Yorkshire Ambulance Service NHS
NHS Trust

An Aspirant Foundation Trust

MEETING TITLE Trust Board Meeting in Public				MEETING DATE 22/07/2014	
TITLE of PAPER	Board Memorandum on Quality Governance			PAPER REF	5.5
STRATEGIC OBJECTIVE	All				
PURPOSE OF THE PAPER	The purpose of the paper is to present the updated Board Memorandum on Quality Governance to the Trust Board for approval.				
For Approval	☒	**For Assurance**		☐	
For Decision	☐	**Discussion/Information**		☐	
AUTHOR / LEAD		ACCOUNTABLE DIRECTOR			

DISCUSSED AT / INFORMED BY – include date(s) as appropriate (*free text – i.e. please provide an audit trail of the development(s)/proposal(s) subject of this paper)*:
The current version has been informed by Executive Director and Senior Manager discussion and by feedback from the Internal Audit review of Quality Governance.

PREVIOUSLY AGREED AT:	**Committee/Group:** Quality Committee	**Date:** 12/06/2014
RECOMMENDATION	It is recommended that the Trust Board approves the Board Memorandum on Quality Governance as an accurate reflection of quality governance arrangements in the Trust.	

RISK ASSESSMENT	Yes	No
Corporate Risk Register and/or Board Assurance Framework amended *If 'Yes' – expand in Section 4. / attached paper*	☐	☒
Resource Implications (Financial, Workforce, other - specify) *If 'Yes' – expand in Section 2. / attached paper*	☐	☒
Legal implications/Regulatory requirements If 'Yes' – expand in Section 2. / attached paper	☐	☒
Equality and Diversity Implications If 'Yes' – please attach to the back of this paper	☐	☒

ASSURANCE/COMPLIANCE	
Care Quality Commission Registration Outcome(s)	All
NHSLA Risk Management Standards for Ambulance Trusts	1: Governance

1. PURPOSE/AIM

1.1 The purpose of this paper is to present the updated Board Memorandum on Quality Governance to the Trust Board for approval.

2. BACKGROUND/CONTEXT

2.1 As part of the Foundation Trust application process, Trusts are required to confirm and evidence that they have robust governance arrangements in place.

2.2 The Guide for Applicants contains model statements in two appendices: The self-certification statement and Board Memorandum on Quality Governance and 14 additional statements relating to Board assurance on a range of other governance issues.

2.3 The Guide to Applicants was updated in April 2013. The template for the Board Memorandum on Quality Governance was unchanged as part of this update, although there were formatting changes and a number of amendments to the content of the 14 additional statements to reflect changes arising from the Provider Licence :

- Removal of a statement about quality governance which duplicates the content of the Board Memorandum.
- Change of statement relating to registration and revalidation of medical practitioners, to include all registered health care professionals
- Expansion of statements relating to planning, performance management and risk management processes
- Removal of reference to the Board operating within its constitution and to governor elections
- Expansion of statement relating to adequacy of management structure

2.4 Monitor defines quality governance as *"the combination of structures and processes at and below board level to lead on Trust-wide quality performance including:*

- *ensuring required standards are achieved*
- *investigating and taking action on sub-standard performance*
- *planning and driving continuous improvement*
- *identifying, sharing and ensuring delivery of best practice identifying and managing risks to quality of care"* (Monitor, 2013)

3. CURRENT POSITION

3.1 The Trust has previously commissioned Deloitte to undertake external assessments of Trust quality governance arrangements in relation to the framework set out by Monitor. The initial exercise was completed in July 2011, giving an overall score of 5.5 (3.5 or below is a compliant score). An action plan was agreed and implementation has since been monitored via the Quality Committee. These actions are now all complete.

3.2 Deloitte subsequently completed two further reviews in February 2012 and July 2012, to give external assurance on progress against the agreed action plan. The scores arising from these exercises were 4.0 and 3.5 respectively.

3.3 A final assessment by Deloitte was completed in February 2013, taking as its starting point the then Board Memorandum on Quality Governance. The assessment was based on an entirely fresh review of documentary evidence supplied in January/February to substantiate each statement made in the Memorandum. The final assessed score for this exercise was 3.0 (a further improvement on the July 2012 position).

3.4 A small number of recommendations were made in the report. These are captured in the Quality Governance Development Plan and implementation has been via reports to the Quality Committee.

3.5 More recently Internal Audit has conducted a review of the Quality Governance arrangements in the Trust and has reviewed the evidence to support the Board Memorandum on Quality Governance. The report following this exercise has been received in final draft form and will be presented in full to the next Quality Committee. Overall scores remain unchanged and compliant with Monitor requirements, with a number of areas showing improvement since the last review. The Quality Governance Development Plan will be updated in the light of any new recommendations.

3.6 Following presentation and approval at the Quality Committee in June 2014 the Board Memorandum on Quality Governance is attached at Appendix 1. The document attached includes a number of updates to reflect changes in process since the last iteration. It also includes issues highlighted in the Quality Committee and refinements highlighted as part of the initial feedback from the Internal Audit review.

4 PROPOSALS/NEXT STEPS

4.1 Subject to Board approval and agreement, the Board Memorandum on Quality Governance, additional statements and associated evidence will be made available to the NHS Trust Development Authority as part of the next phase of assessment. The timescale of this remains unclear at this stage but will be reported through both Quality Committee and Trust Board as the detail emerges.

4.2 The Standards and Compliance team will refresh the system to sustain the evidence requirements and ensure alignment to the specific elements of the Quality Governance Framework.

4.3 The Quality Governance Development Plan will be refreshed to reflect the Internal Audit recommendations.

4.4 Progress on the Quality Governance Development Plan will continue to be reviewed at each meeting of the Quality Committee. Examples from the Internal Audit of the areas of strength include:

- updating of the Clinical Quality Strategy to reflect national enquiries
- improvements in locality level performance and quality dashboards
- improvement to IPR content and format
- expanded scope of Internal Audit plan
- risk flows between Committees strengthened

Examples of areas for further development include:

- staff engagement with Clinical Quality strategy, which will be taken forward as part of the refresh of the strategy, for 2015 onwards
- embedding of Clinical Leadership Strategy
- risk management system embedded at all levels
- A more structured process for feedback for “Listening Watch”

4.5 It is anticipated that the Monitor guidance and statement may be further amended during the year in the light of the recommendations of the Public Inquiry into the Mid-Staffordshire NHS Foundation Trust. The Trust will therefore need to undertake a further internal review at this stage.

5. RISK ASSESSMENT

5.1 There are no requirements to amend the current risk registers.

6. RECOMMENDATIONS

6.1 It is recommended that the Trust Board approves the Board Memorandum on Quality Governance as an accurate reflection of quality governance arrangements in the Trust.

7. APPENDICES/BACKGROUND INFORMATION

7.1 Appendix 1 - Board Memorandum on Quality Governance July 2014

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NHS Trust

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Proforma Board Statement on Quality Governance Arrangements and table of contents for Board Memorandum

Private & Confidential
Monitor – Independent Regulator of NHS Foundation Trusts
4 Matthew Parker Street
London
SW1H 9NP

July 2014

Quality Governance – Yorkshire Ambulance Service NHS Trust

In connection with the application of Yorkshire Ambulance Service NHS Trust for NHS foundation trust status, the board of directors confirm that:

- The board is satisfied that, to the best of its knowledge and using its own processes (supported by Care Quality Commission information and including any further metrics it chooses to adopt), the Trust has, and will keep in place, effective leadership arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients, including:
    - Ensuring required standards are achieved (internal and external[1])
    - Investigating and taking action on substandard performance
    - Planning and managing continuous improvement
    - Identifying, sharing and ensuring delivery of best practice
    - Identifying and managing risks to quality of care
- This encompasses an assurance that due consideration has been given to the quality implications of future plans (including service redesigns, service developments and cost improvement plans) and that processes are in place to monitor their ongoing impact on quality and take subsequent action as necessary to ensure quality is maintained.

The basis of the Board of Directors' confirmation is set out in the attached Trust Board memorandum, dated 22 July 2014.

For and on behalf of the Board of Directors of Yorkshire Ambulance Service NHS Trust.

Chairman

Name: (print)………………………………… (signature) …………………………………

Date: ……………………………………….

Yorkshire Ambulance Service NHS
NHS Trust

An Aspirant Foundation Trust

BOARD MEMORANDUM ON QUALITY GOVERNANCE

EXECUTIVE SUMMARY AND CONCLUSION

The Yorkshire Ambulance Service NHS Trust (YAS) Board has the maintenance and development of effective quality governance as one of its main priorities.

The Board has held dedicated workshop sessions to focus on the arrangements in place for quality governance and to identify the priorities for future development since 2011. A number of key priorities have been achieved since then, including:

- Refreshing and confirming Board definitions of quality and ensuring this is reflected within all strategies and plans
- Review and redefinition of Board governance and Trust committee structures
- Establishment of the Quality Committee as a key mechanism to support Board assurance.
- The development of our performance management systems
- Development of the Board Integrated Performance Report to ensure a sharper focus on key quality issues, including metrics relating to patient safety, clinical effectiveness and patient experience, and a focus on compliance with the Care Quality Commission *Essential Standards of Quality and Safety*.
- Further refinement of our risk management strategy, systems and processes and of the Board's view of risk relating to clinical quality issues.

Specifically over the last year this has included:

- Review of the structure and function of the Senior Management Group to incorporate both the delivery of the operating plan and also contribute and influence strategic direction
- Development of the Trust's quality governance development plan to include national enquiry and reports
- Refresh of the clinical quality strategy to incorporate the learning from the Mid-Staffordhire NHS Foundation Trust public enquiry, and other national reports published in the last 12 months including the national review of the NHS complaints process and report into Winterbourne View.
- An ongoing focus on improving our performance against national ambulance quality indicators, especially those related to patients who suffer cardiac arrest
- Development and progression of the Clinical Leadership Framework, specifically to enhance staff engagement
- Enhancing staff engagement through increasing visibility of the executive and senior management teams and the introduction of the Bright Ideas scheme
- Development of robust quality governance arrangements for the new 111 service

- An increased focus on engagement with other stakeholders in the development of safe, high quality care. This has been specifically in relation to the development of services for patients with urgent needs and the implementation of the 111 service.
- The development of a “Harm free care” programme. This has included the development and testing of a Safety Thermometer for the ambulance sector and the use of service improvement methodology to drive improvement and reduce harm.
- A strong focus on transformational change with the establishment of a Transformation Programme to drive large scale change. This has included monitoring key metrics to ensure the impact on quality is known and managed.

The Trust was inspected by the Care Quality Commission in July 2013 and was assessed as compliant with all of the *Essential Standards of Quality and Safety,* with the exception of Outcome 9, Medicines Management and Outcome 14, Supporting Staff.

In response to the inspection, an action plan was agreed with the CQC which has been implemented. The CQC returned to inspect Outcome 9 in April 2014 and the report is anticipated during May 2014. It is expected the CQC will return to the Trust in June 2014 to reassess compliance to Outcome 14. A number of actions have been completed to ensure compliance, including the process and practice of Personal Development Reviews (PDR), the completion of the full implementation of the Clinical Leadership framework; and the development and commitment to deliver the annual training plan.

A number of external reviews of quality governance have been commissioned and undertaken by Deloitte since 2011. Assessments took place in July 2011and again in January and July 2012 confirm the positive developments in quality governance in line with the quality governance framework. The latter specifically tested the Board Memorandum on Quality Governance.

The quality governance framework has more recently been subject to an internal audit (April 2014).

Further development is focused over the coming months on:

- Providing leadership development for the executive and senior team to ensure capacity and capability to deliver the Integrated Business Plan (IBP)
- Ensuring that the benefits of the clinical leadership framework are fully realised across the service.
- Completing the implementation of service line management Trust wide.
- Further strengthening of the performance management system, with a particular emphasis on the integration of performance management and monitoring at Board, department, team and individual level.
- As part of the Service Transformation Programme a strong focus on staff engagement, effective clinical leadership and supervision, and the strengthening of the professional framework for professionally registered practitioners in the Trust.

- Continuing to develop engagement with the Clinical Commissioning Groups, and external stakeholders and partners to address urgent care needs, specifically in relation to the opportunities related to enhancing the 111 service

1. STRATEGY

a. Does quality drive the Trust's strategy?
- Description of the Board's quality strategy
- Detail of quality goals and how they have been developed and communicated across the Trust

b. Is the Board sufficiently aware of potential risks to quality?
- Description of the Board's approach to assessing initiatives for the impact on quality
- Description of how the Board is assured that CIPs (cost improvement plans) do not compromise the Trust's ability to meet required quality standards
- Description of how financial and operational initiatives are monitored for ongoing impact on quality (e.g. service redesigns and developments)

1a) Does quality drive the Trust's strategy?

1.1 YAS vision and values place quality at the heart of the Trust and significant improvements in quality of care and services have been achieved since the Trust's formation in July 2006. Our *Clinical Quality Strategy*: *Delivering Excellent Services 2012-15*, sets out a framework for development in priority areas, aligned to the wider Integrated Business Plan. This ensures that our plans for the delivery of safe, high quality patient care are effectively linked with operational and financial plans. Objectives in relation to the Clinical Quality Strategy are managed as part of our performance management systems and risks to delivery are formally monitored via our Risk Escalation and Assurance Process.

YAS Clinical Quality Strategy

1.2 The Clinical Quality Strategy draws on the developments in NHS policy and the findings from national enquiry, as well as an internal analysis of the key issues for our service users and opportunities for further development. Its structure and content reflect a focus on the three dimensions of quality, these being patient safety, patient experience and the effectiveness of care.

1.3 In the last year we have incorporated the Clinical Quality Strategy into the reporting framework for the Quality Governance Development plan. This has strengthened the opportunity to:
- Report against milestone progression with effective metrics, including managing risk
- Showcase best practice
- Explore opportunities for development
- Engage with a wider group of stakeholders through our "Expert Patient"

1.4 In summary, the Clinical Quality Strategy comprises six key elements:

- A focus on improvement across a small number of quality issues where evidence shows a real difference can be made for patients within a three-year timeframe. Over the last two years these have included key clinical service developments, including those relating to major trauma, improvement in care and survival from cardiac arrest and stroke care, and development of more integrated approach for patients with urgent, not emergency, care needs.

This has included the successful and celebrated implementation of the 111 service across Yorkshire. In addition, we have had a focus on clinical effectiveness through the delivery of the Ambulance Quality Indicators; and priority developments relating to patient safety and patients' experience of the service.

- Ensuring we deliver higher quality care without increasing costs by eliminating waste from systems and processes
- Action to embed quality and innovation in everything we do through education, training, personal development and the development of our learning and development systems and processes. This has included the introduction of service improvement skills into the training prospectus
- Developing clinical leadership at all levels to support teams in the delivery of excellent care and services
- Development of measures which will enable us to track the quality of our services from the frontline to the Board and to demonstrate our continuous improvement
- An approach to communicating about the quality of our services to the general public, which demonstrates our commitment to openness and public accountability.

1.5 Our staff continue to contribute to the Clinical Quality Strategy through the consultation and engagement process. Elements of the Clinical Quality Strategy have been a feature on Team Brief. The Clinical Quality Forum provides an opportunity to discuss progress and explore opportunities for further development of the strategy with a range of both internal and external stakeholders including commissioners and other health and social care and education providers on quality issues.

1.6 We have also worked with commissioners and other partners to align our Commissioning for Quality and Innovation (CQUIN) targets and Quality Account priorities for improvement to the key themes and objectives of the strategy.

1.7 The Clinical Quality Strategy and associated developments are disseminated to staff via the intranet and internet sites, through regular staff bulletins, staff training and management cascade. The key deliverables for the Clinical Quality Strategy, as outlined above, are now incorporated into the Quality Governance Development Plan. ICT technology is currently being tested with a view to developing mobile phone device applications to cascade information to all our staff.

1.8 Performance measures for quality have been developed and form part of our monthly *Board Integrated Performance Report,* enabling a focus on trend analysis and emerging risks to quality. These build on national standards and measures, such as the national ambulance clinical performance indicators, as well as locally defined measures. These indicators are mirrored in departmental performance dashboards, which are reviewed through the Trust's Performance Review Group, and provide assurance to the Quality Committee through regular reporting and additional focussed meetings which aim to gain a deep understanding of the way information, specifically on quality issues, is utilised by the service lines.

1.9 Delivery of clinical quality is embedded in Trust management arrangements. In 2012 the governance committee structure was revised in order to strengthen the assurance the Board receive. A Quality Committee was established at that time with input from three Non Executive Directors, one of whom is the committee chair. The Quality Committee receives a report at each meeting on progress against the Clinical Quality Strategy as part of the Quality Governance Development Plan. The Committee's annual work plan also includes reports on all aspects of quality and safety, complemented with assurance reports from operational departments and clinicians. This includes a regular report on the quality impact of the Cost Improvement Programme (CIP).

1.10 In the last year the Quality Committee and Finance & Investment Committee have met jointly to receive assurance on the delivery and quality impact of the Cost Improvement Programme. This approach has confirmed understanding regarding process, and also assured both committees that both financial delivery and quality are well managed through the implementation of the CIP. Joint meetings of the Committees have now been scheduled twice a year as an extension of the Board and Committee annual work plan.

1b) Is the Board sufficiently aware of potential risks to quality?

1.11 The Board reviews the Integrated Performance Report at each meeting, and scrutinises the key quality indicators as part of this process.
This report highlights key emerging risks to quality and also identifies specific early warning indicators as part of the Trust's monitoring of the quality impact of cost improvement schemes and other service developments. In addition, the Board and Quality Committee receive at their meetings, a report on lessons learned and a briefing on significant adverse events.

1.11 The Board also receives detailed reviews of independent investigations into wider NHS service failures and has an opportunity to consider the lessons that can be learned from these events. This learning has informed the development of quality governance arrangements in the Trust. Examples in the last 12 months have included the Public Enquiry into Mid-Staffordshire NHS Foundation Trust , the national review of patient safety led by Don Berwick and the Clwyd-Hart review of complaints systems and practise.

1.12 All service developments and cost improvement schemes are required to be assessed via a process defined within the Trust Quality Impact Assessment Procedure. The process, introduced in 2010, has been subject to Board approval and has been reviewed in June 2012 and again in August 2013. This process determines the potential impact of service developments or cost improvement schemes in terms of both costs and savings, and quality and complexity of implementation. The quality impact in terms of any risk to patient safety, experience or effectiveness are reviewed by the Executive Medical Director and Executive Director of Standards and Compliance to inform decisions about scheme approval, risk management and monitoring. Key risks are escalated to the Board via the Risk Escalation and Reporting Procedure.

On-going monitoring of quality impact is managed via the review of the Integrated Performance Report in Senior Management Group, with Board assurance supported through reports to the Quality Committee and Audit Committee.

1.13 Risks to quality are captured in risk registers at department and corporate level, with clear ownership at Executive and Senior Management level and well defined processes for review and escalation in line with the Trust risk escalation and reporting procedure. Risks are also considered in the Clinical Governance Group and Senior Management Group, with escalation of risks and issues from operational and other departments via the department dashboards and exception reports. Mechanisms are also in place to capture feedback from front line staff which informs the view of key risks, including the Datix reporting tool, face to face meetings and the formal 'raising concerns at work' policy.

1.14 To complement the monitoring of formal quality indicators, the Executive and senior management team conduct regular visits to front line services as part of an established 'Listening Watch' programme and Non-Executive Directors also visit operational areas as part of their own experience and assurance process.

1.15 The Quality Committee undertakes detailed scrutiny of risks to quality, safety, workforce and other key aspects of governance, based on regular reports from Executive Directors, senior managers and clinicians, and informs Board consideration of these issues.

1.16 The Audit Committee provides independent assurance on the management of key risks to quality through feedback from the Quality Committee discussions, focused assurance sessions with lead directors, based on the risks, controls and assurances in the Board Assurance Framework, and reviews conducted as part of the annual Internal Audit programme.

1.17 The Board has reviewed the Trust's position in relation to the Quality Governance Framework through a number of workshop sessions and the external reviews of quality governance undertaken by Deloitte, and more recently through internal audit. These and a number of other external reviews have also helped to inform further developments since 2011.

2. CAPABILITIES AND CULTURE

a. Does the Board have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda?

- Overview of leadership arrangements
- Description of Board's approach to challenging quality performance
- Skills assessment review

b. Does the Board promote a quality-focused culture throughout the Trust?

- Explanation of the mechanisms used to drive the quality agenda and promote and open culture
- Description of how the Trust learns from incidents and complaints

2a) Board leadership, skills and knowledge

2.1 The Trust has undertaken significant work in the past two years to develop the Board composition, structures and processes. Strengthening our leadership, challenge and performance management of quality issues has been a key focus of this work.

2.2 The Board now comprises the Chairman, five non-executive directors, the Chief Executive and five executive directors. The executive directors are:
- Executive Director of Finance and Performance/Deputy Chief Executive
- Executive Director of Operations
- Executive Director of People & Engagement
- Executive Medical Director
- Executive Director of Standards and Compliance

2.3 The Board has collective responsibility for setting, maintaining and reviewing quality standards and performance. In addition, we benefit from the particular expertise of our Executive Medical Director who is a Consultant in Anaesthetics; our Executive Director of Standards and Compliance who is a Registered Nurse; and one of our non-executive directors who has also worked as a senior nurse in a local NHS trust.

2.4 The Board scrutinises the quality elements of the *Board Integrated Performance Report* in detail at each public meeting. The Chairman ensures that sufficient time is allowed for this review to enable effective challenge and response. For example work to further develop the systems and structures for learning lessons from adverse incidents has been given high priority and subject to significant discussion at public Board meetings.

2.5 The Board also receives detailed reports on key aspects of clinical quality, including annual reports on Clinical Governance, Safeguarding, Infection, Prevention and Control, Information Governance and risk.

2.6 The Board is responsible for setting and approving the content of the annual Quality Accounts and for signing off the final document. Board members have particular input into the priority setting process and are able to challenge the objectives set for the year ahead to ensure they are in line with overall Trust strategy and will effectively raise standards for patients.
This follows a process of extensive consultation both internally and with external stakeholders. In 2013/14 a workshop facilitated by the Trust's external auditors also supported further development of the Quality Account, drawing on best practice from across the NHS. The Quality Accounts for 2013/14 have been reviewed by the Trust Executive Group, the Board and its committees. The final document has also been subject to External Audit scrutiny in line with Monitor guidance.
The Quality Account provides an annual focal point for quality performance review in addition to the regular review of the *Integrated Performance Report.*

2.7 The developments to the Performance Management Strategy and Framework first introduced in 2012 have been sustained and improved to ensure that the performance management arrangements within the Trust support the delivery of the business plan objectives and other key areas of activity and enable the Trust to monitor progress at all levels.

This will be supported by the completion of the implementation of service line management in the coming year.

2.8 The measures used to review and monitor quality performance have been further developed and will be aligned to the new service lines as these develop, but already senior managers are expected to report regularly to directors on key indicators of safety, effectiveness and experience and be accountable for their department's performance.

2.9 Department-level dashboards have been developed and are scrutinised on a risk assessed basis at two-monthly Performance Review Group meetings. The Board recognises the need to maintain a systematic and consistent focus on quality across its operational departments. Where departments or functions are found to be performing significantly below the level expected, the Executive team and ,where necessary, the Board have initiated additional measures to scrutinise and address the areas of concern

2.10 A Board development programme is also in place and the Trust takes advantage of opportunities to learn from other organisations through the Foundation Trust Network programme and other national events and bodies.

In the last year this has included:

- The respective NED Chairs of the Quality Committee and the Finance & Investment Committee co-chairing the first national meeting of Chairs for these committees. The meeting gave the opportunity to share best practice and identify areas for improvements.
- Establishment of a forum for Trust members in readiness for the Council of Governors which will be established once we are authorised as a Foundation Trust
- Reviewing the Annual Governance Statement (May 2014).

2.11 Following the Care Quality Commission inspection visit in 2013, the Board ensured a clear focus on the priorities for action arising from the inspection report. This included a review of the mandatory training programme and comprehensive review of the Trust policy and procedures for managing controlled drugs, which resulted in a significant strengthening of the arrangements in line with legislative and best practice requirements. It also included a refresh of the approach to implement the Clinical Leadership Framework and confirmation that this was an essential part of the workforce plan for 2014/15.

In addition, as part of the organisational and leadership development plans for the next twelve months the executive and senior management team will all take part in a leadership development programme which will strengthen the team and support delivery of the IBP.

2b) Promoting a quality-focused culture

2.12 During the latter part of 2013/14 the Board spent significant time on reconsidering and confirming the Trust vision and values.

As well as being the basis of Trust strategy, an essential part of this work was the associated communication with the senior management team to ensure that staff and managers were engaged in the process and that we achieved an outcome that reflected our shared commitment, from the Board room to the frontline, to raising the standards of care we provide for our patients.

2.13 In 2014/15 (quarter 1) the Board has again refined the organisation's goals and strategic objectives as a key element of the Trusts' 5-year Integrated Business Plan. This will form the basis for increased staff engagement in relation to key elements of the Trust's clinical strategy. The Clinical Quality Strategy will be redeveloped during quarter four of 2014/15 as it is now in its final year.

2.14 The Trust has made it a priority to raise the profile of the Care Quality Commission (CQC) standards with staff and managers. The Executive Director of Standards and Compliance leads the corporate function which supports the compliance process, and has introduced an "inspections for improvement" programme. This programme involves a multidisciplinary team working together to identify best practice and highlight areas for improvement through a series of risk based visits to ambulance stations and YAS estate. As well as conducting an assessment of compliance to the essential standards with managers it provides an opportunity to discuss the expectations and challenges with front line teams. It also serves to empower operational teams to solve local issues with pace and effectiveness .

This is further supported by all Board members through key messages given at their own staff visits, in particular as part of the regular programme of Executive and senior management team *Listening Watch* visits to front line services. Non Executive Directors are also visit operational areas as part of their own experience and assurance process.

2.15 The CQC inspected the Trust in July 2013. At that inspection the CQC had moderate concerns regarding two outcomes, Medicines Management (specifically elements of controlled drug management) and Supporting Staff (specifically elements of mandatory training, quality of clinical supervision and PDR quality). An action plan has been delivered with significant improvement around audit compliance and controlled drugs management. In April 2014, the CQC returned to the Trust to reassess the medicines management standard and the subsequent report confirmed that the Trust is now fully compliant with this standard.

A significant amount has been undertaken to improve compliance with the supporting workers standard including:

- Structured guidance to managers with regard to the system and practice of PDR completion
- Trust Executive Group approved training plan for 2014/15
- A refreshed and confirmed commitment to fully embed the clinical leadership framework to enhance clinical supervision and staff engagement

The CQC are expected to reassess the Trust against this outcome in June 2014. It is expected that at this point the Trust will be fully compliant with all of the *Essential Standards of Quality and Safety.*

2.16 A particular example of how the Board has signalled its commitment to quality is by building patient stories into the agenda for every public Trust Board meeting, using video recordings or transcripts of the patients' own words. The Board is also playing a visible role in leading the Trust's Dignity and Respect campaign and promoting our YAS six point dignity code.

2.17 Our commitment to openness and accountability is well-reflected by our process for clinical case reviews. Clinicians are encouraged to participate in clinical incident review, a process which is designed to be supportive and to facilitate the identification of individual and organisational learning.

Where a patient or family wishes it, they are kept informed at all stages of the process and in many cases senior members of the clinical team meet with patients directly to discuss what took place and what may be learned for the future. This is a key part of developing an open culture within our frontline operations which supports learning and development. At the last CQC full inspection in July 2013 the Care Quality Commission concluded that the Trust had appropriate arrangements in place for sharing information with patients and relatives, and that the Trust was compliant with the relevant standard.

2.18 An Incident Review Group meets every two weeks to review incidents, complaints, inquests, serious case reviews and other significant events. Lessons learned are identified in this joint forum and actions agreed. Where necessary, Clinical Case Reviews are completed with the relevant staff, to identify both individual and organisational learning from clinical adverse events. A Lessons Learned report is presented to the Senior Management Group, Quality Committee and Board at their meetings. This report triangulates information from the various sources and provides an update on delivery of actions to address key elements of organisational learning. In April 2013 a new risk management data system was introduced across the Trust. This has significantly strengthened the incident reporting processes and ability to analyse and report against Trust incidents. This has also helped to strengthen the quality of data and facilitate cross-cutting analysis of themes.

2.19 Trust plans to develop and foster a culture of engagement, quality, learning and innovation amongst our frontline A&E clinicians have been discussed by the Board, and have been incorporated into the Service Transformation Programme.

The Trust is delivering a focused programme of leadership for the executive and senior management team to ensure that they are well equipped to support delivery of quality care and the IBP. This development is part of the wider workforce and organisational development strategy which is key to undertaking future quality improvements.

2.20 A programme of visible leadership has been undertaken by the executive team through the implementation of Team Brief. This has enabled extensive communication focused on clinical quality and the future developments set out in the Trust's Integrated Business Plan and the associated Service Transformation programme.

2.21 The Trust implemented a Dignity Awareness campaign in 2011 and an annual associated award for staff who promote patient dignity. A Trust-wide Dignity Awareness day was held in February 2014 to refresh and reinforce the campaign messages.

3. PROCESSES AND STRUCTURES

a. Are there clear roles and accountabilities in relation to quality governance?

- Description of roles and committee structures and how responsibilities are cascaded through the organisation

b. Are there clearly defined, well understood processes for escalating and resolving issues and managing performance

- Description of arrangements in place to escalate issues
- Description of how staff can raise concerns and issues
- Approach to clinical audit and how information is used to drive quality
- Internal audit approach to quality governance arrangements
- Description of how the organisation has acted on feedback received, including the resolution of complaints.

c. Does the Board actively engage with patients, staff and other key stakeholders on quality?

- Description of how the Board engages with patients, staff and stakeholders.

3a) Roles and accountabilities

3.1 Trust governance systems are established through the committee structure and also set out in Trust policies and procedures. The Board has overall responsibility for quality governance, with delegated responsibility for delivery of effective internal control on issues of quality and safety delegated to the Trust Executive Group. The Board takes an active leadership role on quality and focuses on quality as a core part of Board meetings, both as a standing agenda items and as an integrated element of all major discussions and decisions.

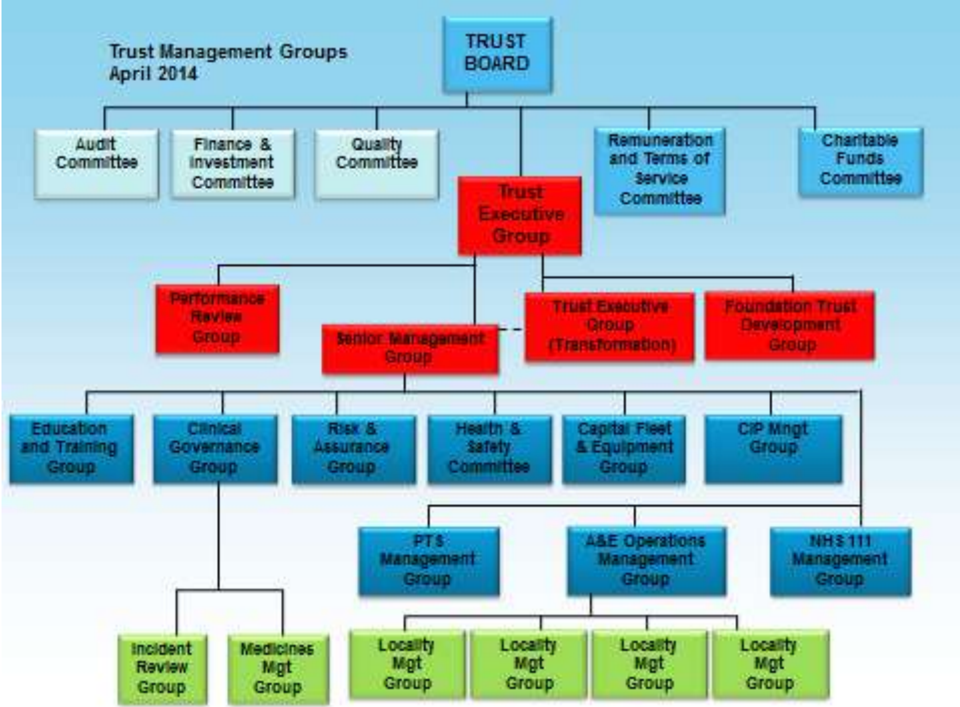
3.2 The Quality Committee is the key Committee supporting the Board in gaining assurance on the management of clinical governance and quality and receives reports at each meeting on Trust and department level compliance with quality standards.

3.3 The Senior Management Group reviews the quality indicators in the Integrated Performance Report at its meeting and receives exception reports from departments and a range of specialist sub-groups. This includes other key management groups which support delivery of safe, effective care, including the Clinical Governance Group, Workforce Governance Group and the Health and Safety Committee.

3.4 The Clinical Governance Group is chaired by the Executive Medical Director and reports to the Senior Management Group. It is the principal management group responsible for development of clinical quality. It receives and considers quality and safety reports from its sub-groups and representatives of other departments.

3.5 The Operations Management Group and Locality Management Groups are responsible for overseeing delivery of Trust strategy and policy in the operational departments of the Trust.

3.6 During 2013/14 the Board further reviewed the function of its committees, to ensure rigorous scrutiny of the management of key risks in the Board Assurance Framework and Corporate Risk Register, and the effective flow of information on key risks between the committees and Board.
The Board committee and management group structure is summarised in the diagram below:



3.7 Executive clinical leadership is provided by the Executive Medical Director and on quality and safety issues by the Executive Director of Standards and Compliance. The two directors work closely together to ensure seamless leadership across the range of clinical governance and quality issues.

3.8 The organisational focus on quality is reflected in the objectives of all Executive Directors and managers. Quality is managed through the line management process, and is integral both to departmental agendas and individual performance review discussions at all levels.

3b) Escalating and Resolving Concerns and Managing Performance

3.9 The Trust has effective systems in place for escalating issues and concerns and for managing performance.

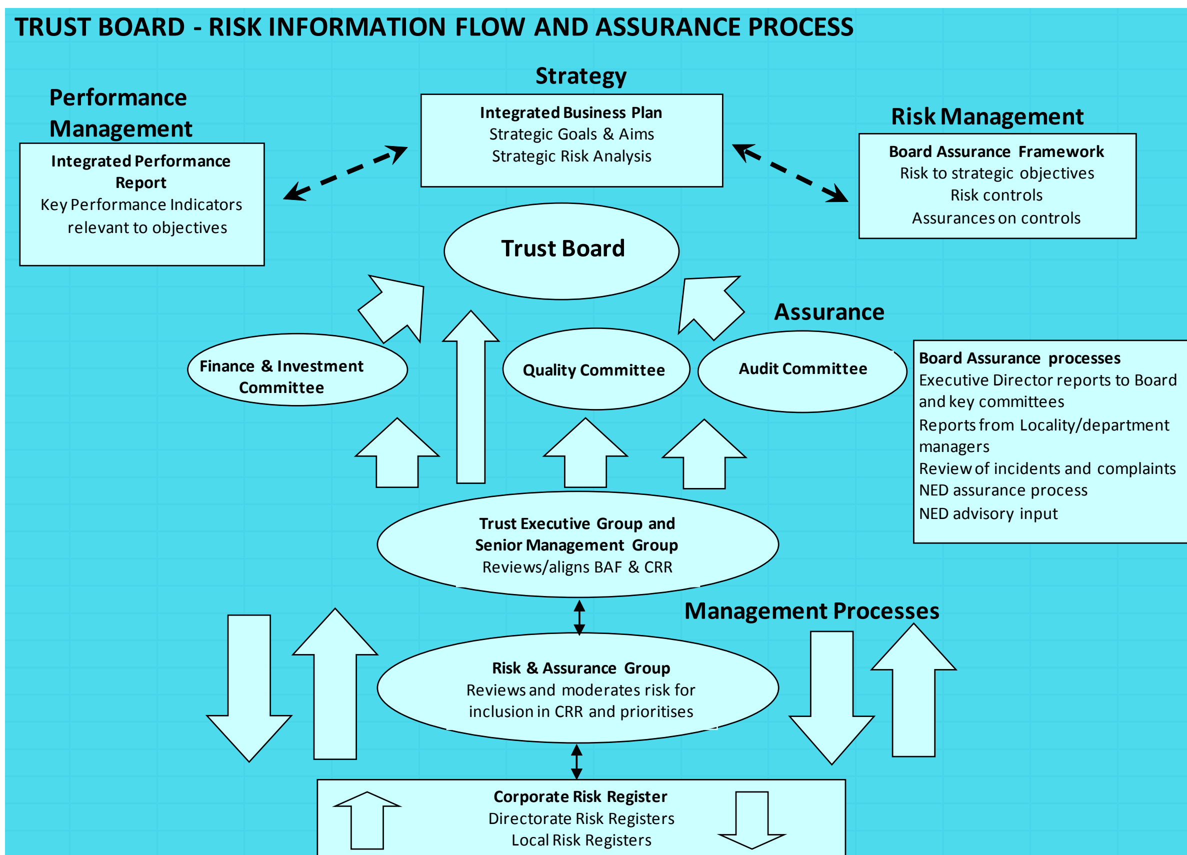
3.10 All staff are made aware of the systems for raising issues, concerns and risks as part of the corporate and local induction programmes. Local induction includes training on how to access and use the web-based DATIX incident reporting system. Supporting the DATIX system, frontline staff are also able to report incidents via our telephone incident reporting hotline. The recent implementation of DATIX during 2013/14 has further strengthened this process. If the concern is a management issue then staff are able to raise this in accordance with the *Raising Concerns at Work Policy*. Designated Non-Executive Directors are also identified to support 'whistleblowing' processes. Staff are again made aware of this policy as part of their induction and it is available via the Intranet document library.

3.11 Issues are escalated through formal reports to Trust management meetings, and via assurance reports to the Board Committees. The Clinical Governance Group receives reports from relevant departments and considers emerging risks and issues.
The Senior Management Group receives formal exception reports from department managers and key management groups including the Clinical Governance Group, to support early identification of quality issues.

3.12 The Trust Performance Review Group provides a vehicle for executive scrutiny of departmental performance, and quality issues are a key focus of these discussions. Where necessary, quality issues can be escalated to this group for more detailed review. In addition the Quality Committee have recently held an additional meeting to seek assurance that quality indicators are cascaded and effectively managed within each service line.

3.13 The Board receives an Integrated Performance Report on a monthly basis. This includes a wide range of quantitative and qualitative measures of quality and is reviewed in detail, with a focus on exceptions in each public board meeting.

3.14 The Risk and Assurance Group has members from all directorates and plays a key role in reviewing escalating key risks including those relating to quality, to the Trust Executive Group and =Board. Risks and issues are identified, recorded and escalated according to our *Risk Escalation and Reporting Procedure.* This is summarised in the diagram below:



3.15 The Trust must be registered with the Care Quality Commission (CQC) in order to be authorised to provide its services and registration is dependent on maintaining compliance with the *CQC Essential Standards of Quality and Safety*. We are responsible for assessing ourselves against the *Essential Standards of Quality and Safety,* and for addressing any issues arising from this. Regular reports on the compliance position are reviewed by the Trust Executive Group and Clinical Governance Group.

The Trust is actively engaged with the development of the new regulatory standards being proposed by the CQC for the ambulance sector and is contributing to the current consultation processes via the national ambulance Quality Governance and Risk Directors group.

3.16 We are committed to delivering effective clinical audit in all the clinical services we provide and see clinical audit as a cornerstone of our arrangements for developing and maintaining high quality patient-centred services. Our *Clinical Audit Plan* sets out how we will use clinical audit to confirm that current practice compares favourably with evidence of best practice and to ensure that where this is not the case that changes are made that improve the delivery of care. The *Clinical Audit Plan* sets out development objectives for the short, medium and long-term. The short-term objectives focus on: compliance with regulatory requirements and national policies, guidance and best practice including the national Ambulance Clinical Quality Indicators, improving data quality and reporting systems; and staff education and training. The results of clinical audits are monitored and reported via the Clinical Governance Group.

Assurance reports on the effectiveness of the clinical audit system are presented to the Quality Committee as part of its annual work programme and it has been agreed that the Audit Committee will also receive reports on key clinical audits, to support its independent review of risk management across all Trust functions.

3.17 The Audit Committee plays a key role alongside the Quality Committee, in gaining assurance in relation to the management controls for the key risks to quality. The work of the Audit Committee is underpinned by the work of our internal and external auditors. The Trust's internal auditors are *East Coast Audit Consortium* and we have an agreed three-year strategic audit plan, which was developed with input from Board members. This includes work to examine and evaluate the adequacy and effectiveness of our governance and risk management arrangements, the system of internal control, and performance management in carrying out assigned responsibilities to achieve the goals and objectives within our business plans. Key quality audits include annual reviews of the Trust Quality Accounts, Information Governance and compliance with Care Quality Commission standards. Additional audits of quality systems in the last year included Medical Device Management, Infection Prevention & Control, ACQI's, Health & Safety Compliance, Training & Education Plan, Incidents and Serious Incidents and the Clinical Leadership Framework.

Audits planned for 2014/15 include Clinical Governance Framework, clinical audit, contract quality, CQC standards, clinical research and medical records management.

Recommendations from internal audits are discussed with responsible managers and action plans agreed. These are reported to the Audit Committee along with a tracking document showing completed and outstanding actions.

3.18 Reports from the Quality Committee and Audit Committee are presented to the Board at each meeting and these provide an additional opportunity to highlight key risks or issues.

3.19 The terms of reference and effectiveness of the Board Committees are reviewed on an annual basis as part of their work plans. A review completed in January 2013 focused on the interface between the Board Committees, to ensure that there is an effective and co-ordinated assurance process in relation to all of the key risks in the Board Assurance Framework. More recently both the Quality committee and Audit Committee have had external effectiveness audits completed.

3.20 When people contact us to tell us about a problem we understand that they want us to respond to their concerns as soon as possible. For each person making contact with us we develop an individual resolution plan to record the issues raised and the outcome they are looking for and a timescale for resolution.

Learning lessons from complaints, concerns and comments is very important to us and we track key issues, themes and trends and match these against other sources of information such as safeguarding cases, patient experience surveys, incident reports and feedback via service-user groups.

3.21 Some of the improvements we made in 2013/14 as a result of issues highlighted through complaints, concerns and compliments were:

- Corporate induction now includes a specific element emphasising treating and caring for patients with dignity and respect.
- A number of issues have been raised by other services regarding Do Not Attempt Resuscitation (DNAR) orders e.g. photocopies of forms being refused by YAS staff or unsigned forms. The guidance on DNAR orders was re-issued to staff and the Trust continues to work with other parties to ensure that DNAR orders are prepared and communicated appropriately to YAS staff, and to facilitate the delivery of appropriate care for patients.
- Complaints and concerns from patients who are assessed as not needing an ambulance increased. A task and finish group was established which reviewed the triage process for non emergency calls and made recommendations to amend the script to patients. This was aimed at increasing the patients understanding of the triage process and to help manage the expectations of the public.

3c) Engagement with staff, patients and other stakeholders

3.22 Engaging staff, patients and partner organisations is a key part of our quality strategy. This includes listening and acting on feedback and involving them in the development and delivery of our future plans.

3.23 A key forum to support staff engagement is the management time out event, which is run twice a year. These events provide an opportunity for managers to meet each other in a single location, hear from the Chief Executive and the executive team about progress over the past year and plans for the year ahead. Workshops focus on key priorities, including quality issues, and allow managers to share best practice and learn from each others' experience. These meetings help to inform key communications in local management and staff meetings.

3.24 From July 2012, we introduced a Clinical Quality Forum with a range of staff and manager representatives as well as invited members with specific clinical and quality expertise drawn from external stakeholder organisations. The Forum provides a vehicle for discussion of key clinical quality issues to inform the decisions of the Clinical Governance Group.

3.25 An annual staff 'We Care' awards ceremony commenced in April 2012, as a vehicle to recognise and rewards achievement and innovation, and a staff 'Bright Ideas' scheme was launched in 2013 alongside other Service Transformation Programme initiatives designed to increase staff engagement.

3.26 Work has been completed to streamline processes for communication with staff, including a new regular team briefing process to supplement the existing electronic bulletins and the face to face communication via the *Listening Watch* programme and other regular Board visits to ambulance stations and other departments.

A programme of station visits by the Chief Executive and Executive Director of Operations during 2013/14 has specifically focused on increasing the awareness and engagement of staff in relation to key clinical service developments in the 5-year Integrated Business Plan. This has included managing the implementation of the Operations Redesign Project. This project has been specifically in relation to changing the working patterns of the A&E workforce. As such this has been a challenging piece of work requiring extensive engagement with our staff, and also negotiations with staff side. The executive and management team demonstrated a strong and clear commitment to patient safety and clinical quality through these negotiations balanced with a need to ensure staff wellbeing with the proposed changes.

The elements of the Operations Redesign Project were all subject to Quality Impact Assessments ensuring that any change was robustly monitored through the identification of metrics and reported to the executive and management team.

3.27 Our engagement with commissioners on quality includes a Clinical Quality Review Group . This was a bi monthly forum and was attended by the YAS Executive Medical Director, Executive Director of Standards and Compliance and Clinical Commissioning Group commissioners to review service quality and performance against CQUIN targets. Additional engagement with commissioners takes place on a regular basis through Board level dialogue, the Contract Management Board (CMB) and on a wide range of operational quality issues via the Trust's locality teams. Most recently the Clinical Quality Review Group has been disbanded and the quality elements of the contract will from May 2014, report directly into the CMB. This will avoid duplication and ensure that quality is reported to the commissioners of the service on an equal platform with finance and performance.

3.28 The emergence of the Urgent Care Boards has provided us with a good opportunity to develop engagement and build positive relationships with the Clinical Commissioning Groups as they embed as the commissioning of Trust services in the future. There has been executive or senior management representation on each of the 15 Urgent Care Boards across Yorkshire & the Humber. These meetings have provided an arena to foster and create joint working across the different sectors of health and local authority care. The Trust approach to engagement has been reviewed again in 2014 in line with the introduction of new System Resilience Groups.

3.29 Since the introduction of the region wide 111 service in March 2013, the focus on clinical and commissioner engagement in relation to the delivery of urgent care has continued. The identification of potential alternative models of care are being actively pursued and in April 2014 we appointed a Commercial Director to further achieve this.

3.30 Following the disbanding of the Yorkshire-wide Local Involvement Network (LINk) Ambulance Group we have worked closely with the new Healthwatch organisations. An engagement event was held in June 2013 with the Healthwatch organisations to initiate an effective working relationship and understand and agree areas of focus for the next year.

In addition, we have appointed a Head of Engagement who will ensure that we remain engaged with all our key stakeholders and partners.

3.31 We acknowledge the important feedback provided via our 14 Yorkshire Health Overview and Scrutiny Committees (HOSCs). Our directors and senior managers attend meetings across the region over the course of the year to report on performance and receive feedback on local issues.
All Health watch organisations and HOSCs were given the opportunity to provide input on the content of our 2013/14 Quality Accounts through a questionnaire and, where possible, meetings with Councillors or presentations to Committee meetings.

3.32 A 'Stakeholder e-News' bulletin is now circulated to key stakeholders to help update them on significant Trust developments.

3.33 We have an 'Expert Patient' who contributes significantly to the Trust Clinical Governance Group and Quality Committee, and advises on the related work programmes. The Expert Patient also facilitates links with a wide range of patient representative groups across Yorkshire.

3.34 The Trust has identified a proportion of its members who have said they are willing to work with us on different aspects of our service provision and development.

3.35 We obtain direct feedback from patients using the A&E, PTS and 111 service through postal and online surveys. These high-level surveys are supplemented by in-depth studies looking at the experience of particular patient groups. The Trust is also working with other ambulance Trusts, the Care Quality Commission and Picker Institute, to support the development of a national ambulance patient survey.

3.36 Information from all the above channels feeds into the Quality section of the *Board Integrated Performance Report.* It is also fed back to managers and staff and used extensively to support improvements in practice. Quality outcomes are made public through the Integrated Performance Report, other Board papers and Quality Account, with transparency both where performance is good and where it needs to be improved.

4. MEASUREMENT

a. Is appropriate quality information being analysed and challenged?

- Process adopted by the Board to select relevant quality information, details of what is reviewed
- Details of how quality performance information reviewed by the Board is backed up by more granular information

b. Is the Board assured of the robustness of the quality information?

- Details of Board's approach to assuring data quality
- How internal audit is used to review robustness of data and a description of how findings are followed up

c. Is quality information being used effectively?

- Examples of how quality information has led to improvements in quality
- Details of targets set and performance against targets

4a) Quality information

4.1 The development of the *Board Integrated Performance Report (IPR)* has been driven by the Board's challenge to the quality of information that it was receiving prior to April 2010. In particular, Board members set out their expectations for greater reporting on quality issues including trend and rate-based monitoring. The IPR has since received a number of reviews and refinements. This included an external review by Deloitte focused on its fitness for purpose, and in particular whether it was sufficiently future-facing and the extent to which it supports strategic decision making. The Assistant Director of Business Planning also interviewed all non-executive directors about their information needs and comments/recommendations on the IPR. As a result of this work a number of significant improvements have been introduced to streamline the indicators, to enable a clear view of performance against targets or trajectories, to provide external benchmarks where available, to enable easier triangulation of indicators, and to highlight exceptions. It is envisaged that the Trust will continue to refine and improve the reporting process and indicators over the coming year.

4.2 To support the work on quality impact assessment of cost improvement plans and other service developments, a range of 'early warning indicators' have been highlighted for special attention in the IPR.

4.3 Indicators in the IPR are mirrored in departmental dashboards which are used to support management review and action within departmental management meetings. The dashboards underpin exception reporting from departments to the Senior Management Group and inform the review and challenge by Executive Directors in the Performance Review Group. They are also used as the basis for assurance reports from departments to the Quality Committee. Further work is continuing to strengthen these departmental dashboards and the Trust will continue to develop more automated systems for production and direct access to live performance information.

The development of a data warehouse and the introduction of electronic patient records, planned to be rolled out during 2014/16 will further improve data access and quality.

4.4 Written reports are supplemented by a programme of internal ‘Inspections for Improvement’. Teams of staff led by an appropriately skilled Associate Director, conduct inspection visits, focused on the delivery of Trust standards for quality and safety. Reports from these inspections are fed back to the relevant team and are reviewed in the Senior Management Group to complement other sources of performance information.

4.5 Board members and senior managers regularly engage with front line staff through department visits and ‘shadowing’. They are also actively engaged with a range of external stakeholders, both through formal meetings and informal networks. Information gleaned from these engagement processes is used to inform discussions and decisions on quality, alongside the hard data in performance reports.

4.6 The Quality Committee receives reports at each meeting from corporate clinical, quality, governance and risk teams and triangulates these with information from departmental managers and individual clinicians.

4.7 The Audit Committee reviews and tests the controls and assurances in relation to each function as defined in the *Board Assurance Framework (BAF)*, including the robustness of key performance indicators and their use by management teams. Reports are provided by Quality Committee and Finance and Investment Committee on assurance in relation to the key risks within their respective remits. Executive Directors are also invited to attend periodically as part of the Audit Committee work programme to provide additional assurance on key issues.

4b) Robustness of Quality Information

4.8 The Board continues to show leadership on data quality and sets high standards for information management throughout the Trust. Regular reviews of data quality are commissioned from internal and external sources to inform the Board’s level of confidence in data presented. Recommendations from Internal Audit review of the IPR have influenced revision of the IPR Report Generation Process including the introduction of a new template for managers defining their data definitions and quality checks.

4.9 The new risk management data system has also significantly supported improvements in the quality of incident, complaints and claim data during 2013/14.

4.10 Ambulance service performance target data definitions are agreed nationally and Trust reports are audited on a regular basis to ensure compliance with agreed guidelines. There are internal data quality procedures and management audits for key reports, with sign off at Associate Director level.

4.11 Data quality for the national performance targets is also audited annually by Internal Audit .

4.12 Clear procedures and data definitions are set out for internal performance reports, including the Integrated Performance Report. The IPR is subject to Internal Audit review as part of the agreed work cycle and the Trust Quality Account is subject to management scrutiny and annual review by External Audit.

4c) Using information effectively

4.13 Trust performance and quality reports are prepared to a strict timetable to ensure timeliness of information provided to the Board and management groups. For most internally generated data, formal reports include data up to the previous month.

4.14 Exceptions are highlighted as part of the reporting process. Where necessary, using a risk based approach additional opportunities are organised, for example in ‘drill down’ sessions involving Non-Executive Directors or Board Development Meetings. These will explore specific issues or exceptions in greater detail, and to inform additional action.

4.15 An example of how information has driven quality improvement is our focus on hand hygiene, station and vehicle cleanliness through monthly audits in all localities. This has resulted in a steady increase in standards since the process began.

4.16 Information is also an essential element of our work to develop alternative care pathways and increase the number of referrals made by our clinicians. This has included year on year increases in referrals to falls teams and other specialist clinical services.

4.17 The review of regular workforce dashboard indicators at senior management level has driven an improvement in PDR completion and mandatory training attendance.

4.18 Quality targets for the year ahead are set out in our priorities for improvement within our Quality Accounts, in the Key Performance Indicators defined in our annual Business Plan and in our CQUIN targets agreed with commissioners. The Business Plan also defines the cycle of performance management activities relating to regulatory compliance, risk and operational performance. These targets reflect the new NHS ambulance clinical quality indicators and support our continued focus on maintaining and improving our clinical performance for stroke, STEMI heart attack, cardiac arrest and other key conditions.

4.19 The *Clinical Audit Plan* sets out development objectives for the short, medium and long-term. The short-term objectives focus on: compliance with regulatory requirements and national policies, guidance and best practice including the national Ambulance Clinical Quality Indicators, improving data quality and reporting systems; and staff education and training. The results of clinical audits are monitored and reported via the Clinical Governance Group.

4.20 An action plan has been developed in relation to the Ambulance Clinical Quality Indicators where YAS is an outlier in comparison with other Trusts.

Delivery of this plan is overseen by the Executive Medical Director and progress reported to the Quality Committee.

4.21 The Trust is actively engaged in benchmarking with other services across a range of measures. This includes performance measures, the Ambulance Clinical Quality Indicators and Clinical Performance Indicators. In addition, the Trust benchmarks through national Directors' groups on incident reporting, complaints, safeguarding and patient experience, using a range of quantitative and qualitative measures.

4.22 The Board and Quality Committee regularly review external publications to identify potential learning for the organisation. This is complemented by the regular sharing of learning across the ambulance services nationally through the Directors' groups. This includes a regular national process for learning from Coroners' Rule 43 letters.

4.23 Information is shared across the organisation to support learning and development via the Senior Management Group, and in the Operational departments through the Operations Management Group. This includes a regular 'lessons learned' report focused on learning from adverse events, as well as reports from development and audit projects. The Trust holds twice yearly management development days, to support cross directorate learning. These formal processes are supplemented by the regular publication and dissemination of quality information for managers and staff through are range of bulletins and online resources.

4.24 A Clinical Quality Forum has been established with representatives from across the Trust's patient care functions, and invited members from other NHS and higher education organisations. This forum provides an opportunity to support sharing of best practice, and for staff to contribute to the development of Trust strategy.

4.25 The Board hosts presentations on key areas of development prior to its public meetings. In recent months these have included YAS developments in mental health care, YAS approach to high quality patient care, high quality care for patients who suffer a stroke and the quality annual report.

5. FACTUAL ACCURACY

5.1 We have read the contents of this Board Memorandum on Quality Governance and confirm that, to the best of our knowledge, all the information is factually accurate.