in agenda.	

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	150/2013 – Claims and Inquest Report EM discussed with CB, therefore item to EB removed from action log. **151/2013 – Claims and Inquest Report** Update report to be presented in January 2014.	
6	**CLINICAL QUALITY PRIORITIES**	
6.1	**CLINICAL QUALITY STRATEGY/QUALITY GOVERNANCE UPDATE** KW presented a report on progress, issues and risks relating to the Quality governance Action Plan including progress on the CQUINs and the Quality Account. The committee had agreed at its meeting in July that due to overlap of the strategy with the quality governance action plan, this would be incorporated with the Clinical Quality Strategy annual implementation plan. Actions from the final CQC inspection report will also be included once received. KW highlighted section 5 which detailed progress against the quality governance action plan and provided assurance that the plan was on track and progressing against timescales, and also highlighted examples of achievement. A summary of progress for A&E and PTS CQUINs was provided in section 7. Quarter one targets were achieved for A&E and feedback was still pending for PTS. Quarter two delivery was being closely monitored specifically in terms of PTS South and East and A&E CQUIN 2 and 6 (non-conveyance and red delivery in four underperforming CCGs). Requirements for quarter two included developing a proposed trajectory for non-conveyance and improvement of clinical AQIs in rural areas which were to be agreed with commissioners. 2013/14 Quality Accounts consultation will begin in October 2013 and an internal review will be undertaken by Deloitte in parallel to this to support learning from best practice and full alignment to FT requirements. PD asked if the committee could be assured that the CQUIN targets would be achieved by the end of quarter four. KW reported there were some risks both in A&E and PTS. These would be reduced should realistic trajectories be agreed with commissioners. KW commented that a meeting was required with JH relating to the PTS CQUINs as negotiation was still required around some targets. JH is in negotiation with commissioners regarding these. Risks were being managed through the PTS project groups and Locality Managers are leading the delivery of the PTS CQUINs. EB commented on section six relating to improving PTS performance. She noted the narrative had taken on board things that happened in the past but did not give an up to date picture of progress since then, or	

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	the current status. Where the majority of work that was undertaken by Unipart, particularly sickness issues, she suggested a more in-depth analysis and recommendations are provided. EM commented on the section relating to effective complaints handling and noted Complaints Policy to be presented to SMG in September, and requested to be included in the circulation/opportunity to comment. **Action:** **KW to forward a copy of the Complaints Policy to EM.** In reference to the safety thermometer PD asked at what point there would be an agreement on what will be measured? KW reported that two had been agreed. i) Falls whilst in receipt of YAS care, ii) Injury whilst in receipt of care. The third, harm, medication errors, would be reported in the Q2 report for CQUINs. PD inquired about the status of the locality dashboards for A&E. SP provided assurance that the dashboards were being regularly reviewed in the Performance Review meetings which consist of other Executive Directors including Rod Barnes, and are presented by Locality Directors. EB referred to the Quality Governance Action Plan Francis report and commented on section 13.4. There were a number of items marked in blue as completed, and although some were covered in the report by GJ, she questioned how detail of on-going success and measurements were being picked up i.e. bright ideas, team brief. SP confirmed these are reported through the Service Transformation Management Group but suggested these should perhaps be presented to this committee. Over 100 ideas had been submitted and were being reviewed by managers. It was hoped this would be actively linked to and involved in project management arrangements, and when appointed, the Executive Director of People and Engagement will take a lead on this. PD commented on the action to report on ambulance discharges between the hours of 9pm and 9am. A discussion was held on the appropriateness of discharges between those hours. **Action:** **PD requested an update at the next Quality Committee.** SP advised that the Greater Huddersfield CCG out-of-hours discharge transport was to be commissioned and therefore there would be other examples that can be reported on. **Approval:** **The Quality Committee accepted the recommendations and was assured that the Quality Governance Action Plan was being monitored and delivered.**	**KW** **DM/KW**

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6.2	**REVIEW OF KEY QUALITY INDICATORS (IPR) / ACTION** PD informed that JM had delivered a very comprehensive presentation at the Board Development meeting on AQIs. PD invited comments on the July 2013 IPR, sections 3 and 4. EB noted in section 3.2 how the clinical hub had an amber rating with a risk associated, and was concerned overall with how the strategy was performing operationally, and felt that the momentum seemed to be coming financially from CIP. There was evidence of challenge from the service transformation programme but was unclear on how progress was being supported. BH responded that CIP was one part of the development and a review was taking place looking at the number of ambulances sent through the hub. The training team had been involved, carrying out observations and produced a training package to be developed for staff. EB felt this process was slow. BH agreed. There had been step changes since the project began, but had now plateaued again. He advised that nationally we should compare Trusts using Prism or other triage system and not against Trusts using NHS pathways. **(JM joined the meeting at 09.50)** EB said she would like to see a more robust debate at TEG that gets to the root of the challenges and plans, and a report back to this committee. BH commented that in its entirety the clinical hub undertakes much more than it did two years ago and is heavily involved in demand management, but with the same level of resource. EB felt this should be seen in the transformation programme plans. KW assured the committee that cross checking had begun at the transformation group with detailed reviews of each of the four elements of the programme. PD stated that a discussion was required on West Yorkshire OOH in Finance & Investment Committee. This was included in the IPR sections for Quality Committee as there may be quality issues. EB questioned section 3.2 IPC Audit. There were four areas at amber that immediately stood out, but more concerning was the green ratings which were greater than 94% but with a number reducing. SP reported that the newly appointed Head of Safety was reviewing current audit practice with a view to improvements and a process for validating local audit results. JM reported that the Clinical Governance Group (CGG) had discussed the deep cleaning schedule and had recommendations to standardise the timescale across the Trust. KW highlighted that section 3 of the IPR reported random sample audits on stations not the deep clean	

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	audit. SP advised the objective triangulation for this was the new Inspection for Improvement visits (I4I). The CQC also recently undertook an unannounced inspection and were happy with their findings relating to IPC; therefore he was reasonably confident on the overall picture. EM commented on the notes on page 2, relating to the loss of Vehicle Control Drug Book and was looking for assurance on what the risks were as Police had been involved. JM explained there was minimal risk to the Trust, as it is controlled drug stationary which contains no patient identifiable information. Patient information would only be identifiable on station. This is a routine way of reporting and contains nothing that can be used in terms of patient data. PD noted in section 3.10 Safeguarding that there was a 30% rise over previous years in referrals, and questioned whether this was putting pressure in the system. BH confirmed there is on-going discussion with the safeguarding team re capacity. **Action:** **PD requested that this issue be raised in the annual safeguarding report**. PW commented that in the North East the rates of referral were significantly higher. DM explained the information we provide was being reviewed in terms of the minimum data required. This may in turn relieve the pressure on health desk teams. PD questioned the rise in section 3.15, 111 complaints and concerns for July. SP responded that new areas were taken over in July. Sheffield and North Yorkshire were the latest areas, with significant additional volume of activity. It was noted there were still significant numbers in general complaints taking over 25 days for a response and it was questioned whether this was due to capacity or complexity. KW informed this was both. Complex cases can take longer to resolve and additionally a small team was managing the process. The recent policy review had aligned to roles within YAS and mapped out a process to respond to complaints. KW reported that all national guidance nationally now requests that the deadlines for response are agreed with the patient. PD looked for assurance that the Trust keeps up contact with complainants in between. KW confirmed that it did via the Patient Relations team. The patient experience survey data 'unknown on return' was a significantly higher negative response rate on family and friends (35.3%) and the committee questioned what this was and whether it could be reviewed in more detail. KW explained this was due to non-completion of postcodes and	**SP**

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	therefore difficult to determine where they are from. SP suggested the narrative is explored and a detailed analysis undertaken for future reports. KW informed of the appointment of a new Patient Relations manager who benefits from a strong analytical background. Discussion was held on the Workforce section around sickness, PDRs etc. PD was interested to see age profiled turnover information. GJ reported Human Resource staff turnover was slightly up but this was due to performance management. PD informed that sickness absence continues to be discussed in the task and finish group and is being driven down but still a variance. PD felt that South CBU should be congratulated as sickness had reduced to 3.9%. There were higher numbers in smaller parts of the workforce. **Approval:** **The Quality Committee was assured, following question, with regard to actions planned and underway.**	
6.3	**(Item 9.2 was moved up the agenda and discussed at this point)** **IMPLEMENTATION OF CLINICAL AUDIT PLAN** JM presented the first quarter year position for 2013-14 Clinical Audit Plan. He informed the committee that the clinical audit reconfiguration process was complete. The roles of the health records clerks and clinical audit assistants which undertook a distinct role now have newly defined duties, which in turn release the Clinical Effectiveness manager's time to improve clinical audit efficiency. This would enable the Trust to conduct the NIHCE recommended audits where previously there was no capacity to do so. Difficulties remained with regard to the data processing software, with an impact on local CPI data. There were two options available; either to obtain new software to deal with scanning and verification; or implementation of the e-PRF. Discussion was required with Rod Barnes to determine viable financial option. New software may be required in the interim given the two year timescale for ePRF. JM working with RB on this. **Approval:** **The Quality Committee were assured and understood the key issues and risks.** **(PM left the meeting at this point.)**	
6.4	**MID-YEAR PATIENT EXPERIENCE REPORT** The committee received the paper detailing the system for management and action on patient feedback including information from complaints, concerns and patient surveys, and PD invited comments from members.	

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	Good explanations had been provided in the report in the event of any issues. The position around 111 was understood and some excellent work had come out of the health watch day and support from AB-P. The committee understood the next steps, including risks as highlighted around staffing and complaints. ABP asked why the survey had changed. KW explained the wording had been reviewed as was rather lengthy and as requested she agreed to forward a copy of this to AB-P in the future. PD commented that further analysis of ethnicity would be useful. Alignment with equality and diversity had been discussed with Karl Portz and this will be addressed in future patient experience reports. KW made reference to section three, which had not been seen in previous reports, but was just an indication that the Patient Services team were not simply dealing with written complaints but are actively addressing smaller issues or concerns proactively. This helps to quickly resolve issues before they become formal complaints and provides assistance to other departments as required. PD acknowledged the significant improvement, and engagement in how we support the influence of patients. PD placed on record her thanks to the team and requested this was fed back to Hester Rowell. AB-P seconded this statement. **Approval:** **The Quality Committee accepted the report and was assured by the systems in place.**	
6.5	**MID-YEAR SAFEGUARDING REPORT** The committee received the paper providing an update regarding safeguarding adults and children across the Trust in 2013/14, and PD invited any comments from members. An improvement was noted in non-conveyance of under 2 year olds. SP explained that there was very active engagement with clinical managers reviewing individual cases, looking at data and underlying reasons and any actions required. It was possible the Trust was over-reporting non-conveyance as there were a number of reasons why children were not conveyed. A better understanding was being gained of the data coming through the clinical managers, but the Clinical Governance Group was continuing to keep a check on progress. PD noted the Head of Safeguarding, David Blain (DB) had recently stepped down as chair of the National Ambulance Safeguarding Group and wished to record her congratulations to him for his part in that. His hard work was recognised, and it was also noted how the safeguarding report had much improved from 18 months ago.	

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	SP explained the Prevent strategy which was an element of the Government Counter Terrorism strategy relating to preventing people becoming terrorists or supporting terrorism, which had now been placed within the safeguarding domain for all health trusts. One of the elements of national strategy was that all staff undertake a two hour training Workshop to Raise Awareness of Prevent (WRAP); however, having raised this through QGARD and AACE, SP confirmed AACE were supportive of looking at a more flexible approach to delivery. **Approval:** **The Quality Committee noted the progress and next steps for safeguarding both adults and children and thanked DB for the report.**	
6.6	**MANAGEMENT OF CONTROLLED DRUGS** The committee received the paper providing an update on developments, emerging issues and risk in relation to the management of controlled drugs in YAS. JM explained the historical difficulties in locating drugs, which involved the loss of morphine, and the subsequent introduction of a bespoke controlled drugs register and procedure, ensuring that location of morphine can be determined at any time. It was anticipated the new ambulance controlled drug stationery would reduce administrative errors in terms of stock control issues and was in process for launching this month. JM informed the committee of the high level of morphine breakages seen within the Trust. He discovered that a number of other Trusts had procured rubber matting for floor and surfaces to help reduce breakages when dropped, and therefore YAS was in the process of obtaining these also. It was noted information in Appendix 2 and 3 was missing. PD noted the risks are around not being able to manage the CD process. EB felt this was old fashioned in methodology and questioned why information technology was not used to record CD stocks. JM confirmed that the legislation dictated the use of paper records. **Approval:** **The Quality Committee noted the content in the report.**	
6.7	**MID-YEAR INFECTION PREVENTION & CONTROL REPORT** The committee received the mid-year report relating to IP&C, including activity undertaken so far in 2013/14 to maintain essential standards, and to review incidents relating to IP&C reported via Datix since April 2013.	

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	The paper was noted as a good summary of the current position, produced by the new Head of Safety, Clare Ashby (CA), who was currently out of the office on a reciprocal peer review arranged with another Trust. PD asked if any responses had been received from the acute trusts relating to the issue of staff needle stick injuries. SP advised three responses had been received to date, two of which were helpful responses with good explanations of their policies and procedures, and he would be shortly following up with a further message. The Trust must respond to the HSE Inspector following the related notice of improvement, and SP confirmed he has this in hand. **Approval:** **The Quality Committee accepted the mid-year report as assurance that IP&C standards were being maintained.**	
6.8	**MEDICAL DEVICES MANAGEMENT** SP presented the report on behalf of Rod Barnes (RB), Executive Finance Director, to provide assurance against the management actions in relation to the recent Medical Device Management audit. SP reported an issue had been identified around the medical device maintenance function and Internal Audit were commissioned to conduct a review which was then presented to the Audit Committee in July 2013. This was a limited assurance report with a number of recommendations for management action. The attached appendix covered the content of the audit report and provides a full update of progress made, with all but one of the recommendations completed. PD referred to tracker technology and questioned whether changes to the PDA's will achieve what the tracker implementation would have done. SP responded that this process may not achieve every single piece of equipment being electronically tracked. There was still the potential for equipment to be moved around and the process therefore still required policing. DM questioned the action on removal of equipment from the inventory. SP informed Internal Audit had picked up a legacy issue, where databases had not been maintained with the movement of equipment. Some had been phased out and replaced and some were obsolete, therefore the action was to cleanse the database resulting in a situation that is now accurate. The exercise enabled the department to reach a credible baseline with equipment that was present out in the field. The equipment department was now keeping a maintenance schedule with missing equipment reduced to single figures. There was an on-going recruitment issue into the Head of Medical Devices function, and it was also noted an external review of the medical devices function would be taking place shortly with an expert	

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	medical devices engineer. Kevin Wynn (KDW) was facilitating this process. PD advised that the report will be presented to Audit Committee again, and having seen the action plan asked if the committee could be assured. SP said he would wish to give assurance on the significant progress in now understanding exactly what is out there, and the proactive process for maintenance, but noted that the department was still reliant on external support to carry out maintenance and sustaining quality of maintenance processes. He was definitive in assurance that schedules for defibrillators were absolutely in place, whilst action on issues with lesser risk items had progressed well but was still in progress. **Approval:** **The Quality Committee was assured on progress against the management actions in relation to the Medical Devices Audit and would wish to receive a further update at the next meeting.**	
6.9	**SOLO RESPONSE BACK UP TIMES** BH presented the paper updating on the current position regarding the back up of solo responders with a transporting resource and actions taken to improve the position. BH informed the paper had been produced following a number of concerns received from clinicians about the amount of time taken for back up to arrive on scene. He explained the CAD is set up where a warning on each code informs dispatchers whether single first response or dual response required. If a solo paramedic response is sent it is their decision if a transporting vehicle is then required. Data for June/July was used and compared to August 2012 but month to month data was not available. The Trust level summary indicated a slight improvement on average for Red 1 and 2 across the Trust. However the 95th percentile had increased slightly, mainly in the ABL area. BH stated that instances of harm to patients are monitored through incident reports in the Datix system and it was proposed that an audit process will also be put in place to identify any issues. It was further noted the average arrival of an ambulance within the green category was within 20 mins for G1, 2, 3 and 4. The 95% had indicated an improvement in G1 & G3 but an increase in G2 and G4. According to Datix there were seven incidents since April related to delayed back up. The table at section 3 detailed the actions that will be taken to improve the position. A new procedure had been produced for	

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	backing up RRVs and had been distributed to managers, but was currently in discussion with staff side representatives. PD commented that a risk section should be included in the document. There were no SI's however seven incidents were reported and she was therefore looked for assurance going forward that this will be addressed. SP suggested a monthly monitoring process to track this data. BH agreed but advised the system does not capture cars that have arrived on scene, assessed a patient, and then called for back-up, and therefore the numbers will be affected due to that factor. **Action:** **PD suggested a fuller report is re-submitted to Quality Committee in six months to include a section on risk, for the committee to be assured by the action plan.**	**BH**
6.10	**SIGNIFICANT EVENTS/LESSONS LEARNED** MH presented the report updating on specific events and lessons learned and invited any comments. PD commented it was beneficial to see the reason for any potential delay in Serious Incident (SI) notification to the CCG. EB felt the CSU review stood out and questioned what was happening, and why there was a backlog. MH informed the backlog related to a delay in commissioners review of SI's and provision of feedback, as YAS was hitting its targets. He advised that the commissioners were happy with the new system and processes set up by YAS for the management and reporting of SI's, but we would appreciate a quicker turnaround of feedback reviews. PD asked if the commissioners were being alerted to this backlog. SP informed this is discussed and reported through the Clinical Quality Review Group and consideration of incidents is reported into a sub-group that reports to this. MH reported a reduction in SIs on delayed responses to patients and commented that the reporting of these incidents is initiated by road staff, and is a real measure of reduction. PD advised on a point of caution not to assume that tough books will provide good reporting, as there were some poor areas of connectivity and the need to be reticent of communication and how it works. MH responded this was hoped to be used as an additional method of reporting and other alternative methods were also being reviewed. EM noted the response bags seemed to be causing difficulties in terms of claims. DM explained there was now a new response bag agreed, one for DCA and one for RRVs. So far approximately 200-250 had arrived of the 500 required, and were beginning to appear on vehicles	

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	now. The first 12 bags were stocked on one station first (Wakefield and Castleford). This was also linked to the process of obtaining AEDs rather than Lifepak defibrillators for RRVs. **Approval:** **The Quality Committee were assured of the effective management and learning from adverse events, and PD thanked MH for a concise and straight forward paper.**	
6.11	***A PROMISE TO LEARN – A COMMITMENT TO ACT: IMPROVING THE SAFETY OF PATIENTS IN ENGLAND*** The committee received the report, which provided an overview of the report published by the National Advisory Group on the Safety of Patients in England, and PD complemented SP on a very well summarised document. Included in the report were the ten specific recommendations for the NHS. SP commented that acting on the recommendations would provide us with the potential to take a fresh look at how safety signs are used and build into management, leadership and development. He further alluded to section 3.8 and 3.9 which emphasised the key points from the report. The committee found the document interesting and noted its emphasis on development rather than inspection as the key to delivery of safe care. **Action:** **The Quality Committee recommended that the principles are taken forward through the Quality Strategy, with a view to review in a future Board Development meeting. SP to discuss with AA.**	**SP**
7.	**<u>ESSENTIAL STANDARDS OF QUALITY AND SAFETY</u>**	
7.1	**OVERVIEW OF TRUST COMPLIANCE AND REPORT ON INSPECTIONS FOR IMPROVEMENT** KW presented the paper which updated on the current position and development of the inspection process. Inspections for Improvement were now embedded into everyday business and combine all elements i.e. CQC compliance, Health & Safety, Security and Information Governance). KW informed the report was based on the draft CQC inspection report, which had been delayed due to a CQC internal management review. Our response to the draft report was forwarded to CQC on 6 September 2013 with comments on accuracy and one area being challenged. SP advised that further clarity was needed on the impact of CQC outcomes in the FT application process, as this was undergoing development since publication of the Francis report.	

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	Approval: **The Quality Committee accepted the recommendations and would continue to work with current knowledge. Any additional actions that may arise from the final CQC inspection report would be reviewed at the November committee meeting.**	
7.2	**LOCALITY ASSURANCE REPORT – PTS** JH thanked the Quality Committee for the invitation to provide an update and assurance relating to Patient Transport Services (PTS). Since November 2012 a number of changes had been put in place in relation to the internal governance arrangements, structure and focus and how information is collated from a number of different sources as a management team. This has supported a link back to contractual performance, patient experience and operational delivery, as opposed to just numbers through the IPR. It was noted that IPR performance continued to be inconsistent. Some areas were improving (Hull and East) and others had significantly deteriorated (South) and this area in particular caused concern since it has had the most focus in transformation support. A number of commissioner meetings had been held in that area who were keen to work with us, and an urgent quarter two service improvement plan has been developed which was shared with them and is already being implemented. There were early signs of improvement already, particularly linked to the implementation of a performance cell. However, concerns remained around sustainability and embedding change. Generally, long waits and post appointment remained a concern. A number of patients were choosing to go to James Cook University Hospital and across the borders into Manchester and Liverpool which in turn removes a crew with a stretcher for extended periods. This 'resource drag' was being reviewed to quantify the implications on the remaining service provision. EM commented on the long term concerns around sustainability following the investment of time and effort put in. Long waits were a consequential issue and the South area had utilised significant time from JH and an external body, and she questioned therefore why the changes were not producing results. JH responded it was a combination not just relating to one issue, possibly around the long history regarding operational challenges, issues around significant contract loss not shared with other areas; and the management / front line staff relationship was not positive as a consequence of that. It was felt that some of the challenges put to the operations management team since November have been met and exceeded expectations and some individuals had struggled, and there are plans to address this, including recruitment of a new locality manager due to retirement. EM suggested this maybe cultural and would therefore potentially not resolve the issue. JH noted that it was also about how management engages with staff as there appeared to	

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	be an ‘us and them’ culture in some parts of the service. JH commented that there was a difficulty with past experience, where there was loss of contracts but no job losses. This may have created a perception that there was no consequence for staff of poor performance and this would not be the case in the future. EB requested details of the restructure for PTS, noting the culture issues are around the middle management area. It was suggested this should be discussed at the Trust Board to gain further assurance. JH stated that much work had been undertaken on workforce between themselves and Recruitment to get up to establishment levels, and this was continuing, although the difficulty remained with access to courses as there were not enough to take through the Band 3 staff in a timely manner. GJ explained the training school capacity focus had been on ECA training and was awaiting a training academy decision. SP suggested that mitigation is considered, and suggested that the HR directorate also needed to look at what measures can be put in place in the short term. Prioritisation must be made with full knowledge of assessment and training. **Action:** **An update on recruitment processes and support was requested for the next meeting.** JH identified that driver assessments were dropping out of the assessment schedule, following a review of the recruitment process and little relationship between assessment and future training success. JH further commented on compliance figures. A full training programme had been provided around PDR’s and therefore the quantity and quality was picking up and feedback from staff was positive. Statutory and mandatory workbooks were imminent and a streamline plan of rolling out was being produced. It was noted PTS has a low rate based indicator for complaints and concerns. Vehicle condition had been discussed many times, and although had not appeared in many formal complaints in user experience surveys, it was figuring as a comment. The most concerning element of the paper was around the number of complaints relating to staff attitude and behaviour. This was a continued theme, particularly around South Yorkshire around management and rotas. Education was required around the appropriateness of that, but was also around not sharing and venting frustrations with public. SP commented that initial NHS TDA Quality Visit feedback for the South had been negative but not only for PTS. JH informed that meetings had been held with the patient relations	**GJ**

		Action
	team and workshops held. All complaints are referenced through locality managers, which was proving to be positive. PW asked if verbal complaints were included. It was noted all complaints received in any form are logged. PTS have five serious incidents registered all formally investigated and all reports submitted on time, two of which were being requested as not an SI for YAS, and awaiting CCG response. All other incidents were falls of patients in our care. There were eight CQUIN schemes in operations mostly connected to issues discussed; responsiveness, long waits, also patient improvements etc. Quarter 1 reports were submitted on time and on track. Following the risk management structure, significant work had been undertaken in constructing locality and directorate risk registers, There were currently 61 risks, although some were repeated across other risk registers. Slips trips and falls and infection prevention linked to vehicle condition were the main themes and had been discussed in RAG and actions for those in paper. Five risks in the directorate risk register related to the Corporate Risk Register and were mostly related to financial viability and the transformation programme managed through TPMG. These were being transferred to Datix. EM asked given knowledge of the market, whether it was thought there were any contracts or elements of our services 'at risk'. JH responded that North Leeds were leading with CSU on developing a tender specification which would only pertain to Leeds CCG. Outside of that there were no other commissioners making strong noises towards any commercial tenders. PD was glad risk management was included and moving forward well. There were culture issues that she agreed should be elevated, and she noted the safety thermometer implementation will be an implication. **Approval:** **The Quality Committee, given the comments, accept the actions and interventions as made.** **Action:** **PD requested an update on the above issues at the February meeting.**	**JH**
8	**<u>QUALITY GOVERNANCE</u>**	
8.1	**CIP QUALITY IMPACT ASSESSMENT (QIA) REVIEW** An update was provided on the Quality Impact Assessment (QIA) of the Trust's Cost Improvement Plans (CIPs). It was noted the QIA process had been revised to reflect the alignment to the Transformation Programme as seen in Appendix 1. KW was	

		Action
	acknowledged for an excellent job in ensuring all CIP updates were maintained. KW advised that key risks to quality and safety were recorded in individual QIA forms and summarised at Appendix 2. She highlighted the key schemes. The commentary for each provides the relevant level of detail and gives early warning indicators relevant to that scheme. It was noted the schemes that posed the largest risk related to reduced overtime/ A&E skill mix/removal of rest break payments and AVP, which are currently being mitigated in the short term by continuing to put in more resources to support performance delivery. **Approval:** **The Quality Committee were assured by the paper and felt there was a positive route of travel, and any risks to patient safety were clear. Agreed to retain on agenda and in work plan.**	
8.2	**SERVICE TRANSFORMATION PROGRAMME UPDATE** An update was provided on the developments, issues and risks in relation to the Service Transformation Programme. Key areas were bright ideas and leadership/improvement skills development programmes. The reporting framework for the management of CIP schemes to the Transformation Programme was developing to provide assurance to Quality Committee, Finance & Investment Committee and Board. A full complement of project managers were now in place including a new Head of Service Transformation, after running for several months with minimal resources to support the function and therefore a step change should now be seen. The programme dashboard was presented summarising the position to date. EM referred to CD7 of the dashboard relating to Cardiac Arrest outcomes and questioned the drop to amber having been consistently at green. JM and DM informed this had in fact returned to green again. This was due to a number of courses being planned for paramedics which had not been filled but that this had since been resolved. SP advised the committee SOL was leading on a commissioned service improvement skills course, and in the short term, the new programme team and Head of Service Transformation were currently looking at in-house material that can be used with managers 1-1 or in small groups. **Approval:** **The Quality Committee were happy with the clear indication of route of travel and were assured on the progress of the Service Transformation Programme.**	
9	**<u>WORKFORCE</u>**	

		Action
9.1	**WORKFORCE UPDATE REPORT** GJ presented the paper which provided an overview of matters relating to a range of workforce issues, including education and training, equality and diversity and employee wellbeing. GJ highlighted further updates since the paper had been written. Long Service Awards had been held and improved on last year. Recruitment activity remains consistently high, with 290 candidates at various stages of progression i.e. chasing references; courses etc. EB asked if this was in line with plan. GJ confirmed in plan but advised this was a risk in terms of volume within the team. It was noted that a complete organisation wide plan was required for next year, with a focus across all service lines. 111 data was now being added in to absence management, which had a negative impact on corporate data due to the NHS direct legacy, and there were absences at the time of transfer. Not all NHSD and 111 were initially captured in the data due to difficulties with GRS and ESR links. This was now resolved and there would be a negative impact on statistics over the next few months. EM asked if staff knowledge of staff absence was considered as part of TUPE arrangements. GJ advised the full details of staff coming across at the point of transfer, was unknown until one week before. A&E operational localities were making good progress with sickness management, but there was concern over the trend developing in PTS and in the corporate finance directorate. Following the procurement process to select a new Occupational Health service provider, the approved bidder People Asset Management (PAM) were on track to commence 1 October 2013. GJ informed they would be present in SH1 restaurant to showcase their service provision 11 September. GJ informed the Committee that a draft recognition agreement between Unison and YAS was in the final stages of draft, with a few changes to be made around more focus on patient safety and experience rather than staff. He further reported another recent protest by the union Unite about patient safety concerns as part of the national agenda about cuts to NHS. SP reported the CEO had received correspondence from the commissioners (CSU) asking for a detailed response related to the Unite fuelled newspaper report. EB noted a plan was not seen for completion of PDRs. Discussion had taken place about phasing and smoothing, but still the paper still reads about having enough time for these to be undertaken. She questioned the plan for completion and effect on percentages, as outstanding PDRs can be pulled from the IPR but not the plan for action.	

		Action
	The year-end position was felt to be at risk due to the number of outstanding PDRs. It was questioned why phasing could not be undertaken at the beginning of the year rather than the end when there are less pressures. Members requested the plan for the next meeting. **Action:** **The Quality Committee understood the action being taken to resolve PDR issues through the year, and PD asked that this be reviewed and discussed at TEG.** **An update to be presented to the November meeting as part of the Workforce report.**	**IB**
9.2	**CLINICAL LEADERSHIP UPDATE REPORT** PM presented the report on progress so far in the Clinical Leadership Framework, building on action stated in the paper previously presented at the July 2013 Quality Committee. It had been recommended that 20 of the development posts would be filled substantively leaving six remaining positions. A recruitment plan was in process with completion dates suggested, which included new clinical supervisors to be in post by 2 September. This would deliver consistency over all CBU's. A minimum of one in each CBU will be a development post. It was confirmed that the new clinical supervisors would now be in place by 30 September across all areas. A series of metrics were recommended to measure the success of the Clinical Leadership Framework, and had been discussed previously at TEG. A number of these were now included in dashboards. SP stated the key issue was measuring the quality of the PDR experience and feedback from staff on their experience of supervision which would be sought through the staff pulse survey. DM asked whether all staff were being supervised, and how well they were being supervised. PM informed of an opportunity to create a 'watch' concept, to align supervisors on duty at the same time as staff as part of the rota review. PD suggested this information is included in the next report. Paul Birkett-Wendes had previously produced a report on actions Clinical Supervisors were taking to fill gaps, and questioned whether any of the actions from this had been achieved, including the issue with clinical supervisors being off the road undertaking tasks that could be done by others. PM responded that staff were in place including staff on other duties, to pick up jobs the supervisors were undertaking. PD highlighted that a risk section was required in the report, as although good work was on-going. Risks need to be seen as the framework was not fully embedded.	

		Action
	EB questioned where the metrics are reported. SP expected to see this through the Executive group. SP asked who was completing work on the dashboard which was to be in place for October, as although happy with the direction of travel confidence was required in who was undertaking this. MFD confirmed the framework for dashboard was ready to be populated, and sits with DW and the operational team. **Action:** **Outcomes were required in the next clinical leadership report, and therefore should be discussed in the operations group meeting.** **Approval:** **The Quality Committee agreed and qualified the report with risks and good news and actions to be provided in more detail.**	**MFD**
	RISK MANAGEMENT	
10.1	**RISK MANAGEMENT UPDATE REPORT** MH presented the risk report including an update on current progress relating to investigation skills training and policy review processes. He wished to assure the committee that elements were also being managed through other committees. The risk grading matrix had been updated with changes to risk thresholds and changes to colours and this was agreed at Health & Safety Committee (HSC), Risk & Assurance Group (RAG), and at the Senior Management Group (SMG). The Board Assurance Framework (BAF) was currently being reviewed through lead directors to produce a quarter 2 report and a high level Corporate Risk Report to SMG, Quality Committee, Audit Committee and Board. Inspections for Improvement (I4I) were being monitored through the Risk & Safety team. To date 2-3 per week were being completed, and currently 26 premises had been looked at. Key elements from the inspections are placed on a master sheet and then reported to HSC. MH reported level 6 staff and above, had undertaken training in investigation skills and a pool of staff was now available to call on if a serious incident investigation is required. PD asked whether a template and protocol was in place where staff are required to make a statement. MH confirmed this was the case for single statement and investigations, but also an after action review may be held. All training elements are sent to members of staff who have attended	

		Action
	the training sessions who are then encouraged to cascade the training amongst their teams. **Approval:** **PD thanked MH for a succinct report and the Quality Committee accepted the recommendations.**	
10.2	**SUB-CONTRACTOR GOVERNANCE** KW presented the report which described the current governance arrangements for subcontractors delivering direct patient care and proposed recommendations to strengthen the process. KW informed the requirement for the report emerged from discussions at the last meeting, and request for assurance relating to good governance around working with subcontractors. The paper describes the current position and proposals around strengthening current processes. It was noted sub-contractors are used to support demand within A&E in the achievement of performance targets. This was a requirement in the short term pending implementation of current workforce and rota review changes. In the long term this would diminish or be removed entirely. KW explained the current Trust contractor control policy provides a policy framework for reviewing contractors, mainly in fleet and estates and describes requirements health & safety, hazard and risk. This policy does not address ones that provide clinical care and face to face contact with patients. She further explained however, that there is a separate protocol in place which provides a list of preferred providers for PTS, who only use sub-contractors on the list. There is also a governance check list attached at Appendix 1 which is applied to any potential sub-contractor in PTS and A&E. It was proposed KW would work with JH and DW and Denise Sayles (DS) and report back to the committee in November to provide an update. EM understood the concern around subcontractors contracts may have issues that may affect us, and a due diligence process was undertaken that may help us, and therefore wondered if this could be built in to help, with some input from legal. SP felt this probably required building into the procurement part of the process. It was suggested an outside conversation is held with DS to ensure that this is addressed in policy. DM advised the clinical care delivery element needs to be strong as the inspection process by the CQC was not the same between NHS providers and private providers. JM would like to see a much more robust process in A&E as we are picking up incidents. These are fed back to the North of England but feedback is limited as to whether issues have been addressed by	

		Action
	them. He questioned how we know that learning is taking place, and suggested strong governance checks were required at the front end and a contingency built in. PD questioned whether any YAS or other ambulance staff would be working for sub-contractors on a part time basis and if so how the situation would be handled should anything happen. It was noted that this was addressed through the secondary employment policy. **Action:** **A further update to be provided in the November meeting.** **Approval:** **The Quality Committee accepted the paper and acknowledged good progress, and that all points made around governance would be picked up.**	**KW** **KW**
11	**RESEARCH GOVERNANCE**	
11.1	**RESEARCH GOVERNANCE UPDATE REPORT** JM presented the report which provided an overview of developments, issues and risks in relation to research in YAS. JM reported there was a period of transition of CLRNs becoming LCRNs. There were currently two bidders for the host Yorkshire & Humber LCRN (Bradford and Sheffield THTs). This is all part of a stream lining process and alignment with AHSNs. A 14% reduction had been seen in funding for the YAS allocation from WYCLRN received for 2013-14 in their contribution to research, compared with 2013-14. A business case had been considered by TEG to determine the future research infrastructure and this would be reconsidered in November 2013. Participation continues in the Astra Zeneca drug trial as the only remaining UK ambulance service. The committee discussed risks associated previously with pharmaceutical trials and agreed that these risks were managed effectively in order to grow the Trust's research portfolio. **Approval:** **The Quality Committee noted the positive developments, challenges and risks as highlighted in the paper and accepted the report.**	
12	**ANY OTHER BUSINESS**	
12.1	**ANY OTHER BUSINESS** There was no other business.	
12.2	**ISSUES FOR REPORTING TO BOARD & AUDIT COMMITTEE** The following were noted as key issues to highlight in committee reports: • PTS	

		Action
	• PDR quality/completion • Recruitment	
12.3	**REVIEW OF COMMITTEE WORK PLAN** It was agreed that PD and SP would review the plan in the light of discussions in the meeting.	
12.4	**REVIEW OF MEETING ACTIONS AND QUALITY REVIEW OF PAPERS** PD commented that a number of papers had not included risk orientation and some did not have fully completed front sheets and asked that these were rectified for the next meeting. PW thanked PD and the Committee for inviting him to attend. He found the information useful and stated he would be adding to his reporting form that he takes out on his A&E visits. He was particularly interested in the discussion around the Clinical Supervisor work and the duties they should not carry out, and was also very interested in the 111 statistics. He was also pleased to meet AB-P our Expert Patient.	
13	**DATE AND LOCATION OF NEXT MEETING** The next meeting would be held on 12 November 2013, in the Boardroom, Springhill 2, WF2 0XQ.	