Yorkshire Ambulance Service NHS
NHS Trust

An Aspirant Foundation Trust

Quality Committee Meeting Minutes

Venue: Kirkstall & Fountains, Springhill 1, WF2 0XQ
Date: Thursday 5 February 2015
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 Dave Macklin	(DM)	Interim Executive Director of Operations

Apologies:

Dr Julian Mark	(JM)	Executive Medical Director
Barrie Senior	(BS)	Non-Executive Director (Observer)
Andrea Broadway-Parkinson	(ABP)	YAS Expert Patient

In Attendance:

John Nutton	(JN)	Non-Executive Director - Designate (Observer)
Anne Allen	(AA)	Trust Secretary (Observer)
Dr Steven Dykes	(SD)	Associate Medical Director
Karen Warner	(KW)	Associate Director of Quality & Nursing
Ben Holdaway	(BH)	Locality Director - EOC
Becky Monaghan	(BM)	Associate Director of Risk & Safety
Shelagh O'Leary	(SOL)	Associate Director, Organisational Effectiveness & Education
Kate Simms	(KS)	Associate Director of HR
Joanne Halliwell	(JH)	Associate Director of Operations – PTS
Paul Mudd	(PM)	Locality Director – West
Jackie Cole	(JC)	Interim Locality Director - South

Minutes produced by:

Mel Gatecliff	(MG)	Committee Services Manager

		Action
	The meeting commenced at 0900 hours.	
1.	**Introduction & Apologies** PD welcomed everyone to the meeting and apologies were noted as listed above.	

		Action
2.	**Review Members' Interests** Declarations of interest would be noted and considered during the course of the meeting.	
3.	**Chairman's Introduction** PD thanked everyone for their attendance and placed on record her appreciation of everyone's hard work and achievements in co-ordinating and managing the recent CQC inspection. It was noted that, although actions and recommendations would be forthcoming, as the inspection was a pilot there would be no final rating. It was agreed that items 6.7, 6.8 and 7.4 would be considered earlier on the agenda, as DM could not stay for the whole meeting. PD stated that a letter about workforce and quality issues had been received from the TDA. It was agreed that SP would provide an update on actions taken in relation to the letter at the May meeting. **Action:** **SP to provide update on actions taken as a result of TDA letter re workforce and quality issues at May meeting.** PD stated that some good papers had been published by the GGI. One related to clinical audit and the other to the role of governance and assurance. AA stated that she would be reviewing the governance report in terms of the Trust's overall assurance process. It was agreed that anyone wanting a copy of either report should contact AA. **Action:** **Electronic copies of the GGI reports on clinical audit and governance/assurance to be circulated.** PD stated that 1 February had been national Dignity in Care day. Some good work had been carried out around the region on dementia and it was agreed that a more detailed report about the Trust's dementia work would be received at the May meeting. **Action:** **Update on the Trust's work on dementia to be provided in May's Quality Committee meeting.** PD stated that a revised code of conduct would be issued to all nurses in April and KW had reminded the nurses employed by YAS to expect this. It was noted that the F&IC action relating to the business model around the Hub & Spoke was not on that day's agenda.	**SP 001/2015** **AA 002/2015** **SP 003/2015**

		Action
	This was due to the fact that further work was being carried out. However, the item would be added to the May agenda as the Quality Committee would need to be involved in the sign off for that work. **Action:** **An update on the Hub & Spoke business model to be provided in the May meeting.** PD highlighted the typographical errors in some of the papers in the meeting and asked that authors paid attention to this for future meetings. SP placed on record his thanks to everyone who had contributed papers to the meeting which had been a major achievement considering the pressure that people had been under to produce them whilst the CQC inspection was on-going.	**SP 004/2015**
4.	**Minutes of the Meeting held on 4 December 2014** The minutes of the Quality Committee meeting held on 12 December 2014 were approved as a true and accurate record of the meeting, subject to the following amendment. **Matters Arising:** Page 14, paragraph 1, final line – 'within' deleted.	
5.	**Action Log** The meeting worked through the Action Log, which was updated accordingly. Closed items were highlighted in grey. **195/2013 - Clinical Leadership** Item covered as part of agenda item 7.4. Action closed. **046/2014 – Education and Training Plan 2014/15** It was agreed this action should remain open until May, as work on the Paramedic career pathway remained on-going. **049/2014 – Action Log – Clinical Leadership succession planning** Item covered as part of agenda item 7.4. Action closed. **084/2014 – Review of meeting, etc** SP stated that PD and he had revised the agenda for that day's meeting to free up more time for certain agenda items. The main opportunity to revise the agenda would be when agreeing the workplan for 2015/16. It was agreed that although the scope of the Terms of Reference could not be reduced, opportunities were there to rationalise some of the papers going forward. Action closed.	

		Action
	085/2014 – Chairman's Introduction SOL stated that webcams had been purchased which should cut down some of the CDMs' unnecessary mileage. However, the CDMs would still be expected to attend certain meetings in person. It was agreed that an update on the real difference that the cameras had made should be presented at a future meeting. Action closed. **086/2014 – Action Log** Item covered as part of agenda item 7.2. Action closed. **087/2014 – Quality Governance Report** PD confirmed she had received a copy of the report. Action closed. **088/2014 – Re-start a Heart** EM confirmed that Jo Wilson had arranged a meeting between the Trust's Fundraiser, Maria Amos and Jason Carlyon in mid-February. Action closed. **089/2014 – Re-start a Heart** Item covered as part of agenda item 6.9. Action closed. **090/2014 – Expert Patient Report** KW confirmed that she had met with ABP to discuss the best way to progress ABP's proposals. Action closed. **091/2014 – Workforce Update Report** Item covered as part of agenda item 7.1. Action closed. **093/2014 – Staff Engagement Update Report** IB stated that a meeting of the steering group had taken place with Zeal earlier that week to confirm the implementation plan for the Staff Engagement Strategy. It was now likely to be April rather than March before the work was concluded. Action closed. **094/2014 – Workforce Plan Update** IB stated that there had been no progress since the Board meeting as work remained on going in relation to A&E Operations. It was hoped that the final version of the Plan would be available for discussion with Unison the following week with a further update to be presented at the May meeting. Action remains open. **095/2014 – Clinical Leadership Progress Report** Item covered as part of agenda item 7.4. Action closed.	
6.	**QUALITY GOVERNANCE/CLINICAL QUALITY PRIORITIES**	
6.1	**Quality Governance Report** KW provided an update on the Quality Governance Development Plan to provide assurance that related workstreams were progressing to plan.	

		Action
	She stated that the final version of the Trust's Savile report had been submitted to the Savile Legacy Unit (SLU). An update meeting had taken place in London and although there was still no official publication date from DOH it would definitely be nationally orchestrated. A corporate communications plan was being prepared to manage the process and the impact of media interest which was anticipated on publication of the reports. KW thanked everyone for their efforts during the recent CQC inspection. She stated that the Trust was only part of the way through the process with the Quality Summit still to be scheduled, following which the draft report would be issued. The Trust continued to engage with the CQC in terms of their requests which included information about back office arrangements at HART and vacancy levels in PTS. SP stated there had been no surprises in respect of the information requested. A lot of queries related to Resilience and HART, which was partly because this was a new service line that the CQC were inspecting as a pilot. KW stated that the development of the Clinical Quality Strategy for 2015-18 was progressing well. There had been good engagement with the Clinical Supervisors which had dovetailed with the Quality Account development and consultation. She further stated that a useful meeting had taken place with ABP to discuss the patient experience components of the Strategy, with one outcome being the creation of the new 'Listen, Learn and Lead' strapline in terms of patient experience. In terms of YAS' Quality Account, letters had been sent out to Members and stakeholders such as Healthwatch, the CCGs, etc. In addition, External Audit had agreed to review the process and contents in the same way as they had the previous year. EM stated that the succinct paper hid the heavy workload pressures that SP, KW and their teams had dealt with over the past few months. She congratulated everyone on their achievements and their ability to absorb the extra work internally with good results. EM further stated that she liked the strategy framework, adding her belief that it would be useful to include the graphs in the next iteration of the IBP. PD asked whether the assurance issues in relation to HART and station security which had been identified during the CQC inspection had been bottomed.	

		Action
	SP confirmed that the CQC carried out a post-inspection visit at HART. Informal feedback implied that this had gone well and that the immediate issues had been resolved. This was also the case in relation to the specific station security issue that had been identified. SP stated that, amongst the actions taken in relation to the out of date consumables discovered at HART, were follow up inspections by his team. To date, the consumable checks carried out at stations were positive. Therefore, although there were sporadic issues around the patch, which was a source of frustration for all concerned, it was not SP's belief that this was a widespread issue around the rest of the organisation. PD stated her belief that there were a number of engagement themes, including the clarification of the Clinical Supervisor role, which needed to be fed back to operational managers. She suggested that the actions required in relation to compliance with Trust policies and how non-compliance was being managed should be considered further at the next meeting. SP agreed that the item needed to be brought back to the Committee as part of the policy review on the workplan. **Action:** **Update on management of compliance/non-compliance with policy to be provided at May Quality Committee meeting.** SD stated his belief that the Trust did not require all of its staff to read all of its policies. PD replied that it was still important for staff to acknowledge that they were aware of what was changing in the Trust's policies. SP stated that the organisation already had a multi-faceted approach to the roll out of policy changes. PD stated her belief that more work was required in terms of hard to reach groups. PD noted that the Trust's complaints process was being reviewed and requested an update on the changes at the May meeting. **Action:** **Update on complaints process review to be provided for May Quality Committee meeting.** **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.**	**SP 005/2015** **KW 006/2015**

		Action
6.2	**Review of Key Quality and Service Transformation Indicators (IPR) / Action – Section 3** SP presented a review of the key quality indicators reported in the quality section of the Integrated Performance Report (IPR). EM stated that there seemed to have been a significant dip in the number of FOI queries being responded to within the deadline. IB replied that there had been staffing issues prior to the appointment of the new permanent member of staff which had coincided with Unite the Union's submission of a large number of requests. However, as he was currently signing off several FOIs each day, he was confident that the Trust was almost back up to its former high standards. EM asked whether the Trust could incur penalties for delayed responses to FOIs. IB replied that delays tended to lead more to reputational issues about lack of organisational transparency than formal penalties. Complaints could be made to the ICO who could implement sanctions but this did not tend to happen often. PD stated it was good to see that the Clinical Audit programme was up to date and asked whether the Trust should be concerned about the outcome of the cleanliness audit. BM stated that in terms of deep cleans there remained two main issues: one related to the availability of staff and the other to the availability of vehicles. This was currently a moderate risk. SP stated that, in terms of audits there was nothing fundamental to be concerned about. The audits were validated by Head of Safety Clare Ashby with recurring minor issues on stations fed back to local managers. PD stated it was good to see that the Friends and Family test results were at their highest level year to date although she noted that responses in North were quite low. JH stated that return rates in North were very small and work was under way to identify the reasons for this as the numbers were disproportionately low in comparison with other areas. PD noted that there seemed to be a large number of incomplete PRF forms. SD stated that further work was required to enable the Trust to understand the lack of data. However, the new ePRF system would help, as it would not allow forms to close down until they were fully completed.	

		Action
	PD stated that following the full implementation of ePRF, the quality of returns would need to be analysed. EB noted that RIDDOR incidents had increased over the past 12 months, adding that the trend was quite noticeable. BM stated that the numbers had increased due to process changes. As the Trust was monitoring incidents more closely the reporting rate had risen. SP confirmed that the underlying themes were not any different and no formal action was being brought about by HSE. KW stated that the organisation was considering changing the format of the patient experience surveys. For example, the general question could be accompanied by a text box in which patients could provide narrative about their experience. Additional questions could also be included about specific parts of the population such as children, people with learning disabilities, etc. A discussion took place about the value of the current data around patient experience and how the richness of that information could be improved by, for example, the use of focus groups. JH stated her belief that the solutions for PTS and A&E would not necessarily be the same solution. It was noted that alterations to the methods by which patient experience data was gathered remained work in progress. AA suggested that it might be worth considering the possibility of some joint working with YAS Forum members, particularly when they presented at hard to reach groups. **Approval:** **The Quality Committee considered the exceptions in the IPR and was assured with regard to the management action planned and under way.**	
6.3	**Significant Events / Lessons Learned** SP provided an update and assurance to the Quality Committee on specific events and lessons learned across the Trust which covered the period 11 November 2014 to 9 January 2015. SP stated that 9 new Serious Incidents (SIs) had been reported to the Commissioners during the period. There had been an increased number of children involved in incidents but no underlying theme. Of the 33 SIs which were currently open, 14 were under investigation and one had been extended due to a police investigation. All other SIs were with the Commissioners for review or closure.	

		Action
	SP confirmed that, in addition to the Trust's regular contact with the Lead Commissioners and cluster leads, it now received direct contact from individual CCGs in addition to the CBU/CSUs. It was noted that A&E made up the largest number of SIs, which were evenly spread between the West and South with a smaller number in the North and East of the patch. SP stated that analysis was on-going in terms of the response time monitoring report. SIs tended to increase in periods of high demand although no clear causal relationship was evident. EM stated she found SP's narrative in the report useful in helping her to understand how many individuals were affected, etc. PD asked whether lessons learned were shared at local meetings. JC confirmed that they were. SD stated that the Trust was working with NHS England to refresh the vascular emergency pathway as it was not as robust as others. BM stated that the number of incidents had increased since the introduction of the 24/7 helpline as it was now easier to report them. In terms of the 4Cs, there had been an increase in the timeliness of complaint responses over the last month following the introduction of policy and procedure and the integration of EOC complaints management. EB asked why EOC/A&E complaints received were zero in October and zero in November but then 104 in December 2014. KW replied that this was due to a backlog of work. EB asked whether the complaints could be entered into the system retrospectively. KW agreed that she would do this. **Action:** **KW to input missing October and November complaints retrospectively.** KW stated that the proportion of complaints about attitude and communication skills of operational staff had risen during the period. In PTS the majority of complaints had been around delays and taking people home from hospital appointments. Complaints received about clinical handling by the NHS 111 and GP Out of Hours services accounted for approximately 20% of all complaints.	**KW 007/2015**

		Action
	KW confirmed that 2 Ombudsman requests for information had been received during the period about which the Trust was awaiting feedback. She stated that there were currently 159 open claims against the Trust, with 35 new claims reported during the period. The majority of claims were around employer liability, the vast majority of these relating to musculoskeletal injuries from equipment and moving and handling incidents. Claims arising as the result of the previously used blue response bags were dropping off with one claim the result of the new green response bag. Vehicle-related claims continued to be received, particularly relating to problems with tail lifts and there had been four new claims reported in relation to clinical negligence. KW stated that the Trusts' involvement in Coroners' inquests continued to remain high in relation to attendance of staff as witnesses with the Trust providing evidence at 43 inquests. The number of inquests opened by the Coroner as a result of delays to response remained high. In terms of common themes arising from incidents, etc, KW stated it had been noted that human factors in EOC had been contributory to several recent SIs and work was underway to rectify the situation. SP confirmed that the Trust had received two HSE contacts during the period, one a visit following the late reporting of a RIDDOR incident and the other a letter following a statutory inspection of vehicle lifts which required the Trust to prepare an action plan. In respect of the latter item, AA asked whether a risk assessment had been carried out in relation to staff safety. BM replied that would form part of the actions that were under way and would be included in the report that went to the HSE. **Approval:** **The Quality Committee noted the current position and was assured in regard to the effective management of, and learning from, adverse events.**	
6.4	**NICE Guidance Implementation** SD provided an update on the identification, evaluation and implementation of NICE guidelines. He stated that the report incorporated all of the NICE guidance issued since the last NICE Quality Committee report in June 2014, which was attached at Appendix 6.1 and 6.2. PD thanked SD for the update.	

		Action
	Approval: **The Quality Committee accepted the paper as part of the assurance process of compliance to identify, evaluate and implement relevant NICE guidelines into clinical practice.**	
6.5	**Expert Patient report** As YAS' Expert Patient, ABP, had given her apologies to the meeting, consideration of her update report was deferred to the May Quality Committee meeting.	
6.6	**CQUIN Progress Review** KW provided an update on the implementation of the 2014/15 CQUIN scheme and advised the Quality Committee of proposals for CQUINs for 2015/16. She stated that three CQUINs were currently in place for PTS all of which were meeting their milestones and expecting to achieve. She added her belief that having a named lead in PTS had helped in this respect. KW further stated that there had been four trust-wide CQUINs in A&E, with each CBU also having a local CQUIN. Some CQUINs would be rolled over to the following year. KW confirmed that, although the Trust had still not received the national guidance for the 2015/16 CQUINs, it was known that the scheme would feature four national indicators with an even balance between physical and mental health. In addition, the four PTS commissioning consortia had agreed to commission collaboratively for 2015/16 with two schemes agreed to date. KW confirmed that contract negotiations for 2015/16 had included discussions for CQUINs. The CQUINs being progressed to a more detailed stage of development were: • Paramedic pathfinder; • Improving care for patients with suspected sepsis; • Pain management; • Mental health pathways; • Human factors within the EOC. SP confirmed that the CQUINs had not yet been signed off. PD stated that the work on the 2015/16 seemed to be progressing well and thanked KW for the update report. **Approval:** **The Quality Committee received the report as assurance in relation to the progress being made in relation to CQUINs 2014/15 and the development of CQUINs 2015/16.**	

		Action
6.7 Taken after action log	**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. He outlined the breakdown of Red Combined Performance in section 2.4 of the report, highlighting December and January as the most difficult months in relation to A&E performance. DM stated that, although the monitoring of delayed response continued, there was a need to refine the process to understand the detail around adverse outcomes for patients, where the Trust needed to concentrate its efforts going forward, etc. The Trust had not found a clear correlation between delays and adverse outcomes but it was clear that the longer a patient had to wait the more risk would increase. DM further stated that, as the role of the Clinical Duty Manager (CDM) and real time monitoring were the most important parts of the work, this was done on a weekly basis. He confirmed that the risk rating, which had been reduced to 20, had been increased back up to 25 due to issues in relation to increased demand and delayed responses. This was being monitored and reviewed on a weekly basis and the current situation, whilst still a cause for concern, was improving. PD asked what the 'strengthening of daily operational management' meant. DM replied that it related to the assurance process around resource hours available each day and whether the processes in place truly reflected the resource available to ensure that the Trust maximised the availability of its resource on day. PD asked how the locality directors' duties had changed. DM replied that there would be a lot more emphasis on local accountability in terms of them having overall control of abstractions for training, sickness, annual leave, etc in their area. They would also be making locality managers accountable for doing the same on a daily basis. JC stated that all managers now had dashboards and met with their teams on a monthly basis to ensure that they had tighter control of their performance, etc. PD asked whether managers were being performance managed and DM confirmed that this was happening.	

		Action
	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.**	
6.8 Taken after action log	**A&E Operations Service Line Assurance Report** PD acknowledged the fact that the format of the presentation was taken from the dashboard whilst adding her belief that it would also be useful to make use of the CQC headings. SP stated that he would look into PD's request to ensure consistency of language. **Action:** **SP to advise service line representatives to include information under CQC headings at future Quality Committee meetings.** **Quality Review** - **West Yorkshire Clinical Business Unit** PM stated that 2014/15 had been a very challenging year to date for the West Yorkshire CBU, especially in terms of Red 1 and Red 2 performance with both remaining below the 75% target at the end of quarter 3. **Red Performance:** • Red 1 Q3 68.7%; • Red 2 Q3 67.4%; • Red 19 Q3 96%. The levels of demand for both Red 1 and Red 2 had continued to increase and RRV back up times had increased to above the YAS average at 16%. However, demand was starting to level out again and as a result some improvement had already been seen in response times. PM stated that in terms of ACQIs there had been some significant improvements on previous years and presented the latest figures from August 2014: • ROSC YAS 27.8% West 27.8% • Stemi YAS 82.3% West 75% • Stroke 60 YAS 57% West 63.6% • Stroke (bundle) YAS 98.2% West 98.5 • Cardiac arrest YAS 10.9% West 16.7% He further stated that improvements required across the CBU in terms of ACQIs were coordinated by the CDMs in conjunction with the CBU management team to ensure action plans were developed.	**LDs 008/2015**

		Action
	PM stated that the number of complaints and concerns were slightly lower than the average YAS rate. Compliments matched the YAS level and 5 SIs were reported in December 2014. In terms of the patient experience survey positive feedback remained the key theme with majority of users and carers satisfied with the service received. PM stated that in spite of demand and resource problems, statutory and mandatory training targets had almost been achieved although Safeguarding Level 2 had dropped slightly. PDR completion currently stood at 77.1%. SP stated that Safeguarding Level 2 compliance had fallen across the organisation and that action was being taken to address the issue with all managers. PM stated that abstractions were below the 31% Business Plan target at 24.8% and sickness levels were above the 5% Business Plan target at 6%. Sickness absence was now being robustly managed within the policy and monthly sickness absence meetings were taking place. PM further stated that staff in post continued to be below the budgeted establishment with current vacancies standing at 14 WTE, confirming that staff recruitment had been on-going all year. He stated that a number of staff based in West had been lost to Yorkshire Air Ambulance and HART as well as non-traditional areas such as A&E departments. Some vacancies had been converted to 'acting' secondment posts and were being closely managed. In addition, a recruitment day for Clinical Supervisors had been scheduled for March across all three CBUs. PM stated that the West Yorkshire Risk Register was in place and reviewed fortnightly by the management team to ensure mitigation was effective and risks fully understood and communicated widely. There was also a monthly meeting with the Risk Manager to review all of the 'live' risks on the register. In terms of Staff Survey and Engagement, PM stated that, working with the HR Business Partner, management team and Staff Forum, an action plan was being developed to take into account the results from the survey. PM provided information about the Quality audits that had taken place. A discussion took place in relation to a realistic achievement date for the achievement of Red performance within West Yorkshire.	

		Action
	DM stated that the chance of hitting 75% in February was looking unlikely. However, additional short terms actions were being taken to ensure resources were used in a more effective way. Diagnostic work around resource management was due to commence the following week and the ORH work was on-going to ensure performance was sustainable going forward. DM stated his belief that the flexibility of the 'new' workforce would enable the Trust to take a huge step forward. EB stated that she took assurance from the update. PD thanked PM for his update and noted the progress being made in relation to quality, safety and short term sickness absence. **Quality Review - South Yorkshire Clinical Business Unit** JC stated that 2014/15 had been an extremely challenging year to date for South Yorkshire CBU, especially in terms of Red 1 and Red 2 performance with both of them remaining below the 75% target at the end of quarter 3. **Red Performance:** • Red1 Q3 68.52%; • Red 2 Q3 65.8%; • Red 19 Q3 95.8%. She further stated that performance had improved slightly that week. JC stated that the South CBU had continued to have increased levels of demand for both Red 1 and Red 2. RRV back up times had increased and were above the YAS average at 17.27%. In terms of ACQIs, JC presented the latest figures from August 2014: • ROSC YAS 27.8% South 27.0%; • Stemi YAS 82.3% South 92.3%; • Stroke 60 YAS 57% South 55.6%; • Stroke (bundle) YAS 98.2% South 98.4%; • Cardiac arrest YAS 10.9% South 6.7%. She further stated that improvements required across the CBU in terms of ACQIs were coordinated by the CDMs in conjunction with the CBU management team to ensure action plans were developed. As there was currently no up to date action plan in South work was on-going to develop one. JC stated that the number of complaints and concerns in South were slightly lower than the average YAS rates. Compliments matched the YAS level and there were 5 reported SIs in December (All YAS).	

		Action
	In terms of the patient experience survey positive feedback remained the key theme with the majority of users and carers satisfied with the service received. JC confirmed that complaints were a standing item on every CBU managers' meeting. JC stated that a lot of training had been cancelled in South Yorkshire in the lead up to Christmas but all courses in February and March were fully booked which should help to improve the current situation. Letters had been sent out to individual members of staff to remind them about the training and Safeguarding Level 2 training had now increased to 62.07%. Completion rate of PDRs which had been standing at 49.5% had now increased slightly and steady progress would continue. JC stated that abstraction levels were currently below the 31% Business Plan target at 24.9%. At the time of writing the report, sickness levels had been 7.2%, which were above the 5% Business Plan target. However, a lot of effort had been put into reducing sickness absence and it currently stood at 4.81%. In terms of long term sickness, there had been 12 people with over 90 days of sickness each but this had now been reduced to three. JC stated that staff in post continued to be slightly below the budgeted establishment with current vacancies standing at 5.15 WTE, which was less than 1%. Band 3 vacancies were being filled but the CBU was struggling to recruit Band 5 Paramedics. SP stated that regionally although the overall vacancy rate was small, there remained a challenge around Paramedic recruitment and retention to which there was no short term solution. PD asked which month the majority of newly qualified Paramedics graduated. SOL replied that there were two cohorts per year, the first in June/July and the second 6 months later. PD asked whether proactive engagement took place with trainee Paramedics to attract them to YAS. JC replied that there were currently 4 student Paramedics in South who were due to qualify that year. PD stated her belief it was more essential than ever therefore that succession planning was in place in the localities, adding that she would like to see information about turnover rates, predicated vacancies, etc in future reports. **Action:** **SP to advise service line representatives to include information about Paramedic succession planning, turnover rates, etc in future reports.**	**LDs 009/2015**

		Action
	JC stated that the South Yorkshire Risk Register was in place and reviewed weekly by the management team to ensure mitigation was effective and risks fully understood and communicated widely. Monthly meetings took place with the Risk Manager to review all live risks on the register and Datix usage and issue resolution had improved with a fortnightly review of all cases. JC confirmed that, of the 5 current SIs, 4 were open and being managed within the process and one was with the Commissioners awaiting closure. In terms of staff engagement, JC stated that there was not currently an action plan in South. However, one was in the process of being developed to take into account the results from the survey working with the HR Business Partner and PM had agreed to share the West Yorkshire action plan. JC stated the same Quality audits had taken place as in West, adding that notice boards were being put up in Clinical Supervisors' offices as a visual aid. EB stated that PDRs remained a massive outlier in terms of the 75% target. JC replied that appointments for PDRs had been booked in with staff so the completion percentage should increase quickly over the next two months. The completion figure at the end of March would be around 72% rather than the target figure of 75%. However, much better planning was in place for the completion of PDRs in 2015/16. PD stated her belief that a Trust-wide plan was required to ensure that the 75% completion rate was maintained across the board, particularly as the current low rate of completion was bound to be raised by the CQC in their forthcoming report. EM stated she had found the information presented and the dialogue with the LDs very useful. However, it was a source of frustration to her that some of the issues faced by the Trust had worsened over time and increased LD and LM accountability was urgently required. PD stated her belief that the required improvements would need to delivered through the Service Improvement Plan which would need to come to Board. SP stated that although the LDs and their teams had a key role in accountability, it remained an issue for the whole organisation. JN stated he had been impressed by staff ideas presented to him during a Listening Watch visit in Barnsley when they had suggested several quick wins in how to improve performance against targets.	

		Action
	SP stated that several suggestions around improving efficiency had been received through the Bright Ideas scheme. Suggestions which were being considered included using RRVs for conveying resources and introducing staff responder schemes. There were also a number of areas within support service functions in relation to Operations which could also be improved. PD thanked JC for her update report. She asked that, going forward, a section about progress in relation to improvements should be included in the body of DM's update report. **Action:** **DM to include an update about implementation of improvements in future A&E Performance Update reports.** A discussion took place about resolving the current issues around resourcing and skill mix. PD stated her belief that the Trust was currently not very good at cross-boundary working and sharing resources and asked what could be done to change the behaviours of LMs in this respect. PM replied that if they were given the right tools to do their job there would be no reason why they could not do it. It would then be easier to hold those who were not performing as expected to account. PD thanked everyone for the lengthy discussion. She stated that it was good to hear about progress and see that the organisation was moving in the right direction.	**DM 010/2015**
6.9	**Annual Cardiac Arrest Update** SD presented that first update to the Quality Committee on the strategy to improve outcomes from cardiac arrest. He highlighted the good work already under way in the region as outlined in the table in section 2.7 of the report. Following the success and good reception by community groups of the 2014 'Restart a Heart' day, SD confirmed that the Trust was hoping to repeat the event in 2015. PD requested an update on the pilot introduction of Red Arrest Teams (RAT) around the region. SD replied that an analysis of the impact of the RAT work on the Clinical Supervisors' workload was due to take place. If it was shown to be sustainable then a regional roll out of the concept would take place and there would hopefully be positive news in the next report.	

		Action
	SD further stated that moves were under way to develop a cross directorate Resuscitation Group, adding that the Trust was currently developing its First Responders to enable them to concentrate on the basics in cardiac arrest. SD stated his belief that the year-on-year improvement in YAS' outcomes was one of the key positives in the report. PD stated that it would be interesting to see when the data for 2014/15 was available if there was any correlation between the December/January spikes in the graph in Appendix 1. SD confirmed that the next report would be presented at the May 2016 meeting. PD thanked SD for an interesting report. **Approval:** **The Quality Committee accepted the report as assurance that the management of cardiac arrest across Yorkshire was good, with plans to further improve YAS' ROSC and STD.**	
6.10	**Sign Up to Safety** BM and SD presented the Trust's Safety Improvement Plan. SD stated that, in terms of working to keep communities safe and well, efforts had been made to triangulate the data coming through in relation to the long-term benefits that YAS' services and other activities achieved, adding that promoting social value by placing social, environmental and economic outcomes was at the heart of everything that YAS did. SD further stated that, in order to make services more effective, the Trust was bringing in new resources by working in partnership with others, including VCS, CFRs, Partnership working with the public, BHF, Fire, Mountain Rescue, HM Coast Guard and taxi firms. SD stated that YAS had prioritised the ways it could develop its services to continue to improve patient care into the future by: • building upon its core strengths: • mobile urgent and emergency care; • Clinical triage; • Technology; • Resilience and emergency planning. He stressed the importance of removing silos between services to maximise the use of expertise and ensure that patients received an appropriate response.	

		Action
	In terms of quality governance and engagement, BM stated that the Trust had needed to move quickly from being a regionally commissioned service to one which engaged with a very wide stakeholder group. It had been a steep learning curve and there was still some way to go but the Trust was working well with SRG forums and the majority of the 23 CCGs. The Trust was currently working with its Lead Commissioner and other stakeholders to review service delivery and identify where services needed to be managed and commissioned on a regional basis and where there was greater scope and a need to tailor services to local need. BM stated that the Trust's Clinical Quality Strategy was due to be fully refreshed in April 2015 based on consultation with frontline staff regarding their thoughts on what was important to them in providing quality care. She provided details of the Trust's current Clinical Quality goals under the headings of: • Patient experience; • Clinical effectiveness; • Patient safety. She further stated that the top risks identified through the Clinical Governance Committee and their mitigations were: • Response and back up RRV times - safety monitoring process in place; • Stand off and risk assessments - action being addressed through task and finish group; • C Spine immobilisation - incorporated within 2014/15 training update; • Falls, trips, slips and injuries / medication errors - monitored through the Safety Thermometer; • Deteriorating patient, sepsis (EWS and pre-alert), and handover suggested for Sign up to Safety. Areas identified from incident data included: • Moving and Handling related incidents; • Equipment related incidents; • EOC Human Factors regarding coding errors; • Safety Monitoring in relation to delayed response; • Dynamic Risk Assessment processes; • Recognising and responding to sepsis. Areas identified from claims data included: • C Spine immobilisation and other moving and handling related; • Deterioration in children and adults; • Human factors in EOC.	

		Action
	BM stated that consultation had been conducted with staff in relation to their views on what goals should be included in the Clinical Quality Strategy. These included: • Effective use of medications - monitored through the Safety Thermometer; • Equipment - action being addressed through the task and finish group; • Elderly care and care of children - suggested for Sign up to Safety; • Mental health - addressed through separate action plan. BM stated that the safety improvement goals submitted for Sign up to Safety were: • To reduce incidents related to Emergency Control Operations (EOC); • To reduce incidents related to Moving and Handling; • To reduce, recognise and respond appropriately to deterioration in adults; • To reduce, recognise and respond appropriately to deteriorating children. A long discussion took place about the above goals. BM stated that the team leading the work would report in to the Clinical Governance Group. PD asked how information would be disseminated. SD replied that there was wide representation on the group and a lot of good ideas about the best ways in which to share the information, as there was no one solution. BH stated that the safety improvement goal relating to EOC would need to be turned into a positive for them as the staff needed to see how it could help them by, for example, monitoring stress levels, etc. SP stated his belief that the goal demonstrated that YAS as an organisation was recognising the extremely pressurised conditions under which the EOC staff worked. In such an environment human errors would naturally occur and the goal could be used to identify ways in which the Trust could support people who worked in that environment. PD stated her belief that the fact that staff had already been involved in the work was a real positive. **Approval:** **The Quality Committee noted the update and the contents of the Trust's Safety Improvement Plan.**	

		Action
7.	**WORKFORCE**	
7.1	**Workforce Update Report / IPR Section 4** 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. PD asked what the unqualified Paramedic Practitioner role was. SP stated that, in essence, they were Band 6 Paramedics who were awaiting training. PD stated her belief that the Trust should change how those roles were referred to, adding that as there were several new roles in the paper she would have expected to see something about evaluation and measures. She asked how the Trust would assess the roles and their effectiveness. SD stated that in relation to the UCP role, individual CCGs would be looking for outcomes, etc. DM stated that the ECP programme had been reasonably well thought through. However, with regard to the other roles, he agreed with PD that how the roles would be assessed, what training they would require, etc had not been given detailed enough consideration. PD stressed that the lack of background work could mean that the Trust had more expensive workforce that might not deliver what was expected of it. EB suggested that existing roles could also be evaluated to identify if there were any gaps or overlaps, as some of the new roles might not be needed. She expressed concern that the Trust was implementing roles without full analysis prior to their introduction and without knowing how they would be evaluated. DM stated his belief that the Trust had tried to make things too simple when it introduced changes a couple of years earlier. It was now clear that simply having a Band 6, a Band 5 and a Band 3 role would not work. There was a skill gap that the organisation had tried to identify in order to bridge the gap between the roles. SP stated that work remained in progress in relation to the new roles, adding that an evaluation would be built in at an early stage. PD asked whether the organisation was clear that it was not taking flexibilities out of the service if the new roles were introduced. DM replied that the Trust was specifically trying to do the reverse and create a more flexible workforce.	

		Action
	PD stated that, in terms of PDRs, there had already been a lot of discussions. She accepted that point that JC had made about catching up, etc but it was essential that the Trust had a clearly defined process delivered at the next meeting so the Trust did not find itself in the same place at the end of the next year. IB replied that, going forward the Trust would be reliant on individual managers to do the work and any failing to delivery their team's appraisals would be held to account. If the Trust did not start to see a significant improvement fairly quickly it would be a performance issue for those managers. PD stated that she wanted to see a definitive plan for the roll out of 2015/16 PDRs presented at the May meeting with input from all departments. **Action:** **KS to present a plan for the roll out of 2015/16 PDRs at the May Quality Committee meeting.**	**KS 011/2015**
	PD asked whether any issues remained in relation to members of staff who had not attended a clinical refresher for several years. SOL confirmed that everyone who had not attended a clinical refresher session for some time had now been picked up. SP stated that a major focus the previous year had been on clearing training backlogs for main core training and/or Statutory and Mandatory training. PD asked how many years the current technicians' terms and conditions were protected for. IB replied that it would be for 5 years but this had not yet been activated. It was intended to enhance the technician role and a refresher course was being designed to this effect. Following its launch, those not intending to do the training would be moved to the Band 3 side of the workforce and the countdown activated. PD stated it was good news that people could now see a career trajectory. PD asked whether overtime was currently being well managed. DM replied that although he was happier around the visibility of how much overtime was being used, it was still not as strategically placed as he would like. It was agreed that DM would present an update report at the May Quality Committee meeting. **Action:** **DM to update on Trust's use of overtime at May Quality meeting.**	**DM 012/2015**

		Action
	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.**	
7.2a	**Workforce Updates: Workforce Wellbeing Strategy** KS stated that the Employee Wellbeing Strategy had been developed by members of the newly formed Employee Wellbeing Group on which every service had representation and which linked in well to the Health and Safety Committee. The strategy set out the Trust's commitment to providing services and support mechanisms for its employees to maintain and improve their own well-being and it was hoped that the more proactive approach and wider range of initiatives being proposed to help support YAS' staff would have a positive impact on sickness levels going forward. KS confirmed that, as part of the Occupational Health contract with PAM, resources were being made available to support the delivery of key parts of the Strategy. She stated that there was both a mental and a physical wellbeing work stream, the finer details of which would be populated at the next meeting of the Wellbeing Group. The aim was to set up a calendar with links to both national and regional events and information which staff could dip into as appropriate. KS stated that the Strategy had been a long time in development but the Wellbeing Group was keen to launch it in March 2015 so it was up and running for the new financial year. Champions were already in place and keen to take the initiatives forward. KS welcomed the comments of Quality Committee colleagues. PD stated that she was impressed by the outcomes of the project, adding she would be keen to see a progress report in 6 months' time. EM asked how much contact YAS had with its new OH providers. KS replied that although they did not sit on the Wellbeing Group, the Health and Wellbeing Advisor was meeting with them on a monthly basis. They were being supportive of the approach being taken and might run some joint training around mental health, etc with YAS. EB asked whether YAS Forum members would be involved in the Implementation Plan mentioned on page 12 of the document. IB replied that a Staff Member of YAS Forum already sat on the Health and Wellbeing Group.	

		Action
	KW stated her belief that the Strategy would be very useful in helping operational managers. The tools in the appendices at the back of the report, particularly those around mental health wellbeing would also be very useful. PD stated her belief that it was good to see the Trust developing such a positive approach to health and wellbeing, adding that she looked forward to the Committee receiving an update report following the implementation of the Strategy at its September meeting. **Action:** **KS to present a Health and Wellbeing Strategy update at the September meeting of the Quality Committee.** **Approval:** **The Quality Committee reviewed the detail of the Employee Wellbeing Strategy and supporting action plans prior to it being launched and confirmed approval for the launch of the Strategy to take place in March 2015 and the on-going development and implementation of the associated action plans.**	**KS 013/2015**
7.2b	**Workforce Updates – Exit Interview Report** KS presented the analysis from the exit interview responses received from the period 1 January 2014 to 31 December 2014. During the period April 2013-March 2014 only 6% of staff leaving the organisation elected to undertake an exit interview. As a result of the low volume of returns, the HR Business Services team undertook a review and adopted a new, more flexible process to encourage greater participation by leavers. KS confirmed that, out of the 591 individuals who left the Trust between 1 January 2014 and 31 December 2014, 18% returned a completed exit questionnaire / survey, which was a marked increase. She further stated that the HR team recognised the need to develop the survey further in order to enable analysis by service areas which could then be reviewed regularly by management teams. A new survey, which would include a drop-down response selection and restrict a participant's ability to ignore sections, was therefore being developed with a planned launch of 1 April 2015. PD thanked KS for her update stating that she looked forward to receiving a further update in 6 months. **Approval:** **The Quality Committee reviewed the content of the report and discussed potential recommendations for improving those responses which concluded a negative perception by the employee as they left the Trust.**	

		Action
7.2c	**Workforce Updates – Volunteer Policy** KS stated that the Trust's Volunteer Policy provided an overarching policy for the recruitment and deployment of volunteers at the Trust. The purpose of her update was to set out the Trust's policy for including volunteers in the delivery of its services, establishing the general principles and guidelines for volunteering across the Trust. KS stated that the Policy, which had been approved at a recent TMG meeting, was attached for the views of the Quality Committee. She stressed that, whilst the Policy did not detract from local volunteer processes which were still in place, those processes would need work under the Trust's policy as the overarching policy. ABP had provided feedback during the development of the policy and it was noted that the area of expenses was a complex item to consider which would need further work. PD stated her belief that the policy was much improved on the earlier version and gave an overarching feeling of assurance across the organisation. She congratulated KS on another good piece of work. EM stated that it would be useful to discuss the contents of the policy with the Trust's fundraiser, Maria Amos (MA), as it might also be useful for her to use it. It was agreed that KS would liaise with MA to discuss her requirements in more depth. **Action:** **KS to liaise with YAS Fundraiser, Maria Amos re suitability of YAS' Volunteer Policy for her needs.** SP stated that a small amount of assurance work remained to be done in relation to CFRs, PTS, etc. In addition, any procedures aligned to the policy would need reviewing in relation to Savile before the Trust's Savile report was published. **Approval:** **The Quality Committee noted the content of the Volunteer Policy and the subsequent review of service specific volunteer procedures to ensure that they adhered to the overarching policy.**	**KS 014/2015**
7.3	**Absence Management Review** KS stated that, following the Quality Committee's request for a report which summarised the Trust's current position in relation to sickness absence levels and the management of sickness absence across the organisation, she had produced a paper which set out the key current trends and themes and action being taken by service areas whose absence levels remained consistently high during 2014/15.	

		Action
	The year to date sickness absence figure was 6.51% against the target level for the year of 5.00%. The absence level for December was 7.21% (4.76% long-term and 2.45% short-term sickness). KS confirmed that the main causes of sickness absence across the Trust continued to be musculoskeletal related absence and anxiety and stress-related conditions. She further stated it was recognised that certain core service areas within the Trust had sickness absence levels consistently higher than the target of 5.00%. The ADs for those areas were tasked with producing action plans which tabled particular concerns and included the development of an improvement trajectory. The current action plans were attached to the report as appendices. KS highlighted the matrix approach taken in the EOC action plan as an example of good practice. Although EOC absence was still high, it was a proactive action plan which should be successful and the HR business partners would share it with their management teams. KS provided a summary of the services provided through the Trust's five-year contract for Occupational Health provision with the provider People Asset Management (PAM). She stated that the OH service was recently the subject of an internal audit which had concluded that the Trust could be offered significant assurance in relation to the current service arrangements. A recommendation from the audit report was that the Trust should consider the establishment of an OH steering group comprising of managers from key service areas and members of the HR team. This would effectively be the Trust's opportunity to feed back to PAM on a regular basis so the proposal was being considered against the role of the newly formed Employee Wellbeing group. Despite the recent positive audit assurance, it had been recognised that there remained concerns about the responsiveness of the OH service, particularly to referrals from managers and the effectiveness of the Day One service. KS stated that, in response to the concerns, the Employee Wellbeing Adviser now liaised with PAM on a daily basis to progress matters as required and there were also monthly and quarterly customer and contract meetings respectively. In addition, the MD of PAM had audited some of calls received from YAS employees to assess the level of concern presented. The feedback had resulted in a joint action plan being developed between the Trust and PAM to ensure any underlying issues were effectively addressed.	

		Action
	KS stated the Trust recognised that, although the provision of an effective OH service was a key to the management of sickness absence, proactive wellbeing initiatives were equally important in the Trust's efforts to reduce sickness absence in the first instance. PD thanked KS for the useful report which she would like the Quality Committee to receive regularly. It was agreed that the report would be added to the workplan to come to every other meeting. **Action:** **SP to ensure regular Absence Management updates included in workplan.** **Approval:** **The Quality Committee noted the detail set out in the report and that actions from Quality Committee discussions were fed into ongoing service performance reviews on the topic.**	**SP 015/2015**
7.4 Taken after action log	**Clinical Leadership Framework Update Report** DM and SOL provided an update on the progress made in improving the organisation's ability to meet the requirements of the Clinical Leadership Framework (CLF). The paper was taken as read. A discussion took place about the process of change and vacancies across the patch. There were currently 113 posts in place and 11 vacancies. DM stated that he wanted a full establishment of 124 Clinical Supervisors in place with any development posts being in addition to those posts. However, further work was required in relation to the cost implications and allocation of such posts. Progress in this respect would be included in future CLF update reports. **Approval:** **The Quality Committee noted the report and was assured by progress made to date.**	
8.	**RISK MANAGEMENT**	
8.1	**Risk Management Report** BM 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. She confirmed that risks rated 12 and above were included in the paper and that all of the risks had been reviewed since the December 2014 iteration of the report and the changes listed on pages 4 and 5. Some gaps in assurance had been filled and some new actions had been added. SP stated that, as discussed and agreed at Audit Committee, going forward reference would be made in the record of changes to when each change was made during the Committee cycle.	

		Action
	SP confirmed that the BDM on 24 Feb would be considering the Trust's draft Operating Plan, looking at the corporate risks in the current version of the BAF and anticipating any new corporate risks. **Approval:** **The Quality Committee noted the developments outlined in the report and was assured with regard to the effective management of risks.**	
9.	**RESEARCH GOVERNANCE**	
	There were no items relating to Research Governance.	
10.	**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** It was noted that the official finish time for the Quality Committee meetings was now 1230 hours. PD reiterated that all documents coming to future meetings should be proofread before submission.	
11.	**FOR INFORMATION**	
11.1	**PTS DATA** PD stated that a paper providing additional information about increased PTS demand for patients with complex mobility problems and the clarification of reasons for aborted journeys had been circulated for information with the meeting papers. **Approval:** **The Quality Committee noted the actions being taken to address issues raised.** PD thanked everyone for their time and efforts. The meeting closed at 1235 hours.	
12.	**Date and Time of Next Meeting:** (0830) 0900-1230 hours **7 May 2015**, Kirkstall and Fountains, Springhill 1, WF2 0XQ	

CERTIFIED AS A TRUE RECORD OF PROCEEDINGS

_____ CHAIRMAN

_____ DATE