East Midlands Ambulance Service NHS
NHS Trust

PB/12/51

UNAPPROVED MINUTES
QUALITY & GOVERNANCE COMMITTEE

Details: **06 February 2012, 11.00 hrs**
Meeting Room 1, Trust Headquarters, Horizon Place

Attendees:

Pauline Tagg	*PT*	Non Executive Director *(Meeting Chair)*
Brian Brewster	*BB*	Director of Finance & Performance
Stuart Dawkins	*SD*	Non Executive Director (Audit Committee link)
Karen Glover	*KGl*	Director of Nursing & Quality
James Gray	JG	Medical Director
Kerry Gulliver	*KGu*	Acting Director of Workforce
Karen Kanee	*KK*	Assistant Trust Secretary
Gill Newton	*GN*	Non Executive Director
Jon Towler	*JT*	Chairman
Robert Walker	*RW*	Assistant Director – Communications & Community Relations

In Attendance:

Rebecca Long	*RL*	Governance Advisor *(minute taker)*
John McGrath	*JM*	Unison Representative (*on behalf of Mark Ward*)
Simon Harris	*SH*	Assistant Director of Operations Derbyshire (on behalf of Peter Ripley)

Apologies: Mark Ward *MW* Unison Divisional Lead – Nottinghamshire

All attendees to this meeting must be aware that access may be given to all minutes and associated documents under the Freedom of Information Act 2000.

The following policies / procedures were approved at this meeting:		***Version***	***ID Code***
a	List all here as well as in the full minutes below.		
b	Policy / procedure title.		
c	Policy / procedure title.		

Minutes		***Action***
QG/12/01	**APOLOGIES**	
	All attendees were welcomed to the meeting. Pauline Tagg pointed out that this meeting was schedule for a two hour duration; however, given the volume of items submitted, to allow time for sufficient scrutiny, future meetings will be rescheduled for a three hour duration. Revised meeting	***RL***

	requests will be issued following this meeting. Apologies were received on the day from: • Peter Ripley (*PR)* - Director of Operations • Lynn Woods (*LW)* - Deputy Director Clinical Quality & Nursing, Derbyshire County Primary Care Trust (PCT)	
QG/12/02	**DECLARATIONS OF INTEREST**	
	Pauline Tagg invited all in attendance to declare any interests in relation to the items to be considered at the meeting. No interests were declared	
QG/12/03	**MINUTES OF THE LAST MEETING**	
	The minutes of the meeting held on 06 December 2012 were agreed as an accurate record subject to the following amendment: • **QG/11/27 – Declarations of Interest**: to be amended to include reference to a declaration of interest made by James Gray in relation to the Medical Appraisal Policy.	
QG/12/04	**MATTERS ARISING ACTION LOG**	
	The QGC Action Log was reviewed. All updates and outstanding actions are shown in the action log below. Completed items have been shaded for ease of reference; outstanding actions will be carried forward. **Action 130 – Governance Strategy:** As discussed at the previous meeting wider consultation was required on the Governance Strategy together with explicit detail around ownership and accountability. It was reported that Karen Sullivan, Trust Secretary Designate, would provide input on this, with Karen Kanee leading on internal consultation. James Gray suggested that scrutiny of the strategy was required prior to submission to Trust Board and it was agreed that this would be discussed further at the Strategic meeting scheduled for 15 March 2012.	

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Actions from the minutes of the Quality & Governance Committee

(New updates shown in bold text - Completed items will be shaded for information and then removed for the subsequent meeting)

Action No	Meeting date	Item No & Title	Action Required	Action allocated to	Comments/progress update	Due Date
17	15 Dec 2010	Item 15, Policy In EMAS update	Work around how to cascade information across the Trust to be revisited at Jan 2011 CQGC meeting	Rob Walker	**February 2012: this is an agenda item at this meeting (item QG/12/15). Action closed.** October 2011: This action now incorporates all strands of policy awareness and dissemination. A report will be collated covering Executive Summaries of policies, policy acceptance software and ensuring dissemination of information across the Trust. A full report will be submitted in December 2011. August 2011: software suppliers coming in September 2011, Intranet been reconfigured to make it easier to locate policies – figures show a significant increase in activity as a result. All actions relating to the cascade of policies should be consolidated into a report the provide assurance to the Committee. Due to the timeline on some of these actions, the report will be submitted at the December QGC meeting. June 2011: Rob Walker was not in attendance and no update was provided. Rebecca Long will liaise with RW to ensure that an update is provided at the August CQGC meeting. 07.04.11 – As Rob Walker was not in attendance no update on progress was provided.	~~January 2011~~ ~~August 2011~~ December 2011

					03.02.11 - Rob Walker not in attendance	
89	18 August 2011	Item 12, Claims Report	Preliminary Analysis - Will Hancock, CEO SCAS, to be contacted regarding access to raw data relating to this incident.	Pete Ripley	**February 2012: Information has now been received from SCAS. Action closed.** December 2011: SCAS claim to have sent the information, but it has not yet been received. October 2011: Pete Ripley requested clarification of the action; SCAS should be approached and asked to provide a copy of any SLA that was in place during the time that Northamptonshire 999 calls were managed by the Deanshanger Emergency Operations Centre.	December 2011
104	10 October 2011	QG/11/09 - Strategic Learning Review Group Annual Report	Discussion to be held with Cheryl Crocker around publicising some of the learning points contained in the annual report.	Rob Walker	**February 2012: As Cheryl Crocker has left the organisation, Karen Glover has been contacted with a view to including information around learning in the Annual Report. Action closed.**	
107	10 October 2011	QG/11/011 - Director of Nursing Report	ADOs to be subject to more robust challenge around how performance against deep clean targets is being addressed	Pete Ripley	**February 2012: Issues around achievement of deep clean targets are specific to one division; the ADO is developing an action plan to address this by the end of February.** December 2011: ADOs are monitoring the deep cleans for their division, Nottinghamshire & Derbyshire ADOs face specific challenges due to the team being half the size of the other teams in Leics and Lincs but will continue to support the release of vehicles to ensure compliance to the targets set. New ways of working are being explored to improve the current model of delivery.	
123	10 October 2011	QG/11/025 - Any Other Business - Patient Safety & Performance	Access to the Directory of Skills & Services (DOSS) to be raised at the Contract Management Board	Cheryl Crocker/ Lynn Woods	**February 2012: This is part of contract discussions. Action closed.**	

124	06 December 2011	Additional Item - Local/ Departmental Risk Registers	Details of risk management process to be circulated	Karen Kanee	**February 2012: details were included in the Assurance Framework paper presented at the December Trust Board meeting. Action closed.**	February 2012
125	06 December 2011	Additional Item - Local/ Departmental Risk Registers	Information to be sought to justify why EOC call handlers are not subject to CRB checks	Kerry Gulliver	**February 2012: CRB Update report included in February 2012 QGC meeting and includes a response to this query. Action closed.**	February 2012
126	06 December 2011	QG/11/031 - NHSLA Risk Management Standards	Discussion highlighted that Executive Directors were not familiar with the detail of what the current position was with respect to reaching the requirements for the Level 2 assessment and it was agreed to refer this to the Executive Team to strengthen the process.	Karen Kanee	**February 2012 - Paper sent to Executive Team 09 January. Follow up paper submitted to Executive Team Meeting 25 January 2012. Action closed.**	February 2012
127	06 December 2011	QG/11/032 - Claims Report	the urgency of the Committee structure review will be relayed to the Chairman and Chief Executive	Pauline Tagg	**February 2012: Chairman and Chief Executive informed on 16 December 2011. Committee review has been carried out and an update will be provided at the next meeting.**	February 2012
128	06 December 2011	QG/11/033 - Claims Policy V6.0	Section 6.6 - reference to General Managers to be amended, plus minor typographical errors. Amended policy and completed Policy Change Notification (PCN) to be forwarded to Governance for publication.	Karen Kanee	**February 2012 – Policy has been published and PCN has been completed. Action closed.**	February 2012
129	06 December 2011	QG/11/034 - Medical Appraisal Policy V1.0	Policy and completed Policy Change Notification to be forwarded to Governance for publication.	James Gray	**February 2012: Policy has been published and PCN has been completed. Action closed.**	February 2012
130	06 December 2011	QG/11/037 - Governance Strategy	Wider consultation to be undertaken and document revised accordingly	~~Karen Kanee~~ Karen Sullivan	**February 2012: internal consultation will be led by Karen Kanee; this action will be moved to the new Trust Secretary in March 2012.**	~~February 2012~~ April 2012
131	06 December 2011	QG/11/038 - Reporting & Investigating Serious Incidents	Serious Incident summaries to be a standing agenda item	Rebecca Long	**February 2012: SI Summaries has been added to the 'Standing Items' section of the QGC Terms of Reference. Action closed.**	February 2012

132	06 December 2011	QG/11/038 - Reporting & Investigating Serious Incidents	Process to be developed to ensure timely escalation of Serious Incidents to ALL Board members	Karen Glover	**February 2012: This paper was discussed at Executive Team meeting 09 January 2012 and will be presented to 20 February Board Development meeting. Action closed**	February 2012
133	06 December 2011	QG/11/038 - Reporting & Investigating Serious Incidents	Procedure and completed Policy Change Notification to be forwarded to Governance for publication.	Karen Glover	**February 2012: completed by Rebecca Long. Action closed.**	February 2012
134	06 December 2011	QG/11/039 - Complaints Policy - Redress	assurance around the indicative costs and the setting of an upper payment limit for redress is required	Karen Glover	**February 2012: The Trust's solicitors have been asked to advise on an upper limit for payments and will revert when they have this information. It is recommended that the complaints policy be reviewed and updated at the April QGC where full information regarding redress can be included together with updates on changes to management structures and complaints response deadlines. The Complaints Policy will be reviewed and submitted for approval at the April QGC meeting.**	February 2012
135	06 December 2011	QG/11/039 - Complaints Policy - Redress	Confirmation to be sought that the document has been agreed with Trust solicitors	Karen Glover	**February 2012: Solicitor response reviewed and approved by Executive Team on 09 January 2012. Action closed**	February 2012
136	06 December 2011	QG/11/043 - Ongong Compliance	PCA for Outcome 11 was incomplete. Exec Team to with identifying a method of addressing this issue and provide an update at the next meeting.	~~Execs~~ Peter Ripley	**February 2012: This has not yet been discussed at Execs. It was agreed that Peter Ripley would be assigned as lead. The PCA for Outcome 11 should be submitted at the April QGC meeting.**	February 2012
137	06 December 2011	QG/11/044 - CQC Essential Standards	CQC Combined Action Plan - Head of HR to be reminded that all actions should be updated in a timely manner	Kerry Gulliver	**February 2012: Reminder issued in writing January 2012. Action closed.**	February 2012
138	06 December 2011	QG/11/044 - CQC Essential Standards	Quality & Risk Profile - direction of travel indicators to be included on next QRP report	Karen Kanee	**February 2012: Indicators have been incorporated into the QRP. Action closed.**	February 2012

139	06 December 2011	QG/11/045 - Assurance Framework/ Corporate Risk Register	Strategic Aims need to be amended to reflect those in Chapter 3 of the Integrated Business Plan. Direction of travel indicators to be incorporated.	Karen Kanee	**February 2012: Amendments have been incorporated. Action closed.**	February 2012
140	06 December 2011	QG/11/051 - Record of Business - for escalation to Trust Board	To be discussed with the Trust Chairman: * Review of Committee structure to include review of governance structure * Assurance Framework	Pauline Tagg	**February 2012: Discussed with Chairman 16 Dec and followed up with an email to the Chief Executive to include in the Committee structure review. Action closed.**	February 2012
141	06 December 2011	QG/11/051 - Record of Business - for escalation to Trust Board	Record of Business to be presented at the January 2012 Trust Board meeting.	Pauline Tagg	**February 2012: the QGC Record of Business was presented at the 23 January Trust Board meeting. Action closed.**	February 2012
142	06 December 2011	QG/11/051 - Record of Business - for escalation to Trust Board	Agenda setting meeting to be arranged (Pauline Tagg, James Gray, Karen Glover, Karen Kanee)	Rebecca Long	**February 2012: Agenda setting meeting was cancelled due to conflicting priorities; instructions on submission of agenda items and papers was agreed and was circulated to QGC members. Action closed.**	February 2012
143	06 December 2011	QG/11/052 - Any Other Business	Memorandum of Understand (111) - copy of MoU to be sent to Trust solicitor for scrutiny	Karen Kanee	**February 2012 - Awaiting amended document from Ben Holdaway, Deputy Director of Operations.**	February 2012
144	06 December 2011	QG/11/052 - Any Other Business	Memorandum of Understand (111) - risk assessment to be undertaken around the 111 call transfer process	Karen Glover / Pete Ripley	**February: The Head of Patient Experience and the Deputy Director of Emergency Operations Centre conducted the risk assessment on 24 January 2012. The outcome of the risk assessment will be submitted to the Operational Governance Group. Action closed.**	February 2012

QG/12/05	**APPOINTMENT OF DEPUTY CHAIR**	
	Pauline Tagg reported that discussion had been held outside of this forum around the appointment of a Deputy Chair. It was agreed that, as the Audit Committee link member, Stuart Dawkins would be appointed as Deputy Chair of the Quality & Governance Committee (QGC). The Terms of Reference will be amended to reflect this.	***RL***
QG/12/06	**QUALITY & GOVERNANCE COMMITTEE ANNUAL CYCLE**	
	The QGC Annual Cycle 2012/13 was received for consideration. The annual cycle provides the Committee with a schedule for items which must be received in order to fulfil its remit. Pauline Tagg commented that the number of items included on the cycle reinforced the decision to make future meetings three hours in length. During discussion James Gray suggested that the 'Other' section could be simplified to state that minutes of all sub groups would be received (rather than listing each sub group specifically). Jon Towler, Chairman, pointed out that the cycle included the approval of the Risk Management Policy and queried what arrangements were in place for other policies. Karen Kanee explained that the Policy Development Framework shows the scheme of delegation which shows which groups/committees are responsible for approval of policies. It was agreed that the Complaints Policy should be included for approval at the April QGC meeting. James Gray suggested that, as the Trust has a two year policy review cycle, that it would be prudent to develop a two year business cycle to ensure that approval of relevant policies is captured. It was agreed that this would beneficial. It was agreed that a two year business cycle would be drafted and submitted for approval at the next meeting.	***JG***
QG/12/07	**QUALITY & GOVERNANCE COMMITTEE SELF ASSESSMENT CHECKLIST**	
	The proposed QGC self assessment was received for consideration. The QGC Terms of Reference require the Committee to complete a self-assessment of the work undertaken over the 01 April 2011 – 31 March 2012. The self-assessment checklist has been identified as a suitable tool. The checklist is structured over four classifications and contains 24 questions for the Committee to consider. Pauline Tagg suggested that the checklist should be completed outside of this meeting and the results collated into an aggregated assessment which will be incorporated in to the QGC Annual Report. During discussion Jon Towler suggested that a 'Don't know' column should be included on the checklist. There was some discussion relating to the Status key and it was agreed that	***RL***

	this should be removed as it was intended for use by the Audit Committee. Kerry Gulliver, Acting Director of Workforce, queried whether there was a standard checklist which could be used by all committees/groups. Karen Kanee responded that this version was adapted from the checklist published by the Audit Commission and was chosen because of the inter-dependencies between the QGC and the Audit Committee. There is also an assessment checklist specifically designed for use by the Trust Board; however, there is not a generic checklist available at this time. During discussion the Governance team was tasked with developing a generic checklist and exploring electronic options for data collection (such as Survey Monkey and the survey facility available on Insite). All members should complete the checklist and forward it to Rebecca Long, Governance Advisor, by 17 February 2012.	***RL*** ***KK*** ***All***
QG/12/08	**REPORTING & INVESTIGATION OF SERIOUS INCIDENTS PROCEDURE – ESCALATION TO THE TRUST BOARD**	
	A proposed amendment to the Reporting and Investigation of Serious Incidents (SIs), to include escalation of certain categories of Serious incidents to the Trust Board, was received for consideration. Karen Glover, Director of Nursing & Quality, reported that concern had been expressed that Board members were not being made aware of Sis in a timely manner. It was proposed that Trust Board members should be notified of the details of a serious incident when one or more of the following criteria are met: • There is media interest • The incident will involve the Coroner (especially when a rule 43 is likely to be given or has been given) • The incident involved a death which was directly attributed to EMAS NHS Trust • Never event (although ambulance trusts do not have never events, these can be interpreted as falling out of an ambulance, or falling from a stretcher) • Member of staff have breeched professional code of conduct (whether this be care delivery or an allegation against staff). During discussion the following suggestions were noted: • first bullet point should be state 'likely/potential media interest' • Reference to Rule 43 should be removed from second bullet point • third bullet point should refer to deaths which were *allegedly* attributable to EMAS • Never Events should be more clearly defined It was agreed that the above suggestions should be incorporated. **After consideration the Committee approved the inclusion of escalation of Serious Incidents into the Reporting & Investigation of Serious Incidents Procedure subject to amendments.** An amended version of the procedure should be forward to the Governance Team for publication together with a Policy Change Notification form.	***KGI***

QG/12/09	NHSLA UPDATE	
	Karen Kanee gave a verbal update on the current position relating to the NHS Litigation Authority (NHSLA). It had previously been reported that the Trust would undergo a formal NHSLA Level 2 assessment in August 2012; a gap analysis was undertaken to determine whether the Trust could reasonably anticipate success at Level 2. The gap analysis was discussed at the Executive Team meeting on 25 January 2012 where it was agreed that the Trust would apply for Level 1 Assessment this year but would work towards achieving Level 2 in Spring 2013, with an ambition to achieving Level 3 in Spring 2014. During discussion Pauline Tagg queried the significance of remaining at Level 1 until Spring 2013. Karen Kanee explained that there would no penalty, although the Trust would not gain the additional discount on premiums that Level 2 would attract; also, maintaining Level 1 would result in an Amber rating on the Quality & Risk Profile. Pauline Tagg also queried whether potential discounts from achieving Level 2 had been taken into consideration when setting budgets for 2012/13. Brian Brewster, Director of Finance & Performance, responded that budgets had been set on the assumption that Level 1 discounts would be awarded for 2012/13. **After discussion the Committee noted the update and endorse the decision to delay the Level 2 assessment.**	
QG/12/10	CLAIMS REPORT	
	The Claims Report was received for consideration. The report showed that the Trust is currently handling 82 Employers' Liability (EL) claims, 8 Public Liability (PL) claims and 21 claims of clinical negligence. Since the last report the following have been received: • 9 EL claims • 1 PL claims Karen Kanee reported that the number of claims being received was showing an upward trend and that the amounts being claimed are also increasing. During discussion Pauline Tagg suggested that, in future, details of changes since the last report and more detailed information relating to risks should be highlighted in the executive summary. It was agreed that this would be incorporated. It was also suggested that more information was required around trends and themes. James Gray queried whether the increases in the volume and amounts claimed were mirrored in other Ambulance Trusts. Karen Kanee responded that benchmarking had shown that volume and amounts were comparable and that EMAS was not considered an outlier in this area. It was agreed that this information should be incorporated into the paper for assurance. Stuart Dawkins queried whether there were risks that the Committee should be aware of other than the number of claims received. Karen Kanee responded that the amounts awarded did not represent a risk as payments were made from the NHSLA pooling scheme (to which the Trust contributes on an annual basis). Gill Newton queried whether the reputation risk had been captured. Karen Kanee responded that this was included on the Secretariat risk register.	***KK*** ***KK***

	After consideration the Committee accepted the Claims Report.	
QG/12/11	**WARWICKSHIRE & NORTHAMPTONSHIRE AIR AMBULANCE – REVIEW OF CLINICAL GOVERNANCE**	
	The Warwickshire & Northamptonshire Air Ambulance (WNAA) Review of Clinical Governance was received for consideration. The purpose of the report is to provide assurance to the QGC on the current clinical governance arrangements at WNAA as they provide clinical care on behalf of the Trust. WNAA are separately registered with the Care Quality Commission (CQC) and operate under a Service Level Agreement with the Trust. The report highlighted the following points: • Overall WNAA have a robust Clinical Governance System. • There are no significant areas of risk • The risk from the practice of extended procedures by WNAA doctors is appropriately mitigated through the clinical governance process and approach to on-going skill review. During discussion James Gray reported that the review had provided assurance that WNAA have a robust clinical governance structure. The service level agreement has recently been redrafted and is currently with the Trust's solicitors for review. Gill Newton queried whether time sharing of paramedic staff with Air Ambulance was a normal model of employment. James Gray responded that it is a commonly used model, although some Air Ambulance organisations are beginning to employ their own paramedic staff. Paramedics favour the time sharing option as it avoids the skill degradation which may occur as a result of dealing with the type of responses usually allocated to air ambulances. James Gray and Simon Harris agreed that there was a positive working relationship between EMAS staff and the Air Ambulance, across staff and managers. **After consideration the Committee accepted the report and the assurance it provided.**	
QG/12/12	**PATIENT SAFETY & PATIENT EXPERIENCE – IMPACT OF OPERATIONAL DELAYS IN RESPONSE**	
	The Patient Safety and Patient Experience: The Impact of Operational Response Delays report was received for consideration. The report is a follow up to the reports received by Trust Board in April 2011 and the Quality Governance Committee in October 2011. Karen Glover pointed out that there was an error in Section 5 of the report (page12)- the chart showing the total number of delay-related patient safety incidents for the Trust should read as shown below: **2011** | **Q1** | **Q2** | **Q3** **PSI (Total)** | 7 | 7 | 3 **SI (Sub-set)** | ~~2~~ 1 | ~~1~~ 0 | ~~1~~ 2 Concern has been raised that a decline in performance and continuing challenges relating to hospital turnaround times may have an impact on	

patient safety and patient experience.

Concern has been expressed by the Executive Team that excessive turnaround delays are compromising patient experience and patient safety. Operational staff and management at all levels have informally reported that patients are regularly being cared for in hospital corridors due to excessive pre-handover delays. Concern has been also been expressed that caring for patients in hospital corridors is adversely affecting patient dignity and confidentiality. Patient safety concerns have also been expressed by crews and operational managers. Where turnaround is high, the Trust is not always able to provide timely responses to new emergency calls in the community. This has been raised this with Commissioners at the Quality Assurance Group (QAG) and the Contract Management Board (CMB).

A risk assessment was carried out in relation to delivery of patient care in hospital corridors and placed on the clinical risk register. This showed a risk level of '8' High (Likelihood 2 x Consequence 4)

A further risk assessment was conducted by in January 2011 to determine whether the risk had reduced following actions implemented. This showed a risk score of '10' High Risk: 5 for likelihood (catastrophic) x 2 for consequence (unlikely).

A risk assessment was also carried out for patients to whom the Trust cannot provide a timely response for due to significant turnaround delays. The risk score was '25' Extreme Risk: 5 for likelihood (almost certain) and 5 for consequence (catastrophic).

The Trust has taken a number of steps to improve patient flows in A/E departments:

- In September 2011, the EMAS Chairman wrote to all Acute Trusts experiencing significant turnaround delays. These Trusts were asked to support EMAS in undertaking operational process mapping events to address turnaround delays

- Turnaround information is shared with Acute Trusts and Commissioners

- Initiated and led operational process mapping exercises with Acute Trusts (LRI, CRI, NUH, SFH and RDH complete. LCH planned for February and NGH/ KGH planned for March)

- EMAS Director of Nursing has met with Executives from Trusts with highest pre-handover delays

- EMAS Director of Operations has ongoing dialogue with Commissioners and Midlands and East SHA

- A business case for a regional electronic sensors project has been developed. This has successfully been used to secure £95k from the SHA Midlands and East Regional Innovation and Improvement Fund (RIF). A RIF Project Initiation Document (PID) will be submitted to the Operations Programme Board in January for approval

It was noted that an increase in complaints/concerns from Q1 to Q2 for both initial response and 'back up' response. These have both fallen in Q3.
When considering the information from complaints, concerns and incidents,

	the data demonstrates that delay and deployment remains an issue for the Trust. The Executive Team will monitor implementation of actions to minimise the detrimental effect on patient experience and patient safety. An action plan to improve patient safety and patient experience was included in Appendix 1 of the report. During discussion Gill Newton queried the causes of extended post handover periods. Simon Harris responded that there had been some issues around recording of post handover cleaning and availability times but that staff apathy may also be a contributing factor. It was also reported that Hospital Ambulance Liaison Officers (HALOs) were also being deployed to hospitals to assist with handover. Karen Glover reported that the latest data did not suggest that there had been an improvement in post handover times and commented that managerial grip and individual accountability may be a factor. Pauline Tagg commented that the actions taken had not provided sufficient assurance that issues were being resolved. Simon Harris responded that HALO cover had been provided on ad hoc basis, however, the Paramedic Team Leader (PTL) rota has now been revised to ensure that a dedicated HALO can be deployed to key sites when required. There was general discussion around the data contained in the report and James Gray pointed out that the data did not reveal the very long pre-handover delays which are experienced on a regular basis in some areas. There was some discussion around communication and reference was made to a recent media article which reflected negatively on the Trust due to a lack of context. Gill Newton suggested that a proactive approach to communications would be beneficial. Pauline Tagg agreed, suggesting that the media could be invited into the Trust; this would provide an opportunity to show turnaround issues from an ambulance perspective. It was stressed that such an exercise would only be worthwhile if post handover times are addressed. Stuart Dawkins commented that hospital turnaround has been the subject of discussion at a number of meetings, which may dissipate the focus, and queried whether there was one committee/group which could manage this issue. James Gray responded that the new Operations Committee would lead on items such as turnaround, although the Trust Board would have oversight. During discussion it was pointed out that the deployment of HALOs is not harmonised across the Trust, although Lincolnshire and Derbyshire divisions have adopted a formal process for allocation of HALOs. James Gray suggested that, if the process was considered Best Practice, it should be implemented across all divisions. Jon Towler pointed out that there had been a time in the recent past when the Trust had been meeting targets; however, since the start of 2011/12 there appeared to have been a step change and understanding what had changed was crucial. Basic investigations need to be undertaken to identify the root cause of post handover delays. Jon Towler also commented on the accuracy of data relating to turnaround, suggesting that this was also an area which needed close scrutiny. It was pointed out that the figures only relate to delays which were recorded; there was anecdotal evidence that a high number of delays were not being recorded by crews when booking themselves as available following handover. John McGrath, Unison representative, commented that many crews have stated that the time required to complete the electronic patient	***PR***

	report form (ePRF) may contribute to long handover times; this is not included in the reporting options available when crews call clear. Gill Newton commented that the report includes the names of individual hospitals and queried whether it was appropriate to do so in a document which was in the public domain, particularly given issues around data accuracy. The Committee reviewed the recommendations included in the report. **Recommendation 1:** The Committee noted the current position and it was agreed that detailed work on why post handover times are so high must be completed. This will be undertaken by Mick Barnett-Connolly, Turnaround Project Manager, with Peter Ripley as the QGC link. **Recommendation 2:** The action plan accompanying the report was not examined in detail, although it was noted that there was minimal information relating to post handover issues and solutions. There was some discussion around an appropriate forum for monitoring the action plan. Pauline Tagg suggested that it be monitored at the QGC, with escalation to the Trust Board if insufficient assurance was received. James Gray commented that using averages for reporting masked the issue and suggested that percentiles would show a more realistic picture. It was agreed that this would be an effective way of highlighting specific areas of concern. The Business Intelligence Unit (BIU) will be informed of the decision. **Recommendation 3:** It was agreed that this issue will be included on the Corporate Risk Register. **Recommendation 4**: As this represents an extreme risk it was agreed that this should be escalated to the Trust Board. Jon Towler commented that, when the item is presented to the Trust Board, action(s) required should be clearly stated and should include an outcome which has been agreed at Executive level**.** **After consideration the Committee noted the report.**	***KGI*** ***KGI/KK*** ***KGI***
QG/12/13	**SERIOUS INCIDENT MONITORING REPORT**	
	The Serious Incident (SI) Monitoring Report was received for consideration. The report provides a summary of the Trust's performance against key targets for the reporting and management of serious incidents. It also provides a thematic analysis on serious incidents reported by the Trust to date. There has been a recognition that the current presentation of information for SIs needed to be improved to give greater clarity to the Trust management of these incidents and the learning thereafter. This report will be presented at each meeting of the QGC, with a summary presented to the Executive Team on a monthly basis. For engagement, delivery and monitoring purposes this report will also be shared with key stakeholders via the Clinical and Operational Governance Groups Section 2 of the paper outlined the current process and Karen Glover pointed out that the key risk is around the time taken to report SIs on the Strategic	

Executive Information System (STEIS). SIs should be reported on STEIS within one working day and the report submitted to the PCT 60 working days from entry onto STEIS; performance in this area is currently below target and is predominantly due to delayed escalation from Divisions. In addition recognition of SIs in formal complaints has, on occasion, been slow.

From the 16 December 2011the new Midlands and East SHA have issued a revised SI policy that states SIs must be reported on STEIS within two working days with submission of final report to the PCT 45 days from entry on to STEIS (for Level 1 SIs). Report submission of Level 2 SIs will continue to be 60 days. The grading is determined by the Trust and agreed by the PCT.

The change to the timeline for submission of SI reports to the PCT from 60 to 45 days is challenging. The new timeline has been shared with all Divisional Assistant Directors of Operations (ADOs) as well as with the Deputy Director Operations (EOC). Achievement of these challenging targets is highly reliant on commitment and co-operation from across the Trust.

Karen Glover reported that analysis (page 7) shows that the two key themes are delayed responses and care management. Of the delayed responses two emerging themes are GP Urgents (3) and delayed responses to G2 calls (4). Improvements have already been made to the process for managing GP Urgent calls. A detailed analysis of all untoward incidents including SIs, formal complaints and PALS is currently being undertaken to identify any learning and will be shared with the QGC in April.

Karen Glover also highlighted the following points:

Key service improvements since 01 April 2011

- Following emerging themes from SIs related to the care of patient under the influence of alcohol and the care of patients with spinal injuries changes have been made to the Essential Education for 2011/12.

- There has been a Trust wide review of the process by which Health Care Professionals (HCPs) can book ambulances for patient transfer. This has removed the one and three hour booking options leaving 999, two hours and four hours as the remaining options. Linked to this, a review of the procedure for managing two and four hour bookings that will go out of time has been undertaken. A clear process has been agreed whereby the call is automatically upgraded in cases where the HCP cannot be contacted to undertake a risk assessment for extending the time for transfer.

- Awareness-raising of the management of sepsis has been done via issue of a clinical bulletin. Use of a proforma for early recognition and appropriate management of these cases is currently being trialled.

Never Events

'Never events' are defined as 'serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers'. To be a 'never event', an incident must fulfil the following criteria:

- The incident has clear potential for or has caused severe harm/death.

- There is evidence of occurrence in the past (i.e. it is a known source of risk).

- There is existing national guidance and/or national safety recommendations on how the event can be prevented and support for implementation.

- The event is largely preventable if the guidance is implemented.

- Occurrence can be easily defined, identified and continually measured

The Director of Nursing and Medical Director have agreed the 'Never Events' that should be reported at future QGC meetings (taken from the nationally specified Never Events - 'Never Events' list 2011/12 DH Feb, 2011). These are indicated below:

- Wrong route administration of oral/enteral treatment
- Overdose of Midazolam during conscious sedation – LIVES or EMICS Doctors
- Oipiod overdose of an oipiod-naïve patient
- Fall from a moving ambulance (adapted from the Never Event 'fall from unrestricted window')
- Failure to monitor and respond to oxygen saturation
- Air embolism

Jon Towler queried how many of the above had been reported in the Trust in the past 12 months. Karen Glover reported that no reports of such incidents had been received.

Gill Newton commented that the reporting procedure was clearly laid out and queried how awareness was raised at Executive level. Karen Glover responded that a report is submitted at the Executive Team meeting on a monthly basis. Executives are made aware of new SIs with the week they are reported. Awareness around themes is raised through the regular bulletins issued by the Strategic Learning Review Group (SLRG).

Pauline Tagg queried the purpose of presenting the report to the QGC. Karen Glover responded that the report had been developed to present SI data in a more structured format than it had been previously. Pauline Tagg suggested that more information around themes, benchmarking data and details around actions being taken to improve performance and assurance that the actions were effective.

KGI

Stuart Dawkins commented that the report was a useful first draft; given that these are 'serious' incidents the fact that performance against the one day reporting target is only at 12% raised questions around the mindset of staff and the robustness of processes and it would be useful to identify specific issues around this.

Stuart Dawkins also went on to state that there have been other items discussed a various meetings where reporting within deadlines was an issue. Karen Glover responded that success in these areas would rely on Executives enforcing more rigorous accountability in division. It was agreed that this should be incorporated into the action plan.

The Committee reviewed the recommendations included in the report.

Recommendation 1:

It was agreed that the format of the report was acceptable, subject to the

	inclusion of information/data discussed above. **Recommendation 2:** Karen Glover reported that concern had been raised around actions arising from SI reports which had been marked as complete with insufficient of poor quality evidence. This was discussed at a recent Executive Team meeting and it was agreed that light duties staff would be sourced to support the Governance team and increase capacity to facilitate quality checking of assurance. **Recommendation 3:** Karen Glover commented that the poor performance in reporting and non-compliance with deadlines was unacceptable and will be taken up via the Performance Management Framework (PMF). Simon Harris pointed out that it would be beneficial to determine why the target is not being met in each division. **After consideration the Committee agreed the report format and noted the content of the report.**	***KG***
QG/12/14	**NPSA 7 STEPS TO PATIENT SAFETY**	
	The National Patient Safety Agency (NPSA) 7 Steps to Safety Assessment and Action Plan were received for consideration. The 7 Steps to Patient Safety (NPSA 2004) provides a simple checklist to help organisations plan activity and measure performance in patient safety. The Seven Steps are: 1. **Build a safety culture -** Create a culture that is open and fair 2. **Lead and support your staff -** Establish a clear and strong focus on patient safety throughout your organisation 3. **Integrate your risk management activity-** Develop systems and processes to manage your risks and identify and assess things that could go wrong 4. **Promote reporting -** Ensure your staff can easily report incidents locally and nationally 5. **Involve and communicate with patients and the public -** Develop ways to communicate openly with and listen to patients 6. **Learn and share safety lessons -** Encourage staff to use root cause analysis to learn how and why incidents happen 7. **Implement solutions to prevent harm -** Embed lessons through changes to practice, processes or systems The first NPSA 7 Steps to Patient Safety self assessment was completed in January 2010; the Trust obtained a score of 29%. As a result, an action plan was developed and formed part of the Patient Safety Strategy. A substantial amount of work was undertaken during the period from January to June 2010. For this reason the self assessment was repeated in June 2010, to demonstrate improvement and to refresh the action plan.	*Initials*

	The results for June demonstrated a significant increase, from 29% to 62%. Further self assessments in January 2011 revealed a score of 82% and 90% in January 2012. Karen Glover reported that Nichola Bramhall has now taken up the post of Deputy Director of Nursing & Quality (DDoN) and has been tasked with conducting an independent review of the score; the action plan will also be refreshed to ensure it is aligned to the Patient Safety Strategy. Jon Towler suggested that cross referencing the scoring to the action plan would make the report meaningful. **After discussion the Committee accepted the report and endorsed the action plan.**	
QG/12/15	**UPDATE ON POLICY MATTERS**	
	The Update on Policy Matters was received for consideration. Over the past 15 months approximately, the QGC and its predecessor committee have been informed of three pieces of work within the Trust that relate to Policy. The report provided an outline of the work which had been carried out on each strand of the subject. Each piece of work has been prompted by consideration of the basic question: How do we know that Policy is followed? Two of the pieces of work have been completed and one is to be undertaken shortly for completion in June 2012. Bringing the three strands together in this report highlighted that, whilst steps are being taken to improve policy content, accessibility and awareness by staff, there is not currently a definitive answer to the question raised above. Moving forward, the newly established Operations Committee will hold responsibility for Policy across the Trust and the current scheme of delegation will be updated in line with the new committee structure that is introduced. During discussion James Gray commented that this issue had been on the Trust Board action log for many months and that it was difficult to accept that no progress had been made. Kerry Gulliver commented that the report gave the impression that each of the three strands had been addressed in silo and suggested that a more holistic approach was required. Gill Newton commented that she was unaware that a new Operations Committee had been established. Phil Milligan, Chief Executive, responded that the Terms of Reference for the Operations Committee would be received for approval at the March Trust Board meeting. Pauline Tagg stated that an Audit Report had been received in October 2010 giving specific guidance on how this could be addressed; most concerning was that this guidance appears to have been dismissed without recording of a clear rationale and no clarity on where that decision had been reported. It was suggested that Executive discussion was needed on a different way to progress this work. It was agreed that this would be discussed further by the Executive Team; feedback will be provided at the next QGC meeting. **After consideration the Committee noted the Update on Policy Matters.** As James Gray had to leave the meeting due to a prior commitment, it was	***RW***

	agreed that items QG/12/17 and QG/12/18 would be taken as the next items.	
QG/12/17	**QUALITY STRATEGY**	
	James Gray reported that the Quality Strategy was a standing item on the QGC agenda. The strategies which are referred to in this overarching document are to be confirmed at the March Trust Board meeting; leads should have been asked to ensure that narratives are still relevant. Any changes to the detailed strategies should be forwarded to James Gray at the earliest opportunity to ensure that the Quality Strategy remains current. Pauline Tagg commented that there needed to be a clear position against the key priorities contained within the strategy. James Gray to discuss with Pauline Tagg around how to best manage the updates prior to the next QGC meeting	**JG**
QG/12/18	**REVIEW AGAINST POSITION FOR AMBULANCE QUALITY INDICATORS**	
	The Review Against Position for Ambulance Quality Indicators (AQIs) report was received for consideration. At the January 2012 Trust Board meeting concern was expressed at the apparent position of the Trust as lowest performer in some key AQIs, as well as some other specific areas. This report explained the current position, the actions being taken to improve them and sought to provide assurance to the Committee of improvement. The report demonstrated that the Trust had made considerable improvement in the areas of Stroke and ST segment elevation myocardial infarction (STEMI – a type of heart attack) care and is in a good position with respect to cardiac arrest care and re-contact rates of patients following face to face assessment. National clinical indicator reporting lags significantly behind the others and the data currently reported is a year to date figure up to and including August 2011; this means that significant improvements since that time are not reflected in the current data. It is for this reason that care bundles and return of spontaneous circulation (ROSC) are included in the Integrated Board Report (IBR) from the Trust's more up to date data. Currently the AQIs are in development format so there is variation in reporting between services, with some trusts giving complete figures for each area with others giving a sample. Currently EMAS gives samples from the electronic care solution (ECS) for Stroke and STEMI and complete data for cardiac arrest. The Trust will move to complete reporting of these indicators from March 2012. James Gray explained that the month to date figure comparison will always be lowest for EMAS, compared to other services, during this year due to the low baseline and cumulative effect. The report also contained benchmarking data around the indicator relating to re-contact within 24 hours following discharge at scene. During discussion it was noted that the report should have contained information relating to the Resolved by Telephone indicator; data around re-contact within 24 hours had been included in error. Pauline Tagg pointed out that, as indicated on the coversheet, the associated risk was rated as 12 and that this should be escalated to the Trust Board. James Gray responded that the report was due to be submitted at the March	

	Trust Board meeting. **After consideration the Committee noted the report and the associated risk.** James Gray left the meeting due to prior commitments. The remaining items were taken in agenda order.	
QG/12/16	**INTEGRATED QUALITY REPORT**	
	The Integrated Quality Report (IQR) was received for consideration. This was the first time that the report had been received in revised format. The report contains performance data and narrative relating to items which had previously been included in the Director of Nursing (DoN) Report and also incorporates information relating to Clinical Performance Indicators (CPIs). The key risks highlighted in the report were: 1. Deep cleaning of vehicles/IPC training for frontline staff 2. RIDDOR reports to Heath & Safety Executive (HSE) within 10 days 3. Timely closure of PALS/Formal complaints **RIDDOR** Karen Glover reported that a RIDDOR reporting telephone line has been introduced and communications issued to raise staff awareness; this will also be supported by the introduction of an electronic incident reporting system which has now been signed off by the Executive Team. Karen Kanee commented that the introduction of the telephone line would improve incident reporting, but queried how it would improve RIDDOR reporting given that RIDDOR regulations only come into force once a member of staff has been off sick for three days. Simon Harris responded that the Resource Management Centre (RMC) would have access to this data. There was some discussion on how this information would be shared and who would be responsible for ensuring that RIDDOR reports were submitted in a timely manner. **Deep cleaning/infection prevention & control (IPC)** It was reported that Nottinghamshire and Derbyshire divisions have met and Best Practice has been shared. Karen Glover commented that, as Leicestershire have been over-performing, the possibility of South Nottinghamshire vehicles being cleaned at Gorse Hill is being investigated. Kerry Gulliver reported that completion of Essential Education Workbooks remains disappointing. Workbooks were issued in September 2011 with a deadline for completion of 31 March 2012; returns to date are extremely low. Pauline Tagg queried whether a reminder system was in place to encourage staff to complete the workbook. Kerry Gulliver responded that there was a process in place and progress against target is monitored via the Education Report which is submitted to each meeting of the Organisational Development Group (ODG). Gill Newton commented that there appeared to be a theme, around delivering objectives, running through a number of items at this meeting and queried whether it was an issue of capacity or capability; Kerry Gulliver responded that it would appear to be a combination of the two. Proposed changes to the Operations management structure involve further education and addressing the development needs of line managers. Simon Harris stated that face to face education had been delivered, IPC audit feedback was positive, the IPC agenda was embedded at the front line and capacity was certainly an issue for Paramedic Team Leaders (PTLs) due to their wide	

	remit. Kerry Gulliver commented that certain areas of education require annual updates and the use of workbooks are used to free up time for Organisational Learning tutors to delivery face to face training. Staff have an obligation to ensure that they fully participate in all education relating to their role. Jon Towler queried the implications of not meeting the 100% target. Karen Kanee responded that this was part of the CQC requirements and non-achievement of the target was one of the key reasons behind the decision to pause the Trust's NHSLA Level 2 assessment. Pauline Tagg queried whether there was a detailed plan in place to ensure 100% completion. Kerry Gulliver responded that meetings are being held with individual Directors to determine how key performance indicators will be met. Simon Harris reported that feedback from staff had indicated that they did not like the workbooks, some felt that they were childish, others that they were too difficult. Pauline Tagg acknowledged that there may be some concerns but stated that this did not negate the requirement to complete the workbook. Gill Newton commented that the issues appeared to more cultural than structural and that they indicated issues around leadership and managerial grip. Pauline Tagg suggested that this should be highlighted to the Trust Board. It was agreed that a letter would be sent to the Chief Executive outlining the issues and associated risks. **Patient Advice & Liaison Service (PALS)** Performance against the 25 day completion deadline for PALS is extremely poor. Whilst all divisions are performing poorly against the target, EOC is particularly poor with only 5% of responses being within 25 days. The Executive Team is monitoring patient experience performance on a monthly basis. **Safeguarding** From 01 April 2012, The Trust will be monitoring and reporting on feedback/follow-up information from safeguarding child referrals. It is a statutory requirement for local authorities to provide feedback on all referrals as stated in 'Working Together' (DH 2010). Currently 5% of follow-up information is provided by local authorities. A letter will be issued to all Local Safeguarding Children Board (LSCB) Chairs to advise of the Trust's intention to monitor follow-up information. A local authority breakdown will be incorporated into the IQR from April. Stuart Dawkins drew attention to the pie chart (page 15) and queried whether there was confidence that the Trust could answer challenges around ethnicity. Kerry Gulliver responded that the Trust must be able to demonstrate that attempt had been made to obtain ethnicity data; this is currently done through the patient survey and sections included on the patient report form. **After consideration the Committee accepted the Integrated Quality Report for assurance purposes.**	***PT***
QG/12/19	**ONGOING COMPLIANCE**	
	A report on ongoing compliance against Care Quality Commission (CQC) requirements was received for consideration. The Provider Compliance Assessments (PCAs) are the tools requested by	

	the CQC when they wish to assess a Trust's compliance on any given Outcome. Each PCA contains a description of how the Trust achieves the prompts contained in each Outcome and also the evidence that can be supplied to verify a declaration of compliance. PCAs were received in respect of the following areas: • **Outcome 6** – Cooperating with other providers • **Outcome 9** – Management of medicines All evidence listed on the PCAs is linked to Covalent, the Trust's Performance Management Tool, by the relevant Leads and updated on a regular basis. The PCA show the Trust to be fully compliant with both Outcomes. Outcome 10, Safety and suitability of premises, was due to be presented at this meeting of the Committee but was not received from the Lead. Pauline Tagg queried the implications of not receiving this PCA. Karen Kanee responded that the CQC can request a PCA for any (or all) Outcomes without notice; should the CQC request a PCA for Outcome 10, the Trust would not be able to produce one at short notice. During discussion it was agreed that non-receipt of PCAs at this meeting was entirely unacceptable. It was noted that this was the second PCA which had not been submitted on time (a full PCA for Outcome 11 – Safety, availability and suitability of equipment – had not been submitted at the previous QGC meeting). It was agreed that full PCAs for Outcomes 10 and 11 should be submitted at the next QGC meeting. Stuart Dawkins noted that the PCA for Outcome 6 did not make any reference to the issues relating to hospital turnaround which had been discussed earlier in this meeting. Pauline Tagg commented that, in order to demonstrate triangulation, the PCAs should reflect current position *and* challenges and suggested that it may be useful to include the prompts which underpin each Outcome to widen the Committee's understanding of the requirements. It was agreed that prompts would be shown in future submissions. The Committee's comments on Outcome 6 will be fed back to the relevant lead for inclusion in the PCA, which will be resubmitted at the next QGC meeting. Due to prior commitments Brian Brewster left the meeting. James Gray rejoined the meeting.	***PR*** ***KK*** ***KK***
QG/12/20	**CARE QUALITY COMMISSION ESSENTIAL STANDARDS**	
	The CQC combined action plan was received for review. It was noted that all actions were in progress, with no overdue deadlines. The Quality & Risk Profile (QRP) was also received for review. The QRP was first published by the CQC in September 2010. Each Trust has its own version which is maintained by the CQC. Only the Trust, Lead Commissioners and the Strategic Health Authority can view the QRP. The QRP is released on a regular basis. It is used by the CQC to predict whether or not a Trust has become non-compliant with the CQC Essential Standards of Quality & Safety. The following points were noted: NHS Litigation Authority (NHSLA) Level 1 is classed as **Amber – Tending**	

towards worse than expected - which is outlined above.

The Trust's Staff Survey results are rated as **Amber – Tending towards worse than expected -** for 'Staff feeling satisfied with the quality of work and patient care they are able to deliver' and 'Percentage of staff agreeing that their role makes a difference to patients'. There is currently an action plan in place to rectify the negative issues on the staff survey with such events as the Big Conversation and Local Conversations taking place to get input directly from staff.

The Local Security Management Specialist (LSMS) attendance at the Counter Fraud and Security Management Service (CFSMS) quarterly and the regional LSMS meetings is rated as **Pink – Worse than Expected**. This appears under **Outcomes 9** – Management of medicines, **Outcome 10** – Safety and suitability of premises, **Outcome 11** – Safety, availability and suitability of equipment, and **Outcome 14** – Supporting staff. The LSMS will now be attending all CFSMS meetings.

Outcome 10: The requirement for a Board Approved Estates Strategy was removed in November 2011 but re-appeared in December under this outcome. The CQC has been contacted to ask if this can be removed from our QRP as the Estates Strategy has been approved by the Board. The CQC have responded that they will not remove this piece of information until new information is submitted.

Outcome 12 Requirements relating to workers: The fact that the Trust is not compliant with this outcome is now registered on our QRP. The Trust has an action plan in place to achieve this outcome and the Committee are receiving this by exception at each meeting.

Outcome 14 - Supporting staff: An item under this Outcome is 'The proportion of published Violence Against Staff (VAS) figures reported to Physical Assaults Reporting System (PARS)'. This item is rated as **Pink – Worse than expected.** The date for this data is 2009-2010, making the information completely out of date. The CQC has been contacted to ask for this information to be removed. Again the CQC will not remove information until they receive new information or until the data is over 2 years old. This should, therefore be removed, in April 2012.

Also under this Outcome, a Staff Survey item is rated as **Amber – Tending towards worse than expected** – 'Work pressure felt by staff'. As mentioned earlier, there is currently an action plan in place to rectify the negative issues on the staff survey with such events as the Big Conversation and Local Conversations taking place to get input directly from staff.

Staff sickness absence for the period 01-31 March 2011 also appears under this outcome rated as **Amber – Tending towards worse than expected**. Detailed action plans are in place in all divisions agreed by Human Resources (HR) Managers and divisional ADOs. Daily monitoring and challenge to all Operational Support Manager / Paramedic Team Leaders carried out on a daily basis regarding abstraction management, enforcement of policy. Non-compliance of KPIs challenged through Performance Management Framework both locally and corporately. Listening events have been held in Northants to improve morale issues which have been around recent rota negotiations - now progressing forward. Derbyshire are engaging with staff side and managers.

Outcome 16 - Assessing and monitoring the quality of service provision: Under this Outcome a Staff Survey item is rated as **Amber –**

	Tending towards worse than expected – 'Staff Reporting errors, near misses or incidents' which is dated October 2010. Serious Incidents numbers increased from 24 in 2009/10 to 70 in 2010/11 due to an awareness campaign and improvements in patient safety culture. Negative Comments: • **7 - Outcome 4** - Care and welfare of people who use services (increased from 4 in October 2011) • **1 - Outcome 7** – Safeguarding people who use services from abuse • **1 - Outcome 8** – Cleanliness and infection control • **1 - Outcome 11** – Safety, availability and suitability of equipment • **2 – Outcome 21** – Records (new Comments from Information Commissioner and CQC Engagement Forms) When further information on negative comments was requested, the CQC responded that these were related to Serious Incidents (SIs) which we had reported to Commissioners. Since these were reported the Nursing & Quality Directorate have reviewed the process for reporting SIs; the process has been refined and now follows National Patient Safety Agency (NPSA) guidance. It is anticipated that this will result in less SIs being reported externally; however, they will still be investigated internally. Karen Kanee reported that, although the Trust has 26 items of concern on the QRP, the majority have either been rectified or have an action plan in place to address the issues. **After consideration the Committee accepted the Ongoing Compliance update and noted the CQC Combined Action Plan.**	
QG/12/21	**ASSURANCE FRAMEWORK/CORPORATE RISK REGISTER**	
	The Assurance Framework/Corporate Risk Register was received for consideration. It is the Public Assurance Framework which provides additional assurance to the Clinical Quality & Governance Committee that the risks are being managed and that the Controls used to reduce (mitigate) these risks are effective. The format of Assurance Framework is currently being reviewed and a sample of the new format was also received for comment. Pauline Tagg pointed out that the revised format and content of the Assurance Framework would be discussed in detail at the February Board development meeting. **After consideration the Committee noted the content of the Assurance Framework/Corporate Risk Register.**	
QG/12/22	**RECORD OF BUSINESS OF SUB GROUPS**	
	The Record of Business of sub groups of the QGC was received for review. **Clinical Governance Group (CGG)** Key points from the meeting held on 20 December 2011: • Vulnerable adults and learning disabilities to be considered in policies and procedures and the full EIA should be conducted if applicable.	

- Approvals:
  - Emergency Operations Centre (EOC) Overcapacity plan
  - Information sheet for complainants on the way calls are managed in the EOC
  - Management of Medical Devices policy and Evaluation of Medical Devices and Consumables Procedure
  - Medicine Delivery Procedure
  - EMICS SOPs Tension Pneumothorax and Surgical Airway
  - Final five Patient Group Directives (PGDs)

- Work ongoing with coroners to try to get a single agreed fact of death form fit for all areas

- Audit of Red 2 calls reviewed and felt to demonstrate the service to be safe. Audit to be repeated every quarter

The following risks and mitigations were highlighted:

- Patient safety risk noted due to prolonged turnaround times - Work ongoing with acute trusts to manage turnaround including HALO roles and some investment for additional resource

- Concerns about the lack of SpO2 monitoring and issues around "migrating" equipment – All ADOs tasked with reviewing the SpO2 monitor situation divisionally and clarification of the holding to account of individuals where equipment missing/ unreported

- Issue noted with very low numbers in audits for IPC leading to inability to gain adequate assurance – Work with the audit team to review the necessary number for assurance as well as the process to ensure fit for purpose

Key points from the meeting held on 18 January 2012:

- Review of the patient safety projects for SBAR, falls and trigger tool. SBAR and trigger tool to be reframed to try and deliver information on "unknown risks" and better support safety netting

- Sepsis project ongoing in Leicestershire. Coordination to be strengthened with Audit and research for methodology

The following risk and mitigations were highlighted:

- Risk inherent in the removal of PHT however very small risk as very little usage - Formal risk assessment to be undertaken of the options for the removal of PHT

- Issues around RIDDOR reporting and deep clean especially in Notts – Escalated to board

- Recommended change to the timescales for PALS and Complaints to be managed. Risk as very labour intensive - To be discussed at QGC

- Changes proposed to risk management audits. These could decrease assurance – Work to be reviewed with the audit team to establish appropriate numbers for assurance

Strategic IPC Group – 05 January 2012

The following risks and mitigations were noted:

- Failure to meet internal deep clean targets consistently across Divisions - Tender exercise being re-evaluated following loss of PTS Contracts

Operational Governance Group (OGG) – 22 December 2011

The following risks and mitigations were noted:

- There have been occasions where newly qualified, inexperienced Paramedics have been deployed to incidents which could cause a clinical risk and place the responder under extreme pressure - newly qualified, inexperienced Paramedics are not to be utilised on Fast Response Vehicles; this should be explicit in the Fast response Vehicle (FRV) Selection SOP

Organisational Development Group (ODG) – 10 January 2012

The following risks and mitigations were noted:

- Lack of uptake of conflict resolution training (CRT) and staff not undertaking a refresher within the 3 year timeframe. - Noted on Risk Register. Development of issue of 'CRT Information Guide' for all staff to refresh knowledge, and prioritisation of outstanding staff for attendance on the rolling programme

- Lack of completion of the Essential Education Workbook and lack of completion of Clinical Supervision and PDR and/or non submission of evidence data - Reported and reiterated compliance targets at OD Group; Executive Group; and followed up with communications to divisions and directorates to stress responsibilities and targets

- High sickness absence rates - Action Plans are in place at divisional level with HR Advisors actively pursuing sickness in divisions to support line management. The target for sickness absence for 12/13 has been agreed with Operations at 5.0% and for 13/14 at 4%. A meeting has been arranged for early February 2012 to develop a corporate action plan to manage sickness absence in line with the new lower target

- Further Industrial Action - Joint working with the Trade Unions and Business Continuity Manager

Strategic Learning Review Group (SLRG) – 20 January 2012

The following risks and mitigations were noted:

- No paper copy of ECG could be found when requested by complainant. Defibrillator monitor memory did not retain ECG recording as more than one month has passed - Lifepak 15 upgrade (due 2012) should reduce risk. Paper to be taken to Ops Governance re retention of paper copies of ECGs

- Inappropriate for members of staff to meet complainants alone as put both the individual and Trust at risk - CQM to reiterate that any welfare visits to members of the public should be authorised by the CQM. Lone worker policy in place

- Clinicians pre-judged situation allowing this to cloud their clinical judgement. 'Framing' (allowing the word of others (in this case Police) to skew professional practice) - Education ongoing re

	Framing. The Trust is continuing to work to produce an operating procedure for Police and Ambulance to work together • PRF not complete as patient was not conveyed; No PRF therefore no record of patient contact. Wider issues discussed regarding multi-person RTC where patients do not wish to travel - CQMs to convene working group to review this – possibly introduce 'scene report'. Paper to Clinical Governance Committee **After consideration the Committee noted the Record of Business of sub groups and endorsed the identified actions.**	
QG/12/23	**EMIAS CQC BENCHMARKING REPORT AND ACTION PLAN**	
	The East Midlands Internal Audit Service (EMIAS) CQC Benchmarking Report was received for consideration. EMIAS, the Trust's Internal Auditors carried out a review of processes surrounding the Care Quality Commission on-going compliance. The resulting report contained a number of recommendations together with the actions to be completed to close these recommendations. The action plan was received for review. Recommendation 2 suggested formally assigning a Non-Executive Director (NED) to lead on CQC compliance to raise the profile of the assurance processes within the organisation; assigning Non Executive 'champions' to individual areas has been discussed by the Trust Board and it agreed that this was not an approach which the Trust favoured. Recommendation 6 suggested that consideration be given to establishing internal peer reviews to provide evidence of compliance but also as a means of raising awareness and understanding amongst staff. Karen Kanee commented that it was unreasonable to expect staff to understand other areas of work in addition to their own workloads. Pauline Tagg suggested that the Executive Team could play a role in implementing this recommendation. Recommendation 7 suggested that the Trust consider using a suitable patient/public/carer involvement group to undertake an assessment of the evidence of compliance that may be collected from local service user forums or networks. Gill Newton suggested that this could be implemented through Local Involvement Networks (LINks). Karen Kanee suggested that the Foundation Trust membership events, rather than LINks, would provide a more appropriate forum. It was agreed that this recommendation should be implemented. James Gray commented that communications input would be required to progress this. It was agreed that involvement would be explored with the Foundation Trust office and recommendations would be submitted to the Executive Team for discussion. **After consideration the Committee endorsed the actions in the EMIAS CQC Benchmarking action plan , with the above exception.**	***RW***
QG/12/24	**COMMISSIONER MATTERS**	
	As Lynn Woods was not in attendance no Commissioners matters were raised.	
QG/12/25	**RECORD OF BUSINESS – ITEMS FOR ESCALATION TO THE TRUST BOARD**	
	After discussion it was agreed that the following would be included on the Record of Business for escalation to the Trust Board:	***JG/PT***

	• Ambulance Quality Indicators • Letter to Chief Executive relating to Essential Education workbooks • Patient safety concerns resulting from operational delays	
QG/12/26	**AUDIT COMMITTEE MINUTES**	
	The minutes of the Audit Committee meeting held on 06 December 2011 were received for information.	
QG/12/27	**MINUTES OF SUB GROUPS REPORTING TO THE QGC**	
	The minutes of the following sub groups meetings were received for information: • Clinical Governance Group – 16 November and 20 December 2011 • Infection Prevention & Control Group – 05 January 2012 • Organisational Development Group – 10 January 2012 • Operational Governance Group – 23 November 2011	
QG/12/28	**ANY OTHER BUSINESS**	
	No additional items of business were raised.	

Details of the Next Meeting
*04 April 2012, **13.00hrs,** Meeting Rooms 1 & 2, Trust Headquarters, Horizon Place*