NHS
Yorkshire
Ambulance Service
NHS Trust

Quality Committee Meeting Minutes

Venue: Kirkstall & Fountains, Springhill 1, WF2 0XQ
Date: Thursday 15 March 2018
Time: 0830 hours
Chairman: **Pat Drake**

Membership:

Pat Drake	(PD)	Deputy Trust Chairman/Non-Executive Director
Phil Storr	(PS)	Associate Non-Executive Director – Acting Quality Committee Chairman
Erfana Mahmood	(EM)	Non-Executive Director
John Nutton	(JN)	Non-Executive Director
Steve Page	(SP)	Executive Director of Quality, Governance and Performance Assurance
Dr Julian Mark	(JM)	Executive Medical Director
Dr David Macklin	(DM)	Executive Director of Operations

Apologies:

Pat Drake	(PD)	Deputy Trust Chairman/Non-Executive Director
Dr David Macklin	(DM)	Executive Director of Operations
Stephen Segasby	(SS)	Deputy Director of Operations
Anne Allen	(AA)	Trust Secretary

In Attendance:

Andrea Broadway-Parkinson	(ABP)	YAS Expert Patient
Christine Brereton	(CB)	Director of Workforce and Organisational Development
Claus Madsen	(CM)	Associate Director of Education and Learning
Karen Owens	(KO)	Deputy Director of Quality & Nursing
Rachel Monaghan	(RM)	Associate Director of Performance Assurance and Risk
Dr Steven Dykes	(SD)	Deputy Medical Director
Suzanne Hartshorne	(SH)	Deputy Director of Workforce & OD
John McSorley	(JMc)	Divisional Commander West
Paul Mudd	(PM)	Divisional Commander North & East
Jackie Cole	(JC)	Divisional Commander South
Alan Baranowski	(AB)	Divisional Commander
Pauline Archibold	(PA)	Head of Service Central Delivery
Chris Dexter	(CD)	Managing Director PTS (Item 6.2)
Tim Gilpin	(TG)	Associate Non-Executive Director (Observer)
Maxine Travis	(MT)	Risk Manager (Observer)

Minutes produced by:

Joanne Lancaster	(JL)	Committee Services Manager

		Action
	The meeting commenced at 0905 hours.	
1.	**Introduction & Apologies** PS welcomed everyone to the meeting and explained that Pat Drake had been unable to attend due to an unavoidable prior commitment in her diary. In PD's absence the Trust Chairman had asked PS to Chair the day's Quality Committee. PS had been shadowing PD since 2017 and would take up his appointment as a full NED and Chair of the Quality Committee on 1 April 2018. This would have been PD's last meeting before she left to take up a new role in a different organisation. PS formally thanked PD for her contribution and hard work that she had put in to her role as the Chair of the Quality Committee. The meeting was preceded by a presentation on Diversity and Inclusion developments presented by Kez Hayat, Head of Diversity & Inclusion. Discussion took place in relation to staff behaviours in certain areas of the YAS region where specific complaints had been raised. Work was on-going to look at the staff survey, complaints, grievances etc. to try and ascertain where there were any trends in this regard and develop actions to mitigate same. CB advised that the D&I profile was being raised across the organisation. The Board and QC's support on this agenda was welcomed by the team and regular updates on D&I would continue to be provided. PS thanked KH for the update.	
2.	**Review Members' Interests** Declarations of interest would be noted and considered during the course of the meeting.	
3.	**Chairman's Introduction** PS referred to the winter period and the challenges the adverse weather conditions had brought to the service. He thanked the staff for their hard work and dedication.	
4.	**Minutes of the Meeting held on 14 December 2017** The minutes of the Quality Committee meeting held on 14 December 2017 were approved as a true and accurate record of the meeting with the exception of the following: Page 5, paragraph 6 – This should read 'Clinical Governance Group (CCG)…..'. Page 6, paragraph 8 – This should read 'HQIP…..'.	

		Action
	Page 7, paragraph 5 - This should read 'compliance of audits for prescription only medicines….'. **Matters Arising:** There were no items for discussion that were not addressed through the day's agenda.	
5.	**Action Log** The Quality Committee considered the open actions on the Action Log. Action 031/2017 – Multi-skilled workforce - This was on the agenda for June. Action closed. Action 040/2017 – Capability Procedure cases - CB confirmed that there were no formal cases in the system at present. Action closed Action 041/2017 – ESR Developments – This was included within the agenda. Action closed. Action 049/2017 – Staff behaviours - It was noted that a number of different workstreams addressed this issue across the whole of the organisation. Action closed. Action 050/2017 – ARP Category 2 in the South to be highlighted to Audit Committee – This was included in the A&E Update on the agenda. Action closed. Action 051/2017 – Vehicle availability within A&E Operations - This was included in the A&E Update on the agenda. Action closed. Action 052/2017 – Rota post implementation review – A general update would be provided to Audit Committee. Action closed. Action 053/2017 – Staff Survey Action Plan – This item was on the agenda. Action closed. Action 054/2017 – Workforce Audit Recommendations – This was no longer a standing item as updates would be provided through the regular general workforce updates. Action closed. All other actions were noted as being appropriately closed.	
6.	**QUALITY GOVERNANCE/CLINICAL QUALITY PRIORITIES**	
6.1	**Quality Governance and Clinical Quality Strategy** The paper provided a summary of quality governance developments and delivery of the Clinical Quality Strategy. The workstreams under Sign Up to Safety were due for a review of progress against agreed outcomes and would be refreshed. There was a planned engagement process with staff across the organisation	

		Action
	with the first round of sessions due to take place the week commencing 19 March 2018. The response rate for complaints was noted at 95% across the whole of the Trust against a target of 85%. Work had been ongoing to address the issues raised in relation to some staff's behaviour in the South of the region. It was noted these issues were not isolated to this location although some areas had seen a decrease in such complaints. The Trust remained confident that new management structures and enabling strategies would bring about culture change and lessons would be learned and shared with other areas in this regard. The Critical Friends Network (CFN) continued to be a focus for the Trust. At present the CFN was a small membership of 16 and the group would be involved in key projects to utilise their expertise effectively. It was noted that there were currently 13 adult and 13 children's safeguarding Boards across the Yorkshire and the Humber. A Memorandum of Understanding (MoU) was in place between these, the 22 CCGs and YAS (led by NHS Wakefield CCG as the lead Commissioner of 999 services in YAS). The MoU aimed to ensure multi-agency working and clear lines of accountability across the geographical area of YAS. It was likely that the children and adult Boards would merge to provide single safeguarding Boards in the future. The MoU would be refreshed in April 2018 to reflect any changes which came into force. YAS' representation at the many safeguarding Boards was a challenge due to the number across the region. Adult Level 2 training compliance was gradually increasing and focused communication to promote e-learning for safeguarding children and adults Level 2 was currently taking place through Team Brief. The Trust had received positive feedback on the recent improvement in the quality of safeguarding referrals from the Lead Commissioners for safeguarding. It was noted the new CQUIN for 2018/19 was in 'improving the care of patients with respiratory disease' and had been confirmed through contract negotiations. The Bright Ideas scheme continued to receive ideas from staff at an average rate of 9-12 per week. Feedback was always given to staff submitting an idea. It was noted that the Clinical Quality Strategy was being developed into a Quality Improvement Strategy which would recognise the Trust-	

		Action
	wide approach and commitment to the continuous improvement in the quality of services YAS offered to patients, carers and families. A separate Clinical Strategy had been developed which aligned to the Quality Improvement Strategy and the overall Corporate Strategy. The Care Quality Commission (CQC) action plan had been closed down with the agreement of the Board as the actions had been delivered with the exception of a couple that had expanded or required final sign-off and these had transferred to service leads. The Trust had not received notification as of yet from the CQC in relation to an inspection. The production of the Quality Accounts 2017/18 had begun and consultation on priorities with internal and external stakeholders had taken place in November and December 2017. The 30 day consultation period with Commissioners would start on 2 April until 11 May. The final draft would be presented to the Board on 24 May 2018. ABP advised that she had not had sight of the draft Quality Account 2017/18 post December 2017. KO apologised if this had not been sent and, following receipt, encouraged ABP to feedback any comments she may have during the 30 day formal consultation period. PS asked that a presentation be provided at the next Quality Committee relating to Hull and East Riding complaints to identify any trends and themes. Going forward this would be done on a rotational basis for each of the divisions. **Action:** **1. A presentation to be provided at the next Quality Committee relating to Hull and East Riding complaints to identify any trends and themes.** **2. Divisional complaints to identify any trends to be submitted on a rotational basis to QC.** SD advised that the 2017/18 Clinical Audit Programme remained behind schedule due to the delay in the new national Ambulance Clinical Quality Indicators (ACQI) publication; YAS continued to monitor the key indicators. JM added that the quality of data should improve under the new ACQI as the methodology used end to end metrics and would be a system indicator rather than just an ambulance indicator. It was noted that due to delays in processing the health care records that data was currently only available for the first two months of Quarter 3.	**KO**

		Action
	There had been a number of clinical incidents across the region where care provided to patients in cardiac arrest had fallen below the expected standard; each of these had included the failure to defibrillate a patient who was in ventricular fibrillation. The subsequent serious investigation reports in to these cases all concluded that two of the root causes were a lack of exposure to cardiac arrest incidents and a lack of on-going training in how to manage them. The Trust Executive Group had recently agreed to an improved programme to boost training and experience in resuscitation. The programme would be 5 hours in duration on an annual basis and would cover adult cardiac arrest management and post Return of Spontaneous Circulation care using simulation. This placed YAS ahead of other ambulance services that all provided a three yearly cycle training programme. A more detailed update would be provided on Red Arrest Team (RAT) attendance at cardiac arrest incidents at the June meeting. The indicator reviewing arrival at a Hyper Acute Stroke Centre within 60 minutes had shown a slight deterioration since the beginning of the year. It was noted that Leeds, Bradford and Airedale CBU were performing at the national average of 55.7%. YAS continued to be actively involved with the Stroke Unit reconfigurations across the region. A programme of work with the Acute Trusts included an agreed Sepsis Screening Tool and referral pathway and training package. A random sample of sepsis patients who were conveyed by YAS to the agreed receiving hospitals was reviewed and audited. This demonstrated continued improvement in sepsis care over the two year programme. The latest developments included an updated NEWS score (NEWS2) which was currently being rolled out and further education on detecting sepsis in children. The YAS developed ePR was currently being piloted within the Rotherham area with positive feedback being received. A Business Case would be presented to Board to approve a full roll-out programme across the region. It was confirmed that action plans were in place to improve compliance with Prescription only Medicine Audits for the North and East of the region. ABP asked whether there was a pre-alert from NHS 111 for sepsis patients. SD advised that the software had been updated within NHS 111 to identify sepsis but this did not generate a pre-alert. He emphasised that all ‘red-flag’ sepsis patients generated a pre-alert.	

		Action
	SP notified the Quality Committee that an external assessor had been appointed to lead YAS' Well Led Framework review. **Approval:** **The Quality Committee received the report as assurance that quality governance and clinical quality remained a key priority for the Trust and that related work streams were progressing to plan.**	
6.2	**Service Line Assurance – PTS** The paper provided assurance that quality and patient care were being met by the PTS service line. It was noted that performance against KPIs had improved. Some detailed work was taking place to analyse the KPIs for the West Yorkshire region and the reporting of the tail of performance which had been well received by Commissioners. SP suggested that as the KPIs in the South of the region were different to the other KPIs this should be differentiated in future reports. **Action:** **Differentiate the KPIs for the South KPIs in future reports.** It was noted that PTS operational activity remained on trend with a reduced number of journeys. The North contract expected a 30% reduction in journeys through applying stricter eligibility criteria. The Trust was mindful of media and Local Authority Scrutiny Committee attention in this regard; the Trust was applying the criteria set by the CCGs. It was confirmed the CCGs fronted the questions posed by the Scrutiny Committees and that YAS were in attendance. The Trust signposted patients to alternative transport options where the Trust was unable to undertake the journey. It was noted that the eligibility criteria was unlikely to impact on renal patients. PTS workforce information was provided and it was noted that sickness absence remained challenging. Work was ongoing with partners in HR to address sickness absence cases and support staff back to work. Work was ongoing to identify themes and trends of absence and it was hoped that the new management structure would help with reducing the level of sickness absence. PDR compliance was at 87%; it was noted this was positive when benchmarked against the sector. There had been a small increase in the number of complaints for PTS although this equated to 0.02% of all journeys undertaken which was	**CD**

		Action
	a small number. PTS received a large amount of compliments from patients. The five workstreams within the Quality Improvement Plan for PTS were noted. Work was progressing at pace against each of these. PS thanked CD for the update. **Approval:** **The Quality Committee noted the update report taking assurance on performance across the PTS service line and noted service developments.**	
6.3	**Review of Quality Impact Assessments 2017/18 CIPs** The paper outlined the progress made in completing the Quality Impact Assessments (QIAs) of the Cost Improvement Plans (CIPs) and reports on the monitoring of indicators relating to the safety and quality of service for 2017/18 schemes. It was noted that 'Fleet System Efficiencies' had gone from a RAG rating of 'green' to 'amber'. This was due to operational demand and the availability of vehicles. A number of mitigations had been put in place including the appointment of night and weekend managerial cover and the merger of helpdesks provided with the Fleet, Estates and Facilities Directorate. Discussions were continuing with Hambleton, Richmond and Whitby CCG relating to the quality impact of the proposed removal of a dedicated transfer ambulance and staff attached to the Friarage Hospital. The Committee discussed the proposal of the removal of this resource from Friarage and the negative impact for YAS and the safety of patients within that area; the Trust had voiced these concerns to Commissioners. **Action:** **To consider moving the risk relating to the dedicated resource for Friarage being de-commissioned by the CCG to the Corporate Risk Register.** SP confirmed this was receiving the necessary attention at TEG with weekly briefings on the issue. It was noted that CIPs for 2018/19 would all be subject to the QIA process. **Approval:** **The Quality Committee noted the paper and gained assurance with regard to the current position of the QIA monitoring and actions to mitigate emerging key risks.**	**SP**

		Action
6.4	**Expert Patient Report** ABP updated on the projects she was involved with as YAS' Expert Patient. She welcomed the emphasis on patient safety within the reports. She advised that she had been involved in the Moving Patients Safely workstream. She referred to the progress of the Critical Friends Network (CFN). She believed this was a positive opportunity for the Trust to engage and work with the CFN and suggested the group could be more 'user-led' notwithstanding the need for it to meet organisational expectations. She had been approached to look at the Clinical Strategy which she had welcomed involvement in. She had also been consulted on the Quality Improvement Strategy. She would follow up on the Quality Account with KO. She referred to the Trust's Membership database and she would speak with Ali Richardson, YAS' Community Engagement Manager to ensure it was being utilised effectively to engage with different groups of people (within the new GDPR rules). **Approval:** **The Quality Committee received the YAS Expert Patient verbal report on actions since the last meeting for information.**	
6.5	**Significant Events/Lessons Learned** The report provided an update on significant events highlighted through Trust reporting systems and by external regulatory bodies and provided assurance on actions taken to effectively learn from adverse events. The Trust had 20 open Serious Incidents (SIs) of which 8 were under investigation. All other SIs were with the Commissioners to review a submitted report or awaiting review of evidence that would provide assurance of implementation of the agreed actions. It was noted that the real-time escalation and monitoring of response in EOC continued although it was challenging to continue at a consistent level of scrutiny during periods of high demand. Assurance was provided that plans were underway to strengthen elements which would assist this. Positive assurance had been received from the 'Winter Review' which had been carried out; this had analysed quality measures including incidents, complaints and SIs together with performance related data to provide assurance on the safety of the service during this time. It was confirmed that all actions which arose from SI investigations continued to be tracked by the Quality & Safety team and reported to	

		Action
	Commissioners. The number of violence and aggression incidents in Q3 was 246, of these 54 were physical assaults and 182 non- physical; this number remained stable. The Trust was raising awareness of violence and aggression towards staff and encouraged reporting of such incidents. The conflict resolution training course had been refreshed for staff to attend and launched in July 2017. The Trust followed up on such incidents and where it was appropriate to do so applied sanctions to those individuals where behaviour had been unacceptable. The Trust continued to provide Acute Trusts with information relating to handover delays in excess of two hours; national guidance from NHSI was that turnaround delays that meet the SI criteria was over 60 minutes. There had been a national focus on handovers with weekly telephone calls with NHSI in this regard. The number of new and open claims that had been reported to NHS Resolution Insurance Scheme for 2017/18 had reduced compared to the previous 4 years data. This was a positive indicator of steps taken to reduce harm to both staff and patients. The Trust's frequency of involvement in inquests continued to remain high with 270 open inquest cases at the end of Q3. During Q3 the Trust received a further 99 new requests and had provided evidence (written and/or oral) at 88 inquests. There had been one Prevention of Future Death (PFD) report where the Coroner had raised concerns that pathways to a specific crisis team were not effective. The Trust responded to the Coroner with details of the function/facilities/options available to YAS' Mental Health Nurse team. The Coroner was satisfied that YAS had the correct processes in place and had plans to strengthen these further. As referenced earlier in the item a safety review had been conducted led by the Head of Investigations and Learning to retrospectively look back at the quality measures reported throughout the challenging festive period in conjunction with performance measures to assess the safety of the service delivered by YAS. The review had provided assurance that there was no additional patient harm as a result of the winter pressures. There would be a review by the Ambulance Leadership Forum which would share learning and reflect upon the winter period. The East of England Ambulance Service would be holding a risk summit to provide further opportunities for learning. **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	**A&E Update** AB guided the QC through a presentation.	

		Action
	The overall performance for the Trust was presented against the national ARP standards. Details were also broken down for each area of the region. It was noted that achieving the Category 2 standard was challenging for the Trust across the region; this category received the highest volume of calls so it was a more difficult standard to achieve. It was noted that over 6000 hours had been lost due to turnaround times at the hospitals over the winter period. This had a significant negative impact on performance. Within the EOC the proportion of 'hear and treat' patients had increased from 0.6% to 7.4%; YAS' aspirational target was 10%. The CORA (auto-dispatch) system had improved allocations by 1.7%. Work continued to forecast call handler requirement following the introduction of ARP. Call activity was being analysed to provide an insight into why the call volume had increased above that forecasted following the introduction of ARP. It was noted that A&E had filled vacancies with current staff numbers only marginally short of numbers forecast for the year-end. Work continued with the HR team on recruitment and retention of staff. Sickness absence remained a challenge and work continued with HR to support absent staff back to their duties; work continued to analyse sickness absence trends and issues. PDR compliance was 69.13% and it was acknowledged this was not at the required 90%. Assurance was provided that this should increase providing the focus on PDRs was maintained. PS sought assurance on the PDR compliance target being achieved should the current demand for A&E services not reduce. AB provided assurance that plans were in place to ensure that staff received their PDRs and the compliance rate would increase. CB added that nearly 70% against the target was a positive position and this would increase once demand for services lessened. SP added that A&E management retained a keen focus on ARP and updated TEG appropriately. Plans were in place to aid with the management of demand such as the Low Acuity transport initiative. The QC noted the financial position of the A&E service line, this had been discussed frequently at F&IC and at Board. The QC noted a number of achievements and developments within	

		Action
	the A&E service line. It was confirmed that Community First Responders (CFRs) had an awards ceremony where volunteers were nominated under different categories. Inter Facility Transfers (IFTs) remained challenging particularly in the South region. Work was ongoing to resolve the issues. Planning for Easter was underway and it was expected that additional staff would be required over this period. The Easter planning included A&E, NHS 111 and PTS. It was noted that it was difficult to compare YAS' performance against the ARP national standards as there was no like for like comparison to be had. It was expected that there would be a national review of coding. **Approval:** **The Quality Committee noted the update report taking assurance on performance across the A&E service line and noted service developments.**	
6.7	**Programme Management Office (PMO) Update** The report updated on the Trust's four Transformational programmes and updated on workstreams supported or managed by the PMO function. It was noted that the RAG status of each scheme was as follows: • A&E – Amber; • Hub and Spoke – Amber; • PTS – Amber; • Integrated Urgent and Emergency Care - Amber. Work continued against all four workstreams. As a result of the NHSI Planning Guidance received in February the A&E transformation had moved to workstreams that would support and improve the delivery of the national ARP standard. **Approval:** **The Quality Committee noted the update and gained assurance that the Project Management Office was assured of the effective management of the various projects and initiatives across the Trust.**	
6.8	**Independent review of Liverpool Community Health NHS Trust** The paper provided a summary of the report of the Liverpool Community Health Independent Review and described the implications of the report for YAS. Assurance was provided that there were no concerns relating to findings of the report into Liverpool Community Health NHS Trust	

		Action
	within YAS. YAS had strong arrangements for clinical governance and learning from adverse events and there was an appropriately balanced focus across quality, performance and finance. It was noted that some of the issues in the report resonated with YAS priorities and areas of focus and these were areas that the Trust had already recognised needed to be strengthened. Specifically in relation to the organisational culture across the organisation; YAS had already introduced new Vision and Values and the Behavioural Framework as part of the organisational culture workstream. PS thanked KO for the excellent report and commented on the useful summary at section 5 of the report. **Approval:** **The Quality Committee received the report as a summary of the findings of the Independent Review of Liverpool Community Health NHS Trust and gained assurance that the recommendations made within the review, which resonated with YAS priorities, were being addressed by the Trust.**	
7.	**WORKFORCE**	
7.1	**Workforce and Organisational Development Update** The paper provided an overview of matters relating to a range of workforce issues including staff engagement, equality and diversity and employee wellbeing. It was noted that a new Workforce and Organisational Development Strategy was being developed which would be agreed through TEG, TMG and then presented to the Quality Committee and Board for assurance. This would be an enabling strategy of the Trust's Corporate Strategy and would set out the agenda for the Directorate and the direction of travel for the workforce at YAS. It was expected the Workforce and Organisational Development Strategy would be finalised by October 2018; a set of indicators and measures were being developed. This Workforce Strategy Group would provide governance and monitor performance against the objectives. The National NHS Staff Survey 2017 was live from 3 October until 1 December 2017 and YAS had achieved a 34.5% response rate (compared with 37% in 2016). The response rate was slightly below the sector and wider NHS average. More detailed analysis of the data would be undertaken and presented to the Board. Going forward it would be important for the Trust to demonstrate to staff what action had been taken following feedback from staff surveys and other engagement events. Leadership development continued across the Trust and a Strategic Leadership forum was planned for the beginning of May 2018 to consider the Corporate Strategy. From May 2018 a tailored	

		Action
	leadership development programme would be launched for all people leaders within the Trust: YAS Leadership in Action. October would see the annual Leadership Summit take place for 200 leaders from across the organisation. Work continued on embedding the Vision and Values and Behavioural Framework across the Trust. A presentation had been provided to Board in this regard. Going forward the recruitment process would also include competencies based on the Trust's Values. The first Health and Wellbeing Steering Group meeting had taken place the previous day; the Health and Wellbeing Plan for the next 12 months, which had been agreed by TEG, had been considered. It was noted that the PAM contract for Occupational Health was due to end on 30 September 2018 and a paper had been agreed by TEG for the Occupational Health model that the Trust would aim to procure going forward. It was confirmed that a data cleanse was taking place for ESR in readiness for the launch of the ESR portal and self-service app. Assurance was provided that all key workforce risks were being managed. EM referred to previous discussions relating to how the Charitable Funds may be able to help with distinct staff welfare projects and asked whether there had been any progression in this regard. CB would meet with Danielle Norman, YAS Fundraising Manager to discuss options. It was noted that the Trust had been recognised as a Training Provider by the Education and Skills Funding Agency to enable the Trust to deliver some of the apprenticeship training internally. ABP asked whether the Trust had made progression on using the Critical Friends Network as part of the recruitment process. SP responded that whilst there may be some specific roles the CFN could potentially be involved in it would not be feasible to include them in every recruitment exercise. CB added that the Trust valued external scrutiny in its processes. It was important that recruitment panels were diverse and inclusive. **Approval:** **The Quality Committee noted the update and gained assurance by the progress made within the Workforce and Organisational Development Directorate.**	

		Action
7.2	**Education and Training plan update** The report provided an overview of matters relating to education and training and the training plan. It was noted that the training plan was on track for delivery. External training provision had been reduced. There had been a significant increase in the number of 'placement' requests over the last 2 years due to the number of Paramedic Programmes YAS was now providing placements for. There had been an increase of 11,000 plus since 2015/16 with the same team managing the process. Through the restructure of the Directorate there was an option for an apprentice to support the team. The Trust had been successful in securing funding from Health Education England to allow Paramedic Academic Top Up programmes to be offered to up to 60 Paramedics that did not hold a Level 6 or greater qualification. Performance against the Statutory and Mandatory training was noted. The next stage of the Training Needs Analysis project would focus on support staff, volunteers, sub-contractors and bank staff. KO asked what CPD was on offer for staff other than Paramedics. CM responded that there was a limited amount of funding available for staff to apply and go through an approval process for. The Governance Boards would prioritise what CPD the Trust should support. **Approval:** **The Committee noted the update and gained sufficient assurance on the training and education plan. The risk in relation to placements was noted.**	
8.	**RISK MANAGEMENT**	
8.1	**Risk Management Report Annual Review and Priorities for 2017/18** The paper updated on quarterly projections on the BAF 2017/18 and outlined plans for the closure of the BAF 2017/18 and recast of the BAF 2018/19. Changes to the Corporate Risk Register (CRR) were highlighted and there was a specific focus on risks relating to the remit of the Quality Committee. Assurance was provided on plans for the General Data Protection Regulations (GDPR) and work being undertaken on vehicle accident reduction. It was noted that the BDM session on 22 February 2018 had reviewed the close down of the 2017/18 BAF and recast the BAF for 2018/19. This would be provided at the May Board for formal approval.	

		Action
	There had been a number of new risks added to the CRR since the last meeting, of particular note as previously been discussed at the QC: • Risk 1056: Measles outbreak – potential on staffing and operational delivery; • Risk 1079: Health Records processing delays. An update was provided on work being undertaken to reduce vehicle accidents and improve staff and patient safety. The Driver at Work Policy had been reviewed and updated to take into account changes in the law and national policy. The Policy recommended a fair, supportive and consistent approach to reduction, investigation and learning and claims management. Discussion took place relating to the implementation of the Policy. It was noted that the trade unions had some reservations relating to the points system and discussions were on-going with them in this regard. The GDPR would come into force on 25 May 2018. Assurance was provided that the Trust had a number of workstreams in place to deliver GDPR. There was a significant amount of work to do and this was being managed by the Information Governance team and the Trust Solicitor. JM commented that he believed the GDPR would create challenges for data sharing and in turn patient outcome. This had been raised with NHS Digital. It was suggested that a session on GDPR be presented to Board. **Action:** **Consideration of a session on GDPR to be presented to Board.** **Approval:** **The Quality Committee noted the progress made and key changes to the risk profile and gained assurance from the robust processes currently in place to manage risk across the Trust.**	**AA/SP**
9.	**RESEARCH GOVERNANCE** No items for discussion.	
10.	**ANY OTHER BUSINESS**	
10.1	**Issues for reporting to the Board and Audit Committee** PS summarised the items to be presented to the Board and Audit Committee.	
11.	**FOR INFORMATION**	
11.1	**IPR – Workforce and Quality** The report was noted.	

		Action
11.2	**Quality Committee Workplan** This item was noted. The meeting closed at 1200 hours.	
12.	**Date and Time of Next Meeting:** (0830) 0900-1230 hours 7 June 2018, Kirkstall and Fountains, Springhill 1, WF2 0XQ	

CERTIFIED AS A TRUE RECORD OF PROCEEDINGS

_____ CHAIRMAN

_____ DATE