Yorkshire Ambulance Service NHS
NHS Trust

Quality Committee Meeting Minutes

Venue: Kirkstall & Fountains, Springhill 1, WF1 0XQ
Date: Tuesday, 12 November 2013
Time: 0830 hours

Chairman: **Pat Drake**

Attendees:

Pat Drake	(PD)	Deputy Chairman/Non-Executive Director
Dr Elaine Bond	(EB)	Non-Executive Director
Steve Page	(SP)	Executive Director of Standards & Compliance
Dr Julian Mark	(JM)	Executive Medical Director
Mike Fox Davies	(MFD)	Interim Executive Director of Operations

In Attendance:

Andrea Broadway-Parkinson	(ABP)	YAS Expert Patient
Graeme Jackson	(GJ)	Associate Director of HR
David Williams	(DW)	Deputy Director of Operations
Dr Steven Dykes	(SD)	Associate Medical Director
Mark Hall	(MH)	Associate Director Risk & Safety
Karen Warner	(KW)	Associate Director of Quality
Ben Holdaway	(BH)	Locality Director – EOC
John Nutton	(JN)	Non-Executive Director - Designate (Observer)
Anne Allen	(AA)	Director of Corporate Affairs/Trust Secretary (Observer)
David Whiting	(DW)	Chief Executive (Observer)
Jonathon Idle	(JI)	Internal Audit (Observer)

Apologies:

Erfana Mahmood	(EM)	Non-Executive Director
Barrie Senior	(BS)	Non-Executive Director (Observer)
Ian Brandwood	(IB)	Executive Director of People & Engagement
Dr Dave Macklin	(DM)	Deputy Medical Director
Sheila O'Leary	(SOL)	Associate Director, Organisational Effectiveness & Education

Minutes produced by: (MG) Board Support Officer

		Action
	The meeting commenced at 0830 hours.	
1	**INTRODUCTIONS & APOLOGIES** PD welcomed everyone, including Jonathan Idle (JI) from Internal Audit, who was attending as an observer. Apologies were noted as listed above.	

		Action
2	**REVIEW OF MEMBERS' INTERESTS** Declarations of interest would be noted and considered during the course of the meeting.	
3	**CHAIRMAN'S INTRODUCTION** PD confirmed that a separate meeting had been arranged with External Audit on Friday 15 November to go through the Quality Accounts section of the governance process for the following year. She also confirmed that, due to the heavy agenda and joint meeting with members of the Finance and Investment Committee later that day there would be no presentation prior to the meeting on this occasion. PD stated that, between them, the NEDs had attended a significant number of events since the last Quality meeting. These included the excellent Urgent Care Conference in October and the Best Practice day in York which 90 staff had attended. This had been a useful event, particularly the presentation from Tricia Hart on culture issues arising from the Francis report. It was agreed that JM would circulate the presentations from the day for further consideration. **Action:** **JM to circulate Best Practice event presentations.** PD further stated that work on the national review of complaints was under way which the Committee would consider in more depth at its February meeting. She added that it had been useful to attend and receive feedback at the recent Clinical Quality forum. The safety thermometer was crucial and there remained issues around communications and the attitudes and behaviours of some of the workforce. PD acknowledged that all new staff would be going through the new values based recruitment process and asked how the Trust's current staff would receive similar values-based training and assessment. GJ replied that HR was currently considering this matter and IB would provide feedback at the February meeting. **Action:** **IB to report back to February meeting re suggestions on the best way to share the Trust's values-based information with staff.** PD stated that an action plan update in relation to the Community First Responder limited assurance Internal Audit report would also need to be presented at the February meeting. It was noted that the CFR concerns were largely around the recruitment, induction and training process rather than strategy.	**JM** **IB**

		Action
	Following further discussion, it was agreed that DWi should provide a detailed update report at the February Quality Committee meeting. **Action:** **DWi to provide detailed update on the CFR action plan at February meeting.**	**DWi**
4	**MINUTES OF THE MEETING HELD ON 10 SEPTEMBER 2013** The minutes of the meeting held on 10 September 2013 were approved as a correct record of the meeting subject to the following amendments. **Matters Arising** Page 2, Chairman's Introduction, para 2 – 'Willits' to be amended to read 'Willets'. Page 6, Item 6.2, first line – remove apostrophe from 'AQI's' to read 'AQIs'. Page 18, action – 'January' to be amended to read 'February'.	
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** Items covered on that day's agenda – actions closed. **114/2013 – Action Log** SP stated that this item had been covered at SMG and MFD confirmed that a programme of training was currently underway with vehicles to be rolled out from December 2013. Action closed. **151/2013 – Claims and Inquest Report** Update report to be presented in February 2014. Action remains open. **156/2013 – Clinical Quality Strategy/Quality Governance Update** Complaints Policy forwarded to EM. Action closed. **157/2013 – Clinical Quality Strategy/Quality Governance Update** JM stated that the Trust pushed back against acute trust requests for out-of-hours discharges whenever possible although there still remained low numbers of such discharges. PD stated that information about the national position would be useful. KW stated that she would drill down further into the available statistical information to look at risk assessments, etc. PD expressed her concerns about the safety of patients, etc as it was her belief that YAS did not look like a quality organisation if it was taking patients home to an empty house in the middle of the night.	

		Action
	SP stated it had been agreed that staff would question out-of-hours bookings to confirm, for example, that patients had been assessed by the hospital as being safe to be discharged out-of-hours. PD asked if there had been any incidents and SP confirmed that there had been none to date. It was agreed that a further update would be shared at the February meeting as part of the Governance report. **Action:** **A further update to be provided at February meeting as part of the Governance report.** **160/2013 – A Promise to Learn – A Commitment to Act: Improving the Safety of Patients in England** AA confirmed that the Berwick report had been included on the Board forward plan. DW stated that it should be considered at the February BDM, as there was likely to be relevant intelligence available by then and it would be helpful for the NEDs to be briefed on what the new inspection regime was likely to look like as soon as possible. Action remains open. **Action:** **AA to include Berwick Report on agenda for February 2014 BDM.** **161/2013 – Locality Assurance Report - PTS** Item addressed via workforce update report. Action closed. **163/2013 – Workforce Update Report** Item addressed in workforce update report. Action closed. **164/2013 – Clinical Leadership Update Report** Item included in clinical leadership report. Action closed. **165/2013 – Sub-Contractor Governance** Item on agenda for that day's meeting. Action closed.	**SP** **AA**
6	**<u>CLINICAL QUALITY PRIORITIES</u>**	
6.1	**CLINICAL QUALITY STRATEGY/QUALITY GOVERNANCE UPDATE** KW stated that, rather than having separate CQC and Francis Report action plans, the Trust had combined everything together into one action plan to enable best practice to be viewed without a label to foster professional behaviour. She confirmed that progress against the Quality Governance Development Plan was on track and progressing in line with the timescales. KW stated that 'Putting the patient first' was key to YAS and the recent best practice event ran a staff training programme as a pilot.	

		Action
	It had focussed individuals on a set of tools to understand patient safety better and use as a cascade in their teams. This process worked well in acute trusts and although it was a first attempt in an ambulance trust, it had been well received. The Trust was now looking rolling it out across the wider organisation. In relation to the outcomes of the staff survey, it was believed that the introduction of a series of pulse surveys would give stronger feel of current workforce feelings. KW stated that in relation to CQC Outcome 14 the PDR process had been strengthened and work had commenced to ensure the provision of two-way messages in relation to patient safety, etc. In relation to the CQC's minor concerns in Outcome 9, the process for returning controlled drugs was in place and would go live on 1 December. KW further stated that, as part of the 2013/14 A&E CQUIN programme, collaborative working with the top 100 highest care homes users had been recognised as an important priority and work was under way to provide support, advice and training for care home staff with a view to reducing conveyance. Good progress was already being made with a 16% reduction in Quarter 2. EB asked if the top 100 users were concentrated in any particular geographic areas. KW replied that they were all over the region. DW acknowledged that good progress was being made. KW reported that development of the 2013/14 Quality Account was already underway with a workshop to look at best practice in line with Monitor's requirements for Foundation Trusts, facilitated by Deloitte, was due to take place that month. JM reported that, in addition to the consultations that DW and he had already undertaken with staff, Hester Rowell was considering how best to engage with patients and staff in relation to the contents of the Quality Account. A user-friendly shortened version would be produced to allow frontline staff to see pertinent information at a glance, the draft format of which would be brought back to the Quality Committee at an appropriate time. SP stated that, although a summary version was produced each year, the audience in mind had been the Public rather than staff. The new format would therefore need to fulfil the needs of both groups. KW stated that the Quarter 2 CQUIN report had been submitted to the Commissioners at the end of October with main feedback due to be received the following week. There were concerns in relation to the targets for CQUINs 2 and 6 so the plan was currently being reviewed and revised to ensure delivery of those targets.	

		Action
	In relation to PTS, difficulties were being experienced in relation to the delivery of the South CQUIN but the others were on target to deliver. PD asked whether PTS representatives had been included in DW's Team Brief sessions. DW replied that he had been attending the A&E rather than the PTS sessions because of the clinical leadership framework. Other Directors had been attending the PTS sessions but his aim was to attend some of these sessions in the future. **Action:** **DW to look into options for delivering future PTS Team Briefs** A discussion took place about A&E/PTS culture at station level. For example, PTS staff, when they were co-located with A&E staff, often had to ask for keys to get into offices, etc. It was agreed that these issues would need to be considered in more depth. KW stated that the Quality Governance Action Plan was attached at Appendix 1. PD asked whether it was possible to theme and break down further the key interventions that had been identified in the action plan. SP replied that two key themes had been identified. Attitudes, behaviours and communications and the safety thermometer were the main strands for next year, which would be expanded accordingly. AA stated that she was due to review the consistency of operation of locality boards across A&E and PTS with SP and RB. SP agreed with the importance of using locality boards and local management meetings to reinforce corporate messages, etc in a consistent way. PD asked whether patient safety was included on every operational agenda. DW replied that JM wanted to bring a paper back to TEG on this topic. DWi stated his belief that form and function were critical. He stated that patient risk and safety were fortnightly standing agenda items but he would welcome a review of the structure although it was his belief that locality meetings were already robust. PD stated that the Bright Ideas scheme was a good development and asked whether a report could be produced to identify what suggestions were being implemented. It was agreed that SOL should present an update report at the February meeting.	**DW**

		Action
	Action: **SOL to present 'Bright Ideas' progress report at February meeting.** PD asked the Executive Directors whether they could let the NEDs know when they were due to go out on Listening Watch visits to enable them to accompany them when appropriate. It was agreed that they should let Jo Kane (JK) know when visits had been arranged and she would inform the NEDs. **Action:** **Executive Directors to inform JK when dates for Listening Watch visits agreed.** **JK to provide NEDs with dates of Listening Watch visits.** JN asked whether the paragraph about anonymised claims in the effective complaints handling section was inviting fictitious claims. JM replied that the Trust was bound by the Francis recommendations which stated that anything which caused moderate harm needed to be published in an anonymised form. It was agreed that JM and SP would meet with JN outside the meeting to discuss the complaints process. **Action:** **JM/SP to talk JN through complaints process outside meeting.** **Approval:** **The Quality Committee noted the progress, issues and risks as outlined in the paper and was assured with regard to the management of the Quality Governance Action Plan, including CQUINs and Quality Account.**	**SOL** **Execs** **JK** **JM/SP**
6.2	**FEEDBACK FROM NHS TDA QUALITY VISIT** SP provided a summary of feedback from the TDA's Quality Visit. A number of themes for further development and focus were highlighted and these were broadly issues about which the Trust was already aware. As there was significant overlap with the CQC's findings much had already been covered in the Quality Governance action plan. DW noted that an issue relating to legacy issues from former Trusts highlighted in the feedback related to South Yorkshire which seemed to be bit of an outlier. The other areas seemed to have a higher degree of integration which had been acknowledged by the TDA during the feedback meeting with the Chairman and him. SP stated that the feedback on staff involvement in the cost improvement process was focussed on how YAS engaged with staff at the front end of the process in identifying potential schemes rather than whether they were involved in delivery of the actual schemes.	

		Action
	DW stated that several CIPs had actually come through the Bright Ideas scheme. SP noted that some of the TDA's questioning had been in relation to report titles rather than principles. For example, 'what is your Francis report action plan?' JM was concerned that staff should not label things 'Francis' or 'CQC' as everything should be about professionalism. SP acknowledged that there were some pertinent points to reflect on and build into the Trust's plans. The TDA recommendations will be included in the Quality Governance action plan and extracted on a monthly basis to provide the TDA with a specific update. Although there was no requirement for the TDA to undertake a second formal Quality Visit they had offered to come back to carry out a further unofficial visit if the Trust thought it would be of assistance. SP stated that although Kim Smith, NTDA Quality Manager North, had originally been due to attend that day's meeting, it had been agreed that she would attend the February meeting instead.	
6.3	**REVIEW OF KEY QUALITY INDICATORS (IPR) / ACTION** SP provided a review of the key indicators reported in the Quality and Workforce sections of the Integrated Performance Report (IPR). EB requested an update on the recent problems in relation to the backlog of unprocessed patient record forms and the potential effect on the AQIs, etc. JM outlined actions taken to date to alleviate the problems being encountered on an on-going basis. He stated that by pulling clinical audit staff off other duties to input patient records forms for national reporting, claims, requests, etc the Trust had managed to provide an acceptable level of reporting during this time JM further stated that the software provider had agreed to come on site until the system was fixed. He stressed that there was currently no 'off the shelf' data processing software suite available that could handle such a huge amount of data on a monthly basis. SP outlined the broader consequences of the problems being unresolved for a longer period. JM confirmed that, although the current backlog meant that the Trust was not yet in a position to start pulling off data for the National Institute for Health and Care (NICE) audits, it was working around alternatives. For example, the Clinical Audit department structure had been changed to free up the Clinical Excellence Managers so that they could work with local staff to do local audits.	

		Action
	EB asked whether legal advice had been sought in relation to the Trust's position with the third party provider. JM replied that there some contractual issues on which Director of Finance, Rod Barnes, was working. EB asked why the ePRF training plan had been reduced from three days to one day per person. GJ stated that the 2014/15 training plan was currently at an early stage of development and although the launch of ePRF would be high profile, serious consideration was being given to whether a 3-day training plan was necessary for the system. Current proposals included one day of training followed by support 'on the road' and a paper would go to TEG for consideration in due course. SD stated that he had learned the majority of the system in under a day so he was unclear as to the benefit of people attending three days of training. PD agreed that three days of training did not seem to be necessary. SP stated that there had been a useful general discussion in the recent Clinical Governance Group meeting about changes to the current approach to clinical training. It was agreed that SOL would provide a further update on the provision of ePRF training at the February meeting. **Action:** **SOL to provide progress report on ePRF training plans at February meeting.** In section 3.11 PD asked why the national average for recording of pain scores in patients with below knee fractures was 72% whilst YAS was only at 57%. JM replied that the reason was currently unknown but he would look into the figures in more depth and report back at the February meeting. **Action:** **JM to provide exception report on recording of pain scores at February meeting.** In section 3.16 PD expressed concern about the large number of EOC and ABL complaints that had not been responded to in more than 25 working days, stressing that response rates needed to improve. PD asked why, in section 3.18, East was an outlier. SP replied that work was on-going in this respect, adding that PTS was also a fairly significant outlier and action was also being taken to work through this problem.	**SOL** **JM**

		Action
	PD asked whether there had been an improvement in the take up of flu jabs. SP confirmed that there had been. SP also confirmed that the completion rate of PDRs in the Standards & Compliance directorate was now well above 50% as a result of focussed activity in the NHS 111 team. DW stated that the next step would be to improve the quality as well as quantity and the Executive team and he were pushing for this. There was also a need to validate data, as the TDA suspected that the Trust was currently under-reporting. When considering section 4.4, Reasons for Absence, PD asked whether there were any issues in the background of which the Committee should be made aware, as anxiety and stress seemed to be increasing incrementally. She stated that she would welcome a report from the new Occupational Health (OH) providers about stress management in organisation at the February meeting. **Action:** **IB to present an OH report at February meeting re background reasons for stress absence and work taking place to combat this.** PD thanked SP for his update, adding that the standard of the report continued to improve. **Approval:** **The Quality Committee was assured, following questioning, with regard to the management action planned and under way.**	**IB**
6.4	**UPDATE ON MORTALITY INDICATOR** JM presented an exploratory analysis of mortality rates in ambulance services, focussed on on-scene patient deaths using the CAD stop code of “patient deceased”. JM stated that, as ambulance services had not needed to provide these figures to date, it had been difficult to work out YAS’ contribution to mortality. The work had been run as a pilot and a year’s worth of clinical incidents data had been pulled down and reviewed by SD. The figures had been quite reassuring with the overall mortality rate of all incidents attended by YAS being 1.07%, with a slight peak in the winter. JM stated that of greatest concern were deaths in the green categories, particularly in the known diabetic fitting, heart problems and choking with abnormal breathing codes, which were higher than expected. He further stated that AMPDS codes 12C03 and 11D01 would be considered in greater depth. Patient record forms would be pulled and the data looked at in more depth to try to identify learning for the future.	

		Action
	PD stated that the document had been a useful analysis and complimented JM on its thoroughness, adding that it would be good for the Quality Committee to receive an update report in six months. **Action:** **JM to provide a mortality indicator update report at June meeting.** DW questioned whether all stroke codes should be red. SD replied that they only went red if the patient was likely to need stroke care or thrombolysis. The call would be green if a patient woke up with the symptoms of a stroke. AA asked how the codes for further investigation had been identified when there were others with far higher mortality rates and higher patient numbers. JM replied that they had been chosen because a green-coded stroke call should be unlikely to have a high mortality rate and a known diabetic who was fitting would also not be expected to die in YAS' care. **Approval:** **The Quality Committee noted the findings of the exploratory analysis and supported the further work outlined to develop understanding of mortality data in the ambulance sector.**	**JM**
6.5	**NICE GUIDELINE AND QUALITY STANDARD REVIEW PROCESS** JM provided an update on the process of receipt, review, adoption and audit of NICE guidelines. He stated that Appendix 1 outlined the current process in place and Appendices 2 and 3 were examples of the type of information that came to the Clinical Governance Group. Appendix 2 was a breakdown of all of the appropriate NICE guidance that came into the Trust on monthly basis, the vast majority of which was not appropriate to the Trust as it related to acute care. Appendix 3 was an update on Quality Standards which were reported in a slightly different way. JM stated that the bulk of the guidance was 'business as usual' or contained very minor changes. PD stated she would like the Committee to receive a 6 monthly summary report of changes ie a short form version of Appendix 2 which included exception reporting of any changes which could lead to significant cost implications for the Trust. **Action:** **JM to provide a summary sheet of changes to the NICE guidance on a 6-monthly basis which included details of cost implications by exception.**	**JM**

		Action
	Approval: **The Quality Committee accepted the report as assurance that a robust process for NICE guidance evaluation and implementation was in place.**	
6.6	**SIGNIFICANT EVENTS AND LESSONS LEARNED** MH presented an update on specific events and lessons learned across the Trust for the period 23 August to 28 October. He confirmed that the HSE was satisfied that SI number 2013/30380 had been as a result of human error and no further action would be taken. SP stated that SI number 2013/30002 related to a national IT issue. He had written formally to the company to place YAS' concerns on record and a meeting had been arranged to reconcile the position. Although he had yet not received final confirmation that the problem had been resolved, SP confirmed that there had been no problems since the reported events. EB asked whether there was an internal mechanism in place to pick up incidents such as 2013/28771 when there was a delayed response for back up. JM stated that a piece of work was currently under way looking at how long it took to get an ambulance to the scene, any outliers in terms of time taken, mortality, etc. SP stated that a reason was yet to be found for SI number 2013/28738 and confirmed that immediate action had been taken in relation to the staff who had not reported the incident, as the Trust should not hear about incidents first from patients' relatives. He further stated that in SI 2013/28319 it looked as if the patient involved had experienced a cardiac arrest outside a public house but the outcome of the investigation was still awaited. JM confirmed as Caldicott Guardian he was satisfied that there were no significant issues arising from SI 2013/25733. SP stated that of the Trust's 28 open SIs 19 were currently awaiting closure. Delays were being experienced in relation to CCG/CSU feedback with the Trust unable to close off the SIs until such time as feedback was received. It was agreed that this problem should be picked up with the CCGs. **Action:** **SP to pick up issue of delayed SI feedback with CCGs.**	**SP**

		Action
	PD stated that the Health & Safety Committee had picked up on the increased number of falls and violence and aggression-related incidents and had requested a detailed report at its next meeting. She asked how the new response bags were being received by staff. JM replied that no formal feedback had been received to date but he would present an update at the February meeting. **Action:** **JM to provide update on usage of new response bags at February meeting.** **Approval:** **The Quality Committee noted the content in the report and supported the actions detailed in the paper.**	**JM**
6.7	**WINTER PLAN UPDATE** MFD updated the Committee on the Trust's winter planning arrangements and escalation process on which YAS' Head of Resilience, Ian Walton, had been working. He stated that the region's 17 Urgent Care Boards and 23 CCGs had increased the challenge for YAS in engaging with Commissioners on winter plans. He further stated that this was the first winter that YAS had hosted the region's NHS 111 service. MFD confirmed that the Trust's 'Winter Concept of Operations 2013' had been issued and circulated to all UCBs for their early information and moving forward, *ResWeb* had gone live within YAS and for its NHS partners. It was noted that no additional funding was currently forthcoming. PD observed that the Trust would have to accept the report and the wider risks around the system, pending further discussion with the Commissioners about winter resilience funding. EB stated her belief that the NHS 111 plan looked a lot less developed with the appendices quite limited. SP replied that the documents circulated were produced in September and a lot more work had been carried out since then. SP stated that the Trust was ensuring that recruitment for the 111 service was keeping pace with the high turnover of staff. Triggers for escalation and the management of patients were also being looked at where peak pressures were encountered. A discussion took place on funding allocations with EB stating that she could not gain full assurance as the Trust could not guarantee that it would receive additional funding for the winter period.	

		Action
	DW stated that he would follow up his initial letters to the CCGs requesting additional funding with phone calls to key individuals. The Committee acknowledged that although the Trust continued to push for additional funding, the situation was not yet resolved. DW recognised that the NEDs were not assured and agreed that, following a presentation from SP at the following day's TEG meeting, he would email an update to the NEDs. Further discussions would take place at the Board meeting at the end of the month and updates provided when appropriate. **Action:** **DW to provide NEDs with further updates on the Winter Plan at appropriate times.** **Approval:** **The Quality Committee was not assured but noted the report; noted the risks associated with wider system communication and NHS 111 service resilience in particular; and supported the further work under way to finalise the Trust's plans.**	**DW**
6.8	**RED PLAN** MFD presented an update on the Red Plan, which had been revised to ensure continued improvement from October 2013. He outlined the short/medium changes to Plan. These included: operational model changes to provide more staff cover at weekends and during evenings; and the introduction of a total of four Static Medical Units, two of which had already been implemented. Long term changes included the review of all operational A&E rotas, with the new rotas due to be rolled out in January 2014. DW stated that the changes to date had brought about a small positive impact on Red 1. It was his belief that, clinically, the organisation now had the right approach and Red 2 improvements should now follow. PD stated her belief that the report was missing a detailed risk section. In relation to the negotiations with Unison, PD questioned the professional acceptability of staff not interrupting their meal break to attend a Red 1 call. DWi stressed that the negotiations were under way with the Union because the introduction of the new rotas would lead to major changes in working practice. KW asked whether the Trust picked up the maintenance for the AEDs when it match-funded with the British Heart Foundation.	

		Action
	MFD confirmed that although it currently did this the Trust would need to fully work through and agree what its funding formally involved. DW stated that supportive local councils were very keen to engage with their local communities to facilitate the provision of defibrillators. The Trust would need to the remember that they could deliver a significant contribution to YAS' targets so it remained important that YAS did what it could to make sure this happened. DW asked whether the location of AEDs was linked to CQUIN 6. DWi confirmed that it was. PD requested a further assurance report to be presented at the February meeting which included a risk outline. **Action:** **DWi to present a further Red Plan assurance report at the February meeting, including a risk assessment.** **Approval:** **The Quality Committee supported the Plan agreed by TEG and agreed to receive further assurance reports on delivery in future Committee meetings.**	**DWi**
6.9	**SUB-CONTRACTOR GOVERNANCE** KW presented a report which highlighted the work currently being undertaken to strengthen governance arrangements for subcontractors delivering direct patient care and proposed relevant recommendations to support the delivery of this. She outlined the current system in place, noting that further work was under way to tighten up procedures in relation to some aspects of the on-going monitoring and review process. PD asked whether an auditable check list of the approach was available. KW confirmed that there was although part of the work of the Sub-Contractor Governance Group was to strengthen the checklist and build it more explicitly into policy going forward. It was agreed that KW would provide a further update at the February meeting. **Action:** **KW to provide a further update on Sub-Contractor Governance at the February meeting.** **Approval:** **The Quality Committee noted the current arrangements and supported the process outlined for further review and assurance.**	**KW**

		Action
6.10	**CIP QUALITY IMPACT ASSESSMENT (QIA) REVIEW** KW presented a paper, the purpose of which was to: • Assure the Quality Committee of the progress made in completing the Quality Impact Assessment (QIA) of the Cost Improvement Plans; • Provide an opportunity for the Committee to review and agree the risks and mitigations identified through the QIA process; • Report on the development and use of early warning indicators relating to the safety and quality of services. It was noted that this item would be covered in more depth during that day's joint Quality and Finance & Investment Committees' meeting. PD stated that this was a good piece of work, with the paper containing significant work on the detail of the process itself. Further details would be forthcoming during the later meeting. **Approval:** **The Quality Committee was assured, subject to the later joint meeting, with regard to the current position of the QIA monitoring; noted the implementation and progress of the early warning indicators; reviewed the risks and mitigations identified through the Quality Impact Assessment process.**	
6.11	**LOCALITY ASSURANCE REPORT – EMERGENCY OPERATIONS CENTRE (EOC)** BH presented an overview of the governance and assurance processes within the EOC; a detailed breakdown of the key performance indicators within EOC with key actions and interventions; and an outline of the next steps in relation to service improvement. Headlines included: revisions to the monthly EOC Clinical Governance Group agenda; the commencement of monthly individual performance management meetings with the new Duty Management team; the addition of new actions to the EOC Management Team meeting; workshops being held with every team to review SIs and lessons learned; and the provision of absence management training for all front line managers. PD asked how the absence management training would fit in with the proposed leadership management training. SP replied that the workforce team was working on a longer term approach and that their pilot activity would ultimately be aligned to the wider plan. BH stated that further work was needed on the time taken to answer 999 calls, as demonstrated in the table in section 3.2. He further stated that the re-contact rate had improved significantly in the last 12 months. A major element of this improvement was the reducing number of calls being sent through to NHS Direct.	

		Action
	BH stated that the EOC workforce was more or less at establishment. There were a lot of new call takers which was good for the winter plan and the last tranche were in training to be ready for the festive period. A recruitment plan was in place for the Clinical Hub to recruit to the full establishment and create a pool of bank clinicians. It was also hoped to recruit 10 EOC apprentices. BH stated that there had been a significant improvement in relation to PDR compliance, which would now be maintained and outlined details of the Quarter's complaints, etc on page 6 of the report. PD asked whether a section outlining the reasons for any complaints that had taken over 25 days to respond to could be included in the next EOC report. **Action:** **BH to ensure that reasons for complaint response times of over 25 days be included in next EOC report to Quality Committee.** BH stated that over the next few months EOC would concentrate on: • Enhancing the performance framework to ensure team specific data discussed at 1:1 and actioned accordingly; • Cultural survey for all staff; • 360 degree to be carried out with all band 7 managers to drive management competencies via individual 12 month development actions plans; • Reporting of the risk registers through Datix; • Continuing to review the complaints themes / trends and action accordingly; • Improving PDR compliance and support a systemic roll out of the new workbooks. PD stated there was a lot of good news in the report. EOC seemed to be embedding a team-based approach and it would be good to see an evaluation at the end of the first year. SP stated it had been a helpful report and the review and analysis of the data had been very useful. He commended this as an approach to be taken for future locality assurance reports, adding that it would be useful to share the report's format across other areas of operations. PD suggested that the report could be built into a template for use as the basis of future locality assurance reports. **Action:** **SP to consider EOC report to inform the template for future locality assurance reports in 2014/15 workplan.**	**BH** **SP**

		Action
	Approval: **The Quality Committee noted the interventions and processes outlined in the paper and was assured by the actions being undertaken.**	
6.12	**SERVICE TRANSFORMATION PROGRAMME UPDATE** KW provided an update on developments, issues and risks in relation to the Service Transformation Programme. She stated that the TPMG had agreed to meet monthly to tie in with the project groups' monthly meetings and on the top of each agenda was a review of the policy deployment matrices. SP stated that a workshop, which would inform the BDM meeting on 3 December, had taken place the previous week and the Programme dashboard (appendix 1) summarised the position to date. EB asked whether a chart of roles and responsibilities could be produced and shard with the Board. **Action:** **KW to update Service Transformation Programme structure chart and share with the Board.** PD stated that more details about on-going projects, mitigations, etc would be useful. As some spanned more than the current year it would give an indication of priorities for the following year. **Action:** **KW to share information with Board about on-going projects and plans for 2014/15.** **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.**	**KW** **KW**
7	**<u>WORKFORCE</u>**	
7.1	**WORKFORCE UPDATE REPORT** GJ presented an overview of matters relating to workforce issues, including education and training, equality and diversity and employee wellbeing. He stated that there was continued concern about the behaviour of Unite the Union. A meeting with ACAS was arranged for 19 November to explore the current issues further. GJ confirmed that A&E and EOC headcount had been achieved.	

		Action
	DW stated that A&E headcount numbers had been increased from 2106 to 2164 staff at no additional cost to allow Clinical Supervisors the guarantee of being able to work more closely with their team members. GJ stated that the Trust's new values based recruitment was being used as a case study by NHS Employers. An internal audit of recruitment had identified examples of good practice and highlighted a number of recommendations for improvement. He further stated that the Occupational Health reporting had gone live on 1 November. There had been a few teething problems and some data issues but this should settle down in a couple of months. Flu jab take up was increasing which was positive news. There had been initial problems with vaccine stocks which had been overcome. DW stated that vaccine usage would suggest a current 30% take up but data was coming in via various routes and was not feeding through quickly enough. GJ stated that, in relation to unsocial hours' payment deductions, it had been agreed to suspend deductions to staff absent due to sickness and trade unions had agreed to suspend their industrial action ballots. It was planned that talks would be held on what unsocial hours' arrangements should apply during sickness absence, including the potential application of Section 2 and options to change Annex E. Deductions from Annex E payments would cease with immediate effect, with no back-dating to 1 September 2013 and no deductions would be processed for October. In addition, monies deducted from Annex E payments to date would be repaid in February 2014. GJ stated that YAS' values based induction, which followed on from the recruitment process, went live from 1 November. Learning from the pilot would be developed over the forthcoming months. PD asked whether consideration could be given to running sessions for the rest of YAS' staff. JM stated that this had been discussed but was at a very early stage. PD asked what action would be taken in relation to technicians not presenting themselves for paramedic training. GJ replied that this was always going to be a year one issue, which should be resolved in year two as the process became embedded. SP commented on the specific challenges in relation to the recruitment of 111 staff, arising from the need for rapid recruitment to support the mobilisation process and on-going high level of staff turnover. The standard recruitment process had been adapted to meet the needs of the service.	

		Action
	SP had met with IB to talk about how to handle the situation going forward to ensure that the process was adequately supported. GJ confirmed that no adverse issues had arisen from the process variations, which had been carefully planned and risk assessed. **Approval:** **The Quality Committee formally reviewed, was assured by and scrutinised the Workforce Update Report for October 2013.**	
7.2	**CLINICAL LEADERSHIP PROGRESS REPORT** DWi outlined progress to date on the Clinical Leadership Framework. He confirmed the development of the Clinical Leadership dashboard, adding that a series of quantitative and qualitative metrics had been agreed which would change to reflect the work undertaken as the service matured. DWi stated that useful feedback was being picked up from Team Brief sessions as the Clinical Supervisors (CS) gained in confidence and experience. The CS baseline survey had been very much around quality and would be used in CS planning days with SOL and her team. PD stated that she would have liked to have seen a risk section on the dashboard but she was glad to see that it was shared. PD asked whether information could be included in the next report about what CSs were doing that they should not be doing. It would also be good to look at the number of completed PDRs and how new starters were inducted, which were issues raised at the recent Clinical Quality forum. EB stated that she would like to see some success stories and a greater depth of spread and reporting across the various localities. **Action:** **DWi to include additional qualitative information in the February Clinical Leadership report.** SP stated it was good to see the dashboard developing but feedback from the staff being supervised was still missing. DWi stated that the next step would be to carry out a pulse survey as soon as practically possible with a view to this being done on at least a quarterly basis. **Approval:** **The Quality Committee noted the update report and supported:** • **The Clinical Leadership Framework Dashboard Tool in its current state and proposed direction of travel;**	**DWi**

		Action
	• **The intention to undertake a clinical supervisor baseline survey;** • **The intention to undertake a series of clinical supervisor development days.**	
7.3	**ANNUAL EDUCATION & TRAINING PLAN DELIVERY – PROGRESS UPDATE** GJ outlined current progress in relation to the on-going development and delivery of the education and training plan. The biggest issue related to the Technician to Paramedic conversion which had implications for the wider workforce plan. PD stated that the development of the Diploma in Health Care Support for Emergency Care Assistants was good news. DW asked whether the numbers in section 4.4 reflected the additional staff establishment of 2164 instead of the original 2106. GJ confirmed that it did. He added that, to keep numbers consistent, there had to be constant recruitment and he was not confident of reaching the new total by the proposed date. DW stated that he would bring these concerns back into TEG. **Action:** **DW to raise GJ's concerns about recruitment in TEG.** JM stated members of staff who had not attended a Clinical Update for two years had been targeted with the aim that by the end of 2013/14 everyone would have been picked up to start afresh in 2014/15. GJ replied that he was not sure how much progress had been made and agreed to look further into the matter. It was his belief that 53 people were still outstanding. **Action:** **IB to report back to the February meeting with an update re how many staff still needed to attend a Clinical Update.** **Approval:** **The Quality Committee reviewed and was assured by the content of the report.**	**DW** **IB**
8	**<u>RISK MANAGEMENT</u>**	
8.1	**BOARD ASSURANCE FRAMEWORK (BAF) AND CORPORATE RISK REPORT (CRR)** MH presented an update giving assurance that the Board Assurance Framework (BAF) for 2013/14 had been updated following peer review and to validate that the Audit Committee supported that progress towards achievement of the objectives.	

		Action
	A key change was the introduction of the progress notes column in Table 1 which was related to the objectives with the narrative giving the reasons for any movement. PD noted that there were a significant number of actions due for completion by October and requested an updated version of the paper be presented to the Board at its November meeting. She further stated that the BAF was turning into a readable, easily digestible document and asked that a report be provided at the February meeting which provided information about the risk of any actions not being completed by March 2014. **Action:** **SP to provide an update of any actions at risk of not being completed by March 2014 at the February meeting.** **Approval:** **The Quality Committee accepted the proposals outlined relating to completion and update to the Framework and agreed assurance relating to the risk management processes.**	**SP**
8.2	**MID-YEAR INFORMATION GOVERNANCE REPORT / IG TOOLKIT REVIEW** MH provided a mid-year update on the management of information governance and the IG Toolkit and assurance that the arrangements were being managed effectively. He stated that the Trust was improving its compliance levels with assurance via the two Internal Audits already undertaken and a third audit planned for Quarter 4. PD asked whether there were any Trust-wide issues in relation to how documents were stored, disposed of, etc. MH replied that there had been a recent amnesty and the Trust was doing everything it could to ensure all documents were captured. It was his belief that there were currently no significant problems although the work was not yet complete. JM stated that he was comfortable with the processes in place. SP confirmed that the Information Governance Manager had been making significant inroads into a number of on-going issues. **Approval:** **The Quality Committee noted the current position and was assured in regard to the effective management of information governance.**	

		Action
9	**ANY OTHER BUSINESS**	
9.1	**ANY OTHER BUSINESS** There was no other business.	
9.2	**ISSUES FOR REPORTING TO BOARD & AUDIT COMMITTEE** Key issues to highlight in the Committee's reports were: • The Quality Committee noted that further work was on-going in relation to winter resilience planning; • The Red Plan needed to be further refined and an update presented in the February meeting; • The limited assurance internal audit report around CFRs needed to go to the Audit Committee and back to Quality Committee in February; • A further update report was requested on the Clinical Leadership framework for next meeting.	
9.3	**REVIEW OF COMMITTEE WORK PLAN** No concerns were raised in relation to the workplan.	
9.4	**REVIEW OF MEETING ACTIONS AND QUALITY REVIEW OF PAPERS** PD stated that the general standard of papers was improving although a couple needed to have a risk section added and several others did not list the Committees by whom they had previously been considered. She asked that these issues were addressed for the next meeting. PD thanked everyone for attending what would be a long day of meetings. The meeting closed at 12 noon.	
10	**DATE AND LOCATION OF NEXT MEETING** 6 February 2014, the Boardroom, Springhill 2, WF2 0XQ.	