Yorkshire Ambulance Service NHS Trust

Additional Trust Board Meeting – 'Quality Committee' Business Minutes

Venue: Kirkstall & Fountains, Springhill 1, WF2 0XQ
Date: Thursday, 13 June 2019
Time: 0830 hours
Chairman: **Tim Gilpin**

Membership:

Tim Gilpin	(TG)	Non-Executive Director/Deputy Chairman
Kath Lavery	(KL)	Chairman
Anne Cooper	(AC)	Non-Executive Director
Jeremy Pease	(JP)	Non-Executive Director
John Nutton	(JN)	Non-Executive Director
Stan Hardy	(SH)	Non-Executive Director
Rod Barnes	(RB)	Chief Executive
Christine Brereton	(CB)	Director of Workforce and Organisational Development
Dr Julian Mark	(JM)	Executive Medical Director
Steve Page	(SP)	Executive Director of Quality, Governance and Performance Assurance
Nick Smith	(NS)	Executive Director of Operations
Mark Bradley	(MB)	Executive Director of Finance
Karen Owens	(KO)	Director of Urgent Care and Integration

Apologies:

Kath Lavery	(KL)	Chairman
Anne Cooper	(AC)	Non-Executive Director
Jeremy Pease	(JP)	Non-Executive Director
Stan Hardy	(SH)	Non-Executive Director
Rod Barnes	(RB)	Chief Executive
Mark Bradley	(MB)	Executive Director of Finance
Stephen Segasby	(SS)	Deputy Director of Operations
Mark Millins	(MM)	Associate Director Paramedic Practice

In Attendance:

Phil Gleeson	(PG)	Critical Friend Network representative
Clare Ashby	(CA)	Associate Director Quality & Nursing
Dr Eithne Cummins	(EC)	GP and Clinical Director - IUC
Phil Storr	(PS)	Associate Non-Executive Director
Suzanne Hartshorne	(SH)	Deputy Director of Workforce & OD
Claus Madsen	(CM)	Associate Director of Education and Learning
Steven Dykes	(SD)	Deputy Medical Director
Dave Green	(DG)	Head of PTS Service & Standards (item 6.6 only)

Minutes produced by:

Andrea Jackson	(AJ)	Executive Personal Assistant

		Action
	The meeting commenced at 0905 hours.	
1.	**Introduction & Apologies** TG welcomed everyone to the meeting and apologies were noted as above. Dr Eithne Cummins, GP and Clinical Director - IUC and Phil Gleeson, Critical Friend Network representative, were also welcomed to their first Quality Committee. The meeting was preceded by a presentation on national Clinical Quality Indicators by Jacqui Crossley, Head of Clinical Effectiveness and Governance. JC explained Ambulance Clinical Quality Indicators (ACQI) were not about time but quality of care to patients. A review of ACQI had been undertaken, and the presentation included how new indicators were developed, tested and implemented across YAS along with future reporting, a number of examples and a clinical story tying data into a patient. Reporting began in 2016 nationally, but little was learned, with the same results regarding pain scoring and peak flow asthma. A monthly ACQI report was in place for heart attack, stroke, survival to discharge rates, patients with that particular type of heart attack and time to get there. CPI data was collected every quarter including; Hypoglycaemia; Asthma; elderly fallers. Again, although data was gathered, there was no further learning. Two years ago the decision was taken with the National Clinical Director for Urgent Care and the Joint Ambulance Improvement Programme Board to review and develop CQI's to improve clinical care and the training packages in place. New clinical care bundles were proposed and agreed including; Sepsis; STeMI (new reporting); Stroke (new reporting); Cardiac arrest management; ROSC (post ROSC care bundle). In January, technical guidance was extracted and tested by the new Clinical Audit and Informatics team (CIA). The guidance was taken and converted to a SOP, and shared with clinical managers for dissemination. National reporting linked directly to the cardiac arrest registry (Warwick University), NICOR (MINAP) and RCP (SSNAP). JC explained the acronyms to members.	

		Action
	YAS processes undertaken by the CIA team included; extract from ePR/paper records warehouses; adhere to YAS audit programme timelines; follow 'Technical Guidelines' and develop SOP; develop a YAS reporting programme; and link with national team NASQG. Reporting changes were captured, and data resubmitted to NHS England. A report on the testing year was expected to be published on 21 June. This re-submitted data related to the Utstein data set. This had changed from the previous Utstein interpretation, in order to highlight true bystander CPR rates and improve comparability between Trusts. JM explained the change relates to a lay person bystander witness, not ambulance personnel, and relates to the interaction between a bystander and patient. Reports from Warwick University specifically request information on our EMS and lay person involvement to allow us to compare our Utstein category definition. TG asked if this is undertaken in consultation with resus staff/paramedics undertaking the clinical process, as a measure to a clinician on the frontline may be different to that of Warwick personnel, and in order for practice to be improved, engagement is required in the process of specific measures. JC explained as part of an audit programme feedback is obtained from clinicians in the Clinical Quality Group, in terms of suggestions for what should be reviewed. Now that the analytics team is in place, if there are sufficient themes, data can be extracted and put through to YAS Academy, which in turn will be used to educate and support staff. JM informed a workshop had been held with the Lead Paramedic Group and NASMED, with members of the Clinical Quality Group present where all elements were refreshed to determine the value of the data collected before seeking ministerial approval JM added the Joint Ambulance Improvement Programme Board was responsible for developing AQI's, and an exercise took place with straight forward performance indicators to ensure all parties were measuring in the same way, and following benchmarking for assurance that all would be measured on the same thing. JC summarised 2018/19 was phase 1, a development year; the testing process was complete; implementation successful; republished data expected June 21 2019, and action plan in development. TG moved proceedings to the formal Committee meeting.	
2.	**Review Members' Interests** Declarations of interest would be noted and considered during the course of the meeting	

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3.	**Chairman's Introduction** TG welcomed all to the meeting, and explained the reason behind the change of the meeting from Quality Committee to an additional Trust Board meeting, was due to quoracy and to ensure continuity of business. All present introduced themselves for the benefit of any new members. TG confirmed the meeting would be managed as per previous meetings.	
4.	**Minutes of the Meeting held on 14 March 2019** The minutes of the Quality Committee meeting held on 14 March 2019 were agreed as an accurate record, subject to suggested amendments and matters arising received prior to the meeting from JM, which would be incorporated. **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. 010/2018 – Closed as included on agenda. 012/2018 – SH explained there was no correlation between FTSU and Employee Relations cases; there was nothing significant to report. SP confirmed Freedom to Speak Up (FTSU) concerns are all reviewed by the FTSU Guardian, CB, RB and himself. Action closed. 002/2019 – Authors were asked to include a highlights section at the start of longer papers to draw Quality Committee members' attention to key points. Action closed. TG highlighted the need to achieve a balance between volume and meaningful information. It was felt that plain short reports can have limited impact, however in significantly longer and detailed reports, it is often difficult to detect the key information with any ease, therefore a format to enable sharing of key highlights would be beneficial and enable an understanding prior to the meeting, the reason for presentation and key issues to look for. SP agreed this initiative would be incorporated going forward, in significantly detailed reports, in order to achieve the right balance and demonstrate good governance.	
6.	**QUALITY GOVERNANCE/CLINICAL QUALITY PRIORITIES**	
6.1	**Clinical Governance and Quality Report including:** • **Patient and Staff Safety;** • **Clinical Effectiveness;** • **Patient Experience.**	

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	The paper provided a summary of the developments and delivery of clinical governance and quality. CA updated on Patient Safety and Patient Experience which included a summary of accounts for 2018-19 and work which had commenced for 2019-20. Three priorities in the Quality Accounts were being closed off for 2018-19, with four priorities agreed for 2019-20. 2019-20 priorities included delivery of sustainable improvement in emergency ambulance response performance, as this was a key standard. Mortality review process to be embedded. An extra priority added to cover development of the Trust's role in place based care coordination, since its success in the IUC tender; and a patient experience focus on patients with learning disabilities. Incident reporting in Q4 via Datix had seen a steady increase in reporting, which was a good sign of an organisation that is learning and reporting. Safety huddles continued to be successful across the Trust, which were implemented as a way of communicating, and was now fully embedded in the EOC, NHS 111 and most areas of PTS. Work was ongoing with the clinical directorate to scope the potential of virtual huddles within the 999 setting. Great success had been seen with the Moving Patients Safely work stream as part of Sign up to Safety. The Clinical Directorate and Quality Safety teams had worked collaboratively to support the zero avoidable harm work stream running from 2019 through to 2023, with a more detailed plan for the first year. CA listed the aim of the objectives set out in the plan. Progress was being made in incident reporting within the new Datix IQ Cloud platform which contains more analytical ability to support learning and improvement. Target compliance was being achieved for Level 1 and Level 2 Safeguarding Children and Adult training. CA highlighted a risk had been added to the Corporate Risk Register (CRR) relating to Level 3 safeguarding knowledge, competency and skills for paramedics and other staff in certain supervisory roles. Year one of a three year implementation plan was under way. Work was ongoing with the EPR and Clinical team in order to enable clinical staff to automate safeguarding referrals. Referrals were currently undertaken by the Health desk, however there had been delays seen when calling the desk, and also when calling IUC.	

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	Once the electronic system was in place it was envisaged an App would be created, which would enable IUC to utilise it too. Safeguarding progress for the paediatric frequent caller pilot had been agreed at TMG, and a business case approved for a Frequent Caller Paediatric Liaison role. A frequent caller adult service was currently in place, however this did not incorporate Under 18s, and it was found many were using the NHS 111 and 999 service, therefore categorised as frequent callers but without the same support currently as adults. Infection, Prevention and Control (IPC) was an ongoing issue with a marked increase in the number of contacts with blood and bodily fluids. It was likely this was attributed to more awareness and reporting. It was noted the Respiratory Protective Equipment (RPE) hoods had been delivered which negates the requirement for fit testing, and these will be placed on all vehicles, with roll out commencing in the North followed by distribution across the organisation. Fit testing will continue with FFP3 masks, until full roll out is completed. The FTSU annual review took place at the end of Q4, along with the recruitment to replace the current FTSU Guardian, following the natural end of the current post holder's secondment. Handover to the new FTSU Guardian had taken place. CA updated on the celebration of success in the Always Event pilot within the PTS service, developed by NHSE and co-produced with patients, including members from the Critical Friends Network (CFN). The pilot involved suggestions on what patients wished to happen when on vehicles. Suggestions included the request of a briefing/schedule of the journey. There were positive impacts for dementia patients. This was a small pilot currently run in Leeds and following its success, would be rolled out to the rest of the Trust. The Patient Experience team were also working with colleagues to achieve accreditation in the Investors in Volunteers initiative, which would see YAS noted as a 'good' organisation to volunteer for. Work was ongoing with the CFN for their contribution. Work was ongoing with Commissioners on PTS Eligibility. KO explained the focus was very much on physical conditions which impacts on who becomes eligible, and therefore questions were being revised to include mental health and dementia. NS asked whether commissioners were assuming any responsibility. It was noted some were more actively supportive than others but YAS was continuing to engage closely to ensure a good outcome for patients.	

		Action
	SD updated national ACQIs continue to be updated and in the process of being embedded into clinical practice as well as audit and reporting processes, as alluded to by JC in the pre-committee presentation. The data included in this report was submitted and will be published on 20 June 2019. The plan will be presented in an improved format to enable a clearer view of activities. The Electronic Patient Record (EPR) had been rolled out to all hospital emergency departments in Yorkshire concluding with James Cook in Darlington this week. 80% were now electronic. Improvements in the quality of information being received was already being seen and the marked improvement in information was impacting on the clinical audit and research team. The Clinical Audit Team had been reconfigured with much improved clinical audit information. SD updated on three audits that had been undertaken; Conveyance to Northern General Hospital (NGH) and Sheffield CCG, to understand conveyance to the ED and the patient journey; Community First Responder (CFR) use SpO2 monitoring, their skills to provide more patient care and whether they are used effectively; and Non-Conveyance, following a serious incident two years ago, to determine any gaps but an action plan was now in place and would be re-audited later this year to review improvements. Work had continued on Medicines Management in relation to the EU exit strategy, and the use of the pharmaceutical chain internationally, as work was ongoing in maintaining medicines. There were three drugs which were currently difficult to source. The formulary team were working with NHSE to become a prescribing centre, including non-medical prescribing through non-urgent care. The Codeine drug had also been added to the Specialist Paramedics formulary and will begin to be procured as successful. The Q4 incident report reviews both controlled and non-controlled drug incidents and it was noted the most common incident related to damaged drugs, ampoules of morphine. There had been a marked improvement in non-controlled drug incidents. Drug discrepancies within medicine cupboards had begun to be reported by the procurement and logistics team. POM audits revealed that compliance had significantly increased due to the hard work undertaken by operational colleagues and improved safety of bags.	

		Action
	A CQUIN report on mortality review was summarised in the paper. Following sight of the national Learning from Deaths policy, a workshop was held to review the current process and develop the next phase of Learning from Deaths. The draft policy for the Trust was awaiting formal release from NHSE. Work was ongoing. A review of the YAS Public Health Plan was currently underway in line with the longer term NHS Plan and the new Trust Clinical Strategy. Work was ongoing nationally and agenda setting with a focus on ICS Prevention work streams in suicide prevention and a review into ambulance service response. In relation to key risks on the Board Assurance Framework, it was noted that Risk 1079: Health Care Records processing had been increased to 20 on the Corporate Risk Register. The final quarter CQUIN report highlighted achievement in most of the requirements, but only partially met in relation to Health and Wellbeing as the improvement remained inadequate, despite the vast amount of work undertaken. Significant work had been undertaken in relation to the Flu campaign with a target of 75% compliance for 2019-20. National CQUINs had been agreed and released for 2019-20 with the threshold for Flu vaccinations now increased to 80%. A further two indicators had been added relating to Access to Patient Information at scene a) for assurance and b) for demonstration purposes. Quality Accounts for 2018-19 were now complete and with the internal comms team for final edit and would be published later this month. It was noted the CQC had undertaken their unannounced inspection and the next part, the Well Led inspection, was scheduled for 26 – 28 June. TG thanked CA and SD for the report and noted good progress in all elements of the report. **Approval:** **The Quality Committee received the report as assurance that delivery of clinical governance and quality was progressing well through the implementation of the patient safety, patient experience and clinical effectiveness work streams.**	
6.2	**Significant Events and 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 report primarily covered the period 1 Jan to 21 March 2019, during which time 16 SIs were reported and listed in the paper, with further detail included at Appendix A.	

		Action
	There were no overriding themes in summary, but a number related to coding of calls and pressure of workload. There were two road traffic collisions, neither of which appeared to be as a result of inappropriate practice in YAS. There were issues relating to patient assessment; a moving and handling incident with a significant skin tear to an elderly patient which has instigated a review of our approach to tissue viability. It had been agreed that a number of staff in the Quality and Safety team would be trained, which was now complete, and was a first step to strengthening guidance to staff on the subject. There had also been an incident involving a member of YAS staff who had been drinking alcohol whilst on duty. A number of actions arising from those incidents were listed in the report and full learning would come from root cause analysis in the Incident Review Group (IRG). Real-time escalation and monitoring of response in EOC continued, and a major piece of work undertaken at the turn of year extracting all cases where responses were outside of an agreed time threshold. Cases meeting agreed criteria were subject to further clinical review and the object of the exercise was to understand the relationship between delayed response and harm to patients. The review identified very few cases of actual harm to patients. It also provided an understanding where reasonable thresholds can be applied for ongoing monitoring of cases. A new process has been instigated in the EOC which runs on a real-time and post-day basis and agreed to run even when busy. A supportive exception will apply during periods of increased activity with additional support from the corporate departments. The Trust had contributed towards 11 external investigations, as detailed in the paper, working in partnership with other organisations to support learning. Relevant investigations included a case in liaison with EMAS, which resulted in learning around sepsis and issues relating to resources, and the importance of lessons being shared. The Trust is also working with the Healthcare Safety Investigation Branch (HSIB) to support the completion of three maternity cases under investigation. A round table exercise had also been undertaken to review cases where YAS had involvement. Feedback related to some internal practices and themes that were being considered and developed and a number in relation to AMPDS guidelines, which would be reviewed and taken to the Clinical Governance Group (CGG) to formulate a full response.	

		Action
	An update on information relating to Violence and Aggression was included in the report, which remains in the top three reported categories of incidents at YAS and the highest in the category of Staff Affected Incidents. Significant work had been highlighted on compliments in recent months, with the backlog decreasing and ensuring feedback is provided to staff in a timelier manner. On a wider basis, the patient relations team were reviewing their processes including lean principles, in order to effectively manage an increasingly complex workload, including planning with other parts of the organisation to undertake proactive work on themes coming from complaints. An update was provided on legal and claims. 151 open claims currently reported, 11 of which were new claims reported in Q4. The Coroner Inquest workload remained high and demanding and had significantly increased in the last year. There were 394 open inquest cases at the end of Q4, which included 184 new requests during this period. There were no significant safeguarding investigations reported. Four FTSU concerns were raised during Q4, relating to recruitment and selection processes; gross weight of rapid response vehicles; and professional integrity of staff on a Trust training course. These were being managed through the FTSU log and process as described earlier. TG thanked SP for the report. **Approval:** **The Quality Committee noted the current position and was assured in regard to the effective management of and learning from adverse events.**	
6.3	**Review of Quality Impact Assessments 2018/19 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 2018/19 schemes and progress in relation to QIA and CIP plans for 2019/20. Key risks to quality in 2018-19 were in the Workforce and Organisational Development; A&E Operations and Patient Transport Service directorates, but not all directly as a result of CIPs. Work was ongoing via the CIP Management Group and locality dashboard indicators to undertake the QIA process.	

		Action
	All QIAs are signed off by the Executive Medical Director and SP, who often seek further information and clarity on Clinical Quality Indicators for impact on patient safety and clinical effectiveness. New CIPs had been approved for 2019-20 and a number were pending, as awaiting further information prior to sign off. SP commented on the QIA recently completed on end of shift and meal break policy, as this was a major potential CIP. Discussions were ongoing and included in the Trust Executive Group held yesterday. Most QIAs were agreed, however a small number are required to be managed carefully. NS highlighted the difficulty in that the CIP was a high value and would be difficult to negotiate, therefore it was likely to be debated at the Trust Board. **Approval:** **The Quality Committee noted the paper and gained assurance with regard to the current position of the QIA monitoring and actions to mitigate key and emerging risks.**	
6.4	**Regulatory Compliance Report** The report provided an update on the current position of regulatory compliance within the Trust along with Inspections for Improvement (I4I) in 2019-20. I4I for this year were underway and members of the Executive and Trust Management Groups had been invited to attend and observe an inspection of their choice to promote visibility from senior roles within YAS. SP updated on the current position with regard to the CQC. The observational assessment had taken place, with the clear focus on PTS and EOC. Initial observations were positive in both areas. Inspectors were impressed with their observations in EOC and the knowledge of staff. Feedback was provided around a potential need for development in staff communication and rationales for change, and mental health support and well-being for staff. PTS overall was extremely positive with significant improvements since the last inspection. A key message was around strong IPC, and it was gratifying to receive positive comments around leadership in PTS. Issues to note related to safeguarding training where compliance rates for completion of learning are high, but variability in the articulation of actions in certain scenarios. This was being covered in the face to face training but was only part way through and would be explained in the CQC interview scheduled with the Head of Safeguarding.	

		Action
	SP had attended, and presented to the Inspection team on developments since the last inspection, which would be used as part of the briefing within the Well Led Inspection. The Chief Executive was scheduled to present to the CQC, with SP in attendance to add governance information. The CQC were then scheduled to interview a selection of staff. Information requests were still being received, with around 30 items relating to EOC, therefore still in progress and will continue to the conclusion of the Well Led Inspection week. A draft report will then be produced and received by the Trust approximately one month later. Other regulatory compliance information was included for reference. TG thanked SP for the report. **Approval:** **The Quality Committee gained assurance on the Trust's arrangements for regulatory compliance.**	
6.5	**Programme Management Office (PMO) Update** The paper provided an update on the current position and next steps in relation to the Trust's Transformation Programme. Core programmes were up and running with strong agendas and much work ensuring programmes are supporting delivery of the priorities aligned to the Trust strategy. A number of elements continued to be scoped and others were live. An update on each of the programme boards in detail was included in Appendix 1, and was discussed in the last Board meeting. SP noted key highlights from the Programme Boards. The Service Delivery and Integrated Workforce were working on the detail of assurance around the 2019-20 programme and in particular recruitment and training elements of that. The operational team had undertaken excellent work with the Academy in ensuring plans were in place. This had proved to be complex and challenging but with a high level of confidence. Further work had been undertaken around the extent of the ambition for Hear and Treat and the detail. EOC functional design work was ongoing, and additional resources had been agreed around recruitment and retention in the short term of Clinical Advisors workforce, and a Workforce programme senior lead appointed. The Place Based Care Board was self-explanatory, including patient flow work together with an increased grasp on engagement with the wider system.	

		Action
	The Infrastructure Board focussed primarily around EPR, Unified Communications, AVP and logistics and Rapid Process Improvement Workshops (RPIW). Capacity & Capability Board - work on the accountability framework was scheduled to commence with a programme lead in place. Scoping under way of the future training model. CM was leading on this work. Further work is in progress to ensure clear alignment of transformation developments to CIP programme. **Approval:** **The Quality Committee noted the update and was assured of the effective management of the various projects and initiatives across the Trust.**	
6.6	**Service Line Assurance – PTS** The paper provided an overview of the PTS Service and that quality and patient care for patients was being met by PTS Service Line standards. Exceptions included an increase in short notice on-day and weekend stretcher patients in Scarborough, Vale of York (VoY) and East. It was questioned whether this related to the Acute Trusts and the pressures they faced. The VoY and Scarborough had seen a significant increase compared to previous reports. In relation to Core KPI's generally, KPI's 1, 2 and 3 were performing very well, with the exception of South. Good discussions had taken place with Commissioners regarding KPI 4, including much around whether there was a national benchmark. KO explained the intention to review late evening activity, and those patients being transported after 9pm, working on numbers and profile by hour and challenge back to organisations, to ensure there is no inappropriate transport of frail patients home when support is not available. DG explained recent contracts obtained in the East and North were 24 hour contracts and were utilising the service. SP reiterated from previous discussions, around having the confidence that confirmation is being sought from the discharging organisation that they have checked sufficient support is awaiting at a patients at home. DG confirmed this is the case and the default reaction was to return to the ward. TG questioned whether this type of information is fedback to the commissioners. DG confirmed this and added that if crews are in any doubt they contact the duty manager or return the patient and log the case on Datix.	

		Action
	DG explained each area has its own challenges, the priority is the safety of patients and the desire to have processes in place from a social wellbeing perspective, if there is no clinical need for the patient. Training compliancy levels continued to improve and were effectively managed, with significant improvement on all levels of training month on month year on year. Statutory and Mandatory training workbook compliance stood at 98.3%, most on hard copy some tablet work trialled, which was above the Trust target. The number of reported incidents within PTS during April had increased by 19.8% compared with the previous month, prior to a drive in reporting at a PTS away day. The challenge was around determining normal incident reporting in order to highlight any spikes, which would take a number of months. PTS staff were previously believed to have a culture of under-reporting but this has been seen to improve. The establishment of regular PTS Leadership away days had commenced, with quarterly full day training mainly informed by themselves, an example of this was the design of their own patient risk assessment forms. The next away day in September will focus on safeguarding elements and risk assessment training. A member of the PTS team had been selected as a Quality Improvement Fellow, secured for 12 months. This would tie in with the learning picked up from the PTS CQUIN for 2018-19 around the testing of an electronic App collecting patient views on the PTS service. It was noted the return journey element required improvement including how patients are kept informed. Often vehicles may be assigned, but due to capacity issues, may be changed. This task would be assigned to the QI Fellow. The PTS Governance Group was meeting regularly to discuss operational and clinical issues relevant to PTS and escalating as necessary into the Clinical Quality Development Forum and the CGG. The group was established and well received. PTS had recently been reaccredited in Business Continuity with no recommendations or conformities, therefore outstanding practice. It was noted that all PTS fleet now have AEDs on board the vehicles, and the life of a gentleman had recently been saved thereby demonstrating the first successful use. Personal issue devices were being rolled out to frontline staff, which would be an effective way of communicating with crews. SP highlighted positive initial feedback from the CQC inspections, including positive outcomes around leadership and staff comms.	

		Action
	He noted the increase in complexity of contracts recently, where much more flex was required to manage the demand and complex patients, and how the service had responded positively in a flexible way whilst also improving quality. He highlighted the work undertaken by the team around Eligibility Criteria, with a strong patient focus. He felt the team should be commended by the Committee for its excellent work. JN noted financial performance had also improved tremendously since the last CQC visit. TG thanked DG for the report and update. **Approval:** **The Quality Committee noted the update report taking assurance on performance within the Patient Transport Service and was assured with regard to performance risks.**	
7.	**WORKFORCE**	
7.1	**Workforce and Organisational Development Report** The paper provided an overview of matters relating to key priorities within the Trust's People Strategy and an update on progress against the Diversity and Inclusion policy. There were five strategic aims in the People Strategy and a summary outline was included of progress on each. Also appended to the paper were the KPIs relating to the Strategy to provide a baseline for discussion. SH provided an update in relation to Workforce: Recruitment of Emergency Care Assistants (ECA) has resulted in the ECA workforce and training plan being exceeded, with a number of staff on a waiting list should any withdraw, and ready to commence with next year's training plan also. The ESR group had undertaken work on the Oracle Learning Module (OLM) in ensuring training records were robust and remapped against the matrix on ESR and this is monitored by the non-clinical PGB. Records were not previously all in one place, when YAS 24/7 was used. It had been brought to light that DBS periodic re-checks were not mandated by CQC or NHS Employment Checks, however the Trust had continued to undertake this process at a significant cost. Outcomes were generally low risk, and those that were, were many years old. Links with Police and safeguarding teams also ensures patients are not at risk. A decision had therefore been made to continue with DBS checks at the recruitment stage only, and re-checks would cease with the exception of patient transport crews and volunteers. TG asked if this had been included in the Quality Improvement CIP, as related more to risk than finances.	

		Action
	SP advised that the risk assessment has been formally recorded. It was concluded a safe and appropriate step to take but monitoring would continue and the QIA would be reviewed to a fuller extent than normal schemes. The new Occupational Health contracts were going well with good feedback from staff and KPIs were being met, and appointments were strict with a maximum of 30 minutes travel. CM provided an update on Education and Learning: Discussion was held at the Trust Management Group around Personal Development Reviews (PDRs) and the requirement to increase the quality and compliance. A proposal for transforming the process and culture was discussed and principles to be taken forward in a three year plan. The task and finish group would continue their work with trials in the aim to improve the basics. It was noted YAS was the lowest in the ambulance sector on quality of appraisals. The Trust had received an Education Quality Assurance Accreditation visit, and received a positive outcome and commended for details, with 16 learner portfolios and various evidence. CM stated the comments would prepare the Trust for an Ofsted inspection which was imminent due to its delivery of apprenticeship programmes. The Apprenticeship KPI related to draw down from the Levy, and it was noted by the end of the financial year the Trust will have drawn down more that it had deposited, and was therefore accessing investment from the government. CA commented on the functionality of OLM compared to YAS 24/7. SP explained discussion was held in the non-clinical PGB, and some elements of functionality of the YAS 24/7 system were not replicated in OLM and migration would be required in a planned way. CM added there are some limitations in OLM regarding content and therefore elements would remain on YAS 24/7, however recording of competencies for compliance reporting purposes will be in the OLM system for real time reporting. TG questioned employee relations, given the experience of other ambulance trusts, whether there was any benchmarking/comparison undertaken with them. CB explained that local work was ongoing in the Northern Ambulance Alliance, and HR Directors were meeting to discuss a common data set, in order to obtain commonality on the measurement of complexity and fairness in employee relations case work.	

		Action
	CM informed he is the Chair of the new national network 'Culture and Leadership Network for Ambulance Services' (CALNAS), and a meeting was scheduled for next week along with discussion with NHSI around a culture dashboard they have developed for acute trusts, which could potentially be evaluated for the ambulance sector. Culture is extracted from a number of areas and triangulated, and extracts from the staff survey generating categories. Early discussions were underway at a national level. TG suggested an update is provided to the Quality Committee on developments at a future meeting. SH updated an internal mediation service was due to be launched as part of the wider dignity and respect campaign. 31 referrals had been received to date, all with positive outcomes. The mediation service will be formally launched in Dignity and Respect campaign. The Dignity and Respect policy had also been recently signed-off, and replaces the Harrassment and Bullying policy. An update had been received with regard to Risk 814 holiday pay, but the outcome continued to be assessed. The appeal lodged by the East of England Ambulance Service had not been successful. TG concluded, as a Board, there was a clear line of sight to a strategy that was developed, and how implementation was being measured. CB suggested focus on Health & Wellbeing at the next meeting, which will provide an opportunity to showcase the work being undertaken. TG agreed at each meeting, a drill down into a particular element of the strategy is undertaken. The reports would continue to be provided, and taken as read, as provides assurance, with the addition of a short presentation on the chosen theme. A schedule for the year to be produced. **Action: CB** **Approval:** **The Quality Committee noted the update and gained assurance by the progress being made within the Workforce and Organisational Development Directorate.**	**Action 003/2019**
8.	**RISK MANAGEMENT**	
8.1	**Risk Management Report** The paper provided detail of updates to the Board Assurance Framework (BAF) and changes to the Corporate Risk Register (CRR) including an update on Security developments since the last Quality Committee meeting.	

		Action
	Additions to the risk register were noted including; (1193) Non-conveyance decisions; (1197) Falsified Medicines Directive Legislation; (1207) Handover of Critical Risk information; (1208) Level 3 Safeguarding training; and (1209) 5 yearly Emergency Driving Section 19 Requirement. Two risks were amended; (1096) Friarage update reframed following signed off QIA to capture proposed reconfiguration arrangements; and (1039) FOI compliance reduced to moderate following increase in staff capacity. The following risks had been removed from the CRR; (1119) Financial viability of IUC bid, bid successful and signed off; (1184) Voice Recorder failure, support offered therefore risk reduced to local risk register; (1148) Fleet Restrictions during AVP implementation, work completed; (1155) Planning Application for Fuel Tank, application awarded; and (1018) MYHT reconfiguration – A&E Ops mobilisation, actions agreed and closed at the RAG. The report included an update on recent security developments, including completion of the annual declaration against the NHS Protect Security Management Standards Self Review Tool (SRT). Standards relating to Violence and Aggression reduction were expected to be announced later in the year. Work was ongoing through the national ambulance Medical Directors group along with the Local Security Management Specialist around safe holding and restraint of patients. This is a significant development that will inform the training plan from 2020 due to a change in practice and quality. TG thanked SP for the update. **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.**	
9.	**INNOVATION, RESEARCH GOVERNANCE**	
9.1	**Clinical Development and Innovation Report** The report provided an update on clinical developments and innovations as part of the Clinical Strategy update. Research activity had been strong in the last year with increasing levels of YAS involvement in development and bidding for funding for research studies, with three studies having successfully been awarded funding. YAS staff also had 16 peer reviewed articles published which was good news for many frontline paramedics.	

		Action
	YAS was participating in a mix of studies involving staff, patients and data. Details of the studies opened 18-19 varied and were included at Appendix 3. A full list of Right Care, Right Place Pathways by area and type were included at Appendix 7, which highlights significant work the clinical pathways team had undertaken with local CCGs and stakeholders ensuring pathways are fit for use and encouraging their use. Good relationships had been developed with operational staff to improve access and utilisation resulting in crew confidence in using pathways in non-conveyance. The chain of survival was key to long term survival and quality of life in Cardiac Arrest patients. Survival rates are increased on receiving early resuscitation (CPR) or early access to defibrillation (AEDs). Work was ongoing to enhance this work. The Red Arrest Teams (RAT) continued to work on early access to advanced care of cardiac arrest patients, which was valuable to support crew knowledge of cardiac arrest. Significant work was ongoing in relation to Stroke, not only operationally, but clinically. The pathways team had developed a Yorkshire stroke pathway, in addition to mechanical thrombectomy and direct-to-scan pathways at appropriate hospitals. Good support and feedback had been received. Sepsis was high on the agenda with much focus on training previously, but NEWS is now calculated as part of the YAS electronic Patient Record (ePR). Work was ongoing with emergency departments to improve an integrated approach to the management of sepsis patients and would continue to explore the introduction of the latest early warning systems. In relation to major trauma Yorkshire remains the only region with a coordinated approach to clinical governance in pre-hospital critical care across all providers and a joint critical care SOP for the HART, BASICs and West Yorkshire Medical Response Teams (WYMRT) had been refreshed and published. YAS also continues to lead the way in provision of advanced analgesia to trauma patients and how this is used in a wider setting with a review of intravenous access. Funding had been obtained for vacuum splints, which had since been purchased and were being distributed on all frontline DCA vehicles. Work was ongoing closely with midwives on maternity care, equivalent of ICS. The West Yorkshire & Harrogate Local Maternity System and YAS had begun working together and a Senior Midwife had been appointed to work on a number of initiatives.	

		Action
	The Midwife had worked with the YAS Academy reviewing policy and procedures to bring together maternity care and a review of future developments. Respiratory care work continued with a significant focus on COPD (Chronic Obstructive Pulmonary Disease) and asthma. Air driven nebulisers had been deployed onto every DCA and RRV. The OxyMultiMask was currently in use across the region providing benefits to patient care including the ability of better oxygen therapy. Referrals to respiratory services had improved. Pathways had been developed for Falls patients who require ongoing treatment, with a number of agencies that assist with non-injured fallers. The End of Life Care (EoLC) improvement plan had been produced and approved by the Clinical Governance Group, and a network of EoLC champions established across the region. A new way of training without involving a classroom had been developed in the form of ECHO (Extension of Community Healthcare Outcomes) which is a community of practice developed using remote telecare technology. Andrew Hodge was leading on this and feedback had been positive. SD invited any questions from members. NS asked how the preferred CFR Mobilisation application (approved by TMG) fitted into the strategy and linked to “GOODSAM”. JM informed YAS was using an App developed by the South Coast Ambulance Service (SCAS) which maps all AEDs in the region, and is fed into the national AED database, then fed back to all ambulance services in terms of a managed database. He advised GOODSAM was an acceptable platform to access all the required information, whereas the App currently used is disjointed. JM added, there had been a number of publications this year, that YAS were not only participating in, but SD and MM were also lead contributors in some of them, with a bundle of publications, and therefore building a foundation as a research organisation. TG felt YAS must be a leading ambulance service in relation to the amount of research undertaken. KO informed members that Suzie Southey, Urgent Care Lead Nurse, was leaving the Trust at the end of June, and wished to formally recognise the work she had undertaken in relation to the mental health agenda. The recent international Nurses Day had been celebrated with mental health the main focus and highlighted a network and collaboration in the progression of that mental health agenda. TG thanked JM and SD for the report.	

		Action
	Approval: **The Quality Committee accepted the report and gained assurance on clinical developments across the organisation.**	
9.2	**Quality Improvement (QI) Report** The paper updated on the progress against the Quality Improvement (QI) strategy, including the conclusion of the 2018-19 implementation plan and progress against the 2019-20 implementation plan. An evaluation had been undertaken on the QI implementation plan 2018-19, including time spent with the outgoing QI Fellows to determine progression in the last year. The QI Fellows had received focussed training opportunities around QI, facilitated and supported by the NHS Improvement Academy (NHSIA), and were now trained to a silver level, which has now provided YAS with its own internal silver trained team, whereas many organisations continue to send staff to the NHSIA. A number of YAS staff had accessed the bronze and silver level training as indicated in the chart and further sessions would be planned in 2019-20, and a campaign undertaken. The Trust Board had committed to Quality Improvement and undertaken a session delivered by NHSIA and were then successful in joining the first cohort of the NHS 'Leadership for Improvement' board development programme, which would run from January 2019 – March 2020. A number of roadshows had been undertaken by the QI Fellows to allow operational colleagues the opportunity to share thoughts and ideas around quality improvement, and encouraging staff to book on training. CA highlighted the outline of projects undertaken by QI Fellows through 2018-19. It was noted that a number of the outgoing QI Fellows had become QI Advisors. One of the Fellows was continuing to sustain their role as an Advisor for 2 days during their substantive role in EOC, which highlights great commitment. The QI Fellows were supported by the core QI team working closely with the Project Management Office (PMO), and work had been undertaken on a QI App, containing much information and development of reports. The number of Bright Ideas submitted continued as expected, including the launch of the OneYas Facebook page. The core QI team had also been supporting the #ProjectA programme run by NHS Horizons, with the Head of Quality seconded to them one day per week.	

		Action
	The Northern Ambulance Alliance (NAA) Trusts had been key players in that project in driving it forward and recognised at the highest level. PMO team developments recently involved a Rapid Process Improvement Workshop at York ambulance station where the consumables storage cupboard had been reviewed. Workshops had been held using Virginia Mason techniques and a focussed week spent on improvements. Feedback from participants was positive. NS informed he was the executive sponsor of the RPIW project, and he felt it would make a significant impact in the organisation, and had seen positive engagement. The next RPIW project would focus on the logistics in moving vehicles around. NS was also pleased to inform that when he attended his Corporate Induction course, there were only two members of the 12 present, that were not on their first day of employment with the Trust, which was an improvement. CB added this was also the result of a RPIW project. CA explained a number of areas would be carried over as actions to the 2019-20 QI implementation plan, including work on the QI toolbox; a celebratory QI event (to be observed by the CQC) and strengthening of governance and project management. The next level of the QI strategy includes the new incoming QI Fellows who have had their initial training and will be spread across various services including Facilities and Estates, NHS 111, PTS, EOC and across 999 operations. Work will continue on silver level training to obtain an accreditation scheme, to then work on QI projects. It was noted student paramedics are obtaining a taster session for QI. In relation to wider engagement, one Fellow was supporting the OneYas page to ensure focussed and positive. #ProjectA would continue to be a focus for the QI team including work on Falls; and virtual collaboration with NHS Horizons. The Core QI and PMO teams had been successful in their application to the QSIR college practitioners scheme, which would enable all to be trained to the same level and fits with Board NHSI work. It was recommended that the Committee notes the progress and significant work undertaken to support the work and implementation plan going forward. TG noted the good results and benefits observed of QI, in undertaking very practical improvements that can demonstrate an impact.	

		Action
	SP added there was now a base to work from and could therefore begin to build capacity and capability, and then determine how this is incorporated into corporate priorities. Greater alignment would be enabled and consideration into how we think more systematically of the scale and spread of small ideas. TG asked, when a Fellow is selected, whether there was a geographical reach i.e. each station with technologies and the ability to implement ideas, as occasionally some are untouched due to a lack of volunteers. CA responded that a good spread was now being seen, with a number of applicants arising from areas where work had been seen by them. **Approval:** **The Quality Committee noted the progress in implementation and proposed next steps and gained assurance that appropriate processes were in place to enable implementation of the Quality Improvement Strategy.**	
10.	**ANY OTHER BUSINESS**	
10.1	**Review of the Meeting, New Format and Terms of Reference** TG sought feedback from members in relation to how the meeting had been conducted in relation to assurance and good discussion, aiming the question primarily at PG, as a new member of the Committee. PG explained he had attended a number of NHS meetings and every one was different, and involving a tranche of acronyms. He suggested a table of meanings were put on the table rather than only verbally, and suggested a list of general ones. The suggestion was welcomed. PG agreed that he felt welcomed with the opportunity to contribute if required, and felt the meeting was chaired in a timely manner. SP commented in relation to the Workforce paper, and questioned in the same spirit, whether there were any topics to be covered in the pre-committee presentation at the next Committee meeting in relation to any other papers, for discussion. JN commented on the continued interest in sickness, which CB would follow up in the Health & Wellbeing (H&W) paper. He added there was a view in the Finance & Investment Committee also in how that would be tackled. It was hoped the H&W plan would hopefully become preventative going forward. A proposal would be put to TEG to request suggestions for the pre-committee.	**Action: 004/2019** **Action: 005/2019**

		Action
	TG questioned the system implications in relation to some of the changes being rolled out, particularly in primary care, and suggested a pre-meeting discussion, or within a meeting, in the future around what some of those changes mean for us i.e. retention of staff. CB reminded discussion had been held previously around the possibility of presenting to Board on plans around paramedics and endeavouring to be a centre of excellence. TG highlighted the need to reflect on the degree to which an author speaks and the degree that colleagues question the content in relation to assurance, as it should not only be the Non-Executive Directors. It is a unitary committee as much as the Board, and felt there should also be challenge between Executive Directors also. He also noted the need for conciseness from authors to allow sufficient time for challenge and debate. CB agreed that focus should be aimed on key details, which should also be linked to risk areas. Summaries should be given by presentation or executive summary on success and areas for improvement. The chairman closed the meeting at 11.55 hrs.	
11.	**FOR INFORMATION**	
11.1	**IPR – Workforce and Quality** The report was noted.	
11.2	**Quality Committee Workplan 2018/19** The workplan was noted.	
11.3	**Quality Committee Terms of Reference** The TOR were noted for information.	
12.	**Date and Time of Next Meeting:** (0830) 0900-1230 hours 12 September 2019, Kirkstall and Fountains, Springhill 1, WF2 0XQ	

CERTIFIED AS A TRUE RECORD OF PROCEEDINGS

_____ CHAIRMAN

_____ DATE