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| Meeting | UHNM CQRM: M2 |
| Venue | Microsoft Teams |
| Date/time | Thursday 14 th July 2022, 12:00 – 13:30 |

| Attendees: | | |
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| Steve [REDACTED] | [REDACTED] | ■ |
| [REDACTED] | [REDACTED] | ■ |
| [REDACTED] | [REDACTED] | ■ |
| [REDACTED] | [REDACTED] | ■ |
| [REDACTED] | [REDACTED] | ■ |
| [REDACTED] | [REDACTED] | ■ |
| [REDACTED] | [REDACTED] | ■ |
| [REDACTED] | [REDACTED] | ■ |
| [REDACTED] | [REDACTED] | ■ |
| [REDACTED] | [REDACTED] | ■ |
| [REDACTED] | [REDACTED] | ■ |
| [REDACTED] | [REDACTED] | ■ |
| [REDACTED] | [REDACTED] | ■ |
| [REDACTED] | [REDACTED] | ■ |
| [REDACTED] | [REDACTED] | ■ |
| [REDACTED] | [REDACTED] | ■ |

| In Attendance: | | |
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| [REDACTED] | [REDACTED] | ■ |
| [REDACTED] | [REDACTED] | ■ |

| Apologies: | | |
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| No | Item | Action Lead |
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| 1.0 | Introduction & Apologies | |
| | <p>■ asked that due to a large number of attendees, that introductions are given when speaking throughout the meeting.</p> <p>No apologies were discussed.</p> | |
| 2.0 | Declarations of Interest: | |
| | None noted. | |
| 3.0 | Minutes | |
| | The minutes from the meeting on 16 th June 2022 were confirmed as a true and accurate reflection of the meeting. | |
| 4.0 | Action Log | |
| | <p><u>Action 69 – Culture and bullying report Action plan:</u> ■ confirmed to close. [Action Closed]</p> <p><u>Action 70 – Quarter-four Patient Experience:</u> ■ confirmed to close. [Action Closed]</p> <p><u>Action 71 – High Sickness in Midwifery:</u> ■ received a response and provided more data over the sickness reasons. [Action Closed]</p> <p><u>Action 76 - ■:</u> ■ attended the July CQRM. [Action Closed]</p> <p><u>Action 77 - Discharge Incidents:</u> ■ reviewing data indicator that goes into the report in a meeting with ■, week commencing 18th July. [Action Open]</p> <p><u>Action 80 - Quarter 3 and 4 104-day:</u> ■ agreed to send an update on the reports by Tuesday 21st June 2022. Agreed to add to the July CQRM. No updates were received. ■ to take back to ■. ■ mentioned the clinical reviews haven't been completed, however, quarter 3 will be completed by August. [Action Open]</p> <p><u>Action 82 - CEF Summary Report:</u> Paper was added to July CQRM. [Action Closed]</p> <p><u>Action 83 - Separate Staff Survey Action Plan:</u> Discussed under BRAP action. [Action Closed]</p> <p><u>Action 84 - Preventable Measures for Staff High Sickness:</u> No update provided. Not discussed. [Action Open]</p> <p><u>Action 85 – Previous Performance Reports:</u> Reports received [Action Closed]</p> <p><u>Action 86 - Patients who go straight from WMAS to SDEC:</u> ■ confirmed to close the action and pick up separately. [Action Closed]</p> <p><u>Action 87 – Investigate if IPNA will be able to interact with EPS:</u> ■ responded to ■. [Action Closed]</p> <p><u>Action 88 - Three Non-Conformities from the Radiotherapy Inspection:</u> Minor points actioned. [Action Closed]</p> | |

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| | Action 89 - CQC Improvement Action Plan add to July CQRM: On agenda and papers. [Action Closed] | |
| 5.0 | Monthly HCAI Report (May 2022) | |
| | <p>■ provided an overview.</p> <p>There have been no reported MRSAB during May. Cdiff Hospital acquired were has 7 cases during May and 2 COHA cases. There has been one clinical areas that had more than one CDIFF case with the same toxin during May within 28 days Ward 102, ribotyping results were completed but one was not grown at test centre therefore patient for patient transmission is indeterminable. Ward 102 has an action in place with a cleaning instigated. Cdiff RCA's for April is under review and almost completed. ■ will discuss with ■ when back from annual leave. No further cases for Ward 227 or Flu. Sepsis, seen a slight improvement in the emergency portal.</p> <p>■ asked for the minutes to be amended to say ■ agreed to review <u>some not all</u> of the patients held on ambulances between January and May 2022. Action.</p> <p>Currently the Trust has three clinical areas with a covid outbreak.</p> <p>■ advised there is a CDIFF meeting to review quarter 1 on the 11th August to do random samples of the RCAs.</p> <p>■ will look into the 5 patients that were not compliant within the 2 hours sepsis administration of IV ABS in the emergency portals to see what the outcome for the patient was. ■ will look into the next report. Action.</p> <p>■ mentioned there are significant sickness and gaps in infection and prevention team at around 50%. Covid numbers have increased to 202 patients, and they are also a regional vaccination centre for monkeypox. Currently prioritising infection prevention tasks. Infection Prevention team are being lead by ■ due to leadership gaps. Prioritising around covid outbreaks. ■ mentioned they want to introduce mandatory surgical infection surveillance and board assurance around Sepsis. ■ will feedback concerns around CDIFF RCAs. ■ will feedback at the CQRM in August. Action.</p> | <p>■</p> <p>■</p> <p>■</p> <p>■</p> |
| 6.0 | Brap and Roger Kline Culture report- Action Plan | |
| 6.0 | <p><u>Brap and Roger Kline Culture report- Action Plan</u></p> <p>■ gave a brief overview for the response to Culture review. Papers circulated for information.</p> <p>There was a review taken earlier this year to look at considering the recommendations and what staff felt about the report. The approach has been to arrange engagement with staff as the first stage and then move on to empowering people to engage in the changes, followed by delivering the improvement and sustainable change and make sure a difference can be</p> | |

made over a long period of time. Some staff recognised what was being said, whereas others didn't. A range of statements in the reports.

The improvement plan was configured around three big tickets. This includes re-humanising the whole organisation. There are issues to be looked at which links to employee relations and some hot spot areas were picked up in the report which needs to be looked at more closely. There is an action plan within the slides, which shows actions are from staff. There is a summary on the final slide that discusses what are seen as immediate actions underway or starting quickly.

■ mentioned that there was a culture review committee set up to oversee the Brap review action plan, along with an executive committee that was responsible to ensure a process was in place to develop the response. Now that one of the plans have been reviewed by the culture review committee, a review of the groups showed that they have completed the responsibilities and discharged responsibilities into the Trusts routine governance structure. Oversight monitoring of implementation will be with the transformation & peoples committee. An executive workforce group will link into the executive group to show what is being done at a local level.

Looking at developing a heat map that shows a range of indicators associated with the culture and showing a visual way of the effectiveness of the action plan.

■ agreed for ■ to share the presentation with ■.

■ advised ■ to add a slide regarding Governance, including some of the overview that was discussed.

■ mentioned that the hotspots shown in the review, show some areas that aren't wards/departments and isn't an impact on patients. ■ have talked about how to triangulate the sources of data. As the heat map is developed the quality of hotspots will be checked.

■ mentioned it will be helpful if a stock check is completed on how progressing in 3 months then 6 months. ■ confirmed the cultural issues are already within the plan with key development and proposed and accepted by transformation committee to a quarterly report. Can share report once started to produce. **Action**

6.1 Patient Experience Summary Report

■ gave a brief overview of the report.

Results from the Maternity survey demonstrate static in most areas in the 44 questions. No questions performed better and 6 performed worse. 2 were in one category which led to them having an overall performing worse in that area. ■ is taking the improvements forward.

The Trusts HUG group remains active. Restricted in quarter 4. Looking at getting increasing opportunities for involvement. Looking at increasing recruitment of patient lead and patient

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| | <p>safety partner. Working with [REDACTED] with regards to wider communication.</p> <p>Overall complaints increased but remains in line with other Trusts. Implemented a new triage process to make sure complaints are managed in a more efficient way. The data regarding this will be in the next report. Looked at annual breakdown which indicates that some improvements need to be made. Still breaching 40 days completion target but the complaints team have implemented a new reporting structure to measure where the complaints are in the process, so they know where to target. They have worked to process some of the older complaints.</p> <p>Pals remains busy but effective.</p> <p>Gathering friends and family data has been a challenge, but working with the wards to improve processes. Friends and family via text messaging should be implemented later this year to Maternity after final stages of IT issues.</p> <p>[REDACTED] suggested that some of the maternity result actions would be useful within the report, however, [REDACTED] has given this verbally.</p> <p>[REDACTED] mentioned patient leader involvement and patient safety partners will not merge together. Potential overlap but two separate roles.</p> <p>Patient Safety partner role personal spec and role has been confirmed and due to go out to advert. Using the same recruitment process as previously used.</p> <p>[REDACTED] mentioned a correction on page 9: Clinical Treatment, we did section, it says set staff member did move patient in but should say did not. [REDACTED] agreed this needs to be amended.</p> <p>[REDACTED] mentioned to [REDACTED] that the maternity report was completed when Covid was high and it is reflected in the report. Currently working with improvement together team.</p> <p>[REDACTED] advised [REDACTED] would have to look into the significant increase of complaints in December and March at County compared to other months. Action.</p> <p>[REDACTED] advised that friends and family in ward 218 has increased this month and once text messaging goes live, Maternity and other departments will also increase.</p> <p>[REDACTED] mentioned any serious incidents feed into the Patient Safety Group to make them aware of any incidents.</p> | |
| 6.2 | <u>Patient Experience</u> Discussed. | |
| 7.0 | Quality Assurance Report Summary (May 2022) | |
| 7.1 | <u>Quality Assurance Report</u> | |

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| | <p>■ mentioned some areas where meeting the set standard targets and other areas where we aren't like Sepsis.</p> <p>13 serious incidents reported and 1 covid definite death and 19 definite onset hospital nosocomial COVID -19 cases.</p> <p>■ mentioned on page 15, there is a narrative on increase on moderate harm. ■ mentioned the theme relates to more increases around the falls and pressure areas. ■ has asked the team to look into this. ■ will catch up with ■.</p> <p>■ mentioned that on page 19, under medication, it says incorrect syringe driver under review, however, has not yet been reported as a serious incident. ■ mentioned they are looking at whether it was a syringe or prescription error. It is currently with ■ under review. Ongoing ■ review and an investigation to be completed. Following the investigation, will look at the harm before reporting as a serious incident.</p> | |
| 7.2 | <p><u>CEF Quality Visits report</u></p> <p>■ mentioned that despite Covid and cancellations of some visits, they have maintained visits in quarter 3 and 4. Completed 35 visits. No bronze awards during those visits. A lot of wards improved despite Covid. Updated and re-looked at the tool kits and added more into the visits and some of the wards have improved in their scores. A lot more engagement from teams and asking to visit more frequently to show their developments and improvements. Details around actions that have been picked up and address the needs. Some issues were that PDRs were being completed but not being uploaded to the system.</p> <p>■ confirmed the CEF scheme covers all areas.</p> <p>■ questioned if they went to Royal Stoke ED because it wasn't shown in the report. ■ confirmed they did attend on 04th April and they achieved a silver rating, however, the report was still being finalised.</p> | |
| 7.3 | <p><u>CQC Action Plan</u></p> <p>■ mentioned they have reviewed the recommendations from CQC and identified 35 actions to complete. 45.7% complete, 48.6% on track and 2 actions have problems relating to the 15 minute assessment at ED and compliance with training. There is a list of the summarised actions in the action plan. There is a focus on what to do against those actions for quarter 2.</p> <p>■ mentioned there are 31 individual actions to do with 19.3% complete and 77.5% on track. One action with problems around recommendation to make speech and language therapy across County.</p> <p>■ to speak to ■ regarding the action plan saying 15 minute target with actions but on the Excel document it says will be monitored but doesn't say what will improve compliance with target.</p> <p>■ clarified that Speech and Language go across to County Hospital when a referral made, however, due to the capacity within the team, there are delays on both sites. ■ advised that</p> | |

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| | <p>■ mentioned Covid was a contributor to the falls numbers during peaks and waves which saw an increase in falls and numbers with a number of contributory factors..</p> | |
| 11.0 | Mortality Report (May 2022 Front Sheet) | |
| | <p>Report received in the papers.</p> <p>■ reviewing the mortality report with ■ which will go to the Governance Quality Committee. When agreed will bring to CQRM quarterly and feed up to Trust board.</p> | |
| 12.0 | Forthcoming UHNM External Reviews | |
| | <p>■ mentioned he is not aware of any forthcoming UHNM external reviews.</p> | |
| 14.0 | Any Other Business | |
| | Nothing to discuss. | |
| <p><u>Next UHNM CQRM: (M3)</u> Thursday 18th August 2022 at 12.00 pm to 2.00 pm Via Microsoft Teams</p> | | |
| <p><i>Please note: Committees must operate on the understanding that the formal record of any meeting (this includes minutes, agendas, recordings, and papers) may be subject to Freedom of Information requests.</i></p> | | |