Yorkshire Ambulance Service NHS
NHS Trust

An Aspirant Foundation Trust

Quality Committee Meeting Minutes

Venue: Kirkstall & Fountains, Springhill 1, WF2 0XQ
Date: Thursday 4 December 2014
Time: 0900 hours
Chairman: **Pat Drake**

Attendees:

Pat Drake	(PD)	Deputy Trust Chairman/Non-Executive Director
Dr Elaine Bond	(EB)	Non-Executive Director
Erfana Mahmood	(EM)	Non-Executive Director
Steve Page	(SP)	Executive Director of Standards & Compliance
Ian Brandwood	(IB)	Executive Director of People & Engagement
Dr Julian Mark	(JM)	Executive Medical Director
Dr Dave Macklin	(DM)	Interim Executive Director of Operations

Apologies:

Ben Holdaway	(BH)	Locality Director - EOC
Becky Monaghan	(BM)	Associate Director of Risk & Safety

In Attendance:

Della Cannings	(DC)	Trust Chairman
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
Dr Steven Dykes	(SD)	Associate Medical Director
Karen Warner	(KW)	Associate Director of Quality and Nursing
Shelagh O'Leary	(SOL)	Associate Director, Organisational Effectiveness & Education
Kate Simms	(KS)	Associate Director of HR
Joanne Halliwell	(JH)	Associate Director of Operations – PTS
Karen Cooper	(KC)	Head of Service Delivery – NHS 111 (Item 6.8)
Michaela Littlewood-Prince	(MLP)	Head of Quality Assurance – NHS 111 (Item 6.8)
Liz Harris	(LH)	Clinical Development Manager – South
Jason Carlyon	(JC)	Clinical Development Manager - North

Minutes produced by:

Mel Gatecliff	(MG)	Committee Services Manager

The meeting was preceded by a presentation between 0830 and 0900 hours on the Clinical Supervisor and Clinical Development Manager roles in practice.

The presentation, which was delivered by Associate Director of Organisational Effectiveness & Education, Shelagh O'Leary and Clinical Development Manager, South, Liz Harris, with input from Clinical Development Manager, North, Jason Carlyon, 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 apologised for the short-notice change of rooms and thanked everyone for their attendance. She provided an update about the previous week's national meeting, which she had attended with the Trust Chairman, and EB as Chair of the Finance & Investment Committee. The event had been organised by YAS and had provided good learning for everyone to take away. A short discussion took place about the pre-meeting presentation. PD stated it would be useful for the Clinical Supervisors (CSs) to see the organisational model of the Clinical Development Manager's (CDM's) role out in the localities, as this role would be key going forward. JC stated that ICT support was a major issue for the CDMs. To enable the role to work more smartly, it was crucial that IT should play a more important part. As JC could cover up to 900 miles some weeks, he could spend as much as half of his working week driving. SOL stated that there were currently no plans to increase the amount of ICT support provided to the CDM role but she would take the suggestion forward as an action and provide an update report at the February meeting. **Action:** **SOL to take forward the requirement for additional ICT support for CDM role and provide an update at the February meeting.**	**SOL 085/2014**
4.0	**Minutes of the Meeting held on 11 September 2014** The minutes of the Quality Committee meeting held on 11 September 2014 were approved as a true and accurate record of the meeting.	

		Action
	Matters Arising: Page 2 – it was noted that the Trust Chairman had already been appointed as a specialist advisor to CQC and had participated in a review. Page 7, para 3, first line – 'the Quality Committee that' added after 'KW informed' Page 7, para 3, final line – 'ot' amended to 'to'	
5.0	**Action Log** The meeting worked through the Action Log, which was updated accordingly. Closed items were highlighted in grey. **195/2013 - Clinical Leadership** IB confirmed that there had been 7 Clinical Supervisor development posts to date. These had been informally managed in the localities. It was agreed that, in order to minimise risk and provide a consistent approach, a more formal process was required going forward. EB asked whether any development posts were currently in place and if so, what the geographical spread was of those posts. DM replied that there were currently no development posts in place. He suggested that a review of the previous posts was required prior to any formal process being established. It was agreed that the action should remain open until the February meeting when further clarification would be provided. **011/2014 - Review of Key Quality Indicators (IPR) / Action** IB stated that the number of exit interviews had substantially increased since the review, with 150 taking place in the last 3 months. Action closed to be replaced by action **086/2014** below. KS would provide a further update report at the February meeting. **Action:** **KS to present exit interviews update report at February meeting.** **031/2014 – Action Log – Governance Arrangements for Sub-Contractors** SP confirmed procedures were in place for A&E and PTS with no specific problems being identified to date. In addition, KW and JM had interrogated the Datix system for information about any problems prior to the forthcoming CQC inspection. Action closed. **046/2014 – Education and Training Plan 2014/15** JM was still awaiting information from the College of Paramedics formally describing the career pathway for Specialist and Advanced Paramedic roles, which he would bring to the February meeting.	**KS 086/2014**

		Action
	EB stated that further clarification about how the new roles would fit into the Workforce Plan was also required. A long discussion took place about the Paramedic career framework nationally. Action remains open. **049/2014 – Action Log – Clinical Leadership succession planning** See update for action **046/2014**. If was agreed that a further update was required at the February meeting. Action remains open. **061/2014 – Workforce update report / IPR section 4** IB stated that SOL and he were still in conversation with Teesside University where there were limited opportunities for conversion courses in 2015/16. Action closed. **065/2014 – Musculo-skeletal (MSK) accidents and injuries** IB stated that the Health and Wellbeing Steering Group would carry out a deep dive into the main issues around MSK injuries, etc and make recommendations for the future. IB had also met with the Occupational Health providers, PAM, to express concern about some of their responses. He was hopeful that matters should now improve fairly quickly and further updates would be integrated into the Workforce update report. Action closed. **071/2014 – PTS** JH stated that the four PTS PIDs had been written and had gone through QIA. They were currently going through internal governance checks with RB, following completion of which they would be circulated to Committee members. Action closed. **073/2014 – Clinical Hub** EB stated she had found it difficult to identify the changes in the revised PID without sight of track changes, whilst acknowledging that it could have been confusing to show all of changes, as several authors had been involved in the process. DM agreed to share the version containing his own track changes. Action closed. **075/2014 – Trust Chairman's Introduction – D Hughes presentation** IB confirmed all presentations were on the Intranet. Action closed. **077/2014 – Significant Events / Lessons Learned including Patient Thermometer** SP confirmed that the full report was included in that day's papers. Action closed.	

		Action
	081/2014 – Workforce Update Report IB confirmed that the latest report contained this information. Action closed. **083/2014 – Clinical Leadership Progress Report** It was noted that the presentation had taken place at the start of that day's meeting. Action closed. **084/2014 – Review of meeting, etc** SP and PD confirmed that this action remained open.	
6.0	**QUALITY GOVERNANCE/CLINICAL QUALITY PRIORITIES**	
6.1	**Quality Governance Report** KW and JM provided a detailed update on the Quality Governance Development Plan to provide assurance that related workstreams were progressing to plan. PD stated that the 'grey' entries in the Plan did not show up very well and asked whether a different shade could be used in future. KW covered the following elements during the update: • Quality Governance Development Plan • An update on matters relating to Savile • Duty of Candour • Never Events consultation • CCG quality event feedback • CQUINS 2014/15 & 2015/16 • Clinical quality strategy 2012/14 & 1015/18. • Policy & procedural documents process KW reported that SP remained engaged with the Savile Legacy Unit (SLU) and provided an update on the work which remained outstanding and the likely publication date of the Trust's report. She confirmed that the Commissioners and TDA had been briefed on the enquiry and the support from the SLU. KW stated that the Health & Social Care Act 2014 detailed the regulations required to be met by Health & Social Care providers. A statutory Duty of Candour had been introduced to the regulations from November 2014, which placed a formal requirement on providers of health and social care to be open and transparent in relation to the care and treatment provided to their service users, which would apply at all times. Initially the duty will only apply to NHS bodies, but was expected to be extended to include all service providers registered with the Care Quality Commission (CQC) from April 2015. KW stated it would be a criminal offence under the new regulation, not to notify a service user of a notifiable safety incident or to fail to meet the requirements for such a notification.	

		Action
	However, the Trust was confident that its policies were robust enough for this not to be a concern. A discussion took place around the definitions of a 'notifiable safety incident' and 'severe' and 'moderate' harm. PD stated that 'moderate' harm was something which the Trust would need to consider in terms of delayed response. SP and JM confirmed that the Trust had a very good process in place to ensure that it was being open. PD asked how the revision of the Trust's 'Being Open' policy had been disseminated. KW replied that it had been included during the CQC preparations as part of the Communications and Engagement Plan. EM stated her belief that the organisation's well-established 'Being Open' policy was something that the Trust could really champion in terms of the forthcoming CQC inspection. PD requested a copy of the consultation that had been issued in relation to the Never Events Policy Framework. **Action:** **DM to provide PD with a copy of the Never Events consultation document.** In relation to the CCG Quality Event feedback, KW stated that next steps would include agreeing the reporting framework to ensure that contractual requirements were met and better served the CCGs with meaningful and valuable information. This would be progressed through the Contract Management Board and discussions with the Lead Commissioners (Wakefield CCG since 1 November 2014). SP confirmed that this remained work in progress with relationships continuing to vary around the patch with varying understanding of the 'quality' part of the process. KW stated that the quarter two CQUIN report was submitted on 26 October 2014 with a contract query notice received for additional information which was due to be submitted on 28 November 2014. As part of the contract negotiations, a CQUIN schedule was being developed. Whilst the 2015/16 national CQUIN guidance had yet to be published it was anticipated the only national CQUIN relevant to the ambulance sector would be the Friends and Family Test. JM stated that YAS continued to strive to agree a CQUIN schedule focussed on patient experience, safety and effectiveness of care.	**DM 087/2014**

		Action
	He further stated that agreement had been reached to commission some CQUINs across the whole of the patch for 2015/16. KW stated that the Trust's Clinical Quality Strategy was developed around the 3 main themes of safety, effectiveness and experience with 15 priorities identified. A great deal of consultation had taken place with staff to identify what should be included in the Strategy. Internal communication had been a focus through autumn 2014, with communication being driven through training school, Clinical Quality Forum, Clinical Governance Group and Clinical Supervisor away days. Themes identified as priorities included: • Training specifically in relation to new equipment; • Consistent alternative care pathways for patients; • Clear role and responsibility for Clinical Supervisors. KW confirmed that, in conjunction with AA, the focus in December and January would be on engagement with the YAS Forum and Members, aligning priorities to the IBP and external engagement. It was noted that an update on the development of the Clinical Quality Strategy 2015/18 would be presented to the Committee in February 2015. KW provided a summary of the policies currently due their planned review with current focus being on the policies due for refresh prior to January 2015. SP stated that the policies on which it was currently not timely to carry out a full review would be given a revised date at a future TMG meeting, where the content of the document was clearly still current. EM queried whether YAS was creating unnecessary work for itself. SP replied that review dates needed to be realistic, adding that although a review did not necessarily lead to a re-write, policies needed to reflect changes in the organisation and wider health landscape. EB asked whether the review dates could be scheduled in a different way to space out requirements for reviews during the year. IB replied that time had been lost on HR policies over the summer due to the on-going industrial relations issues. An extra meeting would take place with Unison in December to ensure the work was completed. The Trust Chairman stated her belief that work should not be delayed for this reason, as the vast majority of policy changes were minor.	

		Action
	It was agreed that further discussion was needed about which areas were most appropriate for union consultation. PD asked how YAS ensured that its workforce was aware of changes. SP replied that this took place through the communications process, team briefings. AA stated that updated policies were not always uploaded to the Intranet in a very timely manner. EB asked how understanding of policy changes was assessed. KW replied that this depended on the individual policy. For example, the number of referrals following the release of the Safeguarding Policy showed that there was a good understanding. SP stated that the results of inspections for improvement were fed back to the management team. JM stated that information was also incorporated into update days. **Approval:** **The Quality Committee received the report as assurance that quality governance remained a key priority for the Trust and that related workstreams were progressing to plan.**	
6.2	**Planning for CQC inspection** KW reported on the plans in place to prepare for the CQC inspection, which was due to take place from Monday 13 January 2015. KW confirmed that the Provider Information Request had been received and was due to be submitted on 5 December 2014. This would be analysed by the CQC and combined with other intelligence monitoring to produce the datapack for the inspection team. She stated that it had been a huge piece of work and expressed thanks to all directorates for their help in compiling the massive amount of information requested, which took up 36 tabs on an Excel spreadsheet. KW confirmed that every query received from the CQC was being catalogued, adding that several responses remained outstanding to queries submitted to them by the Trust. EM asked whether a core response had been agreed on some of the more difficult questions that those being interviewed were likely to be asked.	

		Action
	SP stated that the Trust would remain open about both its strengths and development areas during the pre-submission and inspection stages. These areas would be discussed with the wider management community at the forthcoming leadership event on 9 December to inform the CQC preparations and support a common understanding. The Trust Chairman stressed the importance of staff understanding YAS' rules of engagement in relation to observers, etc. KW stated that, in order to increase staff awareness, a corporate communications plan had been developed which included a range of methods to inform staff about the new CQC process. A theme was to encourage staff to be honest and open with the CQC and the plan had been published under the banner 'Time to Shine'. **Approval:** **The Quality Committee received the report as assurance that the organisation was prepared for the CQC inspection and was well sighted on key strengths, risks and issues.**	
6.3 Took Place After Action Log	**Re-start a Heart** Clinical Development Manager, Jason Carlyon (JC), provided the Quality Committee with an understanding of the background to the 'Restart a Heart' day initiative in Yorkshire and presented a report about the outcomes of the event and lessons learnt. JC stated that 'Restart a Heart Day' is an annual event organised by the Resuscitation Council (UK), which was started in 2013. All UK secondary schools received a DVD called 'Lifesaver' from the RC (UK) in addition to a lesson plan, with the purpose of the schools delivering the training to their pupils. As part of YAS' cardiac arrest improvement strategy in North Yorkshire a system was introduced called "ROSC Feedback" in December 2012. A dedicated email address was set up and staff were asked to notify the management team of any occurrences of ROSC at a cardiac arrest. In conjunction with the clinical audit department an online report was created called 'Survival Report'. JC stated that, since the inception of the feedback process, North Survival to Discharge rates had improved from 6% to 12%, with the current year to date figure standing at 15%. It was believed that the feedback mechanisms had partly contributed to the improvements. On some occasions patients would be invited to meet the crew who responded to them. These events provide both crew and the patient a good opportunity to discuss the event, provide an opportunity for good media coverage, and create a positive atmosphere.	

		Action
	It was after one such event in May 2014, after meeting with a patient and his wife that YAS received a letter and a donation of £500 and locality managers were asked for suggestions on how to spend it. It was suggested that some mannequins could be purchased and the project was born, which ultimately, with the support of the British Heart Foundation, resulted in 51 schools and over 11,000 students taking part in the event and being trained in CPR. The event also attracted a great deal of positive media coverage. Following the event, the mannequins were left with the schools to enable children to take them home to train their families. JC stated that all of the schools involved had been provided with details of how to donate to YAS' Charitable Funds charity, with some already replying that they intend to do some fundraising for YAS. In addition, the publicity surrounding the event had led to the number of public access defibrillators being ordered increasing, with 40 ordered in Bradford alone. JC stated that lessons learned from the event included that more planning time was required for a project of that scale and that future planning documentation needed to mirror the National Decision Model format to show that all risks had been considered and actions to reduce risks had been taken. EB stated she was impressed by the excellent initiative and asked whether it was on the agenda of the management day the following week to enable JC to share the information with everyone. SP replied that an opportunity would be provided to share the initiative. JC stated that he would like to repeat the initiative the following year but in order to further develop it, YAS would need to work with bodies such as St John Ambulance and the Red Cross, as a co-ordinated response would bring about most benefit. He confirmed that British Heart Foundation remained keen to work with YAS on the initiative. JM stated that, as a result of the success of the initiative, JC had visited South Korea to study their 'whole community training' where a challenge had been set to train 1 million people over a 5-year period. During this visit JC had identified a particular project that he would like to introduce as a trial in York. This was the concept of a community-based defibrillator training centre, which offered free CPR training to members of the public.	

		Action
	The centre he had visited in South Korea provided three classes a day, Monday to Friday, with an average of 25 people attending each class and an average of 42 people attending classes on a Saturday. EM stated her belief that this pilot would fit comfortably in with the aims of YAS' Charity and suggested that JC should meet with representatives of the Charitable Funds Committee to work out a suitable support package. **Action:** **Representatives of YAS' Charitable Funds Committee to meet with JC to discuss means by which the Charity could support the Trust's CFR initiatives.** DM stated that JC had done a fantastic job and it was important that his work was taken forward and as the initiative sat within YAS' Public Health Strategy, there was potentially a lot of funding that the Trust would be able to access. The Trust Chairman congratulated JC on his excellent work. She stated that YAS must not lose sight of the successful work in North and East relating to improving cardiac arrest survival rates and asked why South and West had not already introduced the initiatives, adding that they should do so with immediate effect. The Trust Chairman suggested that Charitable Funds could consider funding a post for a year to help drive the work forward. PD agreed that the initial support could help to pull in other funding and asked for an update report at the February meeting. **Action:** **Further update on the support for the development of CPR initiatives to be provided at February meeting.** JM stated that JC had been nominated for two awards on the back of his work. The Committee congratulated JC on his success. **Approval:** **The Quality Committee noted the positive developments and considered the potential implications for future clinical strategy.**	**EM 088/2014** **JM/DM 089/2014**
6.4	**Review of Key Quality and Service Transformation Indicators (IPR) / Action – Section 3** KW and JM provided a review of the key quality indicators reported in the quality section of the Integrated Performance Report (IPR). The paper was taken as read. The Committee agreed that all issues raised within the documents were included as parts of other agenda items at that day's meeting.	

		Action
	It was further noted that all issues had already been raised at Trust Board level and appropriate actions taken. **Approval:** **The Quality Committee considered the exceptions in the IPR and was assured with regard to the management action planned and under way.**	
6.5	**Significant Events / Lessons Learned (including Patient Safety Thermometer)** SP provided an update and assurance to the Quality Committee on specific events and lessons learned across the Trust. The paper was taken as read and SP invited questions from those present. The Committee noted the large number (41) of open Serious Incidents (SIs). SP stated that he would raise his concerns about this item at a meeting with the CSU later that week, given that the majority were awaiting the CSU/CCG review. A discussion took place about YAS' current methods of reporting SIs and the TDA's reported concerns about this high number. SP stated that a proportion of Serious Untoward Incidents (SUIs) did not end up with organisational changes, etc following completion of the RCA. It was agreed that additional narrative could be included in the report to clarify this fact. The meeting considered the line chart in section 4.3. EM stated her belief that the Trust had managed a difficult period very well in terms of minimising the risk of moderate and severe harm, by which she was heartened. **Approval:** **The Quality Committee noted the current position and was assured in regard to the effective management of, and learning from, adverse events.**	
6.6	**Clinical Update (including Clinical Audit and Mental Health Concordat)** JM provided a clinical update focussing on Clinical Effectiveness, Development and Audit. The report did not include Medicines Management or NICE recommendations as information about these was provided in separate reports. JM stated that there had been a recent focus on sepsis, as the mortality rate for severe sepsis was currently 35%, which was 5 times higher than STEMI or Stroke. PD asked how many of the cases related to children.	

		Action
	DM replied that there were very few cases relating to children, with the vast majority of cases relating to older adults. EB asked what the timeframe for the total roll out of the Paramedic Pathfinder model would be. JM replied that, with the exception of AWC (whose CCG had not yet signed up) and Leeds, it would be the end of the financial year. PD expressed concern that one CCG had been able to opt out. JM stated that it related to the tangible cost of tough books, adding that it was very disappointing for the staff working in that geographical area, who had received the training but not the tools to put their training into practice. PD suggested that the issue should be raised with the Lead Commissioners and the Trust Chairman suggested that the issue should also be raised at the January Public Board meeting. KW stated that the project had been rolled out in West Yorkshire though the CQUIN. PD asked what proportion of staff would have access to the Clinical App. JM replied that full implementation would be a lengthy process. However, a paper relating to the upscaling of access was due to go to TEG later in December. He further stated that the Clinical App was based on a SharePoint platform so it would fit in with the roll out of tough books and ePRF. SD stated that the App would also be accessed through smart phones later in the roll out process. JM stated that the Clinical Directorate had developed close working relationships with police, mental health trusts and other agencies, and had instigated the Yorkshire and Humber Multi-Agency Health Improvement Collaborative Meeting, chaired by the Strategic Clinical Network. YAS had pledged support for the Crisis Care Concordat, and was currently in the process of working up the action plans behind the declaration. JM placed on record his thanks to Lead Nurse Urgent Care, Angela Harris who had pushed forward the development of the above. The Trust Chairman stated that the Autumn Statement had promised significant monies for mental health initiatives, especially for young people and asked how YAS would access the funding.	

		Action
	JM relied that the Concordat would provide the Trust with an opportunity to look further into that area. EM stated that she had found the report easy to read with content that was easy to follow and understand and asked how YAS shared the information contained with therein with other stakeholders. SD stated that as much as possible was shared with crews face to face as this was a popular way to receive information. **Approval:** **The Quality Committee noted and accepted the report as assurance of continuous clinical quality monitoring and development.**	
6.7	**Expert Patient report** PD welcomed YAS' Expert Patient, ABP, to the meeting and invited ABP to present her regular report which sought to: • Provide an update about the role and highlight activities of YAS Expert Patient for assurance; • Fulfil requested and agreed action of YAS Expert Patient from the Sept. 2014 Quality Committee following the YAS commissioned internal audit of Quality and the YAS Quality Committee; • Present proposals/ideas for sustaining the development and 'reach' of 'Patient Voices and Influence' in YAS for consideration and adoption; • Facilitate debate and wide YAS engagement on the 'Patient Voice and Influence' work agenda. ABP acknowledged the fact that she was asking for a lot and suggested that the Committee might focus on Appendix 1 and the paper's recommendations before deciding how best to progress. PD agreed that ABP had presented a huge agenda, adding that the most important area to her personally was the issue of wider networking and how YAS could most productively participate in that. PD suggested that it would be useful to sit down with ABP outside the meeting to work out a set of priorities and decide how the Trust could most effectively work through those priorities. ABP stated that her top priority would be the re-introduction of YAS' 'Critical Friends' network. SP stated that the report contained a lot of helpful information. He suggested that it would be useful to feed some of the ideas into the wider planning scenario as it was important to incorporate them into current plans such as the refreshed Clinical Quality and Stakeholder Engagement strategies rather that creating a new, separate plan.	

		Action
	Action: **SP/ABP to meet to discuss and agree the best route to take ABP's proposals forward.** PD thanked ABP for her input which was gratefully received as usual. **Approval:** **The Quality Committee noted the information contained in the report for general information and assurance on YAS' Expert Patient role and activity and agreed to further internal consideration about the feasibility and development of the proposals/ideas.**	**SP/ABP 090/2014**
6.8	**NHS 111 Service Line Assurance Report** Karen Cooper (KC), Head of Service Delivery and Michaela Littlewood-Prince (MLP), Head of Quality Assurance for NHS 111 joined the meeting to provide an update on NHS 111 performance and quality indicators along with the developments undertaken through the year. The paper was taken as read. KC stated that KPI performance and the completion of PDRs remained the two major challenges to the NHS 111 service. Over 7,000 calls had been received the previous Saturday, which was an increase of 1,000 on the previous year. Nationally, the picture was the same. ML stated that a large scale recruitment drive was under way to ensure adequate staff for the winter months. However due to the extensive training (c100 staff), 8 call handlers who were NHS Pathways trainers had to be released from call handler duties during adding to the short term issue. It was also no longer possible to secure NHS Pathways trainers externally. KC stated that there were currently 75 call handlers in training and a small number of clinicians, including dental nurses. In relation to the completion of PDRs, ML acknowledged that the service fell behind in October. However, over 100 had been completed during the previous 2 weeks, so completion was now standing at around 70% with further progress expected, as objectives were now being set during the call handlers' training period. ML confirmed that the quality of completed PDRs was of an acceptable level. The main issue with the remaining outstanding PDRs was the challenge of completing PDRs for weekend-only staff. ML stated that a percentage of PDRs would be brought forward to the quieter months of May, June and July. In addition, a reflection and learning exercise on the PDR issue was due to be completed with the management team to ensure this did not happen again.	

		Action
	ML stated that, although the service faced a lot of challenges, she was confident that it was clinically safe (see Section 5.7). KC stated that confirmation of appointments booked were now texted to patients with positive feedback received from both patients and staff. In addition, an effective referral team had been established. IB stated that sickness absence remained an issue in 111, with the proposed trajectory not yet reached and asked what more could be done to help decrease absence levels. KC stated that good progress had been made in relation to long term sickness absence with the previous year's level of 10% reduced to around 8%. The management team was proactively trying to keep staff at work with an over-50% take up of the department's 'flu' vaccination campaign. A meeting was shortly due to take place to consider what else could be done. KC stated that senior managers were all coming in over Christmas to do back to work interviews. PD acknowledged that the call centre environment would attract a higher level of sickness absence, added to which some of the problems would have been inherited from the ex-NHS Direct staff who had been TUPE'd over. EM asked how appointments were made and confirmed with Primary Care Centres, dentists, etc. KC replied that following the electronic referral of records they would ring the 111 team back. She further stated her belief that to move things forward, the service needed a volunteer GP to pilot giving the service access to their in-house appointment system. EB noted that YAS' 111 'warm transfer' performance currently stood at 38% whilst nationally it was around 64%. She asked whether other services were doing things better than YAS, or whether it was purely a matter of funding. If it was a matter of funding, did the Trust hope to address the issue, as a break negotiation was shortly due? SP replied that it was his understanding that this was mainly around funding and the way in which the contract was set up, so the matter remained on the agenda for the next round of contract negotiations. PD stated that the Trust's clinical performance in this indicator did not look good compared to other services and asked whether some other measure of clinical quality should also be considered.	

		Action
	DM stated that several other 111 providers did not limit their ambulance transfer. There was an option, therefore, to transfer more to go through A&E. However, as a lot of 111 calls were transferred to clinicians for assessing, YAS continue to provide a very safe service. SP confirmed that the contract discussions for 2015/16 were under way and this would be discussed as part of those negotiations. PD thanked KC and MLP for their useful update. She stated that it had been a very good, clear paper containing intelligent use of data. It was her belief that the innovations already in place were excellent, particularly considering the ongoing funding limitations. **Approval:** **The Quality Committee noted the update on NHS 111 and the current service developments and took assurance on the performance across the service line and the associated challenges and actions to the senior management team were taking to address these.**	
6.9	**A&E Performance Improvement Update (including Quality and Safety Issues)** DM provided an update on the process for monitoring quality and safety of delayed responses in A&E, which provided a robust and timely process for the identification and management of incidents. DM stated that Red Combined Performance was 70.4%, adding that he was confident that the quality and safety monitoring process was fully embedded in terms of daily reporting as no change in patient outcome was being seen. DM further stated that if the Red 1 target was 8 minutes and 20 seconds, the Trust would actually be achieving target performance. However, this final 20 seconds was proving very difficult to remove. During week commencing 17 November, eight incidents were escalated to the Clinical Duty Managers due to excessive delay with potential to cause patient harm. DM shared information about each case with the Committee. PD asked whether it would be possible to send a brief to each CCG containing the key points highlighted by DM. DM replied that the Trust was not far away from producing a universal reporting narrative which could be sent out to Commissioners. PD stated her belief that the perceived lack of interaction between the Lead Commissioners and CCG Chief Officers was worrying.	

		Action
	The Trust Chairman suggested that, as the next edition of Stakeholder News was shortly due to be issued, a message about the Trust only missing Red 1 by seconds could be included within the headline messages to stakeholders. PD stated that it had been good to see that there had been no Serious Incidents during the current week to date and thanked DM for his detailed update. **Approval:** **The Quality Committee was assured that the quality and safety implications of the incidence of delayed responses and back-up were comprehensively monitored and processes were in place to identify and investigate potential harm incidents in a timely manner.**	
7.0	**WORKFORCE**	
7.1	**Workforce Update Report / IPR Section 4 (including Education and Training Update)** IB provided the Quality Committee with an overview of matters relating to a range of workforce issues, including education and training, equality and diversity and employee wellbeing. IB stated that it was worth noting that the Staff Friends and Family test results for quarter 2 were heading in the right direction. He further stated that, in spite of a lot of work being carried out on the PDR process, including high level discussions at TEG, the quality of the reviews were still not at the level required across the board. The meeting considered absence management in more depth. IB stated that the overall level of absence within the Trust had decreased to 6.71% for the month of October. The year-to-date figure was 6.57%. In addition to working closely with managers in localities to ensure all staff were at the appropriate stage within the Attendance at Work Policy, the HR team was reviewing the impact of the policy, identifying areas of good practice across the Trust where managers were proactively addressing high levels of absence, to ensure any effective approaches were shared more widely. In areas where sickness absence remained high the Associate Director (AD) responsible for each area had been tasked with producing and implementing an action plan including developing an improvement trajectory.	

		Action
	IB stated that action plans were being monitored by the Executive Team and ADs were being held to account at Service Line Quality and Performance Review Meetings, chaired by AC going forward. Work continued in partnership with the Employee Wellbeing Adviser to ensure positive interventions were in place to support staff. IB confirmed that long term absence was subject to particularly close monitoring with more immediate interventions being implemented to support staff to return to work as soon as possible through alternative duties and phased returns where appropriate. PD asked whether any areas were falling behind on both sickness absence and PDR completion. EB asked why a formal, organisational timetable was not followed in relation to the completion of PDRs, as it was common in other organisations to have set dates by which time appraisals had to be completed. IB stated that it was the responsibility of each AD to ensure that PDRs were completed. EB asked, as this was obviously not happening, how the relevant ADs were being held to account. IB replied that an organisational decision was required about whether or not action should be taken against ADs whose departments did not complete their PDRs. EM expressed concern about the length of time it was taking to get outcomes, adding her belief that it had to be a measureable delivery. PD asked whether exception reports were produced explaining what ADs were doing to improve completion rates, when actions would be completed, etc. The information could then be used to provide evidence for CQC inspections, etc. EB stated that assurance was also required in relation to the quality of completed PDRs. SOL stated that regular audits of PDR experience, including the quality of the PDR, took place. She stated that quality tended to dip at times when a large quantity of PDRs had to be completed. The Trust Chairman stated that it was unacceptable to have any drop in quality, as PDRs were a major route whereby the Trust could show how it valued its staff. A fundamental point of PDRs was to involve individual members of staff. The reviews should be spread out over the course of the year, avoiding particularly difficult times of the year.	

		Action
	The Trust Chairman further stated that she would expect to see a clear escalation plan containing the Trust's expectations of what was expected of managers in relation to PDRs. Any managers continuing to fail should have to justify why this was happening. IB stated that he would circulate the November report, which was due by the end of the week to Committee members, highlighting any areas of concern. The ADs for these service lines would then be contacted and held to account to deliver and he would provide a further update report at the February meeting. **Action:** **IB to circulate November PDR completion report to Quality Committee and provide a further update at the February meeting.** IB stated that his team was also currently working on a policy around incremental progression which allowed it to be linked to performance. He added that the revised Volunteer Policy was almost complete and would be brought to the February meeting. **Action:** **KS to present the revised Volunteer Policy at the February meeting.** **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 091/2014** **KS 092/2014**
7.2	**Staff Engagement Update Report** IB sought the views of the Quality Committee on the development of the Employee Engagement Strategy. He stated that, due to the recent changes to the senior management structure, etc, the paper presented was embryonic to a certain extent. IB stated that it had become clear over the past 12 months that no amount of investment, restructuring or reconfiguration could, in itself, deliver the necessary changes in quality and safety of patient care or associated improvement in working conditions, environment and culture that was needed, unless the way in which the organisation managed change was fundamentally altered. The Trust Chairman stated her belief that if the organisation truly wanted to move forward in terms of staff engagement, it would need to change the current relationship between senior management and staff. She stated that the motivation and pride in their work, which currently existed at a local level, needed to be extended across all levels of the organisation.	

		Action
	IB agreed that current ownership at station level did not consistently extend beyond there. He stated that a project steering group had been established, the first meeting of which had taken place. The group had started to identify key enablers and wanted to encourage Trade Union engagement and involvement in its work. IB confirmed that Zeal Group had been commissioned to undertake a cultural audit of the organisation. Part of their work would include a session at the forthcoming management conference. The meeting considered the current version of the draft Employee Engagement Strategy and the proposed implementation of the new YAS Staff Engagement Approach. It was agreed that, following the recent changes to the Senior Management team, the implementation plan would need to go back to TEG for further consideration. PD stated that several useful and important details, such as the membership of the steering group, proposals in relation to IT developments to improve staff access to information, etc were currently missing from the paper. The Trust Chairman stated that the document read well as a high-level strategic document. However, further information was required in terms of actions to be taken and timescales for delivery. It was her belief, therefore, that agreement of an implementation plan was a priority to allow the work to move forward. Once the implementation plan had been drafted, the strategy and plan would need to go to Board at an appropriate point for further consideration. **Action:** **IB to draft implementation plan for the Staff Engagement Strategy and present to Board.** **Approval:** **The Quality Committee considered and noted the Draft Employee Engagement Strategy.**	**IB 093/2014**
7.3	**Workforce Plan Update** KS provided a summary of the work currently underway to develop the Trust's five-year workforce plan. She stated that, where workforce planning had in the past been undertaken in service silos, there was now real scope to undertake more cross-directorate developments in response to service needs. PD asked which of the suggestions coming forward from the work the Trust was aiming to take forward.	

		Action
	KS replied that a strategic workforce planning group would be established for the main patient-facing areas. In addition, an initial meeting of ADs to discuss pathways, etc had come up with some useful ideas to take forward. However, there remained some recruitment issues to address. EB asked when the full plan was due to be shared. KS replied that the A&E workforce planning was due for completion in mid-January, with outcomes from the Curzon work with PTS due at a similar time. It was her understanding that the refresh of the IBP Workforce Plan was due later in the spring. The Trust Chairman stated her belief that the external refresh of the IBP needed to match the production of the internal documents A discussion took place about Unison involvement in the formulation of the plan. DM stated that it had been made clear that the Trust Board was the arena in which final decisions would be made. It was agreed that KS should provide a time-framed update, containing detailed information about the on-going risks at the February meeting. **Action:** **KS to provide detailed update on the progress of the Workforce Plan, including information about risks and the time-frame for implementation, at the February meeting.** **Approval:** **The Quality Committee noted the detail of the report and the progress made to date.**	**KS 094/2014**
7.4	**Clinical Leadership Progress Report** IB provided an update on the progress being made in improving the organisation's ability to meet the requirements of the Clinical Leadership Framework (CLF). He stated that Bronze Commander Training and Clinical Supervisor (CS) induction days, which had been a key issue, had now been reviewed and delivered. In addition, the CS Away Days had been fully implemented and well-received. DM confirmed that a support role would be put in place to take unnecessary administrative workload away from the CSs. IB stated that the Clinical Development Managers (CDMs) had been transferred to the Directorate of People and Engagement and their role was being enhanced.	

		Action
	Current variations in their abilities, including the more complicated, softer leadership elements, were being addressed by SOL and her team. Going forward, leadership abilities would be tested as part of the recruitment process. SOL stated that she would circulate the draft Clinical Leadership competencies to the Committee. **Action:** **SOL to circulate draft Clinical Leadership competencies to the Quality Committee.** It was agreed that, although the embedding of the CDM role would help greatly, the CLF should remain on the Quality Committee agenda until such time as the Committee believe the risks around its implementation had reduced to an acceptable level. **Approval:** **The Quality Committee noted the report and was assured by progress made to date.**	**SOL 095/2014**
8.0	**RISK MANAGEMENT**	
8.1	**Risk Management 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 confirmed that the paper was the same as that considered at the recent Trust Board meeting. The Committee noted the risk around internal management arrangements. **Approval:** **The Quality Committee noted the developments outlined in the report and was assured with regard to the effective management of risks.**	
8.2	**CIP QIA Review** KW provided an update to: • assure the Committee of progress made in completing the Quality Impact Assessment (QIA) of the Cost Improvement Plans (CIPs); • provide an opportunity for the Committee to review and agree the risks and mitigations identified through the QIA process; • report on the development and use of early warning indicators relating to the safety and quality of services. She confirmed that meal break arrangements had been amended as a result of using the early warning indicators. PD asked whether the system was now working as expected.	

		Action
	DM replied that the measures, which had been implemented the previous day, had addressed quality concerns but not performance issues. Safety was continuously being monitored but more understanding of the situation was required prior to any additional changes being made. The Trust Chairman commended DM on the approach being taken, as it was important to give changes the chance to embed before the full impact could be analysed. PD stated that it was good to see that the QIAs were working effectively and raising appropriate issues. **Approval:** **The Quality Committee reviewed the risks and mitigations identified through the Quality Impact Assessment process; noted the further development of the quality and safety indicators in relation to operational performance; and was assured with regard to the current position of the QIA monitoring and action to mitigate key and emerging risks.**	
8.3	**Information Governance Mid-Year Report** SP presented the mid-year report on the management of Information Governance (IG) and the IG Toolkit (version 12) to provide assurance that the arrangements are being managed effectively. The paper was taken as read. SP stated that work continued in relation to the risk treatment plans for IG risks on the risk register with the most significant risk relating to records management: Datix ID 150 - Breach of the Data Protection Act due to theft or inappropriate access to identifiable information stored on YAS premises (secure and insecure). It had been agreed that CSs would carry out a systematic trawl of all Trust premises to ensure that the issue was concluded. The IG work plan was monitored by the IG Working Group which continued to meet on a quarterly basis. Many work areas were continuous and whilst progress against the IG Toolkit continued to appear positive, this should not be taken solely as a measure of the maturity of information governance in the organisation. The Trust's Information Asset Owners were integral to continuing to ensure information governance was implemented at a local level. PD stated that the report contained a lot of positives and noted the fact that Trust was doing well to manage its increasing number of subject access and FOI requests. **Approval:** **The Quality Committee noted the current position and was assured in regard to the effective management of Information Governance.**	

		Action
8.4	**AACE Peer Review – A&E Performance Reporting – Update on Actions** SP provided an update on the actions arising from the AACE peer review audit of ACQIs in YAS. SP stated that recommendation two: '*Consider increasing the extent to which appropriate incidents are re-categorised on receipt of additional information from subsequent calls'* had not been taken forward because of the variation of practice around the country. The Trust Chairman stated that the report had been encouraging, especially in light of Unite the Union's constant claims that the Trust had issues around recording of data, about which they constantly refused to share more information. The Trust Chairman further stated that, following her recent meeting with MPs at the House of Commons, she had asked them whether they would be willing to request more detailed data from Unite. **Approval:** **The Quality Committee noted the action taken in relation to the recommendations and was assured with regard to management of the ACQI processes.**	
9.0	**RESEARCH GOVERNANCE**	
	There were no items relating to Research Governance	
10.0	**ANY OTHER BUSINESS**	
10.1	**Issues for Reporting to the Board and Audit Committee** PD stated that SP and she would agree the issues for reporting to the Board and Audit Committee outside the meeting.	
10.2	**Review of Meeting Actions / Quality Review of Papers** PD apologised that the meeting had run over by 30 minutes and asked whether future meetings could be scheduled to finish later. The Trust Chairman stated that she would be happy to move the NEDs meeting to another day or to hold it over a working lunch. PD thanked everyone for their time and effort and the meeting closed at 1235 hours.	
11.0	**Date and Time of Next Meeting:** (0830) 0900-1230 hours 5 February 2015, Kirkstall and Fountains, Springhill 1, WF2 0XQ	

CERTIFIED AS A TRUE RECORD OF PROCEEDINGS

_____ **CHAIRMAN**
_____ **DATE**