Yorkshire Ambulance Service NHS
NHS Trust

An Aspirant Foundation Trust

Quality Committee Meeting Minutes

Venue: Kirkstall & Fountains, Springhill 1, WF2 0XQ
Date: Thursday 12 June 2014
Time: 0900 hours
Chairman: **Pat Drake**

Attendees:

Pat Drake	(PD)	Deputy Chairman/Non-Executive Director
Dr Elaine Bond	(EB)	Non-Executive Director
Steve Page	(SP)	Executive Director of Standards & Compliance
Ian Brandwood	(IB)	Executive Director of People & Engagement
Dr Julian Mark	(JM)	Executive Medical Director
Russell Hobbs	(RH)	Executive Director of Operations

Apologies:

Erfana Mahmood	(EM)	Non-Executive Director
Dr Dave Macklin	(DM)	Associate Medical Director

In Attendance:

Dave Whiting	(DW)	Chief Executive
Barrie Senior	(BS)	Non-Executive Director (Observer)
John Nutton	(JN)	Non-Executive Director - Designate (Observer)
Anne Allen	(AA)	Trust Secretary (Observer)
Andrea Broadway-Parkinson	(ABP)	YAS Expert Patient
David Williams	(DW)	Deputy Director of Operations
Dr Steven Dykes	(SD)	Associate Medical Director
Dr Dave Macklin	(DM)	Associate Medical Director
Karen Warner	(KW)	Associate Director of Quality and Nursing
Becky Monaghan	(BM)	Associate Director of Risk & Safety
Shelagh O'Leary	(SOL)	Associate Director, Organisational Effectiveness & Education
Kate Simms	(KS)	Associate Director of HR
Ben Holdaway	(BH)	Locality Director - EOC
Benita Jones	(BJ)	Internal Audit

Minutes produced by:

Mel Gatecliff	(MG)	Committee Services Manager

The meeting was preceded by a presentation between 0830 and 0900 hours. 'A&E CQUIN programme for 2014/15', which was delivered by Head of Service Planning & Development, Helen Hugill, Head of Quality, Gareth Flanders and Service Planning & Development Manager, Darren Lee, was well-received by those present.

		Action
	The meeting commenced at 0900 hours.	
1.0	**Introduction & Apologies** PD welcomed everyone to the meeting and apologies were noted as listed above.	
2.0	**Review Members Interests** Declarations of interest would be noted and considered during the course of the meeting.	
3.0	**Chairman's Introduction** PD stated that, to aid with the flow of the meeting, items 6.10 and 7.4 would be taken together. In addition the Musculo-skeletal injuries presentation at item 8.2 would follow consideration of item 7.1, the Workforce update report. She confirmed that, following the recent Quality Committee Effectiveness Review, it had been agreed that a similar Workforce event would take place on 23 July 2014 at which EB and PD would represent the NEDs. PD stated that she had attended the YAS Managers' Conference early that week. It had been an excellent event, with a lot of challenge and questions around cultural change.	
4.0	**Minutes of the Meeting held on 3 April 2014** The minutes of the Quality Committee meeting held on 3 April 2014 were approved as a true and accurate record of the meeting subject to the following amendments. **Matters Arising:** Page 8 – Paragraph 3 amended to state:' IB gave assurance that the importance of robustly applying the new absence management policy was being reinforced to managers. The new policy, alongside other measures, should lead to major improvement.' Page 19 – 'long term offenders' replaced by 'any member of staff consistently not attending training.'	
5.0	**Action Log** The meeting worked through the Action Log, which was updated accordingly. Closed items were highlighted in green. **159/2013 - Solo Response Back-up Times** Covered in Item 6.10 on agenda. Action closed. **173/2013 & 174/2013 - Clinical Quality Strategy/Quality Governance Update** KW confirmed that the 2014/15 Listening Watch schedule had been circulated and she would ask JK to share information about planned visits with NEDs. Action closed.	

		Action
	195/2013 - Clinical Leadership PD stated that, as it was not apparent how development posts would be managed going forward, this action should remain open. It was agreed the RH would provide an update under agenda item 7.4 and that a proposed structure in relation to succession planning would be presented at the September meeting. **Action:** **Proposed structure for Clinical Leadership succession planning to be presented at September meeting.** **008/2014 - Clinical Quality Strategy/Quality Governance Development Plan Update** Covered in Item 6.1 on agenda. Action closed. **009/2014 - Review of Key Quality Indicators (IPR) / Action** Covered in Item 6.3 on agenda. Action closed. **011/2014 - Review of Key Quality Indicators (IPR) / Action** IB stated that some progress had been made but he would be able to provide a more detailed update report in September. Estimated Closure Date extended to September 2014. Action remains open. **012/2014 - Review of Key Quality Indicators (IPR) / Action** Covered in Item 8.2 on agenda. Action closed. **017/2014 - Community First Responder (CFR) Scheme - Actions Arising from Internal Audit Report** RH confirmed that the action plan had been circulated and all actions were on track. Action closed. **018/2014 - Community First Responder (CFR) Scheme - Actions Arising from Internal Audit Report** KS stated that the Trust was looking at the wider strategy in terms of the volumes of volunteers in each area, adding that a number of workshops to help formulate future strategy were taking place. EB expressed concern about progress in this area as it had been her hope that the policy should have almost be in place by now. IB acknowledged that the Trust needed to make faster progress. EB asked whether new volunteer recruits knew what was expected of them, as there was no up-to-date policy in place. IB replied that the Trust tried to ensure a consistent approach to volunteers across the organisation, adding that he would ensure the policy was finalised by the September meeting. Estimated Closure Date extended to September 2014. Action remains open.	**IB/SOL**

		Action
	025/2014 - Inspections for Improvement - Review of Key Themes BM confirmed that PAT testing had been carried out. Action closed. It was agreed that a detailed update on key H&S themes, the actions being taken to identify circumstances where additional support was needed on site, etc should be provided at the September meeting. **Action:** **BM to provide further update re actions in relation to key H&S themes at September meeting.** **029/2014 - Chairman's Introduction** SP confirmed that details had been circulated. Action closed. **030/2014 - Chairman's Introduction** SP confirmed that a session had been scheduled for a Board Development session in October 2014. Action closed. **032/2104 - Clinical Quality Strategy Annual Review/ Implementation Plan 2014/15** JM confirmed he had emailed an update to the NEDs. Action closed. **033/2014 - Clinical Quality Strategy Annual Review/ Implementation Plan 2014/15** RH confirmed that the action had been completed. Action closed. **034/2014 - Significant Events and Lessons Learned** KW confirmed that an easy ready communications guide was available on the YAS website. Action closed. **035/2014 - Significant Events and Lessons Learned** SP stated that incidents would be picked up through the Datix system following which serious cases would be proactively followed up through to prosecution if necessary. He stressed that the Trust took great care to ensure it supported all members of staff who were involved in incidents of violence or aggression. Action closed. **036/2014 - CIP Quality Impact Assessment (QIA) Review** SP confirmed that the CIP assurance process had been added to the joint Committees' meeting agenda as a standing item. Action closed. **037/2014 - Review of NHS Constitution** SP and KW confirmed the action was complete. Action closed. **038/2014 - Review of NHS Constitution** AA confirmed that ABP's comments had been incorporated into the document. Action closed. **039/2014 - Review of NHS Constitution** AA confirmed that JM's comments had been incorporated into the document. Action closed.	**BM**

		Action
	040/2014 - Expert Patient Update SP confirmed that ABP and he had held a detailed catch up. Action closed. **041/2014 - Draft 2013/14 Quality Account and review of 2014/15 A&E and PTS CQUIN schemes** SP confirmed that the data had been shared. Action closed. **042/2014 - Draft 2013/14 Quality Account and review of 2014/15 A&E and PTS CQUIN schemes** SP confirmed that comments received on the draft had been incorporated. Action closed. **043/2014 - Service Transformation Programme Update** Item covered in 6.9 on agenda. Action closed. **044/2014 - Workforce Annual Review and Workplan 2014/15** IB confirmed that a detailed report would be presented at the September meeting. Action remains open. **045/2014 - Workforce Annual Review and Workplan 2014/15** IB confirmed that this information would be covered during the Workforce update section. Action closed. **047/2014 - Clinical Leadership Progress Report** Item covered at 7.4 on agenda. Action closed. **048/2014 - R&D Annual Review and Workplan 2014/15** JM confirmed that the conversation had taken place and provided a short update about possibilities for external funding and relationship building with higher education facilities. Action closed. PD asked which papers needed to be considered by TEG and/or SMG and which did not. AA stated that, generally speaking the approval process for 'policy' documents was through SMG whereas 'strategy' documents needed to be developed within TEG to go through the Committee route. For assurance purposes SP confirmed that nothing came to the Quality Committee for consideration that TEG/SMG were not sighted on, adding that Chapter 9 of the IBP also described the process. EB stated that she had noticed an improvement in papers in terms of the meetings in which papers had been sighted before coming to the Quality Committee. However, it was her belief that further information was required about where informal discussions, etc had taken place.	

		Action
6.0	**QUALITY GOVERNANCE/CLINICAL QUALITY PRIORITIES**	
6.1	**Clinical Quality Strategy/Quality Governance Development Plan Update** KW updated the Committee on the implementation of the Clinical Quality Strategy and the progression of the Quality Governance Development Plan. She stated that the information contained in the accompanying paper had already been considered by various management groups in the organisation. The Development Plan, which was the tracker for all quality governance recommendations, was attached at Appendix A. KW further stated that 2014/15 marked the final year of the current Clinical Quality Strategy and as such marked a significant step change in how clinical quality was managed and had improved within YAS since the strategy was initially written in 2011. She outlined details of key achievements delivered to date during Quarter 1 of 2014/15. Leadership and culture remained key priorities for the current year. This included the recent review of the key functions and responsibilities of SMG. An internal review of the Patient Relations department had taken place and areas for improvement had been presented to the Clinical Governance Group. KW confirmed that Patient Relations Manager, Jacqueline Taylor and she were due to meet with ABP and PD the following week to carry out a peer review of complaints cases mirroring national work. KW stated that, following the two recent CQC 'listening events', a meeting had taken place with the CQC and informal feedback received with no formal report to be published. There were no major new issues raised and SOL, KS, BM and KW were due to meet to ensure actions were in place to take the informal recommendations forward. SP stated that, as the original intention had been to share the written report with managers and staff, there was now a need to agree the best format in which to share the feedback as soon as possible. **Action:** **SP to consider the most appropriate format in which to share feedback from the CQC listening events with staff.** In relation to the Trust's responsibility for healthcare standards, SP reported that an update on the actions in relation to CQC Outcome 14, Supporting Workers, would be covered in the Workforce section.	**SP**

		Action
	In relation to CQC Outcome 9, Management of Medicine, the CQC had undertaken a number of visits to ambulance stations during April 2014 and had fed back their findings that the Trust was now compliant with the medicines management standards. SP stated that he had received the draft report and submitted some feedback comments. The final report should therefore appear on the CQC website shortly. As YAS had not been chosen to be a pilot for the new inspection regime, its inspection should take place around the end of the year. KW stated that a readiness assessment confirming that YAS had plans in place to implement the national CQUIN had been completed in preparation for the Friends and Family test and submitted to NHS England. The Quality Account had been presented to the Trust Board on 3 June and had now gone for publication on 30 June. SP stated that the process whereby the direction of the Clinical Quality Strategy for 2015/16 onwards would be agreed was due to commence shortly. Some of the work would be done through the Clinical Quality Forum. PD stated her belief that there should be a major focus on urgent care against the IBP priorities in the Strategy going forward. SP confirmed that there would be more extensive engagement with managers and staff than when the original Strategy was drafted. **Approval:** **The Quality Committee received the paper as assurance of the continued implementation and progression of the Clinical Quality Strategy and the Quality Governance Development Plan**	
6.2	**Board Memorandum on Quality Governance and Quality Governance Framework Assessment** SP provided an update on the Board Memorandum on Quality Governance as required as part of the Foundation Trust (FT) authorisation process to confirm and evidence that YAS had robust governance arrangements in place. SP confirmed that a requirement for assessment against Monitor's Quality Governance framework was the expectation that trusts would both self-assess and have external assessments. A number of assessments had been carried out by Deloitte and showed progress in compliance with the requirements of the framework. It had been agreed that in 2014/15 the Trust would work with Internal Audit to assess the organisation's current position.	

		Action
	The work had been complex but progress was being made. BJ confirmed that the work was nearing completion, adding that her observation of that day's meeting would form part of the review. SP stated that initial feedback confirmed that the Trust continued to head in the right direction. The report would be shared as soon as it had been finalised and the actions arising out of it would be picked up in the Quality Governance action plan. SP invited comments from those present, as the updated document was scheduled to go to Trust Board for sign off in July. AA provided a number of amendments: • the wording 'seeking to establish a forum' in 2.11 on page 11 should be re-worded, as YAS Forum was now established; • 'the Board will again refine the organisation's goals' in 2.14 should be re-worded as this had also been done; • the medicines management section in 2.16 needed to be updated. It was agreed that any additional feedback should be provided to SP outside the meeting by 27 June 2014. **Action:** **Additional feedback on Board Memorandum on Quality Governance to be given to SP outside the meeting.** SP stated it was possible that a further assessment might be required following agreement of the final Monitor authorisation process. **Approval:** **Subject to further minor amendments, the Quality Committee noted and approved the updated Board Memorandum on Quality Governance as assurance of effective quality governance arrangements in the Trust and recommended the Board Memorandum to the Trust Board.**	**All**
6.3	**Review of Key Quality Indicators (IPR)** KW provided an update on the key indicators reported in the Quality and Workforce sections of the Integrated Performance Report (IPR) and invited comments from those present. JN asked whether the headings in 3.17 were the wrong way round. KW confirmed that this was the case. EB expressed concern at the low percentages in relation to the Friends and Family test, particularly in West.	

		Action
	She requested further information about the Clinical Effectiveness measures in 3.1 as the RAG rating was currently amber. JM stated that the nationally-dictated Clinical Performance Indicators were currently RAG rated green. However, YAS' Clinical Audit programme was still restricted so it was RAG rated amber. He acknowledged the need to split out the two items to give a different interpretation, adding that the confusion was related to the historical nature of CPIs and how they were reported. EB asked why the Clinical Leadership risk was RAG rated green, as it was her belief that it should be amber. SP replied that this risk was different to that discussed earlier. It was a separate discreet piece of work with a different set of actions. PD noted the updates on patient and medication-related incidents in C3 and asked whether a deadline had been agreed for the production of the guidance around EOC responses. BH replied that he would follow this up and agree a deadline. **Action:** **BH to agree deadline for production of guidance around EOC responses and report back to September meeting.** PD questioned the loss of keys reported in the medication-related incidents section. JM replied that this was a fairly regular occurrence although he agreed that it should not happen. He agreed to take action to ensure that the need to protect keys was reinforced. **Action:** **JM to reinforce message about the seriousness of losing keys.** PD stated that, if someone lost keys to a drugs cabinet in a hospital, formal disciplinary action would be taken against that individual and asked what action the Trust would take. JM replied that losing keys was currently regarded as the equivalent of having a morphine incident so it was followed up with an investigation and put on the individual's file. PD stated her belief that a disciplinary process was urgently needed in this respect, particularly if someone lost keys more than once. SP agreed that it was a serious issue although he would not expect the Trust to take disciplinary action for a 'first offence'.	**BH** **JM**

		Action
	EB stated her belief that the introduction of a disciplinary process would act as a deterrent as people would take more care of the keys. **Action:** **JM to draft a process re care of keys for drugs cabinets and bring back to a future meeting.** **Approval:** **The Quality Committee considered the exceptions in the IPR and was assured with regard to the management action planned and under way.**	**JM**
6.4	**Significant Events/Lessons Learned** SP presented a report which provided information and assurance on specific events and lessons learned across the Trust. He stated that the report covered the period of March to May 2014 and picked up all relevant information relating to SIs, etc. PD asked whether the patient in incident 2014/15563 on page 4 had recently had chemotherapy before experiencing difficulties. BM confirmed that this was the case. JN and EB requested more details about incident 2014/14011. BM replied that, although more information would be available in due course, all that was currently known was that the nearest available vehicle had been allocated. PD stated her belief that the staff member who rang the local press but did not report the matter as an incident had failed in their duty. BS asked whether assurance could be given that all incidents were being reported. SP replied that it was unlikely that all incidents were reported and how to close the gap was a big challenge. However, the Trust was working hard to encourage staff to report all incidents and this featured as a major part of BM's objectives for the year. SP further stated that he was more confident about the reporting of serious incidents, although indications were that some work also remained to be done in this area. A discussion took place about the ease of reporting incidents since the move from Prism to Datix. BM confirmed that a 24-hour reporting line had been introduced and would be available from 1 June 2014.	

		Action
	SP confirmed that an all-staff notice was issued when the telephone line was launched through 111, adding that he would issue a reminder about incident reporting to give the NEDs further assurance. **Action:** **SP to issue an all-staff reminder re incident reporting** In relation to incident 2014/10999, PD asked whether all of YAS' Paramedics had appropriate spinal injuries skills in relation to immobilisation. JM replied that, although this was being reinforced by means of refreshers on clinical update days, the roll out was not as consistent as he would like it to be. It was agreed that an update on the above should be provided at the September meeting. **Action:** **IB to provide update on spinal injuries skills refresher training at September meeting.** In relation to incident number 2014/15906, SP confirmed that the member of staff had been released from hospital although the long term prognosis was currently unclear. Immediate support had been provided by the local management team, adding that the accident reduction manager had also been heavily involved and a full investigation was under way. PD noted the good news about the decrease in the number of complaints received about the attitude of operational staff in 5.7. BM confirmed that Section 7, common themes arising from incidents, complaints and legal proceedings was a new section in which a number of common themes could be identified from the analysis earlier in the report. These common themes were: moving and handling; spinal management; delayed response; conveyance; lone responders. BM confirmed that significant work had taken place in relation to the Lone Worker Procedure which formed part of the Safety and Security Policy that was due to be approved at SMG on 18 June. SP stated that the new policy included a more flexible and dynamic risk assessment and provision of training for staff on how to conduct such a risk assessment. PD requested more information about the delayed response information contained in 7.6.	**SP** **IB**

		Action
	It was agreed that BM would provide an update at the September meeting. **Action:** **BM to provide update on 7.6 delayed response at September meeting.** **Approval:** **The Quality Committee noted the content and supported the actions detailed in the paper.**	**BM**
6.5	**NICE Guidance Implementation** SD presented an update which highlighted the current position of NICE guidance evaluation and implementation. He stated that the appendices included information about everything that had been received and worked through during the previous 12 months. The area of head injuries had been looked at in more detail. An audit had taken place to identify the Trust's compliance and would be developed into a local CPI and built into the forward planner. There were some areas for improvement and currently areas of poor performance would be built into action plans. PD stated it was good to see the information in its current format and she would welcome a summary of the detailed audit at a future meeting. **Approval:** **The Quality Committee accepted the paper as part of the Trust's assurance of compliance to evaluate and implement appropriate NICE guidelines to clinical practice.**	
6.6	**Expert Patient report** ABP presented an update to inform the Quality Committee about the YAS Expert Patient role and activities and to provide highlights from a patient perspective as part of a patient voices' focused approach by YAS. She provided copies of the Expert Patient consultancy role outline and the slides delivered to IGC by Hester Rowell on behalf of the YAS Expert Patient in December 2010. PD thanked ABP for her thorough report, which was taken as read. ABP stated her hope that the report would provide assurance and clarity about the activity in which she was involved and would help to inform YAS' activity going forward even though it had been written from a layperson's perspective.	

		Action
	PD stated that the report would certainly help with quality governance, adding that going forward how ABP linked with others and engaged with the Trust's membership would be very important. ABP agreed to provide alternate verbal and written reports at future meetings. It was noted that SP and ABP would continue to meet regularly to review priorities and actions. **Approval:** **The Quality Committee received the report, noted the activity updates and discussed the highlighted points presented from a patient perspective with a view to informing further developments at YAS.**	
6.7	**Medicines management including management of Controlled Drugs** SD provided the six-monthly update with regards to Medicines Management. Highlights of the report included: • The identification of a Medication Safety Officer (Trust Pharmacist, Rebecca McLaren) to be a member of the new National Medication Safety Network. ABP as Expert Patient will attend MMG meetings as the required patient representative; • Home Office changes to the licensing of controlled drugs had led to YAS having to change the way it procured controlled drugs. Hull and East would test out the new procurement process and the Medicines Management Group had worked with the Operational Directorate to come up with a process which had the lowest impact operationally; • The Clinical Directorate had also worked with Operations to identify morphine Hub stations within each of the areas; • The Clinical Supervisors and Managers had been shown the new process and all stations would have flow charts and procedures within the Morphine room; • The Trust Pharmacist had been working with the Ambulance Pharmacist Network to provide guidance on end of life care within patients' homes; • Drug guidance had been completed which would sit in the EOC Clinical Hub. PD stated that the creation of the morphine hub stations was good news and asked for this item to be kept on the Quality Committee agenda for the foreseeable future.	

		Action
	Action: **Update on introduction of morphine hub stations to be given in September meeting.** **Approval:** **The Quality Committee noted and commented on the contents of the report.**	**SD**
6.8	**Mortality review development** SD reported on the findings of the deep dive into the original AMPDS codes and mortality paper, which was a follow on from a session at an earlier Quality Committee meeting. He stated that, following a re-audit of all of the codes, it had been discovered that some had initially been incorrectly coded which had in turn skewed the data and artificially increased the mortality rate of those codes. SD confirmed that work was underway with the EOC Quality team to monitor Green codes and death on scene as a trigger for a full investigation. Discussions were also underway on generating regular reports and how these would be used. PD stated that it was a positive development that the Trust had identified learning and was being proactive in implementing changes. SD confirmed that the Clinical Governance report would include this information going forward. JM stated that he would be feeding the information back to NASMeD. **Approval:** **The Quality Committee noted the report.**	
6.9	**Service Transformation Programme update** KW provided an update on developments, issues and risks in relation to the Service Transformation Programme. She stated that the 2014-16 Programme would be governed via the Trust Executive Group (Transformation) (TEGT) with the Executive Directors reporting on the three work streams by exception on a monthly basis. The planning for 2014-16 was almost complete with a Programme Brief and PDM Level 0 in development. KW stated that effective working strategies were currently being developed with Corporate Communications to ensure that engagement and communication momentum could be maintained. A Transformation Communication and Engagement plan was also in production and awaiting sign off through the Programme Board.	

		Action
	The YAS Improvement Academy was in development alongside the Education team and project risks had been uploaded onto Datix. One of the key risks had been taking forward the urgent care agenda without a manger. However, a manager was now in post. The new dashboard was an interactive document. For example clicking on the ticks would inform people which milestones had already been delivered. It was agreed that Head of Service Transformation, Helen Daly, should be invited to the next meeting to provide more detailed information about the three work streams and achievements to date. **Action:** **Helen Daly to be invited to September meeting to provide update on progress re the three work streams.** **Approval:** **The Quality Committee noted the developments, issues and risks, as outlined in the paper and was assured with regard to the Transformation Programme management arrangements and actions.**	**SP**
6.10	**Response performance delivery** RH provided an update on response performance delivery and the actions being taken to improve the current challenging position faced by the Trust. He stated that performance currently stood at: Red 1 – 69.18%, Red 2 – 69.57% and Combined – 69.57%. DW stated that the biggest drop off had been in urban CCGs and the level of this drop was the Trust's main concern as rural areas had not generally dropped. RH stated that key issues, which had led to the drop in performance included: • a significant increase in demand, particularly Red demand at weekends; • a drop in operational hours, with an average of 5400 per day and no use of private providers; • efficiencies introduced by the Trust, including ECA deployment, changes to meal break arrangements and changes to the relief policy. RH stated that there had been an increase in overall activity of 4.0%, with an increase in Red demand of around 13%, which had increased to 20-25% over some weekends. BH stated that EOC had received 900 Red calls on only three occasions the previous year but this had already happened 6 times in the current year to date.	

		Action
	DW stated that the majority of trusts were currently struggling with performance. A detailed specification was due to go to AACE in relation to a piece of work around ambulance Red demand. RH presented details of the Trust's recovery plan. **Demand** - the number of Clinical Hub staff had been increased with big strides being made to increase Red and Green triage. There would also be more clinical floor walkers at certain times to assist 111 and help lower their referral rate. **Operational hours** – efforts were being made to recruit to full establishment. The number of St Johns' teams, currently running at 2-3 per day, would increase over time to 10 per day. Help with urgent care cases would be provided from PTS at weekends. **Efficiencies** - revised deployment of ECAs and relief policy. An extended meal break window had also been introduced. RH stated that although there was frustration in the organisation around the perceived lack of progress in negotiations with union colleagues, the Trust had needed to implement some changes without their agreement. PD stated her belief that, as these changes had related to basic care issues, the Trust had done the right thing. A discussion took place about YAS' current relationship with the unions and that fact that the Trust was not prepared to put its patients' safety at risk to meet their demands. The Committee discussed what the current performance issues meant to safety. RH stated that, as there was a direct correlation with meal breaks when there was a huge increase in demand, the decision had been taken to extend the meal break window to ensure that resource was spread out more evenly. DW stated his belief that this had been the right thing to do as it placed the emphasis back on patient safety. BS asked what work was being carried out to identify the reasons for the huge increase in demand. JM stated that data had been collected which proved that the increase was spread across Red demand as a whole and could not be pinpointed to any particular issues. Although it had taken a year to manifest itself, there was now a real gap in terms of the long term management of conditions across primary care.	

		Action
	RH stated that, although Datix did not reflect huge increases, there had been an increase in complaints relating to delayed response and clinical case reviews were being conducted in relation to potential harm. JM stated that, although there did not currently seem to be any harm incidents relating to the situation, the risk remained and active monitoring of the situation would continue for the foreseeable future. In summary, RH stated that: • the Operations, Clinical and Quality teams continued to work closely together; • individual case reviews were ongoing; • there was currently no over-riding theme of a significant impact on quality and safety, although there was a clear need to continue close monitoring and to raise awareness of incident reporting.	
7.0	**WORKFORCE**	
7.1	**Workforce update report / IPR section 4** IB provided an overview of matters relating to a range of workforce issues, including education and training, equality and diversity and employee wellbeing. The report was taken as read. IB stated that the new style Workforce section of the IPR, which PD had seen before, had been attached. A discussion took place in relation to conversion training and how to encourage people to undertake it. It was agreed that the issue of staff who chose not to take up the offer of conversion training should be passed back to TEG for further discussion. **Action:** **IB/TEG to consider options for staff who chose not to take up the offer of conversion training.** **Approval:** **The Quality Committee formally reviewed and scrutinised the workforce update report, noted the key risks to the organisation and was assured by the progress made.**	**IB**
7.2/7.3	**Annual staff survey / Staff engagement update report** IB and SOL updated the Quality Committee on the results of the most recent staff survey and provided an overview of the themes from the pulse surveys undertaken. This item had been held over from the April meeting to allow additional time to provide more detailed information.	

		Action
	SOL stated that the 2013 overall staff engagement indicator score was 3.21, which represented a slight improvement upon the 2012 result of 3.18. The Trust's score was slightly above average when compared with other ambulance trusts. She confirmed that the 43% return rate, which was lower than the previous year's, had been a smaller sample size. SOL stated that she had provided both an overview and the full report, which was attached as an appendix. An updated action plan for the staff survey had been provided at a recent BDM. It was agreed that many of the actions relating to staff engagement needed to be implemented at a local level. SOL further stated that the cultural audit had been aligned to further developing the Trust's values and behaviours, adding that the friends and family test, which was out across the June period, would report its results back to NHS England for publication. . JN stated that it was a good report which he had enjoyed reading. His overall view was that the Trust rated fairly highly although there were individual issues to be picked up by the various directorates. IB agreed that slow but steady progress was being made although the best trusts' level of engagement was massively different from the Trust's current position. PD stated that the report had been very informative, adding that it would be useful to focus on a quality review of the staff survey to triangulate staff, patient and management experience. She asked whether action plans were expected from the locality directors. IB replied that he would expect the HR business partners to work with the locality directors and bring forward action plans. PD stated that a more structured approach was required, adding that it would be good to hear some good news stories as the survey did not currently measure individual motivation to engage. It was agreed that, following liaison with DW, IB should provide an update to Board which outlined actions which were in place to move things forward. **Action:** **IB to provide update to Board re actions being taking to move things forward in relation to outcomes from the staff survey.** **Approval:** **The Quality Committee noted: the results of the Staff Survey 2013; the results of Pulse Surveys undertaken; the requirements of the NHS Friends and Family Test; the action being taken in**	**IB**

		Action
	2014 relating to the YAS cultural audit; and reviewed progress against that 2012 action plan.	
7.4	**Clinical leadership progress report** RH presented an update report on progress to date in relation to the implementation of the Clinical Leadership Framework (CLF). Key issues related to the provision and delivery of training and the review and updating of the dashboard. RH stated that all Clinical Supervisors (CS) should have completed their bronze training by the end of June, which was the first time this had been achieved. RH placed on record his thanks to SOL and her team for their efforts. Although the new CS competencies had taken longer than envisaged to draft they were due to go to Clinical Governance Group the following week for final sign off. In terms of the completion of PDRs, local abstraction training time would be used to ensure that they took place. RH stated that final evidence in relation to the CQC 'minor concern' would come through in the dashboard to provide a true assessment of the Trust's position, although this would not be available for a further couple of months. SOL stated that now the principles had been set, the emphasis would be on the practicalities of making the systems and processes work which would take some time to come to fruition. EB stated that she welcomed the honest and detailed report and asked what RH saw as the biggest ongoing risks and mitigations. RH replied that performance was currently the biggest risk, as the current demand management situation meant that the CSs had to be escalated up the scale and would have to go out responding. EB asked how often that was likely that happen. BH replied that as this action was a last resort it had only happened on a couple of occasions. He would rather utilise the CSs' skills have supporting the system elsewhere. RH stated that it would tend to happen at weekends and during the meal break window if it was going to happen. DW stated that the paper had provided a good update, although the situation would need to continue to be closely monitored going forward. He asked from a risk point of view where the current position left the Trust in relation to CQC actions, as there was currently a chance of them carrying out their follow up before the work was finalised.	

		Action
	SP replied that the implementation of the CQC action plan was almost complete albeit that there was still a period of time during which it needed to operate in practice before all of the benefits could be seen. It was agreed that IB should provide a further update at the next meeting to include examples of evaluation to provide assurance of progress to date and a simple plan with timescales for the next stage of implementation. **Action:** **IB to provide update at September meeting to include examples of evaluation to date and timescales for further implementation deadlines.** **Approval:** **The Quality Committee noted the update and the on-going development work.**	**IB**
8.0	**RISK MANAGEMENT**	
8.1	**Corporate Risk Report** SP provided an update on the risks recorded in the Board Assurance Framework (BAF) and Corporate Risk Register to provide assurance on the effective management of corporate risks. He stated that the Corporate Level Risk Register at Appendix 2 was the latest available version and had been progressed through the Risk Assurance Group. It would continue to be refined prior to going to the Board in July 2014. SP further stated that on page 1 of the Risk Register a number of items relating to A&E Operations performance would be further reviewed in view of the Trust's current position. There were no additional comments. **Approval:** **The Quality Committee noted the key risks outlined in the report and was assured with regard to developments in the risk management processes and action.**	
8.2	**Musculo-skeletal (MSK) accidents and injuries** KS and BM presented an update on the actions currently under way within the organisation to reduce the number of musculo-skeletal accidents and injuries being experienced by staff. KS updated the Committee on the sickness management data for April 2013 to March 2014, which included the reasons for sickness absence and a breakdown of MSK and general back injuries by area.	

		Action
	BM stated that in a 12 month period there had been 1357 incidents which had resulted in harm to staff; 601 of which were MSK related. 105 incidents had been classified as RIDDOR reportable. 298 incidents needed further attention. Further breakdown to type of incident showed that most were related to moving and handling. However some related to incidents of violence and aggression. IB confirmed that a Claims paper was due to be considered at the Joint Committee meeting later that day. There were currently 180 open employer liability claims. Since 2010 there had been 45 claims relating to the blue response bag with 38 currently still open. BM outlined the Health & Safety themes taken from recent incidents and the work under way to improve things. She stated that equipment-related incidents, particularly in relation to response bags and carry chairs had been recurring themes. Further work was required to ensure the Trust policy provision in relation to moving and handling and display screen equipment use, which were high risk tasks for MSK injuries, was working effectively. BM further stated that a more co-ordinated approach was required in relation to the implementation of new equipment to include lessons learned from the roll out of the new response bags and carry chairs. Further improvement in the completion of risk assessments for high risk MSK tasks was also required which would include making sure that manual handling assessments were up to date and increasing the number of DSE workstation assessments completed. It was noted that, in spite of the fact that manual handling was a significant health and safety risk for the Trust, it did not have access to specialist technical advice such as a manual handling adviser. BM stated that a number of actions were under way to address the challenge, including the introduction of new kit. Work was continuing to reduce the overall weight of response equipment carried by staff. The development of Display Screen Equipment guidance was currently being trialled within EOC. Bariatric equipment vehicles had been purchased and implemented and were now working in South CBU and a Bariatric task and finish group had been established. New standard manual handling equipment had been issued to every vehicle and a manual handling task and finish group had commenced work to review and improve current moving and handling policy provisions and ensure adequate training was provided to managers and staff on the risk assessment process. DW expressed concern about the amount of carry chair training that had taken place and both PD and he stressed the urgent need for further progress.	

		Action
	KS provided information about the services provided by Occupational Health (PAM) to support MSK issues and the next steps to be taken. She stated that a scoping exercise was required to assess how manual handling expertise could be sourced and a co-ordinated approach to the procurement and implementation of equipment was required. IB stated that, looking at the break down of MSK sickness absence by area the proportion of absence in A&E West was twice that in south and asked why this was. DW replied that West was a much bigger area. SP stated that there was also a large disparity between CBUs in terms of 'blue bag' claims and wondered why this was the case. PD agreed that further investigation was required and it was agreed that the matter should go back to TEG for further consideration. **Action:** **SP to provide a further update on 'blue bag' issues and related claims.** SP stated that the presentation had provided assurance that progress was being made although there was clearly still the need for further work. It was agreed that IB should provide a further update at the September meeting in relation to progress against the training roll out and front end proactive support. PD stated that it would be also useful to receive an update on how quickly the Trust was getting people back into work and whether this had improved yet. **Action:** **IB to provide update re roll out of training, speed of return to work from MSK injuries, etc at next meeting.** **Approval:** **The Quality Committee noted the update report.**	**SP** **IB**
8.3	**Patient Safety Alerts – Medication Error and Medical Device incident reporting and learning** BM presented an update to provide assurance of the effective management of patient safety alerts. The paper was taken as read. PD thanked BM for the update as it was important for the Quality Committee to be clear and assured that matters were being handled correctly and being dealt with in the correct arena.	

		Action
	She further stated that it was good to see that the Medication Safety Network and Vehicle and Equipment groups were up and running. **Approval:** **The Quality Committee noted the process outlined in the report and actions taken to achieve compliance with CAS and Patient Safety Alerts.**	
9.0	**RESEARCH GOVERNANCE**	
	There were no items relating to Research Governance	
10.0	**ANY OTHER BUSINESS**	
10.1	**Quality Committee Effectiveness Review:** **a) Review report** **b) Updated Quality Committee Terms of reference** **c) Updated Clinical Governance group terms of reference and updated Terms of Reference** PD thanked people for their attendance at the recent Quality Committee Effectiveness Review. SP provided an update on the Review and the proposed changes to the Committee's Terms of Reference (ToR) arising from this. He asked if there were any comments on the report which Committee members had already received in draft. There were no comments on the report so SP invited comments on the reviewed ToR and membership of the Committee IB asked for his job title to be updated in 4.1. He further added his belief that the AD of Risk should be added to expected attendees and pointed out a typo in 6.4. EB stated that the F&IC ToR were due to be considered at that afternoon's meeting. It was agreed that both sets of revisions should be considered by AA to ensure that there was no mismatch between the two sets. AA stated that she would get comments back to SP as soon as possible. **Action:** **AA to compare revised Quality Committee and F&IC ToRs to ensure no mismatch between the two sets and report back to SP as soon as possible.** PD noted that EB and PD were members of each other's respective committees. She further noted that although no one was present from PTS at that day's meeting from September the Associate Director for PTS would attend Quality Committee meetings.	**AA**

		Action
	PD stated that, in addition, the Committee would continue to encourage the attendance of other senior managers as observers. SP stated that the remaining changes to the ToR were mainly factual, including the addition of the two joint meetings with F&IC. It was agreed that any other comments should be submitted to SP as soon as possible. SP would make further minor amendments with the amended ToR to go to Board in July PD stated that, as a matter of assurance and governance, the Committee needed a named Deputy Chairman, adding that EM, as the other NED member of the Committee was the obvious choice. It was agreed that, prior to EM being formally approached, SP would approach the Trust Chairman for her opinion, as EM was also Chairman of the Charitable Funds Committee. **Action:** **SP to liaise with Trust Chairman for her opinion prior to EM being approached to be Deputy Chairman of the Quality Committee.** **Approval:** **The Quality Committee noted the report and recommendations from the Committee Effectiveness session; agreed the changes to the terms of reference of Quality Committee; and noted the changes to the Clinical Governance Group terms of reference.**	**SP**
10.2	**Issues for reporting to the Board and Audit Committee** PD stated that she would discuss the contents and wording of the assurance statement to the Audit Committee with BS outside the meeting to ensure that a suitable entry was included going forward. **Action:** **PD to discuss contents and wording of assurance statement to Audit Committee with BS outside the meeting.**	**PD**
10.3	**Review of meeting actions quality review of papers** It was agreed that the papers were generally of a good standard and the meeting had allocated sufficient time for each agenda item. It was agreed that more time would be required for workforce issues at the next meeting, so the order of the agenda might need to be moved around. PD thanked everyone for their time and effort. The meeting closed at 1215 hours.	

		Action
11.0	**Date and Time of Next Meeting:** (0830) 0900-1230 hours 11 September 2014, Kirkstall and Fountains, Springhill 1, WF2 0XQ	

CERTIFIED AS A TRUE RECORD OF PROCEEDINGS

_____ **CHAIRMAN**

_____ **DATE**