Yorkshire Ambulance Service NHS
NHS Trust

Minutes of Joint Meeting of the Finance & Investment / Quality Committees

Venue: Kirkstall and Fountains, Springhill 1, WF2 0XQ
Date: Tuesday, 12 November 2013
Time: 1230 hours

Chairman: **Elaine Bond**

Attendees:

Dr Elaine Bond	(EB)	Non-Executive Director
Pat Drake	(PD)	Deputy Chairman/Non-Executive Director
Erfana Mahmood	(EM)	Non-Executive Director
Dave Whiting	(DW)	Chief Executive
Dr Julian Mark	(JM)	Executive Medical Director
Rod Barnes	(RB)	Executive Director of Finance & Performance
Steve Page	(SP)	Executive Director of Standards & Compliance
Michael Fox Davies	(MFD)	Interim Executive Director of Operations
John Nutton	(JN)	Non-Executive Director – Designate (Observer)
Karen Warner	(KW)	Associate Director of Quality
Anna Rispin	(AR)	Associate Director of Finance
Anne Allen	(AA)	Director of Corporate Affairs & Trust Secretary (Observer)
Alan Baranowski	(AB)	Associate Director, PTS *(Item 2 only)*
Joanne Halliwell	(JH)	Associate Director, PTS *(Item 2 only)*
Ben Holdaway	(BH)	Locality Director – EOC

Apologies:

Barrie Senior	(BS)	Non-Executive Director (Observer)
Mary Wareing	(MW)	Non-Executive Director
Ian Brandwood	(IB)	Executive Director of People & Engagement
David Williams	(DWi)	Deputy Director of Operations

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

		Action
	The meeting commenced at 1230 hours.	
1	**INTRODUCTION TO MEETING** EB welcomed everyone to the meeting, the aim of which was to receive updates on the main Cost Improvement Programme (CIP) schemes. Apologies were noted as above. EB stated that the meeting had been arranged following a suggestion at Board that it would be useful for the financial and quality aspects of the CIP Schemes to be considered in a joint meeting.	
2	**PTS** EB welcomed the two PTS Associate Directors, JH and AB to the meeting to provide an update on the PTS CIP.	

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	JH confirmed that her role concentrated on the planning and strategy side of the service whereas AB's role concentrated on the service from an operational perspective. She stated that the three main CIP schemes during 2013/14 were: • Subsistence Payments, worth £80k, which had delivered in full year to date and which was expected to be fully realised; • Apprentice Expenses, worth £32k, which had delivered in full year to date and which was expected to be fully realised; • PTS Transformation Programme, worth £2,900k, based on an August 2012 business case. This scheme had partially delivered (£1.3m) and mitigation schemes were currently being developed to cover the remainder of the balance. The original August 2012 business case was comprised of three component parts: • PTS management (original value £106k). The management structure had been streamlined with Locality Director and Heads of Service roles removed and the scheme had secured £191k; • PTS Communications and Controls (original value £193k). Workforce numbers had been rationalised and although the new management structure was currently in consultation, the scheme had secured £267k; • PTS front line staffing and vehicles (original value £2.6m) had only secured £842k to date as the component had been dependent on baseline assumptions in the case which had not been delivered for a variety of reasons. JH stated that the original financial assumptions of the PTS Transformation programme had been based on key assumptions regarding: demand; patient mobility; income; contracts; and a full year effect of staff and vehicles out. These figures had now been revisited. She stated her belief that the 2013/14 PTS CIP of £2.9m was still achievable if the support requested was made available; activity declined as predicted; staff and vehicles could be taken out of the operating model; and income was retained. JH stated that when the plan was originally drafted a number of key assumptions underpinned it. These included: • Additional operational support would be available. This had been secured from 1 November 2013; • Demand would decline, which had not been the case with overall demand in the current year predicted to be approximately 8000 journeys up on original predictions; • Patient mobility changes would favour more complex mobilities; • There would be no loss of contracts. However, YAS did not bid for the South Yorkshire discharge contract which removed both PTS and GP Urgent activity from Sheffield; • Income and contract structures would remain constant; • Eligibility criteria would be more rigidly applied, which had not been the case;	

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	• Abortive journeys would reduce but these remained constant; • Vehicle availability would support operational delivery but although there were now some newer vehicles in the fleet, more reliable vehicles were still required. The milestones associated with the rota implementation had been reviewed. Delays in South meant the Trust needed to review the whole programme and limited specialist resources to carry out the modelling and rota design work meant that delays had occurred. JH stated that early indications in South were that the 10 hour shift pattern was not working as well as it had been hoped, adding that a major challenge had been tackling the current approach to flexible working which had been a strong cultural shift. Several new schemes and mitigations had been worked up and costed and were currently in the process of being implemented. These schemes included: • Expanding the number of PTS Volunteer Drivers; • Although there was currently no central resourcing model in PTS, the service was aiming to develop a 'Bank' of workers with zero hours contracts (around 20 wte in 2013/14 and a further 20 wte in 2014/15). However, broader discussions were still required about the wider implications of managing the "bank"; • Additional income (non-recurrent) being linked to recurrent winter monies. JH confirmed that an unplanned care desk was currently being manned to 2am every day as a pilot; • Eliminating 'run backs'. AB reported that 'run backs' took around 40 minutes on average so significant savings could be made if this mitigation was introduced. PD agreed that the establishment of a central bank would be useful and DW confirmed that IB would be closely involved in this work. JH stated that other potential opportunities for mitigation schemes, some of which were more mature than others, included: • The introduction of a volunteer portering service with a joint pilot with NEAS was being considered at James Cook hospital; • A review of shift allowances - a transactional, one-off exercise; • The introduction of patient reception centres across the region; • PTS Fleet and Telemetry introduction; • The introduction of automated booking processes; • Income through private patient services; • Pricing model at cost per journey and activity caps by case mix. JH stated that the final option would be a huge piece of work for PTS but it would provide an income opportunity with a move away from the current block contract. EB asked whether any benchmarking data was available to compare YAS' costs, etc with those of private providers.	

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	JH replied that YAS currently tended to be more expensive per journey. She stated that, in addition to operational data, quality impact was reviewed fortnightly by the PTS Project Team with each review incorporating: performance; people; programme delivery; finances; and patient experience. PD asked whether patient incidents were also considered. JH confirmed that incidents and complaints were considered as part of the 'people' section. JH stated that risks to delivery included project slippage due to: • Capacity; • Competing priorities; • Complexity and interdependencies; • Staff and staff side engagement. She further stated that a constant issue for PTS was the fact that although heavy investment was made in staff training, as soon as people gained valuable experience, many of them wanted to move on to A&E. The constant drain of resources was damaging to the business as it meant that PTS was constantly recruiting. EB stated that the presentation had been very encouraging, adding that the detail contained in the papers was excellent. PD asked whether the current drop in sickness levels was sustainable. JH replied that if the current level of around 6% could be maintained until the end of the year this would be a significant improvement on the previous year. She further stated that the increased take up of flu jabs was encouraging, as was the fresh approach being taken by the new locality manager in South. JM and SP were both happy with progression from a QIA perspective. EB thanked JH and AB for their presentation.	
3	**A&E SKILL-MIX & OVERTIME** MFD presented the A&E Operations Directorate's updates as DWi had a long standing prior commitment. An operational sustainability challenge was the need to maintain emergency performance at 75% in a context where there was: • An expected 17% service demand increase in the five years to 2016/17; • An economic climate of austerity with a need for public sector savings; • A changing service Commissioning environment in the NHS; • An emerging market risk with an increasing number of alternative providers.	

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	MFD outlined the details of the three phases of the A&E Operations service redesign programme development, the implementation of which remained planned for January 2014. He stated that the programme was due to bring in savings of around £3.9m, which was a significant proportion of the total £10.9m CIP programme. The Redesign Programme included work on: • Skill mix, with the move to the Band 5 (Paramedic) and Band 3 (Emergency Care Assistant - ECA) model due to save around £2.1m; • Overtime, with the A&E Workforce Plan and rota redesign reducing overtime need by around £920k; • Clinical Leadership, with the introduction of the Clinical Supervisor role due to bring in savings of around £619k; • Rest Breaks, with the removal of payments for missed rest breaks saving around £688k; • Clinical Hub, with work on workforce capacity, call triage and reduced conveyance due to bring in savings of around £1.4m; • EOC Establishment, designed to meet the expected emergency calls in the Hub, which should bring in savings of around £194k. MFD outlined the key deliverables of the skill mix work, which were: • A workforce model based on Paramedic Band 5:ECA Band 3; • Paramedic numbers increasing over the life of the plan; • A Paramedic on every DCA & RRV; • Specialist Paramedic numbers maintained; • ECAs to work under the supervision of a clinician at all times and not to respond as single responders; • Emergency Technician role to be phased out through a combination of factors; • ECA role deemed suitable for conversion of Assistant Practitioners (APs) and Intermediate Care Assistants; • Clinical Leadership arrangements to be significantly enhanced with the implementation of a single Clinical Supervisor team, aligned on a ratio of 1:16 front line clinicians. As of 31 October 2013. Overall figures were on track with actual figures currently standing at 2,091against a plan of 2,106. Key issues included: • Band 3 competency in relation to conversion to ECA role; • 300 Technicians with no motivation to convert to Paramedic; • Technician failure rate on the Paramedic conversion courses; • Staff side lobbying for a residual Urgent Care Tier for Band 3s. MFD confirmed that the A&E Workforce Plan of £2.1m savings in 2013/14 was currently on target although remaining risks included: • Lower than forecast activity levels could affect the CIP going forward; • Failure to deliver reduced B5 Technician numbers, which would require an action plan.	

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	DW confirmed that the number of Technicians had already dropped from 452 to 325. A discussion took place around the issue of protected pay. PD expressed concern that staff might wait for 4 years before deciding to convert and asked whether it could be made clear to Unison that conversions would need to take place as soon as possible. RB replied that although Unison was aware of the likelihood that pay protection might be wound up before the end of the five-year period he was happy to reiterate this message. MFD confirmed that the A&E Overtime CIP Plan of £932k savings in 2013/14 was also on target with workforce plan and rota redesign implementation reducing dependency on overtime. The cumulative October position was a £810k reduction in overtime expenditure compared with the corresponding period in 2012/13. The main risk related to increased overtime usage following the withdrawal of private providers in October 2013. It had been agreed that the position would be monitored on a monthly basis and a draft mitigation plan would be created. EB asked whether A&E Operations was currently on track to make its £3.9m scheduled savings. MFD confirmed that this was the case. She stated that the current £2m overspend in A&E because of the use of private providers alongside the statement that the CIP was on track did not give her the assurance she desired, especially as missing targets could lead to possible performance penalties. MFD replied that recruitment was on-going to ensure the achievement of the planned 2,106 workforce which would in turn release the Trust from its reliance on private providers. DW stated that although some CIPs were under-performing, others were over-performing so the Trust would need to ensure it had an effective bridging plan in place. He added that certain elements of the Red Plan would also need to be brought forward. JM stated that it was implicit that Clinical Supervisors would be Band 6 specialist Paramedics who would be appointed from the current Band 5 Paramedics. This would put a pressure on the whole model which had yet to be fully discussed. MFD outlined the comments and recommendations coming out of the Quality Reviews: • Clinical Quality: Staff engagement was included in the plan through union representation and direct communications to staff; • Impact on Operational effectiveness: KPIs and early warning indicators had been identified, which included performance, clinical incidents, complaints and sickness levels;	

		Action
	• Patient Experience: An expert patient was involved through the Quality Committee and CGG; • Patient Safety: The potential to impact on quality and performance meant that the tracking of KPIs, early warning indicators and early escalation would become increasingly important once the plan went into implementation phase. SP stated that intrinsically the developments were a good idea but phasing and balance were the keys to their success. Early warning indicators had been built into the Locality Directors' dashboards and nothing was currently standing out as an adverse quality impact. EB thanked MFD for his update.	
4	**CLINICAL LEADERSHIP** MFD stated that the Health & Social Care Bill (2011) outlined a Central Leadership Role for Clinicians. The Clinical Leadership Competency Framework (CLCF), which applied to all clinicians at all stages of their professional life, was the basis for the A&E Clinical Leadership Redesign and appropriately pre-empted the full A&E Workforce Redesign Programme Implementation. MFD outlined the Clinical Leadership Redesign objectives, which were: • Provide effective clinical leadership, mentorship and supervision for A&E staff, irrespective of role, banding or skill level; • Provide support mechanisms for all staff; • Promote a clear line of responsibility and accountability; • Provide consistent and effective education and training; • Provide a flexible workforce responsive to changes including rising demand, expectations and changes in national and local strategies. The benefits of the Clinical Leadership Redesign, all of which were clinical, included: • Provision of clinical leaders to drive service quality improvement and health outcomes for patients; • Improved clinical competence and confidence; • Delivery of consistent safe practice; • Improved patient experience and clinical outcomes with positive impact on Trust and staff reputation; • More efficient training and assessment programme for staff through new, more localised arrangements; • Significantly increased clinical leaders' patient facing time with provision of supervision in the field. MFD stated that the Clinical Leadership Redesign Programme would: • Enhance the quality of patient care by significantly increasing patient facing time of Clinical Leaders; • Release cost savings equivalent to £1m in 2013/14 with 4 B6 Clinical Leadership (CS) posts held vacant and a recurrent saving of £618k from 2014/15 with B3 recruitment to B6 Posts;	

		Action
	• Include a review of agreed A&E Workforce Plan based on confirmed 2,106 frontline numbers and a specified requirement for 124 CSs to drive safe leadership on a 16:1 staff ratio to deliver the CIP. He confirmed that the main risk in relation to the Clinical Leadership Framework remained Clinical Supervisor (CS) recruitment numbers. However, things were on target with 118 CSs out of a planned recruitment figure of 124 currently in place with an advertisement due to be placed shortly for the remaining vacancies. KW asked whether the remaining posts would be development posts and if so, how it was envisaged that the arrangement would work. MFD replied that the development posts were to ensure arrangements for succession planning were in place and agreed to clarify whether the six posts going out to advertisement were development or permanent. **Action:** **MFD to clarify whether the CS posts to be advertised were permanent or development posts.** PD stated that the development posts were seen as a flexible dynamic, more information about which was to be provided to the Quality Committee for further consideration. Feedback from the Quality Impact Assessment review included: • Impact on Operational Effectiveness: 'Long term monitoring and management of clinical training is required to ensure effectiveness and full implementation of leadership framework'; • Patient Experience: 'Expert patient involvement through CCG and QC'; • Patient Safety: 'Improved arrangements for Clinical Supervisors'. EB acknowledged MFD's statement that the CIP was on track to meet its year-end target but asked whether F&IC could be provided with 'before and after' figures to clarify this and provide assurance. **Action:** **MFD to provide F&IC with figures to clarify that the Clinical Leadership CIP was on track to meet its year-end target.** PD stated that, in terms of the Quality agenda, there was a need to demonstrate that the revised 1:16 from 1:15 staff ratio would have no negative effect. JM stated there was no evidence that the increased ratio would negatively affect the quality of patient care. It was his belief that the development posts would be more of a risk from a quality perspective so careful planning would be needed in relation to their geographical distribution, etc.	**MFD** **MFD**

		Action
	Action: **Quality Committee to consider geographical distribution of Clinical Supervisor development posts.**	**PD**
5	**CLINICAL HUB** BH stated that the Clinical Hub CIP, which had been built on the number of incidents closed by the Hub, was an efficiency rather than cash saving which would be delivered through overtrade assumptions. He further stated that the value of the CIP would be £1.4m in 2013/14 and £1.2m per annum for the next 4 years and explained how the numbers had been built in. BH showed a graph of the 2013/14 actual versus trajectory, which showed current performance at £100k over trajectory for year to date. He stated that the project plan included: • Designing a specific training and development package; • Individual performance reports; • Improved referrals options; • Access to alternative systems such as the Directory of Services; • Recruiting to establishment; • Peer review with East of England, a good 'hear and treat' trust; • A new team management structure for the hub. BH stated that there had been a step change over the past 12 months and the changes were now starting to embed in much the same way as Clinical Leadership in EOC. As the Hub had been neglected over the years, the new team management structure and training and development were the absolute keys to the success of the project plan. He confirmed that the three main risks identified in the Quality Impact Assessment were: • Impact on clinical quality - telephone triage might deliver poor outcomes if procedures for staff training were inadequate. The mitigation for this was to ensure robust procedures and training delivery in addition to an on-going audit of processes. • Impact on patient safety – the potential impact on face to face care if the triage process was ineffective. The mitigation for this was monitoring operational KPIs and early warning indicators. • Impact on patient and carer experience - some patient groups might be adversely affected by receiving telephone rather than face to face care. The mitigation for this was a review of the needs of specific patient groups and monitoring of the patient experience survey. He further stated that the quality indicators being used were: • AQI Re-contact Rate following Telephony advice; • Complaints & Incidents following Heat & Treat outcome; • Patient satisfaction Survey; • Percentage of calls closed through telephony advice.	

		Action
	EB asked what the main challenges would be until the end of the year and what further changes the organisation could expect to see. BH replied that leadership would become embedded, adding that although the CIP would be delivered, it would not be over and above the 2013/14 planned level. He stated that the number of NHS Direct calls was slowly decreasing with the total number per month now down to less than 600. By January 2014 all calls would be back in the Hub. PD requested details of the training package on offer. BH replied that managers would participate in YAS leadership training. Other training would include specific triage training. He stated that remaining risks included: • The current recruitment and workforce plan; • Staff rising to the challenge; • Release and funding for Training and Development; • Clash of priorities (RED assessment, etc); • Access to referral pathways including the DoS; • Operating model and abort rates; • Future year trajectory and questioning assumptions made. EB asked where YAS' Clinical Hub's performance stood nationally. BH replied that it was mid-range. RB stated that the Clinical Hub's advice line was currently outside the scope of the business case. BH replied it would need to be included. It was agreed that further discussions would take place outside the meeting and that the Service Transformation Group should schedule a deep dive into the CIP for a future meeting. **Action:** **Service Transformation Group to schedule a deep dive into the Clinical Hub CIP at a future meeting.**	**SP**
6	**SICKNESS MANAGEMENT** EB expressed disappointment that no one had been available from the HR department to present an update on sickness management. DW stated that he would discuss this with IB and ensure that an update was provided to Committee members as soon as possible. **Action:** **DW to liaise with IB re urgent provision of an update on sickness management.**	**DW**
7	**CLOSING COMMENTS** EB asked those present for their comments on the meeting.	

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	PD stated that the meeting had been very useful, adding that it would be a good idea to carry out a similar review of schemes twice a year. SP agreed that it had been a useful exercise to look at the CIPs from a financial and quality perspective in the same meeting. PD stated that she had been nervous about YAS' use of banks due to the large number of clinical risks. It was good therefore to see some organisational principles being introduced around the use of banks. The meeting closed at 1400 hours.	